HMA

HEALTH MANAGEMENT ASSOCIATES

Blue Print for a Community Based Mental Health System in Douglas County

PREPARED FOR
THE DOUGLAS COUNTY MENTAL HEALTH INITIATIVE

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Background

The Douglas County Mental Health Initiative (DCMHI) is a partnership of over forty organizations committed to finding solutions to provide effective, coordinated mental and substance use healthcare services for Douglas County. DCMHI launched in June of 2014 with support from Douglas County Commissioners and Douglas County staff, following a series of tragic events in the community. DCMHI sought to address unmet mental health needs, connect people to mental health services, and prevent those in need from falling through the cracks of the mental health system. DCMHI began by identifying existing gaps in the mental health delivery system. Gaps were found related to serving individuals having a mental health crisis, clinical support for the Office of the County Attorney who was managing 250+ petitions for involuntary commitment and certifications per year, and the early identification of children experiencing a behavioral health issue. DCMHI focused its initial programming on addressing these gaps with development of the Community Response Team (CRT), the Mental Health Navigator Program, and Project Upstream.

The CRT is a co-responder model, consisting of a specially trained law enforcement officer and licensed mental health clinician. Together, the team responds to 911 calls with a primary concern related to mental health or substance use. The team's goals are to avoid emergency department placement for a mental health hold (M-1) for the purpose of medical clearance and placement planning in a safe environment; avoid criminal justice charges for individuals whose primary issue is a mental health concern; lessen the burden on first responder systems to respond to mental health crises; and effectively connect individuals to appropriate behavioral health services with a response that is designed to meet their needs.

The Mental Health Navigator Program is a partnership between the DCMHI and a local psychologist's office to provide clinical support for the Office of the County Attorney (OCA). The OCA is, in part, responsible for the County's legal engagement for all Involuntary Commitment and Certifications. The Mental Health Navigator is a master's level clinician who provides direct clinical case management and support for individuals, and their support system, who are the subject of a mental health proceeding. Both CRT and the Mental Health Navigator Program have made a meaningful impact on improving mental and substance use disorder healthcare services for Douglas County residents.[1]

Project Upstream is a school-based program for children and their families when the child is showing early signs of behavioral health issues. The program is implemented in all Douglas County Middle Schools and is overseen by the Douglas County Youth Initiative.

[1] Community Response Team, *Annual Report: May 8, 2017 – April 30, 2018* (Douglas County, CO: Douglas County Mental Health Initiative, 2018), https://www.douglas.co.us/documents/crt-annual-report-may-2017-to-august-2018.pdf

In 2018 DCMHI purchased case management software, Julota, to collect and share relevant information necessary for care coordination. Julota has the ability to connect to the databases of other organizations to support information sharing between partners.

Since its inception, the DCMHI has achieved much success, particularly with its work in response to mental health crises. This success, and the unique collaboration of the DCMHI, is drawing national attention and holds the promise for even greater gains in addressing mental health and substance use in Douglas County. In the summer of 2018, Douglas County hired Health Management Associates (HMA) to support development of a community based mental health care delivery system. The following report describes HMA's approach to gathering the information necessary to inform the county's mental health care delivery system model, the model determined by DCMHI to be implemented, and a blue print for implementing the model. The model and blue print for implementation were developed in an iterative, stakeholder-driven process. The model is county-based and intended to support education and resources to the general population, improve the health of individuals with mild to moderate mental health issues, as well as connect and convene intensive and wrap around services for those with significant and complex conditions. The model design is payer blind, that is all elements of the continuum are available regardless of payer.

Approach

Phase One: Collect and review relevant data

HMA used a two-pronged approach to review relevant data. The first prong was a review of any existing quantitative data related to existing services within the DCMHI. This included mostly data from the CRT and Mental Health Navigator program. Other quantitative data included a brief review of Colorado public reports from the All Payer Claims Database and Douglas County public health data and reports.

The second prong was qualitative stakeholder engagement in multiple formats including surveys, interviews, and focus groups. Initially, the stakeholder input focused on a few key areas:

- ✓ The overall strengths of the mental health continuum of services from prevention to treatment existing in the County;
- ✓ Gaps in services or populations that needed specific programs or services that were unmet in the County;
- ✓ Strengths and challenges of the DCMHI and key priorities for the future;
- ✓ Specific solutions or ideas about how to improve the gaps in services and improve the work of the DCMHI; and
- ✓ Long-term vision for the DCMHI

Phase Two: Explore potential models and develop preferred model

HMA took the data (both quantitative and qualitative) from Phase 1 to develop themes about the future of the DCMHI. HMA then developed a vision statement and a model of care that incorporated all the areas of opportunity outlined by the stakeholder feedback. The model focused on three primary areas including expansion of the prevention and community-based services for the public; expansion of engagement of primary care to enhance integrated care; and expansion of specific programs in the specialty behavioral health system of care. HMA also offered a potential governance structure of Collective Impact to support the ongoing collaboration of the DCMHI in moving the vision and the model forward.

Stakeholder engagement has been an ongoing part of the project, again leveraging multiple formats (surveys, work group meetings, and facilitated activities with the whole DCMHI). The groups have provided feedback to:

- ✓ The draft vision of the DCMHI;
- ✓ The specific programs already existing in each areas of the model (community, primary care, and specialty care);
- ✓ Gaps in each area of the model as well as ideas for expansion of services;
- ✓ Prioritization of work in each area of the model; and
- ✓ Individual organization interest in, concerns about, and other feedback regarding the model and priorities chosen by the group.

Phase Three: Develop implementation plan (blue print) for preferred model

HMA worked with stakeholders from a working group of the DCMHI and the larger DCMHI membership to refine the implementation plan, including identifying and prioritizing activities.

Data Review

HMA staff reviewed county data from the CRT and the Mental Health Navigator Program, population health data, and to a limited extent, Medicaid cost-related data and state level healthcare utilization data from the All Payer Claims Database.

The most recent CRT quarterly report for September-December 2018[2] revealed that welfare checks with a behavioral health component and suicidal subjects represented the most frequent type of incident involving CRT response (39% and 27% of the 179 calls respectively). Forty-eight percent of the suicidal

[2] Community Response Team, *Quarterly Report: Sept. – Dec. 13, 2018* (Douglas County, CO: Douglas County Mental Health Initiative, 2018), https://www.douglas.co.us/documents/crt-quarterly-report-sept-dec-13-2018.pdf

subjects were youth and 29 percent were young adults. Fifty-six percent of the suicidal subjects were male. This trend echoes what was shown in the May 2017-April 2018 annual report.[3]

Data from the Tri-County Health Department 2018 Community Health Assessment[4] showed that mental health and access to mental health care ranks among the top health concerns for Douglas County residents. There was a steep increase in the rate of suicide between 2006 and 2016 in Douglas County. The rate of suicide in the County between 2014 and 2016 was highest among men, at a rate of 28 per 100,000; and the white, Non-Hispanic population at a rate of 17.1 per 100,000 followed by 13.7 per 100,000 among the Hispanic population. In 2016, suicide death was most common among people aged 65 years and older at a rate of 27.6 per 100,000. This does not align with the CRT data showing most of the suicidal calls to which CRT responded involved youth and young adults, suggesting that those 65 years and older may not be expressing suicidality, may not be calling for help, or may not be with someone who can call for help. Also, of note, in 2016, 52 percent of all suicide deaths in Colorado involved a firearm, and in Douglas County 60 percent involved a firearm.

In the time span of 2011 - 2016, between 15 and 20 percent of adult respondents to the Behavioral Risk Factor Surveillance System reported binge drinking (4 + drinks per occasion for women; 5+ per occasion for men) and between five and 10 percent reported heavy drinking behavior (8+ drinks per week for women and 15+ for men).[5] Following similar patterns across the state and U.S., Douglas County saw an upward trend in overdose deaths related to opioids (prescribed and illicit) between 2001 and 2016, as well as a sharp increase in overdose deaths related to Methamphetamines in 2014.

The DCMHI would need to prioritize data collection and analysis from multiple sources to get a better understanding of mental health and substance use issues in Douglas County, including health care utilization, associated costs, and population health outcomes of mental and substance use disorders.

Key Informant Interviews

DCMHI leadership helped HMA to identify key informants with whom to have in-depth conversations about questions like those asked during the focus group discussions, including: what is and is not working well in the county in terms of behavioral health prevention and treatment, priorities, and opportunities and barriers for the DCMHI. At least one key informant was identified from each of the five sectors including: law enforcement, judiciary, providers, county government, and community organizations. In total, 17 interviews were conducted by phone. As the DCMHI begins implementation of their plan for a community based mental health system it will be important to continue seeking input from additional stakeholders, including but not limited to school-based partners.

[3] Community Response Team, *Annual Report: May 8, 2017 – April 30, 2018*
[4] Tri County Health Department, *2018 Community Health Assessment,* (June 2018), http://www.tchd.org/DocumentCenter/View/5134/TCHD_Community-Health-Assessment-2018?bidId
[5] Ibid

Focus Groups

HMA staff conducted focus group discussions with DCMHI stakeholders to understand what is working well in the county regarding behavioral health prevention and treatment; what gaps or pain points exist; ideas or solutions for addressing the gaps or pain points in the short and long-term; how to maximize or enhance what is working well; the long-term vision for the DCMHI; and priorities for that vision. HMA staff separated DCMHI stakeholders into groups based on knowledge, experience, or work within the DCMHI. Groups included first responders, judiciary, providers, county government, and community organizations.

Online Surveys

HMA disseminated two online surveys throughout the project period. The first, disseminated early in the process, was done so with the goal of gaining a better understanding of the perspective of DCMHI stakeholders regarding goals for the community behavioral health system, including potential barriers and opportunities. The information from this survey supplemented information collected through the key informant interviews and focus group discussions. The second survey was disseminated toward the end of the process and was intended to give participants a final opportunity to share feedback or thoughts about the model, including concerns, apparent gaps, ideas about what should be prioritized, key partners, and key implementers. Participants were asked to respond from both an individual perspective and from the perspective of their organization.

Summary

Overarching themes about the future of the DCMHI and the future of the model are highlighted here. Specific feedback about the strengths and opportunities for the system of care as well as specific populations in need is reviewed below.

Stakeholders remain committed to the DCMHI with a sense of pride in the breadth of membership and the strength of the collaboration over numerous years. Although many stakeholders wanted a broader vision for the work so that it included more than the CRT, the importance of doing the work collectively was high-lighted numerous times.

There was a lot of consistency among stakeholders about framework or principles of a future model including that it needs to be:

+ Sustainable;
+ Adaptable;
+ Collaborative;
+ Forward Thinking; and
+ Decrease Stigma Around Mental Health

These are many of the words used to describe the existing work of the DCMHI and stakeholders are committed to keeping these core elements central to the future regardless of the focus of specific services.

Sustainable

All stakeholders believe that development of services that can be maintained over time is vital and there is recognition of the need for diversified funding for the services designed. Many see opportunity for the services to provide revenue or enhanced financing for service providers or other key partners within the model. However, determining the funding and financing of services is seen as one of the challenges potentially moving forward and there is recognition that it can create tension among the partners.

