COVID-19 Special Assignment Committee Report

September 17, 2020

COLORADO
Behavioral Health Task Force
Department of Human Services

In May 2020, Governor Polis asked the Behavioral Health Task Force to establish the COVID-19 Special Assignment Committee. This document is the result of the combined efforts of the individuals listed below. We are grateful that these subject matter experts were willing to come together so quickly and develop recommendations that will strengthen Colorado's behavioral health system in a future crisis.

COVID-19 Special Assignment Committee Members

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Acknowledgements

The COVID-19 Special Assignment Committee was coordinated by Christopher Miller, community programs manager of special projects at CDHS, and supported by program assistant Larena Hatley.

The Office of Behavioral Health, Community Behavioral Health, Evaluation Team who disseminated and analyzed two statewide surveys for this Committee: Matt Best, Elizabeth Brooks, Detre Godinez, Tim Gruzeski, Anoushka Millear, Gregor Rafal, Shaina Riciputi, Stephanie Rogers, Amy Smith, Ari Stillman, Katie TenHulzen, and Heather Tolle.

NOTE ABOUT THIS DOCUMENT

Throughout this document, references are made interchangeably between "Coloradans," "people," "people in need of services," "consumers," and "clients."

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Executive Summary

The COVID-19 pandemic affected the behavioral health needs of Coloradans, leading to increased incidence and prevalence of stress, anxiety, social isolation, and financial hardship accompanied by a concurrent increased demand for behavioral health services and support. The State's crisis hotline experienced a 30% increase in average monthly calls and a record-breaking number of texts. Reports released early in the pandemic by The Colorado Health Foundation, as well as national studies, indicated that COVID-19 is impacting the behavioral health conditions of people across the country, including Coloradans.

After soliciting input from Coloradans across the State, as well as behavioral health providers, reviewing and analyzing data, and identifying the areas in most need of strengthening for future emergencies and pandemics, the Committee developed key recommendations for consideration in a future crisis:

Recommendations

Tele-Behavioral Health

1 Expand/Increase Tele-Behavioral Health Services, including:

- Complete a comprehensive analysis for expanding tele-behavioral health
- Promote tele-behavioral health via training and public awareness
- Promote consumer-centric values for tele-behavioral health
- Review opportunities to permanently enact regulations and administrative flexibilities
- Continue to strengthen the State's broadband infrastructure
- Ensure adequate, flexible resources are available to providers
- Create a proactive outreach plan to identify and reach the most vulnerable populations

Behavioral Health Services

2 Behavioral Health Providers should be recognized as essential health care providers.

3 Ensure the Capacity Tracking System, which is scheduled to launch in January 2021, is adequately resourced to function successfully and address any enhancements.

Outpatient Services

4 Expand services offered by the Colorado Crisis System.

Residential/Inpatient Services

5 Ease specific regulations and oversight standards to increase capacity during an emergency.

6 Ensure clients accessing bed-based services are able to be transferred to facilities to continue their substance use disorder (SUD) treatment even when they are COVID-19 positive.

7 The safety and well-being of patients/clients should not be compromised to respond to a pandemic, disaster, or state emergency.

8 The State Emergency Operations Plan should include continuous quality improvement.

9 During a state of emergency that burdens the inpatient bed capacity, preemptive efforts should be made to reduce the reliance on inpatient beds.

10 Protocols and proper equipment are needed for staff working in substance use and mental health settings, including 24/7 residential and hospital facilities.

Substance Use Disorder Services

11 Ensure all treatment modalities are available to those seeking substance use disorder (SUD) treatment, via telehealth or other forms. This includes establishing different forums for social support groups to help individuals maintain recovery and other interventions that are group-based.

12 Colorado should take steps to ensure that medication-assisted treatment (MAT) services are not interrupted during a pandemic or state emergency.

13 The State should address requirements that create barriers for greater access to transportation services.

Children and Youth

14 The state agency responsible for public health should coordinate with child-serving agencies and educational institutions to prepare a public education strategy to respond to the social/emotional implications that children are experiencing as a result of COVID-19.

15 Develop new strategies and processes to identify and screen children and youth for their behavioral health needs.

16 Ensure evidence-based preventative measures that decrease suicide and other behavioral health concerns are adequately resourced in schools.

17 Ensure there is a strong balance of local and state alignment to have consistent and centralized access to information and coordinate available services between these agencies and educational institutions (i.e., "no wrong door" approach).

18 The State, in conjunction with counties, should ensure that foster children and youth have the behavioral health services they need to successfully navigate the pandemic.

19 As it relates to a pandemic or state emergency, funding agencies of direct and support services for families should adopt flexible funding strategies that ensure all families can access all levels of whole person care and behavioral health services.

20 For children's services, the State should assess which crucial community provider organizations are in jeopardy of closing or laying off their workforce.

Equity

21 Assess and rectify inequitable access for all Coloradans within children, youth and adult behavioral health services during the current pandemic and in future State emergency responses.

Emergency Response

22 Formalize the role of community behavioral health organizations with the capacity and capability to actively participate in the Colorado Department of Public Health and Environment's (CDPHE) emergency preparedness, response, and recovery activities.

23 The State should review the roles of the various state agencies involved in the pandemic response as it impacts behavioral health service delivery and coordinate and align state agencies for emergency responses in meeting the behavioral health needs of individuals and communities.

Funding Flexibility

24 Maintain flexible policies to provide services by telephone and videoconferencing.

25 Explore, with the federal Medicaid agency on expanding the pool of Medicaid providers by allowing non-contracted Medicaid providers to provide services to Medicaid recipients quickly.

Introduction

Special Assignment Committee Purpose

In April 2020, Governor Polis asked the Behavioral Health Task Force (the Task Force) to establish the COVID-19 Special Assignment Committee to:

- Create an interim report that highlights the short- and long-term impacts of COVID-19 on the behavioral health system, including access to behavioral health services, especially for vulnerable and underserved populations;
- Evaluate the behavioral health crisis response in Colorado to COVID-19 and provide recommendations for the Behavioral Health Task Force's Blueprint on improvements to behavioral health services for response during any potential future crisis.