Stakeholders viewed setting the right governance structure as central to maintaining the culture of collaboration among the DCMHI members-critical for sustainability. Many members did not have a formal governance structure in mind, however commented on the need for clear leadership, identified roles and responsibilities of the members, a collaborative framework for program design and implementation, and engagement of additional sectors and members in the next phases of work. Many commented on the concern that the governance structure needed to be more formalized and "institutionalized" to ensure that as individual organizational leaders moved away, the collaboration of their organization and the initiative overall would not be impacted.

Another common theme was the differences in regions of the County and some of the geographic differences in need or level of existing services. This led to conversations about scalability and replicating programs that work in multiple locations in the County. CRT is a good example of this with many members commenting on the need to expand the service to regions that are further from the CRT teams.

Adaptable

A foundational component of the history of the DCMHI is its adaptability and capacity to focus energy and resources on what's needed. The initiative is not seen as static or overly focused on any one area (even though most of the resources have been focused for a few years on launching CRT). Members of the group see the initiative as evolving and capable of adapting to need while remaining data driven. There is also agreement among stakeholders that although the initiative started with CRT, there are many populations that can benefit from the same concerted collaboration and that the initiative can prioritize those and build services that support both the public and specific sub-populations with identified needs.

Collaborative

As part of building a more formal governance, there was a clear understanding of the need to include more partners for the future—particularly as the DCMHI expanded its reach beyond CRT to a larger

system of care. Sectors that were frequently noted as important included the private business sector, local businesses and employers, more general population community members such as family members, the service sector, and individuals with lived experience of mental health and substance use. The members want to build greater engagement and buy-in particularly for the general population to support long-term culture change.

Stakeholders also mentioned the importance of evaluating the work that is completed and having data on the work of the DCMHI. This was often tied to a way of measuring collaboration, performance on meeting goals, and capturing processes that supported strong outcomes. Evaluation and strong shared accountability within the initiative are best practice for the process of how the group works together to achieve shared goals. Shared measurement is a key component of the governance structure described later in this report and which DCMHI will put in place. This requires partners of the DCMHI to commit to identifying appropriate measures of success and to sharing information with one another in a structured and consistent way.

Forward Thinking

Stakeholders view the DCMHI as innovative and forward thinking and there is genuine commitment to maintain that approach for any vision of the future. There is pride in building services that are grounded in research and evidence based, best practice approaches and in being a model for other counties in Colorado and nationally. In this vein, the members of the DCMHI want to remain action oriented and "get things done" through implementation of new services rather than simply talking about change. There is understanding of the work ahead but a clear shared belief that the DCMHI can achieve tangible progress.

Other themes in this area included leveraging technology to meet the needs of individuals either through new apps or programs for the public or through tele-health and spreading of services virtually. The initiative is not merely a brick and mortar opportunity for most members with a focus on spreading programs and resources across the county. There may be specific brick and mortar programs in the future, but the goal is to leverage innovation and technology to spread even those hubs creatively. Finally, the members of the DCMHI are interested in exploring more prevention and early intervention for individuals with mental health and substance use needs, as well as examining ways to impact upstream factors to reduce risk and promote health before early intervention is even needed. Innovations such as public health campaigns and integrated behavioral health in primary care are examples of this work.

Current Mental Health Delivery and Funding System

Following highly public and tragic events involving individuals with mental health needs, in June of 2014 the Douglas County leadership decided to spearhead an effort to bring together community and strengthen mental health services in Douglas County. In the last four years, the work of the DCMHI has

been significant in building on the strengths of the existing services and expansion of identified gaps and needs, most specifically crisis services and care management. As part of the CRT program, the County has also expanded access to outpatient therapy following crisis contact.

Strengths and Opportunities

Based on stakeholder feedback and review of existing services, HMA has identified the following strengths of the current system, as well as areas for ongoing development.

Strengths

There are many strengths to the behavioral health system in Douglas County. By far the most frequently mentioned strength by stakeholders is the Mental Health Initiative itself and the ability for multiple stakeholders to collaborate on behavioral health issues. The initiative's development of the CRT program is seen as an example of addressing significant gaps and as a model for how the partners can work together to create change in the County. Stakeholders also see the initiative as being data driven and action oriented which has built buy-in and motivation for the partners involved, as well as other stakeholders.

The CRT program received a lot of attention from stakeholders about the value of diversion from criminal justice and emergency departments/inpatient settings, in addition to providing a new access point for individuals to receive care. The care management offered to individuals who contact CRT was viewed as a strength in bridging services and enhancing follow-up with referral. Because of the CRT program, many see strength in the diversion, re-integration, and law enforcement engagement around behavioral health[6]. Law enforcement understanding of mental health and substance use and the institutionalization of responding—understanding the challenges in the delivery system - were highlighted numerous times. For example, the Sherriff's Office is providing workshops and community seminars on drug use, suicide, and emotional well-being.

Similarly, the commitment of County employees and non-traditional partners was frequently mentioned. The County Attorney was acknowledged for unusual support to complex cases with many stakeholders commenting on the commitment of County leadership to find alternatives for individuals with significant behavioral health conditions. The collaboration of faith-based organizations and other community-based entities was seen as another strength. There was also an overarching agreement among stakeholders to reduce stigma, discrimination, and isolation of those with serious mental illness—wanting to have a community that is more accepting of individuals across the continuum of behavioral health need.

Other areas that were noted as strengths included recent efforts by multiple providers to improve access to outpatient behavioral health services through expansion of services, opening of new offices,

[6] Community Response Team, *Annual Report: May 8, 2017 – April 30, 2018*

and work to expand access for individuals with commercial insurance coverage. Similarly, emergency departments in the area were seen as an ally by stakeholders in supporting the CRT program, crisis services, and the community and in working collaboratively to solve problems.

Additional specific programs that were identified as strengths in the community come from across the behavioral health continuum from public health to specialty programming:

- Let's Talk Colorado, a stigma reduction campaign;
- Youth suicide prevention efforts;
- School programming aimed at raising awareness and normalizing talking about emotions and mental health;
- Expansion of Assertive Community Treatment (ACT) teams for individuals with serious mental illness and often criminal justice involvement; and
- Care management within judicial courts in some areas of the County.

TABLE 1. ADDITIONAL STRENGTHS AND SPECIFIC SERVICES IDENTIFIED IN CURRENT SYSTEM

1. Existing system for collecting quantitative data that can be utilized and expanded upon
2. Media stories in local sources that elevate mental health and substance use disorders as issues, helping to raise awareness and normalize the topics
3. Plethora of existing services and programs that can serve the needs of the Douglas County community including, but not limited to: recreation centers, libraries, NAMI, Oasis, Alternatives Pregnancy Clinic, Rotary Club, the Parker Task Force, Douglas County Youth Substance Abuse Prevention Coalition (DCYSAP), You are Not Alone Mom2Mom (YANA M2M), and Court Appointed Special Advocates (CASA)
4. Existing primary care programs including Parker Family Care, UC Health, Kaiser Permanente, Douglas County Health Access, and other primary care clinics across the county
5. Specialty mental health services including Medication Assisted Treatment, counseling, residential services, a community mental health center (AllHealth Network), outpatient medical detox, intensive in-home services, and other behavioral health programs
6. Culture change that has occurred with law enforcement, both with crisis intervention training and in probation culture
7. Work towards information sharing that has occurred with the partnership with Julota and CRT

Gaps and Opportunities

In addition to the many strengths of the current system, stakeholders described numerous areas for development and improvement. Some of these opportunities exist in various parts of the continuum (general population need or specific programs for individuals with serious mental illness) and by specific

sub-populations (e.g., youth, young mothers, and individuals with intellectual and developmental disabilities). The opportunities are outlined by these categories.

Prevention and Community Based Efforts

Many stakeholders commented on the need for greater prevention of mental health and substance use efforts in the County. As is often pointed out, the services and treatment systems get the focus of development and prevention is a lower priority. Stakeholders expressed the need to have a better understanding and awareness of both risk and protective factors for behavioral health conditions, as well as a need to change the culture in the County around emotional wellness.

The need for a campaign for culture change or "re-branding of mental health" was one of the most consistent themes across stakeholders. There is broad agreement that the County's demographics, generally speaking, have high expectations and considerable internal and external pressure associated with high status in work and social life, and this pressure results in high levels of stress, depression, and anxiety. Stakeholders believe there is both a lack of awareness or understanding of behavioral health conditions, as well as stigma preventing individuals from seeking support. For some populations within the County, mental health and substance use take on almost "taboo" status and are not discussed or shared. This culture leads to individuals only seeking services at the point of an emergency.

Many stakeholders want to see more community based and even in-home services for the general population to develop greater awareness of health and wellness with emotional well-being taking a central role. Specific services identified in this realm included technologies or in-home counseling, public health screening, training of community partners to identify symptoms, and a campaign to normalize emotions and mild behavioral health issues. Many stakeholders believe that there needs to be an effort to change the language used to avoid talking about mental health or substance, and rather, simply discuss health and wellness. Many of these ideas fit within a public health framework while others are more in the spirit of community organizing and social events.

Stakeholders acknowledged that central partners in this broader community effort included the business sector and employers and primary care providers. There was also specific mention of increased screenings and education about behavioral health in primary care. Many acknowledge that Douglas County residents would likely be more open to receiving services and or information from their primary care provider than from a mental health provider.

Specialty Behavioral Health Services[7]

Despite efforts to enhance access to specialty behavioral health services, there was broad agreement that there remain challenges with access to services. Some of the most frequently raised concerns in terms of capacity were access to psychiatric services (especially for children and adolescents) and the need for more telepsychiatry. Additionally, stakeholders see the need for greater choice in services that accept commercial insurance. The network adequacy for Medicaid is viewed as better than for individuals with commercial insurance and the County's population is primarily commercially insured (with only 7% of the population being covered by Medicaid). Many mentioned that there is a need for a concerted assessment of the need and the current capacity across behavioral health providers (e.g., examination of waitlists, services requested, and population trends in need), rather than relying on a sense of capacity. There was also discussion of looking at utilization of services by payer to have a clearer sense of the type of services that need to be developed.

Other specialty behavioral health services identified as growth opportunities included greater access to inpatient psychiatric beds, long-term intensive services, and higher wrap around services that prevent individuals from returning to crisis quickly after returning to the community. Additionally, more robust case management and care management for individuals with co-occurring conditions (e.g., a mental health diagnosis and an intellectual or development disability) is needed to support individuals and families in navigating the system and getting the right services.