Process

The COVID-19 Special Assignment Committee (The Committee) met between May and September 2020 and explored how COVID-19 impacted the behavioral health of Coloradans and service delivery. A myriad of state-based collection efforts was utilized. Additionally, the Office of Behavioral Health (OBH) solicited input from two key stakeholder groups:

1. A survey was issued in partnership with the Colorado Department of Health Care Policy and Financing (HCPF) to examine how COVID-19 impacted factors related to mental health or substance use treatment for people who needed access to services;
2. A survey, key informant interviews, and focus groups provided insights on the impact of COVID-19 on behavioral health service provision from the providers' perspectives.

This Committee used the Strategies for Managing Behavioral Health Standards of Care During a Crisis developed by the Governor's Expert Emergency Epidemic Response Committee (GEEERC) as the foundation for many of its recommendations (and, in some cases, adopted the exact same recommendations). The GEEERC document lays out actionable standards for the modified practice of behavioral health care during times of crisis, such as a declaration of a "state of emergency." The GEEERC document supports such actions as the expansion of telehealth services and other practice adaptations to meet increased needs during a time when some providers may be unavailable. While the GEEERC document is designed to recommend specific regulatory adaptations to be made during a crisis, this Committee's recommendations speak to broader systemic recommendations that should be made to behavioral health during a crisis, as well as some recommendations to be adopted in non-emergent times.

A strong, accessible behavioral health system is critical to meet the demands for substance use and mental health care during a crisis. The initial phase of the COVID-19 response offers many key lessons that should inform future disaster planning and guide behavioral health system reform over the coming years. Defining behavioral health as an essential service and determining how to better reach the most vulnerable and underserved populations is critical. There are opportunities to enhance outpatient, inpatient, and SUD services and educate Coloradans about pandemic terminology and safety protocols as it relates to behavioral health care, i.e. proper face coverings, social distancing, etc.. Tele-behavioral health can be a powerful mechanism to provide timely services when in-person meetings are not an option.

Additionally, this Committee adopted the recommendations (with some modifications and additions) of the Task Force's Children's Behavioral Health Subcommittee. See the Colorado Behavioral Health Task Force website for meeting agendas, presentations, minutes and related materials located under the COVID-19 Special Assignment Committee meeting resources.

Impact of COVID-19 on Behavioral Health

The COVID-19 pandemic affected the behavioral health needs of Coloradans, leading to increased incidence and prevalence of stress, anxiety, social isolation, and financial hardship, accompanied by a concurrent increased demand for behavioral health services and support.

Even before COVID-19, approximately one million people across the State were in need of behavioral health services, and Colorado was already facing significant behavioral health needs. In 2018, Colorado had the seventh highest suicide rate in the nation, and suicide is the second leading cause of death among Coloradan youth. Close to 95,000 Coloradans with substance use disorder went without treatment in 2019.

Limitations on Findings

The input and data used to analyze the long-term impact of the COVID-19 pandemic on behavioral health are limited. This report in its entirety reflects conversations by Committee members over five months. The limitations of understanding the long term impacts of a pandemic on behavioral health are not limited to this Committee as there exist very few comparable situations. Given that Coloradans are still contracting COVID-19, we have yet to truly understand the direct and indirect long-term impacts. The inadequate information available on COVID-19's long-term impact on behavioral health needs makes it difficult to say with certainty the extent of the expected, forthcoming demand for care. It is also difficult to attest if the reintegration back to previous social norms will mitigate any long-term impacts. However, for the immediate future, there is a clear call from consumers and providers to not neglect the impact of social isolation on the mental wellness of individuals. In addition, the collateral economic impact of the pandemic that has resulted in joblessness will likely have a significant impact on the mental well-being of individuals, and increased suicidal ideation and behavior. There is a relatively large body of literature examining the association between unemployment and all-cause mortality, as well as specific types of deaths. Research focused on suicides is the most established, showing that a one-point increase in unemployment rates increases suicide rates by about 1 to 1.3%.[1]

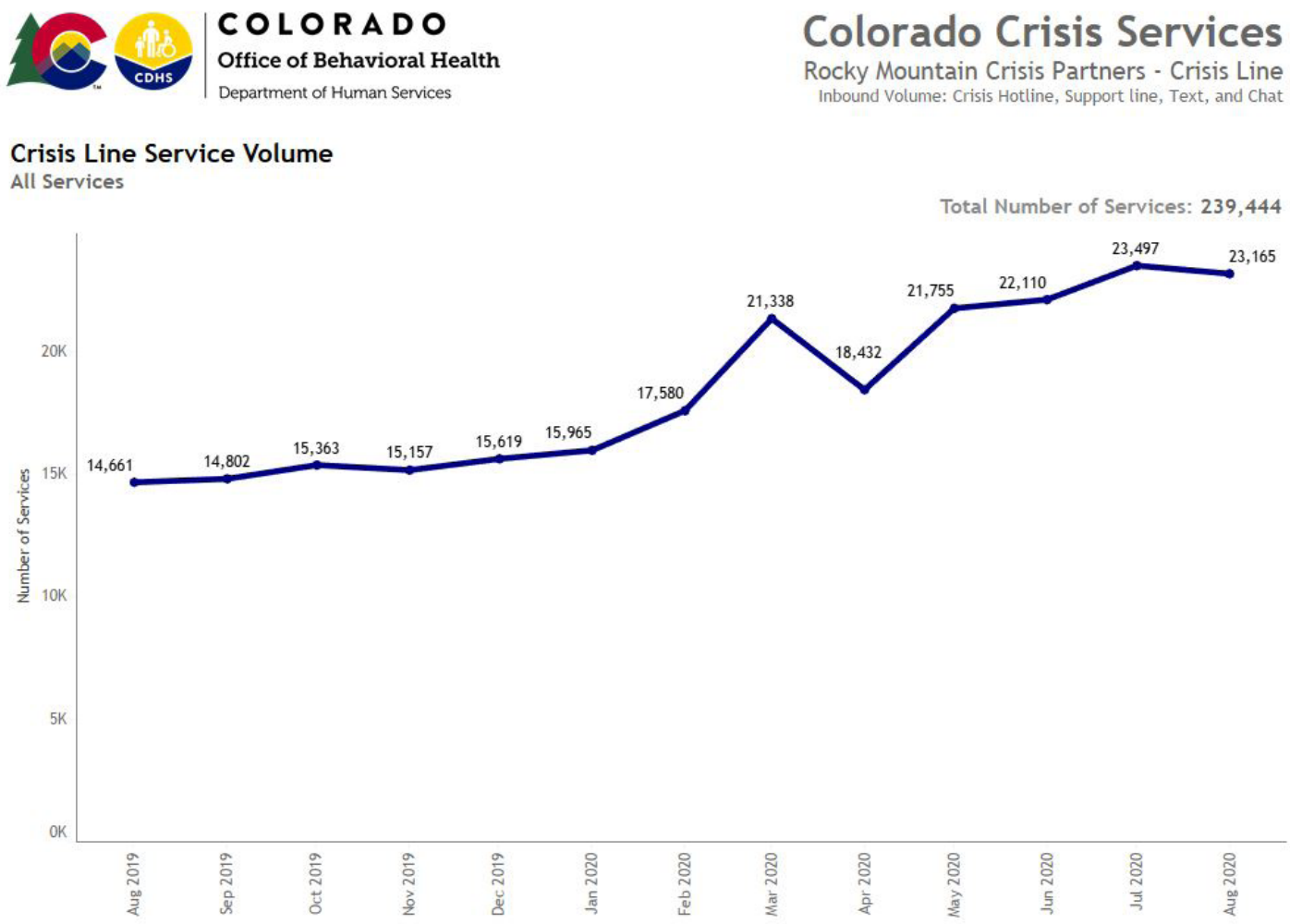
Other than the Colorado Health Foundation August 2020 Survey, the information collected on the pandemic's impact on behavioral health is limited. The committee was unable to obtain a comprehensive analysis on any differences the impact of COVID-19 is having on different groups based on geographic location, race, gender, and other demographics. The data collected by the Colorado Health Foundation found that 20% of minorities reported needing mental health services but were unable to access it. The survey also showed significant differences based on economic status, and that women reported more experiences of increased mental health strain, such as anxiety, loneliness, or stress. One commonality found across all ethnic and racial lines is that about half of the people have been impacted by mental health strain. It is safe to assume that any inequities that existed prior to the pandemic would only be further exacerbated. In addition, it can also be assumed that the pandemic is not impacting everyone the same. While there have been known reports on disparities related to physical health as it relates to COVID-19, this committee was unable to obtain any information specific to behavioral health.

These limitations provide an opportunity for future research and pilot projects to consider the impact of disaster and pandemics on historically marginalized populations and their behavioral health.

Reports and Surveys

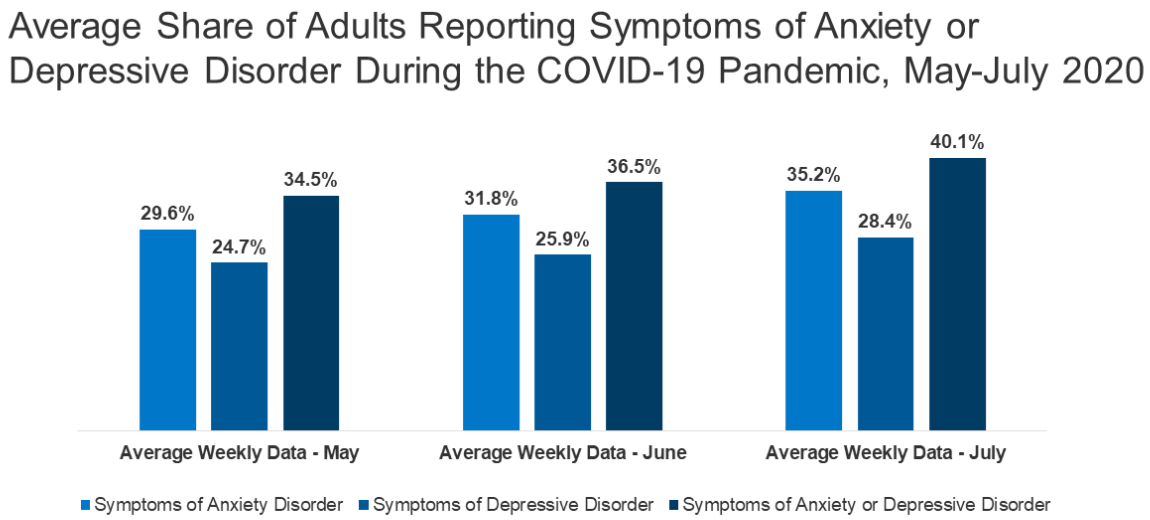
After COVID-19 emerged in Colorado, reports illustrated the negative impact the pandemic and social isolation had on the behavioral health of individuals. This was evident in the 30% increase in average monthly calls to the State's Behavioral Health crisis hotline and a record-breaking number of texts.

Figure 1. The graph below represents the number of Colorado Crisis Services provided each month via the Crisis line from August 2019 - August 2020.



According to a recent survey, released August 21, 2020, conducted by the Kaiser Family Foundations (KFF), more than one in three adults in the U.S. have reported symptoms of anxiety or depressive disorder during the pandemic (weekly average for May: 34.5%; weekly average for June: 36.5%; weekly average for July: 40.1%)[2] (Figure 2). Additionally, a report released by the Centers for Disease Control and Prevention, Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic, found that the public health response to the COVID-19 pandemic should increase intervention and preventions efforts to address associated behavioral health conditions.[3] All of these above studies have amplified the importance of behavioral health in emergency response planning.

Figure 2. Average Share of Adults Reporting Symptoms of Anxiety or Depressive Disorder During the COVID-19 Pandemic, May-July 2020 *Note this is national data.



NOTES: These adults, ages 18+, have symptoms of anxiety or depressive disorder that generally occur more than half the days or nearly every day. Data presented for "symptoms of anxiety or depressive disorder" also includes adults with symptoms of both anxiety and depressive disorder. Data presented for May is the average of the following weeks of data: May 7-12, May 14-19, May 21-26, May 28- June 2; for June, data is the average of June 4-9, June 11-16, June 18-23, and June 25-30; for July, data is the average of July 2-7, July 9-14, and July 16-21 (last week of published data).
SOURCE: U.S. Census Bureau, Household Pulse Survey, 2020.