Specific Populations in Need

Youth

There are also specific populations within the County that stakeholders identified as needing different or additional services. One of the most frequently mentioned was youth who, despite what schools have been doing, are experiencing high stress, anxiety, and depression. There was also some concern about substance use among youth, however stakeholders identified not knowing what youth were doing with substances in the County. A needs assessment completed by the Douglas County Youth Substance Abuse Prevention Coalition[8] compared data from the 2013 and 2017 Healthy Kids Survey (Douglas County did not administer the survey in years between 2013 and 2017). This comparison revealed a sharp increase from 11.5 percent to 41.1 percent in the number of high school respondents (9-12th grade) reporting vaping tobacco. There was also a statistically significant increase in the number of respondents who reported symptoms of depression, a risk factor for substance use (21.5% in 2013 to 27.6% in 2017). Self-reported binge drinking in the previous 30 days also increased in a statistically significant way among high school respondents, increasing from 13.8 percent to 16.1 percent. This mirrors an increase in binge

[7] Specialty behavioral health refers to the continuum of services developed for individuals with diagnosed mental health and substance use conditions. This includes everything from crisis services to outpatient therapy as well as specialized treatment for individuals with serious mental illness or serious substance use conditions.
[8] Tri County Health Department, Douglas County Youth Substance Abuse Prevention Coalition*, Community Needs Assessment*, (November 2016), https://www.dougcoprevention.org/community-needs-assessment/

drinking among adults in Douglas County between 2014 and 2016 (14.7% in 2016 to 17.5% in 2016) as reflected in data taken from the Colorado Behavioral Risk Factor Surveillance System. Gathering ongoing data from these sources to track trends and patterns in youth and adult substance use and mental health is an important next step for DCMHI.

There is considerable concern about the suicide rate among youth and a concern about how to prevent and improve youth awareness on the risks for suicide. Stakeholders described the same culture of high expectation, intense performance in school, athletics, and other activities, and a pressure to succeed—all while not acknowledging stress as a primary concern for youth. Behavioral health providers also see the pattern and stated that they have seen youth volume and need for services increase in the last few years.

Once youth are in crisis, there are limited resources for inpatient treatment, forcing many children and youth to experience emergency department "boarding" or long waits for appropriate placement and treatment. The County has seen higher rates of children and adolescent crisis and many see this as a growing concern and need for service development. The CRT reported 620 encounters with 395 unique individual children and adolescents in 2018. Services ranging from prevention and development of protective factors to specific crisis and inpatient programs were mentioned by stakeholders with many seeing a focus on youth in the County as a central strategy for overall prevention of conditions in the future. Of critical importance is the need to leverage Medicaid resources for children and adolescents in need of care.

Mothers

Another group identified as being socially isolated and experiencing depression and potentially substance use are mothers in the County. Particular concern was raised for women with post-partum or maternal depression who may not feel comfortable seeking help or who may not recognize the need for services. Data from the Pregnancy Risk Assessment Monitoring System showed that 22.7 percent of women reported feelings of depression often or sometimes and 20.9 percent reported having three or more stressors during pregnancy. Stakeholders had many ideas for this population including mental health and substance use education for mom groups (like YANA M2M), baby groups, and neighborhood associations (e.g., Highlands Ranch Next Door). Many believe the best services will be community based with engagement and education occurring in the social environment and social fabric surrounding families.

Individuals with Complex and Co-Occurring Conditions

Although a small population within the County, individuals with complex serious mental illness, individuals with serious mental illness and criminal justice involvement, individuals with intellectual and developmental disabilities, and individuals with serious substance use conditions or combinations of these conditions do not have adequate services in the County. There are particular complexities for some of these populations in eligibility for specific programs, consistency in insurance, and access to

long-term services. One of the specific areas of need is for treatment providers who can hold and provide treatment to individuals who are Certified for Involuntary Outpatient treatment or individuals with an Imposition of Legal Disability. Although there has been improvement in this realm, there is need for additional services.

There is also a need for case and care management for these populations. Although the Regional Accountable Entities (RAEs) provide care management for individuals covered by Medicaid, there are challenges when a person moves on and off of Medicaid or on and off of commercial insurance as care management is payer specific. This makes consistency in care planning and transitions into the community a significant challenge.

Douglas County is also lacking specific services designed for individuals with behavioral health conditions and co-occurring intellectual and developmental disabilities which is a challenge across the State. This is in part due to funding and regulatory silos that create separate systems of care, making it difficult for individuals with co-occurring conditions to obtain the right mix of services.

Substance Use Continuum

Although many stakeholders referred to mental health and substance use services together, there were specific needs identified for individuals with substance use conditions. In general, stakeholders mentioned the need for a more complete continuum of services with additions in prevention, withdrawal management, intensive outpatient therapy, Medication Assisted Treatment (MAT), and recovery services (support groups, sober living or recovery-based living, etc.). This may be an area where additional assessment and evaluation could help identify the specific populations and service needs. Included in this additional assessment would be further examination into the need for withdrawal management as HMA heard mixed opinions on this subject. The data from the existing withdrawal management center available to the county (located in Aurora) may indicate that additional services are not warranted for other locations in Douglas County. However, information from interviews with law enforcement would indicate that there is a need for a closer option for withdrawal management as law enforcement does not have the time or capacity to take individuals in need of these services to Aurora, which means they are taken to emergency departments or back home instead.

TABLE 2. ADDITIONAL GAPS OR SERVICES IDENTIFIED AS NEEDED IN CURRENT SYSTEM

1. The barriers to access crisis intervention training due to the fact that the training is intensive and has a waitlist, which also signals the need for more trainings
2. Lengthy wait times between a patient's evaluation and their scheduled appointment
3. A lack of adequate public transportation throughout the County
4. Need to do more outreach targeting men and boys about their mental health (Tri-County working on this by testing male-specific language for Let's Talk Colorado)
5. Need to expand community engagement to include stakeholders such as businesses/employers, the faith community, and consumers/people with lived experience

6. Need for creative solutions beyond therapy and to look beyond the "one size fits all" model of treatment to one that can respond to the ways people want to get help (the County would need to gather information about how people want to get help)
7. Lack of services for additional underserved populations – I/DD, autism, traumatic brain injury, adults with dementia, and individuals with eating disorders
8. Lack of qualitative data that can be used to highlight successes of the work and illustrate the benefits to the community
9. Need for medication management and overall increase in access to medications
10. Increased access to telehealth services
11. A walk-in crisis center and crisis stabilization unit
12. Need for transitional and/or supportive housing
13. More programs/services that are focused on harm reduction
14. A centralized "one stop shop" for mental health services, linked to a 211 for services specific to the county

Challenges

Throughout the project, stakeholders identified some large systemic, often statewide and national challenges that impact the strength of the behavioral health system in the County. These overarching challenges impact capacity and access to care as well as funding of and innovation in services. Examples of these kinds of challenges include:

- Workforce adequacy for mental health providers generally, and in particular for psychiatry, which is a national concern and may be contributed to in Douglas County by the cost of living;
- Payer and insurance churn and the complexity created by each insurance and public health coverage option having unique eligibility requirements, benefit packages, and service arrays associated with it;
- Growth of the County overall and impact on behavioral health service capacity, as well as a sense of intensifying acuity and severity in behavioral health need as individuals move from urban to suburban areas;
- Changing demographics and increasing challenges around social determinants of health including transportation, housing, and economic stability; and
- State and Federal policy and regulatory requirements (such as Medical Necessity, siloed funding streams for specific populations, etc.) that make development of services, system changes in funding or functionality, and navigation of systems for individuals challenging and costly in terms of human impact, County resources, and health outcomes.

Community Based Mental Health System

The model below is designed to represent a long-term system of care that meets the needs of Douglas County and that builds on the strengths and existing services while improving gaps in care. The model is not designed to be final or to be prescriptive—rather it is a framework for the DCMHI to use in building a networked and integrated delivery system. The specific programs developed and the areas of focus for the DCMHI will evolve and change over time as one of the key tenets of the DCMHI is continuous improvement. The DCMHI will continue to prioritize and adapt the services designed and built across this continuum of services.

Vision

The DCMHI envisions a community based, integrated mental health system that is person and family centered, promotes health and prevention, and meets the continuum of mental health and substance use needs in Douglas County. DCMHI is committed to a system of care that offers a broad network of providers, is adaptable and innovative in meeting individual needs, can be sustained and is data driven and grounded in continuous performance improvement. DCMHI values collaboration and engagement with community partners.

Guiding Principles

- Engage and listen to individuals with lived experience (individuals with mental health or substance use conditions who have directly experienced services) to inform services and system improvement;
- Strive for a system of care that meets the needs of individuals across the continuum from prevention and health promotion to serious conditions regardless of payer;
- Envision a networked approach to behavioral health that has “no wrong door” for entry and provides access to services at the right time and at the right level of care;
- Strive to create a “no fail” system ensuring that no individual in need falls through the cracks;
- Leverage the existing work of the initiative including government resources, structures, and systems as well as existing partner locations and programming;
    - Collectively identify where services already exist and are being met by providers and partners;
    - Collectively identify gaps in the system and a process for development;
- Build the continuum in incremental and tangible steps based on shared community priorities;
- Develop an intentional culture change and communication strategy geared at improving awareness and understanding of the role emotional well-being plays in health for the general population;

    - Simultaneous and aligned with program and service development;
    - Could be modeled after other successful cultural shifts and best practices (for example work done by public health department); and
- Engage technology to support culture change and system development.

Continuum of Care: A Stepped Approach

The framework of stepped care provides a structure that aligns with stakeholder feedback regarding the need to develop services for both the general population and for individuals with identified and more serious behavioral health conditions, as well as the desire of the DCMHI to provide the right level of service for individuals. The model outlined below provides a framework for developing a full continuum of services to meet individuals across the full spectrum of behavioral health need.