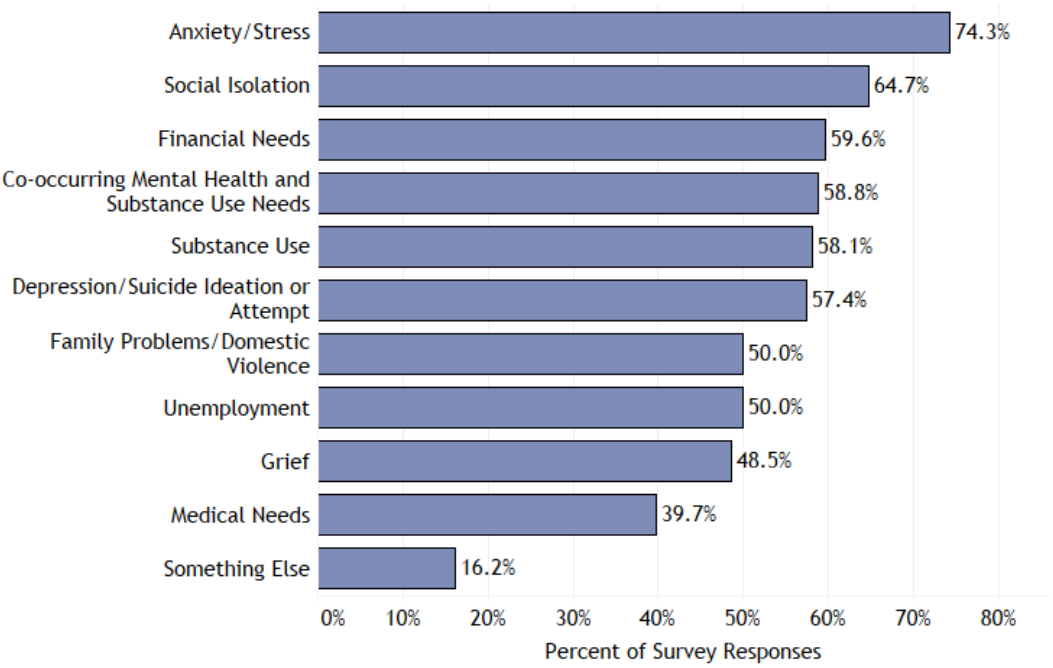
KFF
HENRY J KAISER FAMILY FOUNDATION

Results from a statewide poll completed in August 2020 by The Colorado Health Foundation (CHF) indicated that most Coloradans reported that the COVID-19 pandemic has put a strain on their mental health, contributing to anxiety, loneliness or stress. Coloradans at the lower end of the income spectrum reported more concerns about their mental health. In the CHF survey of 2,275 Coloradans, those reporting financial stressors were most likely to report anxiety, loneliness, or stress (specifically 63% were living on low income, 69% were unemployed and 77% were worried about paying their rent or mortgage). A significant segment of the minority population (80%) who were included in the poll reported that they or a family member were unable to get needed mental health care, and 90% of minorities felt that they needed substance use services, but were unable to get them. Financial considerations were the biggest barrier to accessing services (indicated by 33% of respondents), followed by "Inconvenient/Too distant/Waitlist too long/Didn't know where to go," as indicated by 26% of the respondents.[4]

The Office Behavioral Health (OBH) surveyed behavioral health providers and consumers on how COVID-19 impacted factors related to Coloradans with behavioral health needs. In a survey completed by Coloradans receiving Medicaid (Attachment 1), respondents reported experiencing anxiety and stress "often" at the onset of the pandemic and expressed that depression and anxiety had increased significantly between March and July. Approximately 11% of respondents believed that they used drugs or alcohol "too much" to help them cope with COVID-19. Of those who answered the survey and were caring for children or youth, a majority reported concerns about their children missing major milestones, feeling alone or isolated, experiencing overall mental health challenges, and adapting to new routines.

In a survey completed by behavioral health providers (see Attachment 2), providers shared their observations of behavioral health stressors resulting from COVID-19 in the clients they serve. The most commonly reported stressors were anxiety/stress (74.3%), social isolation (64.7%), and financial needs (59.6%) (Figure 3). Anxiety and stress often stemmed from social isolation and relative lack of contact with clients' usual support systems. Providers reported the prevalence of co-occurring mental health and substance use needs, substance use, and depression/suicidal ideation or suicide attempts.

Figure 3. Client Stressors Due to COVID-19 Crisis as Identified by Providers (Survey Responses)



In addition, specific to telehealth, Colorado's Office of eHealth Innovation and Colorado Health Institute[5] completed research based on clinical documentation by providers in Colorado, and found that behavioral health experienced the highest growth rate in telehealth in comparison to other clinical services and growth in weekly telehealth visits during the pandemic generally decreases as patient age increased. See Attachment 3 for all the findings from the Colorado's Office of eHealth Innovation and Colorado Health Institute's report.

Concerns on Accessing Care During COVID-19

Across the industry, accessing behavioral health care with the sudden changes in how care could be delivered under social distancing protocols was of great concern. Many providers were able to successfully implement tele-behavioral health quickly and offer services to many individuals. While tele-behavioral health helped to mitigate interrupted care for many, it was not a solution for all. This is particularly true for services historically delivered in group settings and dependent on peer social interactions. In addition, geographic location, such as rural and frontier communities, needs to be considered when understanding the utilization of tele-behavioral health services.

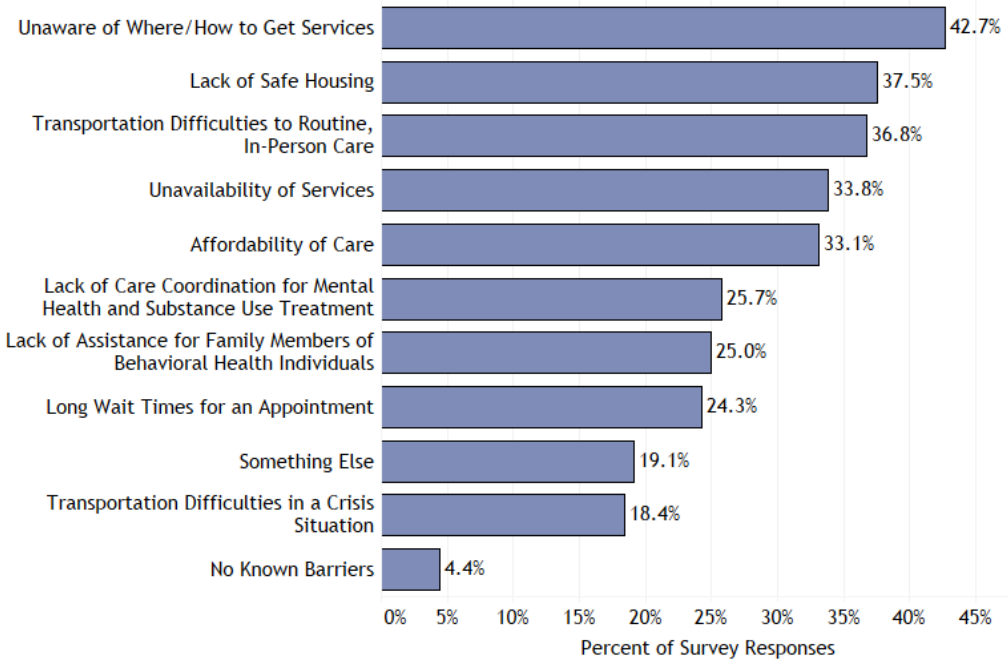
Of the consumers surveyed by OBH, 25% indicated that they had accessed behavioral health services since COVID-19 began (March to August). Treatment was not always available for some individuals; 12% tried to get an appointment after the pandemic began, but were unable. Individuals who sought treatment after the emergence of COVID-19 received care via technology, such as video or telephone (76%) or a combination of technology-based and in-person services (15%). Of those receiving tele-behavioral health care, most believed the care was "good" or "very good" (85%).