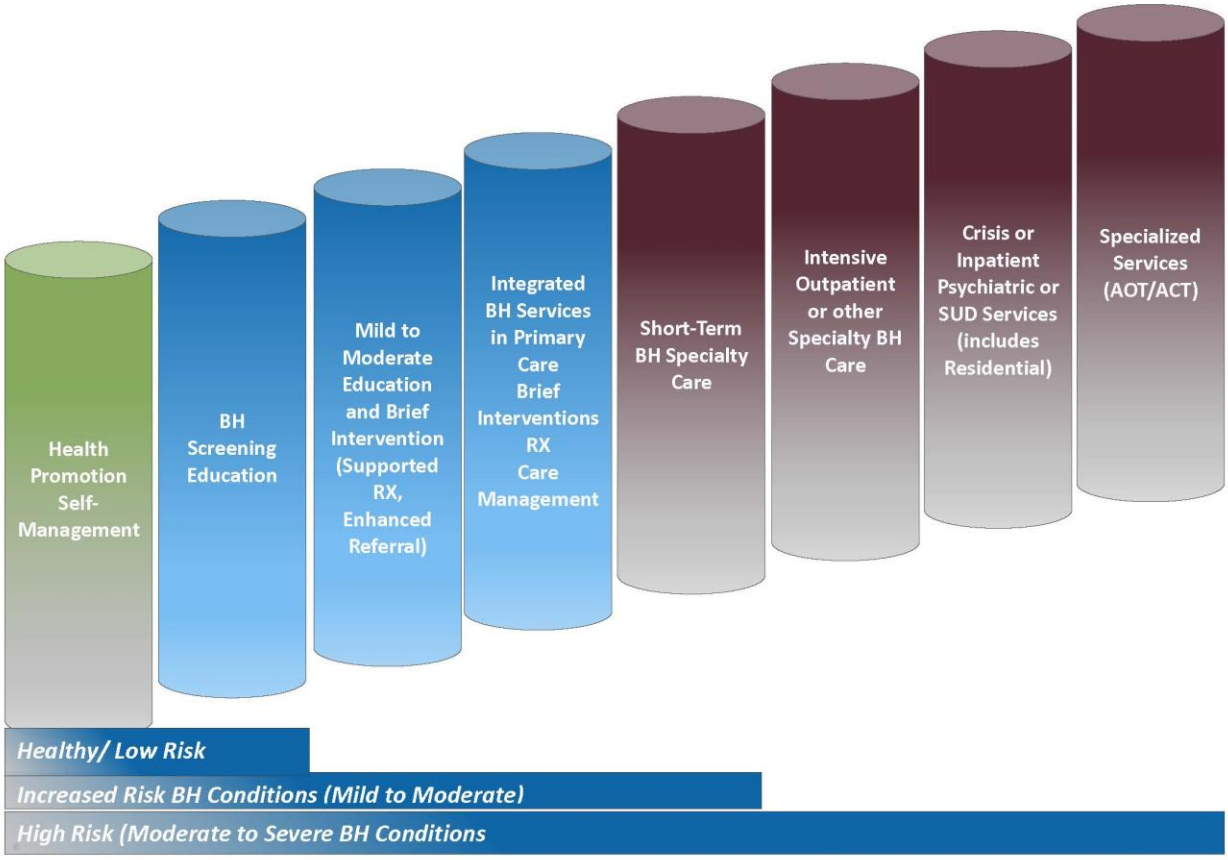
A primary goal for the DCMHI is to expand capacity to offer the right service at the right time and at the right level of care for individuals in Douglas County. The framework of stepped care ensures that more services are offered for individuals to improve prevention, early intervention, and treatment of health conditions. This is a central strategy for addressing current gaps in care.

A central tenet of stepped care (Von Korff and Tiemens, 2000)[9])is that more "steps" or levels of care are offered early on in care and closest to the community to improve prevention and early intervention for emerging health risk and acuity. As a behavioral health need advances, stepped care ensures there are more "steps" built within the community, primary care, and specialty care continuum to prevent increasing risk, acuity, and utilization of acute care services. Individuals can always step immediately to the highest level of care if risk and acuity require that level of care.

Additionally, the goal is that individuals can move fluidly up and down a continuum of services as risk and acuity increase or decrease. The treatment level and intervention (step) will be paired with the individual level of acuity to provide effective care at the lowest level of care, reducing overutilization of resources and reducing impact on individual lives. The goal is to meet individual need at the lowest level possible while ensuring high quality results.

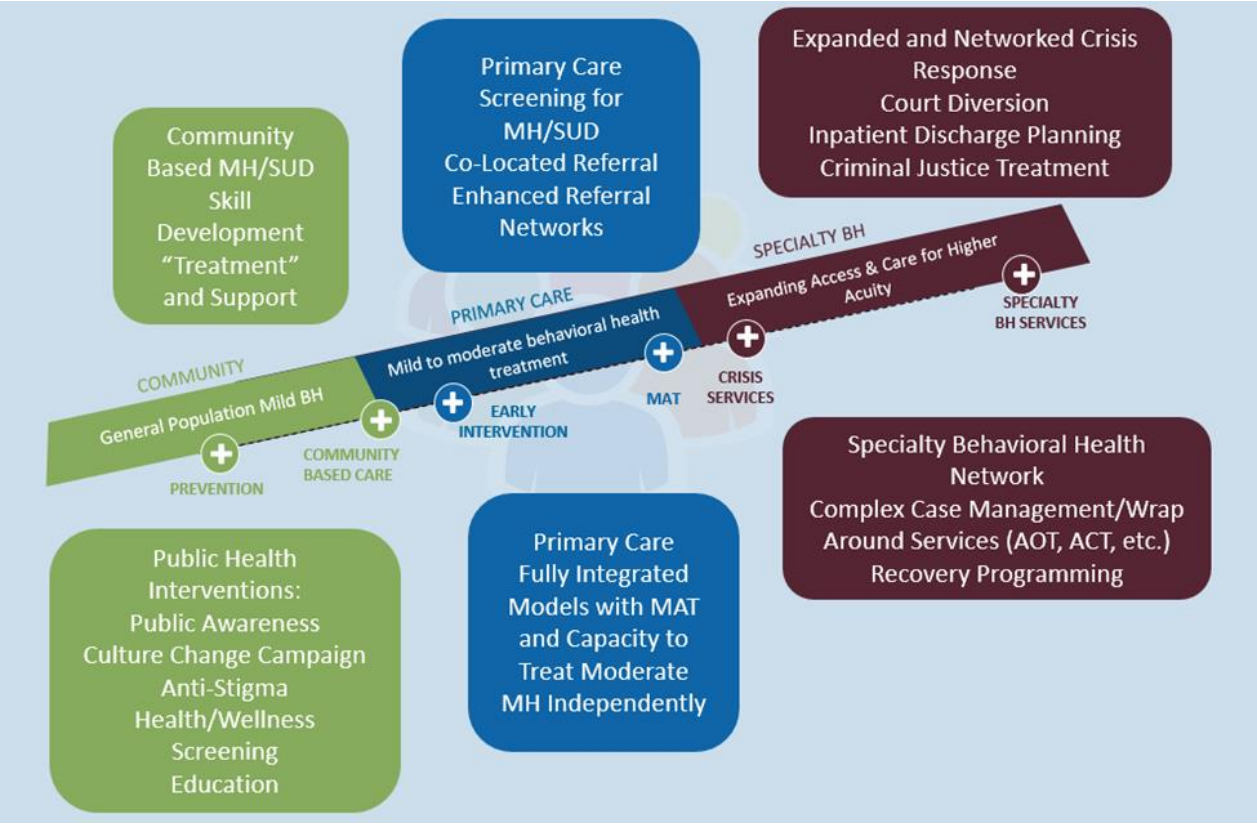
[9] Von Korff, M. & Tiemens, B. (2000). Individualized stepped care of chronic illness. *Western Journal of Medicine, 172*(2), 133-137.

FIGURE 1. STEPPED CARE



For Douglas County, a stepped approach means building services in the community, advancing the integration of behavioral health in primary care, and expanding services in specialty behavioral health.

FIGURE 2. DCMHI MODEL FOR STEPPED CONTINUUM OF SERVICES



Community Based System

In taking a population health approach and striving to meet the needs of individuals in the general population, the DCMHI model builds onto public health efforts and behavioral health services in the community. This level of care focuses on education, awareness building, promotion of emotional health and protective factors, and prevention of mental illness and substance use disorders. The services occur in the community and are incorporated into everyday life. They support awareness and understanding of emotional well-being while reducing stigma and providing avenues for individuals to connect and receive support.

The DCMHI has identified culture change and "rebranding" of behavioral health as a critical need in the community. Connected to demographic and cultural tendencies in the community around high

expectation, status, and performance, there is a need to shift culture and awareness to acceptance of normal distress including depression and anxiety. The DCMHI wants to improve the culture of the County, as well as offer education and self-management skills for all individuals.
The DCMHI aspires to incorporate these services across the community through home-based interventions (perhaps leveraging technology such as apps)[10], the business sector, service sector (e.g., hair dressers), community-based organizations, public campaigns, and social events. The specific services that will be developed will be determined over time and evolve as the DCMHI identifies priorities and programs. Some initial ideas include:

- Public awareness campaign on the importance of emotional well-being and how to support this in settings where people live, work and play;
- Public screening of mental health and substance use similar to blood pressure screening at health fairs;
- Education campaigns on early signs and symptoms of behavioral health conditions, including promoting developmental screening;
- Mindfulness and distress tolerance exercises built into public events or in community locations such as recreational centers;
- Social events focused on the importance of sharing stress and distress and healthy tips on reducing stress such as behavior activation;
- Mom support groups that reduce isolation and provide skills for improving mood; and
- In home sessions via in-person or through technology therapy light.

Primary Care

There is a national movement towards the integration of behavioral health into primary care. The primary reasons for integration include:

- ✓ Increase access to mental health and substance use services across the population;
- ✓ Provide behavioral health services where individuals go to receive care in the community;
- ✓ Identify and engage in early intervention for individuals with mild to moderate mental health and substance use needs by providing services in primary care settings;
- ✓ Prevent the development of worsening mental health and substance use;
- ✓ Reduce the barriers to treatment including stigma, lack of follow-up to specialty services, and long waitlists for specialty providers;
- ✓ Improve chronic physical health conditions by treating co-occurring mental health and substance use conditions; and

[10] Susan Steinbrecher, "A Roundup of the Best Health and Wellness Apps to Keep You Fit and Calm", *Inc.com*, September 27, 2018, https://www.inc.com/susan-steinbrecher/a-round-up-of-best-health-wellness-apps-to-keep-you-fit-calm.html

- ✓ Reduce costs through a reduction in acute services (emergency departments, hospitals) and through savings associated with better control of chronic medical conditions.

Behavioral health services within primary care have become central to advancing behavioral health wellness and improving the continuum and steps of care in communities. The DCMHI model incorporates primary care as a central partner and level of care supporting general population wellness, prevention, and providing additional levels of care for individuals with mild to moderate behavioral health conditions (including access to MAT for substance use). Early priorities for the DCMHI will be identifying primary care partners and understanding evidence-based models of effective integrated care.

Effective Integrated Care Model

Although in practice, integrated care models remain on a continuum from co-location to fully integrated collaborative care teams, there is emerging evidence that specific model elements and functions are tied to outcomes *and* without these elements, models fail. The evidence base for effective integration of behavioral health into primary care comes from over 90 randomized controlled trials of models including IMPACT, DIAMOND, and COMPASS (collectively called Collaborative Care Model)[11] that have identified both core principles for a robust model as well as core elements that result in desired outcomes in whole person care.[12] Although the evidence base for integrating primary care into behavioral health is less robust, key features of the ACA 2703 State Plan Amendment Health Home for the seriously mentally ill (SMI) population have demonstrated the capacity to deliver cost savings and better clinical results. The core features of effective integrated care consist of a set of core principles, specific tasks, and features of the clinical team that serve as a kind of "secret sauce" that binds the elements together in a way that leads to effectiveness and cost savings. When planning integration for a health system these principles, processes, and personnel factors are essential to building a successful model (quality health outcomes and financially sustainable).

TABLE 3. CORE ELEMENTS OF EFFECTIVE INTEGRATED CARE

- ✓ **Team Based Care**- Primary care and behavioral health providers collaborate effectively on care teams using shared care plans. Care managers (often LCSWs or RNs) and psychiatric consultants are important additions to the team.
    - **Embedded behavioral health provider** engaged in care management functions
        - Assessment, diagnosis and brief interventions
        - Routine follow-up with patients (at least 2 times a month)
        - Tracking population in a registry
        - Routine review of registry with psychiatric consultant

[11] IMPACT: Improving Mood—Promoting access to Collaborative Treatment; DIAMOND: Depression Improvement Across Minnesota Offering a New Direction; COMPASS: Care of Mental, Physical and Substance Use Syndromes

[12] R. Whitebird et al., "Effective Implementation of collaborative care for depression: what is needed?", *American Journal of Managed Care,* 20 (2014): 699-707.