Access to care for children was a concern expressed by survey respondents. Over one-third of respondents (35%) were uncertain that children in their home could receive behavioral health care if school was closed. Parents were also concerned about providing for their children. Participants who make less than $30,000 per year were significantly more concerned about being able to meet children's basic needs, such as food or housing, compared to higher-income respondents.

Being able to pay for care was identified as a concern for some survey respondents. Paying for care was harder for one-third of the respondents after COVID-19, but the majority reported no change in their ability to pay.

Providers also identified some concerns for their clients in accessing care (Figure 4). Among the number of concerns listed, they reported many clients were (a) unaware of where or how to get services at the start of the pandemic; (b) lacked safe housing; (c) experienced transportation difficulties to routine, in-person care; (d) found services generally unavailable; and (e) could not afford care.

Figure 4. Client Barriers to Accessing Behavioral Health Services during COVID-19 Crisis as Identified by Providers (Survey Responses)



Associations representing Colorado behavioral health providers reported that providers faced challenges during the pandemic and when responding to other emergencies. For example, bed based care during COVID-19 was significantly reduced in places like withdrawal management and acute treatment units. During COVID-19, providers of these types of treatment modalities had to reduce the bed capacity to accommodate physical distancing standards. With a reduction in bed capacity, there is less revenue generated to ensure these facilities stay viable during such a decline in the amount of care being provided. Also, while the number of people in such 24/7 settings may be reduced, the costs are much higher for providers with additional cleaning protocols (e.g., hazard pay and PPE costs).

What Worked Well

There are initiatives resulting from the pandemic from which Colorado can learn. The identification of these positive learnings contributed to the recommendations of this report as areas to expand upon. Specifically, of the 375 Coloradans surveyed by OBH, 36% reported reduced travel to receive care and 10% reported reduced wait times for scheduling appointments. Some people felt that it was easier to share information with their provider (12%) and believed their care was "better" (11%) using technology.

The success of tele-behavioral health was highlighted by both providers and consumers as an area for continued investment. Specifically, community forum participants stressed the need to continue offering technology-based care "after things returned to normal." However, the Committee did highlight that tele-behavioral health should not be a perpetual substitute for in-person care when clinically appropriate or preferred by the consumer. Tele-behavioral health provides an additional access point for people who are seeking behavioral health services, and it is one tool in the toolbox for providers to assist clients that need access to a continuum of services that are not locally available. However, Coloradans should have the choice to utilize tele-behavioral health and in-person services. While tele-behavioral health was clearly an area that demonstrated success during the pandemic, providers also reported positive experiences in regard to the reduced state and federal regulations on restrictions related to tele-behavioral health service delivery and payment.

The ability of virtual technology to alleviate some social isolation and promote positive mental wellness is another potential area to enhance in the future. Seventy-one percent of consumers surveyed said that they have joined a virtual get-together and believed that it could be a good way to feel less lonely. This finding supports a need for the promotion of social gatherings by professional and community organizations. Over half (53%) of consumers expressed interest in virtual get-togethers sponsored by community organizations.

Additionally, behavioral health stakeholders worked to ensure the needs of Coloradans were met as best as possible in this new environment. At hospitals, behavioral health care workers were brought into the conversation almost from day one, which has not been the case in previous crises. As another example, mental health centers developed creative ways to reach the community, such as offering Facebook live sessions on managing stress, reviewing how to practice meditation, and sharing other resources for the general public. Providers for substance use disorders quickly transitioned to virtual services very quickly to continue client meetings and recovery meetings. State agencies offered unprecedented flexibility, such as allowing workarounds for signatures for consent to treat so that people could get the care they need. The Department of Corrections worked side by side with prison operations and other clinical service providers to adapt how treatment was delivered so that those efforts did not stop. COVID-19 required stakeholders to be innovative, and Coloradans were able to access services under extraordinary circumstances.

Considerations and Recommendations

Tele-Behavioral Health

Many Coloradans are in need of behavioral health services now. As a result of the COVID-19 pandemic, providers in Colorado quickly transitioned to tele-behavioral health so that they could continue to support people in need. When used within comprehensive care plans, tele-behavioral health has the potential to reduce no-shows and cancellations. Although tele-behavioral health has existed in small pockets in Colorado for years, new flexibilities have allowed for increased access for both clinicians and clients who may not have used it before. Colorado's Office of eHealth Innovation reports tele-behavioral health was rarely used prior to the pandemic compared to during the pandemic; Colorado has seen a 700%-500% increase in treatment of anxiety, depression, and substance use via telehealth/telemedicine.

The Committee defined tele-behavioral health as remote treament, via telephone or video conferencing.

Though telehealth provides an additional access point for people who are seeking behavioral health services, it is one tool for providers to assist clients that need access to a continuum of services. Tele-behavioral health can be an important solution to augment resource-dry communities that lack certain types of local services, including specialists and those who serve people with unique needs (e.g., those with limited or no English proficiency, those seeking LGBTQ-affirming care, or those with a preferred language, including sign language). Consumers should have the choice to utilize tele-behavioral health and in-person services.

The reality is that the most vulnerable populations are often hit the hardest during a crisis. Thus, these populations who are at heightened risk for lapses in care or have other disadvantages must be identified to ensure they have access to tele-behavioral health. In addition, Coloradans living in rural areas of Colorado that do not have broadband or lack internet service were at a unique disadvantage to being able to participate in remote service opportunities provided during the pandemic. Many people in these communities did not have the resources to obtain the necessary technology needed to engage in virtual/video tele-behavioral health.