- **Psychiatric Provider Consultant**
  - Psychiatric consultation and recommendations to support primary care prescribing (psychiatric provider is off site and does not see patients)
  - Registry review and clinical oversight for behavioral health provider and team
  - Education and training on psychiatric medications, side effects, etc.

✓ **Evidence Based Interventions -** Patients are offered psychopharmacology and brief psychotherapeutic interventions for which there is credible research evidence to support their efficacy in treating mild to moderate behavioral health conditions. Psychotherapeutic interventions in the primary care setting are briefer in nature – typically 30 minutes.

✓ **Measurement-Based Care-** Each patient's care plan clearly articulates personal goals and clinical outcomes that are routinely measured providing clinical data on improvement or lack of improvement. Treatments are adjusted if patients are not improving as expected through an iterative process that involves psychiatric consultation.

- Universal Screening of behavioral health with validated screening tools
- Systematic measurement of symptom reduction to inform clinical decision making/adaptations in care
- Tracking scores in a registry to review individual and aggregate data and to ensure people who are not improving receive adaptations in treatment.

✓ **Population Based** - The care team shares a defined group of patients tracked in a registry to make sure no one "falls through the cracks." Practices track and reach out to patients who are not progressing as expected and psychiatric consultants provide caseload-focused consultation on all patients who are not improving, not just ad hoc advice on select patients.

Key Tasks in Effective Integration: Research has shown several key tasks are associated with evidence-based integration of behavioral health into primary care such as:

✓ Care manager or behavioral health provider ensuring >1 contact a month following the initiating contact to improve engagement and faster time to benefit.

✓ Regular caseload review by the psychiatric consultant with a care manager or behavioral health provider to make treatment adjustments for patients who are not improving.[13]

✓ Other tasks such as systematically repeating measurement tools (like the PHQ-9) are important to the above processes.

Specialty Care

Central to the history of the DCMHI and its development is the need in Douglas County to care for individuals with identified behavioral health needs. As previously described there are many strengths within the existing specialty behavioral health services in Douglas County. Expansion and targeted program development for specific services and populations will be an ongoing effort and priority for the DCMHI. The specialty continuum includes everything from outpatient private therapy to intensive and

[13] Bao et al. "Unpacking Collaborative Care". *Psych Serv* (2016)

specialized evidence-based treatment for sub-populations. There are five main areas of development for specialty behavioral health:

- Criminal justice diversion and judicial efforts for individuals with behavioral health conditions and criminal justice involvement;
- Crisis, inpatient and residential services with transitions of care;
- Improving access to outpatient services and case management;
- Specialty population evidence-based program development (e.g., individuals certified for outpatient treatment, services for co-occurring behavioral health and intellectual and developmental disability, and others identified by DCMHI over time); and
- Expanded recovery services.

The DCMHI is committed to developing a robust network of providers and services with strong care coordination and collaboration between providers. Additionally, many partners within the DCMHI want to develop specialty programming that is community based and easy to access for all individuals in the County. This may occur through development of integrated or co-located services within a physical hub, leveraging technology and tele-health opportunities to enhance access across the County, partnership with County and Human Service infrastructure to increase access points, and engagement of non-traditional partners including law enforcement, community-based organizations, and others.

Implementation of the Community Based Mental Health System

Building the community based mental health system outlined above should be viewed as a long-term commitment that will require phases of implementation based on needs, community and political will, resources and capacity, and emerging opportunities. HMA facilitated the DCMHI, as well as a smaller work group in discussions to identify goals for implementing the model and the first steps or activities for achieving these goals. The group prioritized activities that should be undertaken by the DCMHI in the first year of implementation. Next steps in the implementation process would be to further refine those activities that warrant deeper discussion, prioritize activities, develop specific workplans that outline the tasks, timelines, performance measures and implementers for each prioritized activity. The *Key Partners* identified under each activity below represent the entities to engage as the DCMHI determines next steps.

Goal 1: Create a Networked System of Care

A frequent theme for the DCMHI is the need for a “no wrong door” approach to entry for any individual in Douglas County, no matter their age, to receive the services needed. The DCMHI partners want to have a seamless and well-coordinated system of care that provides rapid access to services, shared treatment planning, and smooth transitions between providers, community-based organization and other service organizations. A primary element of a networked system is awareness across partners and

"entry" points about the services available including any eligibility, insurance, or other requirements to access services. Additionally, the DCMHI partners identified the need to understand how individuals currently experience the system and where there are gaps in services or whether people fall "through the cracks" and fail to be connected to the appropriate services. Ultimately, the DCMHI is hopeful that there will be a platform or technological solution that will support genuine connectivity across relevant services and provide up to date information for individuals seeking care regardless of where and when they contact the system.[14] The following eight activities support the development of a networked system of care.

Activities

I. Assess and map current resources for individuals with mental health and substance use conditions and other social determinants of health needs in the community

***Suggested components*:** In order to support connecting individuals to the right services, it is important for all partners and "entry points" of the future to have a comprehensive list of resources in the County. One of the lessons of the DCMHI is that despite best efforts, it is difficult for all partners to know all the work of partners or others within the County. As a result, the DCMHI is interested in creating:

- A resource of all age specific services including mental health, substance use (including recovery), social services, family, community, and other services that can be easily updated and expanded;
- A matrix that provides detailed information on each service outlining eligibility, insurance coverage or other factors that are important for referral;
- A platform that is easy to use by individuals, families and natural supports ensuring that identifying information and resources does not require special training; and
- A process for keeping the services up to date including having accountability to partners that the services listed are accurate and up to date.

Key partners: DCMHI members, Douglas County Human Services, Medicaid Regional Accountable Entity (RAE, Colorado Access), Managed Service Organizations, Community of Care Network, community-based organizations, and other institutions that support individuals with mental health or substance use conditions.

Key implementers: DCMHI

II. Map current and future state mental health/primary care referral processes and develop referral protocols

[14] Ideally, this platform would be designed to maximize communication while supporting HIPAA and 42-CFR compliance and allowing data sharing between covered and non-covered entities.

Suggested components: DCMHI partners identified the need to map current user experience of the existing system—from entry through referral and transitions of care to identify gaps, barriers, and areas where individuals get stuck or dropped from the system. The goal would be to use this real-life experience of how the system currently works to inform how it needs to be changed. Following this assessment, the DCMHI would map the ideal flow or process for individuals considering the barriers and challenges that currently create poor outcomes. This may include exploration of transportation needs or centralized points of service as well as opportunities to leverage technology such as tele-health to support access to care.

Key partners: Individuals with lived experience in the Douglas County system of care, DCMHI members, Douglas County Human Services, Medicaid Regional Accountable Entity, Managed Service Organizations, Community of Care Network, community-based organizations and other institutions that support individuals with mental health or substance use conditions.

Key implementers: Douglas County Lean Six Sigma experts

III. Enhance care coordination

***Suggested components*:** Enhanced care coordination across payers and across services requires a robust process for sharing information, developing standardized referral forms (that contain the information needed by each partner), and often requires a lead agency to be the primary care coordinator. The process for care coordination in the Douglas County system of care will take more time and assessment with a group of partners identifying existing care coordination efforts and how to connect and or build onto those services. Potential specific components include:

- Assessment and review of existing care coordination efforts and entities with specific care coordination functions (e.g., Medicaid RAEs, Centura, MSOs, hospitals, etc.);
- Review of existing referral forms and what information is needed to follow the individual to ensure the right information is flowing between providers;
- Develop process for individuals being referred - engagement and education as part of the referral process;
- Review of HIPAA and other data privacy requirements (e.g., 42 C.F.R.) to provide informed decisions on data sharing in meeting standards for care coordination;
- Developing relationships between providers to learn and understand what each other do and how they can work together for shared cases or to support communication when referrals are made;
- Explore how care coordinators can support transportation needs of individuals or identify solutions for areas where transportation is a barrier to the right level of care;
- Develop Memorandums of Understanding or Care Compacts to support communication, shared processes, and workflow for enhanced referral and coordination of care between provider organizations; and

- Develop process for tracking data on referral and care coordination which could include a shared platform for data sharing long-term.

Key partners: Colorado Access (referred to as the, "Medicaid Regional Accountable Entity" under the other activities. Perhaps put Colorado Access in parenthesis after the first mention of the RAE under activity 1, and refer to Colorado Access in the following activities), commercial payers, MSOs, Centura, AllHealth Network, Community Crisis Connection (CCC), Community of Care Network, Denver Springs, Highlands Behavioral Health, and other hospital or emergency department partners, inpatient psychiatric social work staff or discharge planners, outpatient behavioral health providers serving the County, County Attorney, and others.

Key implementers: DCMHI until a specific workgroup or potential lead is identified

IV. Identify and develop/advance network technology solutions, including a searchable resource platform for linking people in Douglas County to care and resources to support health

Suggested components: The DCMHI strives to include technology solutions in its vision for a networked system of care. A technology platform could provide an ability to make the networked system truly accessible regardless of entry point. This technology platform should be user friendly to individuals and families across the County, as well as providers and service agencies. It should provide a platform for shared communication, care coordination and long-term shared treatment planning across providers. This type of technology exists and the work of the DCMHI will be identifying:

- What kind of technology is needed and prioritized functionality;
- A process for reviewing these platforms (including what other counties are using and their experience with specific tools;
- A process for selecting and/or building that functionality;
- Exploring a combination of technologies such as a 211 resource platform with Julota providing the care coordination functionality; review Arapahoe County and other examples of resource platforms.

Key partners: DCMHI members

Key implementers: DCMHI until a specific workgroup or potential lead is identified

V. Create a law enforcement hub

Suggested components: Following success of the CRT, one of the lessons learned for the DCMHI is that law enforcement is often the first point of entry for many individuals in distress. Developing a more formal way for individuals to seek assistance is through a law enforcement hub that could have co-located services and provide a community entry point for referral and entrance to services. It can also

provide closer proximity for law enforcement to support community members and shift culture around mental health and substance use.

Key partners: Law enforcement agencies, DCMHI provider and social services organizations, and Douglas County leadership.

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

VI. Create and support a position for a resource expert across insurers/systems

Suggested components: Another position that could support a networked system of care and greater care coordination is development of a resource expert who can support individuals with mental health and substance use conditions across payers. This individual would have understanding and expertise in programming across the continuum of care, geography of the County, and support individuals, providers and others with accessing the right service and navigating the system.
There are already roles that are similar in other parts of the system such as through the Managed Service Organizations, the Regional Accountable Entities and the Office of Behavioral Health ombudsman. As a result, it will be important for the DCMHI to identify whether this position is needed, what specific role they play in coordination with these other positions, and how they meet an unmet need. If the existing resources are sufficient, then it may be ensuring that the DCMHI has greater connectivity with these individuals to support the functionality in Douglas County.