There are limitations to tele-behavioral health. Some clinicians found it difficult to read body language and non-verbal cues from clients, making it easier to potentially hide or mask issues, and more difficult for clinicians to perform assessments. From the 197 respondents surveyed that represented 161 unique behavioral health organizations, the lack of broadband/internet availability was a substantial barrier for rural areas and lower-income households. For older adults who lacked internet/computer knowledge, it created difficulty accessing services.

The expanded use of tele-behavioral health was largely possible due to waivers issued by state and federal agencies. Governor Polis issued an executive order that made a temporary suspension of certain statutes to expand the use of telehealth services due to the presence of COVID-19, including waiving professional licensing limitations and Health Insurance Portability and Accountability Act (HIPAA) technology restrictions. In addition, the state Medicaid agency (HCPF) allowed for flexibility in payments for telehealth services, including the use of telephone only and live chat modalities. In addition the Office of Broadband and the Colorado Department of Local Affairs developed strategy, goals, and approaches for expanding broadband.

Several federal agencies waived regulations, including HIPAA regulations, that created a barrier to accessing care through tele-behavioral health. These agencies also allowed for the sharing of health information between providers without the need for consent to be written. In addition, CMS expanded Medicare telehealth benefits with temporary flexibilities regarding additional telehealth services in rural areas. These changes are proposed to extend permanently through federal Executive Order 13941. Without these critical changes to state and federal policy and regulations, the transition to tele-behavioral health would not have been possible.

RECOMMENDATION 1

Expand/Increase Tele-Behavioral Health Services, including:

A **Complete a comprehensive analysis for expanding tele-behavioral health,** including:

- Review research studies and literature reviews, incorporating current efforts, to determine the quality and effectiveness of tele-behavioral health services (in areas reflective of the Colorado landscape) as an element of the behavioral health service array.
- Continue to study best practices to incorporate tele-behavioral health into the treatment continuum, and develop best practice guidelines on how to coordinate in-person and virtual care.
- Conduct additional analysis to identify outcomes and understand the effectiveness of tele-behavioral health when used with specific populations.
- Engage clients, caretakers, and families who are using tele-behavioral health for their input on how to improve and strengthen tele-behavioral health services.
- Determine how many people have access to tele-behavioral health services (i.e., understand broadband access, access to technology, etc.). Determine how many providers are willing/able to provide tele-behavioral health services to understand the level of services available.
- Quantify cost savings from the payer, provider and patient perspective. Determine any increased cost to payers, if any.

B **Promote tele-behavioral health via training and public awareness,** including:

- Support providers who offer tele-behavioral health in developing campaigns and protocols to raise awareness of the resources.
- Make available accessible and attainable training for best practices in tele- behavioral healthcare delivery that includes how to transition to HIPAA compliant platforms.
- Promote best practice guidelines to help clinicians decide when telephone or video-conferencing methodologies are best in meeting unique client needs.
- Promote the Health at Home website (Healthathome.colorado.gov) and ensure it includes information about how to access behavioral health services.

C **Promote consumer-centric values for tele-behavioral health,** including:

- Ensure tele-behavioral health solutions have a relationship with providers and services that offer in-person and other levels of care to help augment and enhance the needs of the individual client.
- Ensure consumers have access to outpatient on-site care to ensure that clients truly have the option to visit in person, and don't feel restricted to only virtual options.

D **Review opportunities to permanently enact regulations and administrative flexibilities** put into place as a result of COVID-19 that promote the expansion of tele-behavioral health, including:

- Review SB20-212 (i.e., Reimbursement for Telehealth Services) and other legislation; executive orders; public health orders; and state agency rulemaking and administrative changes. Identify areas not addressed and, where needed, conduct a full review to determine which regulations should be made permanent, modified or repealed

E **Continue to strengthen the State's broadband infrastructure** (including internet, cell, satellite, and telephone coverage) for all of Colorado, including rural communities where internet connectivity and broadband are or can be a challenge. A state broadband strategy needs to reach all who need it for mental health and/or substance use disorder treatment and recovery services, with special considerations for vulnerable populations. As such, the State should explore and implement new innovations that support tele-behavioral health solutions without needing broadband or immediate cellular connection.

F **Ensure adequate, flexible resources are available to providers** who proactively conduct outreach to, and work with, the most vulnerable populations. The behavioral health system needs to be able to address disparities in access to care, in order to provide connectivity to individuals in need who otherwise do not have the technology and/or support necessary to engage in tele-behavioral health service. This may include providing technological hardware to clients, developing drop-in tele-behavioral health sites, or any other locally-designed and clinically-informed solutions.

G **Create a proactive outreach plan to identify and reach the most vulnerable populations** prior to and when a crisis arises. Work with the populations to determine how to ensure these populations have access to tele-behavioral health, and how best to operationalize the plan.

Mental Health and Substance Use Disorder Services

During the pandemic, physical distancing significantly altered the manner in which services are provided. In addition to changes to outpatient services being delivered via tele-behavioral health, other examples include modifications to admissions and discharge protocols for inpatient care, as well as to the delivery of medication-assisted treatments for individuals receiving substance use disorder services.

During the onset of the pandemic and "Stay at Home" order, it was not entirely clear which behavioral health services were considered critical under Executive Order D 2020 017, which instructed all businesses to close temporarily other than those qualified as a "Critical Business" under Public Health Order 20-24. The State had to act quickly to explicitly provide guidance on which critical services needed to continue, which included:

- Colorado Crisis Services, including the statewide hotline, walk-in centers, crisis stabilization units and mobile crisis services
- Withdrawal management programs
- Residential programs and services provided in facilities (jails, Youth Services etc.)
- Opioid treatment programs
- Medication-assisted treatment
- Outpatient services should be maintained if at all possible, including use of telehealth

Even with this communication, providers had difficulty being recognized as a critical business and struggled to acquire personal protective equipment (PPE) as suppliers rejected protective and other COVID-19-related equipment orders. This required OBH to issue an ad-hoc letter reiterating that, "behavioral health is an essential service." To best prepare and respond to future pandemics and disasters, it is important that behavioral health is not an afterthought, especially when it comes to needing psychiatric or substance use treatment beds for people with behavioral health conditions.

RECOMMENDATION 2

Behavioral Health Providers should be recognized as essential health care providers.

As a critical business, providers had to evaluate their capacity for any potential increase in demand. One of the pressing questions during the pandemic was in regard to the availability of services. Some providers had to limit their capacity despite an influx of individuals looking to access services, even if medical hospitals and emergency departments became overwhelmed with COVID-19 positive patients. This highlights a need to have a plan for the current pandemic and future state of emergencies that includes a protocol for massive diversion of behavioral health patients from emergency rooms and an ability to track capacity among behavioral health providers for key services.

RECOMMENDATION 3

Ensure the Capacity Tracking System, which is scheduled to launch in January 2021, is adequately resourced to function successfully and address any enhancements.

A Capacity Tracking System helps a hospital or provider understand how patients advance through the system, from admission to discharge. It offers real-time visibility so that staff have immediate knowledge of available beds and/or providers with capacity. In a situation such as COVID-19, where hospitals were expected to be overwhelmed and people were still in need of behavioral health care, a Capacity Tracking System is beneficial in understanding where to send people. Such a system could include key indicators such as the availability of psychiatric inpatient beds; units accepting infectious or symptomatic patients; psychiatric emergency room services; crisis services (including mobile crisis' ability to conduct community evaluations; availability of timely referrals; ability to handle the volume of calls/wait times; volume-to-staffing ratio; changes in where volumes are increasing); and outpatient services for mental health and substance use disorders (including capacity to do intakes, levels and types of care available); and staffing of services. This data is integral in knowing where services are available for new clients. The capacity tracking system will need to share a limited amount of information with the public, so that they are aware of what services are available and the outcomes of the existing services. The capacity tracking system will benefit both individuals needing inpatient services, and those being discharged from a hospital who need to find available services in the community. The System is currently scheduled to launch in January 2021. Once it is in place, it should be continually reassessed to ensure manual, daily entry of provider information is not be mandatory until the system is enhanced in a way that (1) minimizes administrative burden, (2) maximizes usability for both providers and the public (e.g. transitions from lists of providers to data visualization tools), and (3) undergoes stakeholder review and testing to minimize inaccuracies. Adding these additional requirements is a cost driver for providers.

OUTPATIENT SERVICES

Outpatient behavioral health services are those that do not require a prolonged stay in a facility. When there is not an ongoing crisis, these services could include counseling, group therapy, medical consultations, and psychiatry. Many of these services may be delivered via tele-behavioral health. Outpatient services also include crisis services (e.g., mobile response and walk-in-centers), which are available both during non-emergent and emergent times. These services along with other crisis response services can play an integral role in addressing the immediate and acute behavioral needs of Coloradans.

RECOMMENDATION 4

Expand services offered by the Colorado Crisis System. This includes considering the addition of services and scope to crisis services during a state of emergency to allow for:

- follow-up post-hospitalization;
- increased warm line staffing;
- increased peer services;
- care navigation;
- expansion of safe-to-wait services (STW) and use of qualified volunteers;
- divert calls to community providers/ partners;
- expansion of warm hand off; and,
- expansion of ongoing services provided by the Colorado Crisis Services to bridge care (up to 90 days) for delayed access to outpatient care.

This increased reliance on the crisis services system during a state of emergency/disaster illustrates the need to have an adequate plan to successfully increase capacity for the hotline to handle more calls and potential expansion of other crisis services in future emergencies. An expansion will require that the current service capabilities are defined and future state requirements for expanded crisis services are determined. That includes using data to determine if an expansion of the crisis system is truly needed or if existing services can manage demand. If the services offered by the crisis system change during a future crisis, this needs to be clearly communicated. For response services, in addition to crisis mobile services, there is an opportunity to replicate/scale existing programs instead of creating new programs (e.g., Support Team Assisted Response (STAR) program at Mental Health Center of Denver).

RESIDENTIAL, INPATIENT AND INTENSIVE TREATMENT SERVICES

People in need of inpatient and intensive treatment typically are those who are experiencing thoughts that make them dangerous to themselves or others. The group of individuals receiving these services are in need of intensive treatment and likely need additional support to manage the stressors of the current pandemic or other disasters. Per the aforementioned recommendation, the ability to track behavioral health bed availability is going to be key in future state emergencies, particularly if the medical systems become overwhelmed.

The State needs to fully integrate its behavioral health response with more details in Colorado's larger emergency response plan.[6] The plan needs to provide updated options and solutions for treating individuals who need an inpatient level of behavioral health care in the scenario in which the existing bed capacity is not available in regions of the entire state.

There are several regulatory functions that guide a facility's ability to serve clients. If those regulations are modified to be more flexible in Colorado's disaster/emergency response protocols, it could offset any delays in people accessing care.

RECOMMENDATION 5

Ease specific regulations and oversight standards to increase capacity during an emergency, including:

- Permit emergency credentialing at facilities where the licensed professional is not credentialed.
- The State to petition the easing of Joint Commission/CMS standards to allow repurposing of facility space not historically used for behavioral health.

The more easing of regulations and flexibility in the diversity of services a facility can offer, the better it may help to mitigate limited capacity experienced by other providers. Flexibility in permitting facilities to treat for both substance use disorder and mental health is important in meeting the needs of Coloradans with complex needs. Specific to facility-based substance use treatment, the State should ensure clients accessing bed-based services are able to be transferred to facilities to continue their SUD treatment in the event they are COVID-positive (or any infectious-disease-positive). This could be with a facility approved to provide medically monitored high-intensity inpatient substance use services (an American Society of Addiction Medicine 3.7 facility), assuming clients can be isolated, and the staff can be protected. As another example, it could also be with an Institution for Mental Disease[7] (IMD), with ongoing treatment services offered via tele-video by a SUD treatment provider.

RECOMMENDATION 6

Ensure clients accessing bed-based services are able to be transferred to facilities to continue their SUD treatment even when they are COVID-19 positive.

The easing of any regulation needs to ensure it does increase any safety risks for clients, such as ensuring suicide mitigation protocols are sufficient to address the risk for suicidality among clients. In addition, services still need to comply with the Americans with Disabilities Act (ADA), and providers need to ensure patients with disabilities get the required help with the provision of medical or behavioral health care, activities of daily living, speaking for the patient or keeping the patient safe, even during times when a health care facility may need to move to limited-visitor or zero-visitor policies. Patient and client safety have to continue to be the paramount consideration in any practice changes.