Key partners: DCMHI members, Managed Service Organization, RAEs and Office of Behavioral Health Ombudsman.

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

Goal 2: Rebrand Mental Health and Substance Abuse

Concerns about the stigma of mental health and substance use disorders were shared throughout the key informant interviews and group discussions. In addition to this stigma is a broader culture of high expectation, life and work success, and high pressure for both adults and children in Douglas County. The population overall values putting forward a perception that one's life is successful and that individuals can tolerate high pressure environments. As a result, awareness of normal distress as well as acknowledgement of mental health or substance use issues or need for support is a challenge. This culture devalues sharing distress and help-seeking. DCMHI seeks to lead culture change by rebranding mental health and substance use, including continuing the initiative to reduce stigma (Let's Talk campaign) and helping people to view mental health as health-equal to and connected to physical health. It is also important to educate the public about mental and substance use conditions to reduce stigma and prejudice based on misconceptions about those living with these conditions. This public education should include information about what support services are available in the county.

Activities

I. Develop and implement a social marketing/communication plan focused on culture change in Douglas County

Suggested components: A mixed modality campaign delivered in multiple, diverse settings will seek to normalize mental health and substance use issues and help seeking. DCMHI will engage the sectors where people in the county live, work and play, utilizing natural supports in the community to share campaign messages. Messages should be developed that build on existing efforts like *Let's Talk Colorado*. Messages should reflect framing research from the Frameworks Institute and the research literature on similar social marketing efforts. This work will start with engaging new and non-traditional partners.

Key partners: Business sector; informal supports (hairdressers, faith-based community); DC schools; County information officer; Frameworks Institute (resources around social norming); Colorado Community News; PIOs from organizations already doing awareness campaign work; local public health; community members.

Key implementers: Tri-County Public Health, DCMHI with communication experts

II. Develop and implement a plan for public education about mental health and substance use conditions that includes – upstream prevention, available supports (professional and natural), and expands and leverages connections

Suggested components: In tandem with changing the culture in the county to normalize mental health issues and help seeking, educating the public about mental and substance use conditions and where support services can be accessed is important. This education effort should include information that addresses public safety questions around mental and substance use conditions and presenting the facts about these conditions to address misconceptions. Public education efforts should include targeted trainings such as Mental Health First Aid or specialty trainings like those for law enforcement and providers on co-response to mental health crises. Additional strategies could include community forums and media training on appropriate reporting of mental and substance use conditions and related topics like suicide prevention. DCMHI can continue to foster a relationship with local media and utilize this partnership to educate the public. Finally, this public education effort should include a component that creates a common language across sectors for talking about these issues.

Key partners: Business sector; informal supports (hairdressers, faith); DC schools; County information officer; local media; Frameworks Institute resources around social norming; Colorado Community News; PIOs from organizations already doing awareness campaign work; general public/community members.

Key implementers: DCMHI with communication experts

Goal 3: Develop Programs and Interventions to Address current Gaps

As identified above, the stakeholders have numerous ideas about specific programs for individuals with identified mental health or substance use conditions that are missing from the current continuum of services. A priority for the DCMHI is to move forward with continued assessment of this need and then development of specific services. The services outlined below include current program priorities with some targeting of specific parts of the continuum and other programs that targeting specific sub-populations.

Activities

I. Expand CRT programming and taskforce

Suggested components: The CRT program has been an effective addition to Douglas County services. Many partners within the DCMHI want to expand this program to more locations within the County and to increase the number of co-responder teams. Potential initial steps include:

- Assessment of volume and requests for CRT teams across the County;
- Hot spotting or evaluating areas of need or areas of incidence that are further from current CRT which could include CRT demand outside of geographic range of current CRT;
- Decisions on the number of teams needed and any potential specialization of teams (e.g., youth-oriented co-response team, complex care teams, etc.); and
- Determination of funding needed to pay for additional CRT teams and sustainability of program.
- As part of the assessment process, explore the need for additional diversion and restorative justice programming and identify the specifics of those programs to support diversion of individuals with mental health and substance use conditions from criminal justice settings.

Key partners: Law enforcement, Fire Departments, Dr. Jim Baroffio and Associates, Douglas County leadership, and CRT workgroup.

Key implementers: DCMHI

II. Expand walk-in crisis center

Suggested components: Walk-in crisis can be an important way of meeting community need in a timely manner and in a centralized location. The DCMHI is interested in adding to the crisis continuum to ensure individuals access services when in distress while also providing avenues for individuals to reach out for support prior to a true emergency. Walk-in crisis can fill that role. However, the DCMHI also needs to clarify the specific services in a walk-in center, the locations and geographic disparities best

served by this service, and the data indicating the need for and the specific program design of a walk-in crisis center. Initial proposed tasks include:

- Review of CRT data and other crisis data sources to examine patterns in contacts, volume and location of requests to inform the crisis center services and location;
- Exploration of location where other co-located services exist such as human services, mental health pavilion (described below) to maximize the idea of an integrated sub-hub for access to care;
- Identify the scope of services such as assessment, referral, care management, and potentially short-term treatment if co-located with outpatient behavioral health providers;
- Review of regulatory and administrative rule regarding development of additional walk-in crisis services outside of current state funded services; and
- Funding sources for programming including potentially capital investments for building or materials required.

Key partners: CRT teams, Douglas County DCMHI Coordinator, Community Crisis Connection, Community Mental Health Center, and specialty behavioral health providers

Key implementers: Douglas County DCMHI Coordinator and Community Crisis Connection

III. Assess and develop a plan to increase mental health and substance use disorder screening, referral, treatment and recovery capacity

Suggested components: Identification of mental health and substance use symptoms early on to support referral and connection to treatment and recovery services is central to the DCMHI proposed model. Identification through screening and effective referral are specific activities that cut across goals 1, 2, and 3. Additionally, the assessment data from goal 1 is central to determining specific treatment needs and recovery programming to develop. As a result of the interconnectedness of these activities, the following additional steps are potential tasks:

- Based on assessment and user case mapping completed in Goal 1, the DCMHI will examine current screening processes as well as opportunities for enhanced screening in public health and community settings, in primary care practices, and in other “entry points” for individuals in need;
- Based on the information gathered about referral and care coordination, the DCMHI can start to identify the best methods for enhancing the connection between identification and referral to treatment;
- Specific programs can be outlined for development based on identified gaps in care uncovered in the assessment process (e.g., Assisted Outpatient Treatment, Intensive In-Home Services for youth, at-risk adult programming, etc.);
- Explore the process for development of universal screening of mental health and substance use in primary care settings in the County and brief interventions for mild to moderate conditions as part of integrated care efforts;

- Pilots or detailed planning for development of enhanced referral networks between primary care and behavioral health to improve access to care for individuals identified by screening in primary care; and
- An additional area of review and development in this process will be exploration of recovery programming and gaps in that part of the continuum.

Key partners: DCMHI members, workgroup members focused on the resource development and referral processes indicated in Goal 1, specialty behavioral health providers, and primary care practices.

Key implementers: DCMHI until a specific workgroup or potential lead is identified; opportunity for a public/private partnership.

IV. Explore and Design Approach to Integrated Behavioral Health

Suggested components: The DCMHI is aware of the importance of building services that support the general population and build greater prevention and early intervention for individuals with mental health and substance use conditions. A key element of that continuum is primary care where behavioral health integration can support mild to moderate conditions providing screening and identification of symptoms as well as treatment for individuals of all ages. Development of integrated care is a longer-term goal, however potential immediate tasks for the DCMHI include:

- Develop an understanding of integrated care models with clarity on effective components;
- Engage primary care partners and identify partners and "champions" who want to advance integration within the County;
- With primary care partners, decide on a model of care;
- Identify partnering organizations; and
- Develop an implementation plan that includes potential training needs, operational support, and financial modeling among other key implementation components.

Key partners: DCMHI members (particularly Centura and Colorado Access to support connections to primary care), primary care providers in Douglas County, behavioral health providers who want to partner to do integrated care, and local expertise in integrated care including financing.

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

V. Increase Access to Medication Assisted Treatment

Suggested components: Access to MAT is an important part of the substance use continuum and is an evidence-based approach for treating many forms of substance use conditions. MAT combines access to medications while also offering behavioral therapy and skill development for changing behavior, managing distress and learning to address substance use. MAT can be delivered in multiple settings including primary care and specialty behavioral health. Potential initial tasks for the DCMHI include:

- Review of exiting MAT services and providers in Douglas County including populations served, substances treated, eligibility (insurance or other), and program requirements (e.g., need to be enrolled in intensive outpatient services, etc.);
- Review of substance use data for the County and specific MAT program needs including sub-populations of focus;
- Discussions with primary care partners on expansion of MAT in primary care and partnership needs with behavioral health specialty providers including potentially co-located groups, behavioral health staff embedded in clinics or enhanced referral and shared treatment planning;
- Discussions with specialty behavioral health providers on scope of services offered and potential resources that can be expanded to support MAT in the County (could include peer workforce for engagement at entry points, CRT or walk-in crisis to improve engagement and follow-up in treatment).

Key partners: DCMHI leadership, Signal Behavioral Health, Colorado Consortium for Prescription Drug Abuse Prevention, specialty behavioral health providers, and primary care providers; Tri-County Opioid Prevention Partnership (TCOPP)

Key implementers: Signal Behavioral Health

VI. Implement evidence-based programming for specific sub-populations to improve access to services needed to support health, long-term stability and improved outcomes

Suggested components: The stakeholders identified numerous sub-populations that could benefit from specific programming. Each of these programs would need to include a process of assessment of need (number of individuals, volume, and geographic location), review of relevant evidence-based practice models, payment for models and provider capacity to develop programming. Specific programs of interest to explore include:

- Assisted Outpatient Treatment (AOT) for individuals with serious mental illness leaving the hospital and transitioning back to the community; particularly those who have been certified for involuntary outpatient treatment;
- Assertive Community Treatment (ACT) for individuals with serious mental illness who have recurrent inpatient hospitalization and who have high social determinant of health needs such as homelessness;
- In-tensive in home services for adolescents with significant mental health needs such as Multi-Systemic Therapy, Trauma Systems Therapy or others identified as meeting the population need;
- Behavioral coaching for youth and adults with neurodevelopmental conditions such as autism and Asperger's;

- Programming for at-risk adults including those with intellectual and developmental disorders and those with serious mental illness to live as independently as possible (and as desired); and
- More innovative recovery groups for individuals with substance use conditions (such as Phoenix Multisport or others).

Key partners: Behavioral health providers; All Health Network for programming geared towards individuals with serious mental health (e.g., AOT, ACT, etc.), DCMHI membership, and potentially Department of Human Services, Office of Behavioral Health to support or identify funding or grant opportunities; and Regional Accountable Entities who can support assessment of need with data as well as potential payment ideas.

Key implementers: Behavioral Health Providers such as All Health Network.

VII. Improve care coordination for complex needs

Suggested components: The DCMHI has identified that there are small populations that require intensive care coordination to support community living and long-term stability. Many of these individuals have a mix of complex needs between developmental conditions as well as mental health and/or substance use. Some also have co-occurring physical health conditions. Many are involved with the County Attorney as a result of mental health involuntary treatment, individuals with an imposition of legal disability, or other legal element to their treatment. As a result, there is a need for greater care coordination across providers, across RAE's, across payers and with other systems of care such as intellectual and developmental disabilities providers and the Community Center Boards. One of the main goals it to support a streamlined care experience even as individuals change insurance status (Medicaid to commercial or uninsured or County Medicaid attribution) as well as when individual needs in acuity change. Potential sub-tasks include:

- Review of the number of individuals with these needs;
- Assessment of service providers currently involved in the care for these individuals;
- Development of a work group to assess best approach and ensuring that care coordination efforts are not duplicated; and
- Consideration of placement of care coordination for this population within the County Attorney's office and how this would be coordinated with other care coordination programs (such as through the RAE).

Key partners: DCMHI members, Douglas County Attorney, Behavioral Health Providers, RAEs and other care coordination entities, and others to be determined.

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

VIII. Develop family caregiver support programs

Suggested components: For many of the individuals with complex needs (both adolescents and adults), there is a need to support family caregivers. DCMHI stakeholders identified numerous ways in which this could be helpful including providing education on self-care, support in learning to navigate the system of care, building understanding of legal or other components of the individual's care and at times safety planning for individuals and family members. Potential sub-activities include:

- The development of these programs will require some analysis with families to understand the specific needs of family members;
- Identification of the "right" provider (e.g., behavioral health providers or community-based organizations); and
- Development of a funding stream to support development of programming.

Key partners: DCMHI members, NAMI Arapahoe/Douglas County, individuals receiving services, family members and caregivers.

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

Goal 4: Work on Policy and Systems Improvements

Policy and system improvements will be critical to achieving a community based mental health system that addresses the needs of Douglas County across the spectrum from prevention to recovery. This work should begin with the development of a policy agenda and identification of what system level improvements are required. Part of this process will involve a clear assessment of how existing policies create barriers to system improvements and what strategies are necessary for influencing change. Additionally, identifying the need for new policies, at the federal, state, municipal or organizational level and the appropriate strategies for informing or advocating new policies will be important for DCMHI.

Activities

I. Develop a policy agenda for the DCMHI

Suggested components: Work on this goal needs to begin with the development of a policy agenda. The development of an agenda will be based on an understanding of the existing, pending, and/or needed federal, state, local and organizational policies that are relevant to the overarching goals of the DCMHI. Then, the DCMHI will need to identify its role and strategies for addressing these policy issues. This will include process changes related to medical necessity, understanding what opportunities may exist within Medicaid waivers submitted by the state Medicaid agency (Health Care Policy and Financing), and insurance parity.

Key partners: DCMHI member organizations' leadership; Mental Health Colorado, NAMI

Key implementers: DCMHI

Goal 5: Develop the Workforce

Workforce development will be a key factor in successful implementation of a community based mental health system, especially regarding behavioral health integration in primary care. Engaging an expanded workforce that includes community health workers and peer support specialists will enhance the ability to bring health services out into the community, address the related social support needs of community members, and support recovery from mental and substance use disorders. With an eye toward the future sustainability of the system, developing strategies for increasing interest of young people in this work, while recruiting and incentivizing those entering behavioral health fields to work in Douglas County will also be important. Finally, introducing digital health options as appropriate to support consumers in their health and recovery can alleviate some burden on the workforce and provide a viable option to keep community members engaged in their health care.

Activities

I. Increase access to psychiatric services

Suggested components: There are multiple strategies to enhance access to psychiatry. Nationally, one of the most successful models is to enhance psychiatric consultation where psychiatrists do not see individuals directly but support primary care or other prescribers in developing comfort and skill in psychiatric medication prescribing. Tele-health and other technologies can also spread psychiatry services further. Another area of potential development is expanding the network of services available to consumers through new partnerships and recruitment of psychiatrists and psychiatric nurse practitioners to the network.

Key partners: RAE, member organizations of the DCMHI, University of Colorado Project ECHO, and potentially the Colorado Division of the American Psychiatric Association.

Key implementers: DCMHI, provider organizations

II. Increase workforce with knowledge in primary care integration

Suggested components: As the DCMHI works to engage primary care providers in expanding access to mental health and substance use treatment, there may be opportunity for expanding workforce with capacity to support integrated care. The following are some methods for expanding the workforce:

- Work with graduate programs and academic institutions to draw individuals with training in integrated care to Douglas County;
- Work to support primary care providers in marketing and advertising for professionals with experience in integrated settings to move to Douglas County;
- Explore the use of paraprofessional providers to support behavioral health services in primary care. There is evidence that paraprofessional providers such as Community Health Workers or Medical Assistants with additional training can provide screening, brief interventions, and other supports within primary care settings. This is especially effective when they work as a team with a licensed clinical social worker or another licensed behavioral health provider.

Key partners: Primary care and behavioral health providers, DCMHI members, University and academic institutions.

Key implementers: DCMHI until a specific workgroup or potential lead is identified

III. Increase the interest of young people for work in mental health and substance use disorder prevention, treatment and recovery fields

Suggested components: The DCMHI wants to consider methods for increasing interest in choosing a career path in mental health and substance use to support work in prevention, treatment and recovery. This is a long-term goal and will take time to achieve. Initial first steps will be developing a workgroup to consider strategy and options. Potential early sub-activities to achieve this goal include:

- Investigation into loan repayment or other financial incentives to draw individuals early in their careers;
- Job fairs in the County highlighting careers in these areas including potential shadowing opportunities that may generate interest for young people;
- Recruitment efforts to draw individuals with education and capacity in these fields to Douglas County.
    - Could include development of programs with area schools to train high school students in the kind of work that can be done with behavioral health degrees to expand interest and to provide volunteer opportunities for students who want to explore this area of work.

Key partners*:* DCMHI members, behavioral health providers, colleges and universities with training programs around mental health, Douglas County School District and Douglas County Commerce or other economic development groups.

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

IV. Increase the peer workforce

Suggested components: DCMHI acknowledges the value of individuals with lived experience and peers and the importance of leveraging this experience to inform service design and delivery. There is acknowledgment of the specific expertise offered by this workforce and the national movement of peer-run and peer-designed systems of care.

Key partners: Behavioral health providers, peers, advocacy organizations and individuals with lived experience and potentially national leaders in peer-run program development; NAMI.

***Key implementers*:** DCMHI until a specific workgroup or potential lead is identified.

V. Identify and employ digital health options

Suggested components: There is rapid growth nationally on technology tools that support mental health and substance use for utility with the general population as well as targeted and specific to individuals with more significant need. These range from tele-health techniques to spread specialty services across locations from evidence-based treatment extender program (offering therapy modules through technology) to more general population apps that support individuals in engaging in health promotion and self-management techniques. Potential initial next steps include:

- Determination of goals for technology supports;
- Review of existing tools and what providers in Douglas County may already be using or engaged with (such as myStrength, telehealth for crisis evaluations);
- Assessment of costs and outcomes of the various tools and alignment with overall DCMHI goals; and
- Selection of tools specific to the DCMHI model development which may meet different parts of the continuum (general population, primary care and specialty care).

Key partners: Behavioral health providers, expertise in technology utilization and specific digital tools across the County and others as identified in the process (could include the business sector or other partners in the County not yet engaged).

Key implementers: DCMHI until a specific workgroup or potential lead is identified.

Summary

Many exciting ideas were generated as the DCMHI members explored activities for achieving these goals. As the DCMHI begins to implement the steps necessary for building a community based mental health system under an enhanced governance model (outlined below) the activities described above will need to be further refined and priorities will need to be determined. Activities that were identified and

need to be further developed include in home services that target the general population, the creation of a mental health and substance use disorder resource pavilion and the creation of community centers or hubs where community members can access support services. These activities further serve to reduce stigma and bring services and the behavioral health workforce to the people who need them.

Throughout the discussions about the best mental health system model for Douglas County, there was a strong desire to have options for community members that went beyond the traditional brick and mortar treatment facility while still having places for people to get the care they needed. The activities noted above, as well as those to consider in the future strike this balance.

Governance and Financing

The DCMHI was first convened in response to tragic events which had occurred in Douglas County. Douglas County leadership served as the convener, bringing together stakeholders from the community with an overarching goal to increase access to and efficacy of the mental health service delivery system in Douglas County. DCMHI has been a collaboration of community leaders representing organizations touched by mental health and substance use issues in the county. Given its origins in collaborative work on the complex problem of unmet mental health and substance use disorder needs, and the bold focus on building a community based mental health care delivery system for the county, HMA recommends the use of the Collective Impact framework as a governance model for the initiative's work moving forward.

Collective Impact is a concept first introduced in a 2011 Stanford Social Innovation Review article as an approach for achieving greater impact on complex social issues like mental health and substance use[15]. Collective Impact as a framework brings partners across multiple sectors and organizations together in a structured, intentional way to develop and implement activities designed to effectuate change on a common, overarching goal.

Using a Collective Impact Framework

Collective Impact goes beyond traditional collaboration and isolated impacts achieved by organizations. Collective Impact describes partners commitment to working in a way that is intentional, mutually reinforcing and always toward achievement of a commonly agreed upon goal or end state vision. Participation in a Collective Impact initiative means that partners do more than just share information. Involvement requires a paradigm shift where participation in the initiative is not viewed as additional work, but rather *is* your work because involvement advances the mission of your organization. This paradigm shift is key to effectively solving social problems that cut across multiple sectors at scale.

[15] https://ssir.org/articles/entry/collective_impact#

Successful Collective Impact initiatives have five essential components: a common agenda, a backbone organization, mutually reinforcing activities, shared measurement, and continuous communication.

The Five Core Components of Collective Impact

Common Agenda

A common agenda is a shared vision for change that is shared across all participants in the initiative. The common agenda includes a common understanding of the problem and a shared approach to solving the problem.

For the DCMHI, the common agenda is their vision statement:

> *DCMHI envisions a community based, integrated mental health system that is person and family centered, promotes health and prevention, and meets the continuum of mental health and substance use needs in Douglas County. DCMHI is committed to a system of care that offers a broad network of providers, is adaptable and innovative in meeting individual needs, can be sustained and is data driven and grounded in continuous performance improvement. DCMHI values collaboration and engagement with community partners.*

Backbone Support

Successful initiatives require the support of an organization to serve as a backbone for the work. This includes funded staff and infrastructure dedicated to the initiative. A backbone organization guides the initiative's vision and strategy, promotes mutually reinforcing activities, supports establishment and tracking of shared measures, builds public will, advances policy, and mobilizes resources.

The backbone organization does not set the group's agenda and does not drive or independently determine solutions. The backbone facilitates accomplishment of activities and the garnering of resources that advance the group toward their common agenda.

In many ways Douglas County government has been serving in the role of a backbone organization for the DCMHI and as the work heads into the future and grows in scope, Douglas County is the right organization to continue serving as the backbone.

Mutually Reinforcing Activities

One of the distinguishing features of a Collective Impact approach is that partners intentionally align existing resources and efforts in their part of the system towards achieving the common agenda and shared measures. Partners identify a collective action plan that lays out strategies and actions that different partners are committing to implement. Then, partners hold each other accountable for achievement of these activities. The focus of this component is to align activities in a way that is

mutually reinforcing to the activities of other partner organizations, reducing duplication and leveraging resources.

As the DCMHI moves forward with implementation, the group will develop specific action plans under the identified goals and prioritized activities.

Shared Measurement

Another distinguishing feature is the identification of shared measures of success. All partners in the initiative agree on the ways in which success will be measured and reported. Partners have a shared understanding and agreement about the collection, storing, analysis and reporting of data. The data is used not only to show what has been successful, but also to inform continuous performance improvement across the initiative.

Continuous Communication

Communication-both internal to the initiative's partners and external to the community and potential funders or policy makers- is critical to a successful initiative. With Collective Impact, all partners engage in frequent and structured open communication to build and maintain trust. This component requires that structures and processes are in place to inform, engage and seek feedback from internal partners about the mutually reinforcing activities, and to inform and mobilize the larger community around the DCMHI's vision.

How this looks for DCMHI should be determined by a group that incorporates some communication experience and/or expertise and should be described in a communication plan. This plan will include the structures and processes for:

- communication about and at DCMHI related meetings (larger DCMHI collective, workgroups, steering committee)
- a light touch strategy between meetings by the backbone
- check-ins between stakeholder groups
- use of social media, mailing lists, newsletters, website, and sharing information with the broader community
- onboarding new partners

Douglas County Mental Health Initiative Moving Forward with Collective Impact

As previously stated, HMA recommends that Douglas County serve as the Backbone Organization, coordinating, facilitating and supporting the work, data and evaluation; managing communication; mobilizing funding.

DCMHI is the larger collective with representatives of the system coming together. New partners will need to be engaged and oriented to the DCMHI in order to reflect all parts of the model of a community based mental health care system from prevention to specialty care. Engaging providers in primary care should be a priority as it is a current identified gap in the partnership. Typically, the larger collective meets less frequently than the steering committee and workgroups (described below). Partners are deployed to serve on workgroups and the steering committee and the larger DCMHI convenes to hear updates on mutually reinforcing activities and progress toward achievement of the DCMHI vision. During these convenings, partners reflect on issues like what new resources or partners are needed, what needs to be adjusted to improve performance on activities, what are current opportunities or threats to the work of the initiative.

DCMHI should formally establish a Steering Committee made up of partner representatives from the backbone, chairs of the work groups established to work on goals and prioritized activities and other key partners needed to steer the initiative forward-following the DCMHI vision and the model for a community based mental health care system. Representatives serving on the steering committee should be decision makers and/or influencers within their organizations. This is critical to successfully aligning resources and activities towards accomplishment of the DCMHI vision.
As implementation begins, workgroups will be formed that best support implementation of the goals and prioritized activities. Workgroups are where the “rubber meets the road” and where mutually reinforcing activities are determined, tracked, and measured. Workgroups meet more frequently, and their progress is reported through the steering committee.

Looking Ahead

The DCMHI is a unique and exciting multi-sector collaborative with a deep commitment to improving the mental health of individuals and families in Douglas County. This commitment extends to the health of the community and a desire for creating a culture where talking about mental health and substance use concerns is normal and reaching out for support is valued. Going into 2018, the DCMHI sought to build upon the success of their CRT and Mental Health Navigator programs and create a community- oriented mental health system that included the spectrum of prevention, early intervention, crisis response, treatment and recovery.

Over the course of several months, HMA talked with the DCMHI, as well as facilitated sector-based focus groups, and interviewed many stakeholders across the spectrum. In these discussions we learned that services needed to go beyond the traditional brick and mortar facility and needed to be available for those in crisis as well as those who are not yet in crisis. DCMHI stakeholders placed a high value on ensuring that resources and supports are accessible at multiple levels of need. The discussions led to the development of models for the DCMHI’s consideration and the determination to move forward with one model for a community based mental health system that presents a stepped approach to care along a continuum from community-based programs and services, to integrated care in primary care settings, to the delivery of specialty care. This report included a blueprint for implementing this mental health

system, including a governance model for the DCMHI that best supports implementation moving forward.

Establishment of steering committee and workgroups and action planning

Based on the governance structure outlined above, HMA recommends establishing a steering committee as one of the first activities in implementation. If the vision of the DCMHI serves as the north star, then the members of the steering committee serve to steer the work towards that north star. The steering committee should include representatives with a personal stake or involvement in the development and implementation of a community based mental health system. Members of the steering committee would ideally have formal or informal power within their organizations so that they can influence engagement and investment in mutually reinforcing activities to advance the groups common agenda. Members also serve on the initiative's workgroups as chairpersons. In this role, they report out to the steering committee on the progress of the work and ensure that workgroup activities are mutually reinforcing and connected to the bigger picture. Most importantly, the steering committee represents the larger DCMHI interests.

As a first step, the steering committee should further refine and prioritize the activities outlined above and determine the formation of workgroups to carry forward with implementation of the activities. The workgroups will then convene and develop action plans (also known as workplans) with specific tasks, timelines and measures of success for the work they are undertaking. Potential workgroups could be developed based on the five goals of the implementation plan, or around particular activities that the DCMHI steering committee prioritizes.

Communication plan and outreach to new partners

Communication is essential to effective governance and to gaining and maintaining buy in for the work of the DCMHI. Development of a communication plan that addresses internal and external communication is an important next step for the DCMHI. Internal communications will include establishing the processes and tools for keeping the partners of the initiative informed about progress, meetings, agendas and action items. It also includes how the group onboards new members. As the model for a community based mental health system includes components that are not yet represented on the DCMHI, identification and outreach to potential new partners is a priority.

HMA recommends forming an ad hoc workgroup specific to communication planning and partner outreach. This workgroup should include communications professionals with the background and experience to help DCMHI develop its messaging, especially as it relates to external communications.

Refining a Funding Model

The DCMHI has identified the need to diversify funding for the long-term sustainability of the work of the DCMHI. The model design and some of the priorities outlined by the DCMHI will require braided funding that is currently tied to specific program development (the State funding of co-response teams is a good example) as well as thinking creativity about alternative funding sources. For example, there was some initial conversation about alternative payment structures with private insurance and even creation of an outpatient Independent Provider Association as well as potential funding through another facility designed similarly to the Family Resource Center where revenue is generated through rental agreements and shared space.

The priorities outlined in this implementation plan remain high level with recognition that through the Steering Committee and Workgroup meetings, the specific services or activities designed for implementation will be further delineated. Identifying funding for each priority area will be clearer as the activities become more specific and targeted. The Steering Committee will ideally review funding for the entire DCMHI as well as specific program ideas as a standing agenda item and may want to consider creating a workgroup focused on funding opportunities or development activities.

Potential funding sources for the model components are included below and can be further researched and assessed for appropriateness as the Workgroups are initiated.

Private Funding

There are national funding resources for development of community-based health services as well as development of the healthcare workforce. Large national private foundations have priorities that are aligned with the DCMHI including the Robert Wood Johnson Foundation which is currently funding community-based initiatives, workforce development and health care "innovations" focused on building a culture of health for populations. Another example is the Josiah Macy Jr. Foundation which fosters innovation in health professional education with specific interest in health care training being adapted to meet changing health needs—which aligns well with the workforce focus of the DCMHI.

Although some foundations may see Douglas County as a well-resourced county, the innovation and stakeholder engagement across the community may fit well with funding directed at community-based initiatives. For example, there are some foundations specifically focusing on practice transformation and innovation within primary care such as behavioral health integration (Atlantic Philanthropies) and this may be a growing trend in philanthropy.

Insurance Industry

Many of the ideas within the DCMHI model will ultimately create a healthier community which can lead to cost savings. The DCMHI could develop a specific and targeted ask of private insurers within the County. In partnership with the business sector and large employers, the DCMHI could approach the

County insurer as well as other large business insurers and request funding or support of the DCMHI for specific services, enhanced payment models, or other alternative payment ideas that support the health plan's goals as well as the work of the DCMHI. It may also be worth considering approaching one of the health plan foundations—for example the County insurer is Aetna which has a foundation funding a variety of health initiatives.

Business Sector

In a similar vein to the insurance funding sources, the benefits of the DCMHI over time will reduce healthcare costs and improve employee heath within the county. The business sector could be an important local partner who will directly benefit from work done by the DCMHI. Approaching individual businesses as well as potentially a partnership of businesses could be an avenue for diversifying support of the initiative—especially early on.

Maximizing Reimbursement

Central to the long-term sustainability of the model will be careful attention to the reimbursement of services developed by the DCMHI. Maximizing what can be reimbursed through both public and private payers will be central to braiding funding of services and leveraging payment.

State and Federal Grant Opportunities (Evidence Based Programming)

There are federal funding opportunities for specific programs released by the Substance Abuse Mental Health Services Administration (SAMHSA), and the Health Resources Services Administration (HRSA) as well as other federal agencies (Department of Justice, Centers for Disease Control and Prevention) that may align with program goals within the DCMHI model. Similarly, there are State funded grants that may support program development through the Departments of Human Services (Office of Behavioral Health), Public Health and Environment and others. Often these grants are targeted to specific evidence-based programs or activities, however they may at times align with specific program goals of the DCMHI. Tracking and evaluating potential funding sources will be important for the workgroups and the Steering Committee. These funding streams can be a good way to launch a new program and provide funding for two to three years supporting implementation and long-term sustainability planning.

Taxpayer Funding

Currently, the DCMHI is primarily funded through Douglas County funds. As the DCMHI gains traction and can provide a clear model for the community, there may be interest from taxpayers to support program development or implementation. This is occurring in other counties in the State as taxpayers experience challenges or shortfalls in the behavioral health system of care and understand the need to pay for additional services in their communities.

Creative Funding Development

There are increasing demonstrations of social innovation funding across the country—often developed at the local level. Lessons learned, and work being done across the country can provide examples and insights for the DCMHI Steering Committee. Specific examples of this kind of social innovation funding are social impact bonds which are partnerships generally between private funders, non-profits and government agencies where upfront private dollars are used to fund the expansion of effective interventions which can support long-term cost savings and return on investment. Pay for success is another form of social impact bond aimed at improving the quality of interventions. Third Sector is currently engaged in a trial of pay for performance with counties across the country and this may lead to further funding for a second cohort of counties. Following the cohort 1 counties could be an important source of information and ideas around funding for the DCMHI.

Another creative solution is work being done in Minnesota through a legislatively initiated partnership of communities. Sourcewell is a service cooperative created by the Minnesota legislature 40 years ago and has developed regionally focused programs funding counties. This kind of collective partnership could be proposed in Colorado with a focus on health and wellness and specific behavioral health programming. As counties across the state raise concerns about behavioral health and health promotion, there may be opportunity to develop alternative structures for funding and support. The DCMHI could very well become a leader and model for other counties including leading the path to a new State entity that supports county development.