RECOMMENDATION 7

The safety and well-being of patients/clients should not be compromised to respond to a pandemic, disaster, or State emergency. This includes:

- Risk assessments should consider the risk of admitting (access, whole-person care, accountability) and not admitting a patient based on the care setting to safely treat them.
- Implement infrastructure and practices that prevent the use of seclusion as a physical distancing practice, given the negative health impacts of seclusion on patients and particularly those with behavioral health conditions.
- To comply with ADA and to ensure the best care possible, providers should have and be reimbursed for a designated assistance person to meet an individual's needs, including during times when a health care facility has limited-visitor or zero-visitor policies. For behavioral health services and supports beyond ADA requirements, facilities should explore other methods of support (e.g. virtual options), while balancing the constraints that led to visitation policy changes.

Any adaptations of regulations or practice that are in response to a State emergency cannot be complacent and should use continuous quality improvement to maintain safety.

RECOMMENDATION 8

The State Emergency Operations Plan should include continuous quality improvement, including:

- Identifying "lessons learned" from discharging patients with barriers to safe discharge.
- Using "lessons learned" to help determine when to expand bed capacity (e.g., convention center) versus when to convert existing facilities into different "beds" (e.g., Freestanding Emergency Departments (FSEDs), Ambulatory Surgical Centers (ASC), other residential providers).

Equally important to increasing bed capacity is (1) increasing intensive services to divert individuals away from an inpatient setting; or (2) increasing the number of discharges from a facility in an effort to free up beds. Preemptively being prepared to reduce the reliance on inpatient services during a surge or diminished capacity will be critical in mitigating collateral consequences. This includes providing post discharge supports to make the transition out of inpatient care successful or increase intensive in-home respite care.

RECOMMENDATION 9

During a state of emergency that burdens the inpatient bed capacity, preemptive efforts should be made to reduce the reliance on inpatient beds, including:

- Leveraging technology to increase post discharge support for patients (support groups, care coordination, Health-at-Home apps, etc.)
- Increasing community respite services and high intensity behavioral health community based treatment for children and adults.

Specifically, under COVID-19, the committee recognizes that the physical health of the provider and staff is equally important to that of patients/clients. Staff need the proper equipment to keep patients/clients well during their care. Mental health and SUD providers are medical providers who need the same access to protective equipment and cleaning services as traditional physical health settings.

RECOMMENDATION 10

Protocols and proper equipment are needed for staff working in substance use and mental health settings, including 24/7 residential and hospital facilities, including:

- Ensure the PPE resources available for medical providers are also available for providers and staff of mental health and substance use treatment facilities.
- Consider the health risks when conducting a welfare check. Ensure that the person doing the welfare check has the protection to be healthy.

TREATMENT OF SUBSTANCE USE DISORDER (SUD)

During a crisis, the treatment of SUD must adapt to a model that supports the person in need, while maintaining the safety of the provider. A number of SUD treatment modalities are reliant on social interaction (e.g., peer services, support groups) and access to medication distribution (e.g., naltrexone, buprenorphine, methadone). This makes them susceptible to significant disruptions of care quality when there are any limitations put on service delivery.

RECOMMENDATION 11

Ensure all treatment modalities are available to those seeking SUD treatment, via telehealth or other forms. This includes establishing different forums for social support groups to help individuals maintain recovery and other interventions that are group-based.

Gaps in intervention can have unfortunate consequences for individuals dependent on services to achieve or maintain their sobriety. In addition, SUD treatments that have a medical component need to continue providing services during a pandemic or State emergency. Ensuring clients' access to Medication Assisted Treatment (MAT) in a time of crisis like the COVID-19 pandemic is critical; ensuring they still are receiving counseling/therapy is also important.

RECOMMENDATION 12

Colorado should take steps to ensure that MAT services are not interrupted during a pandemic or State emergency. This includes creating multidisciplinary rapid response teams ready to deploy and support low staffing of SUD MAT and residential treatment programs throughout the State (this needs feasibility planning, with regional considerations).

OTHER SERVICES

Access to services is not limited to the availability of providers. During the current pandemic, disruptions occurred in other support areas that are critical for individuals accessing their care. Specifically, the interruption to public transportation or private transportation services hinders an ability of a person to access in-person care. Transportation was a barrier for specific populations, such as low-income or rural communities, prior to the start of the pandemic. During the pandemic, transportation barriers substantially increased as buses, Uber, and other ride-share programs essentially stopped, leading to difficulties in accessing services for those without reliable, personal transportation. There needs to be careful consideration given by the State to mitigate barriers to accessing care as it relates to emergent and non-emergent transportation during both the pandemic and non-pandemic times.

RECOMMENDATION 13

The State should address requirements that create barriers for greater access to transportation services.

CULTURALLY-INFORMED CARE

Providers should demonstrate proficiency in delivering culturally-informed care and have an understanding of the CLAS standards (Culturally and Linguistically Appropriate Services). Providing culturally-informed care is fundamental to the provision of quality patient care under any circumstances, particularly during a crisis. The National CLAS Standards were first developed by the HHS Office of Minority Health in 2000, and are intended to advance health equity, improve quality, and help eliminate health care disparities. The Standards establish a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services.[8] Behavioral health providers and/or administrators that ignore and/or do not understand the CLAS standards are prone to perpetuate disparities in health care. This includes linguistic access as it relates to the use of sign language for individuals who are deaf or hard of hearing.

Vulnerable and Underserved Populations

The behavioral health impacts of COVID-19 on vulnerable and underserved populations, such as children and youth, older adults and rural Coloradans, can be complex and profound. The first step is to identify those populations who may be in need of services but unable to access them. For instance, once social distancing protocols limited in-person access, it was difficult for individuals experiencing homelessness to access care. Almost all providers had transitioned to telehealth, and many people experiencing homelessness do not have regular access to a phone or computer. Special consideration should be given to addressing the impact of a pandemic or state of emergency on vulnerable populations.

Children and Youth

Children who have previously experienced trauma, economic disparities, separation, loss, anxiety, and depression are at an increased risk for increased behavioral health symptoms according to recent research.[9, 10] Specific to children, the Committee recommends increasing behavioral health screenings, identifying children in foster care who need behavioral health services, and providing funding flexibility where available. (See Attachment 4 for the full list of recommendations from the Children's Behavioral Health Subcommittee.) It is important to note that proactive outreach to children and youth, such as youth and teen mental health first aid, can play a significant role in developing protective coping skills which is important when dealing with a crisis.

BEHAVIORAL HEALTH SCREENING

During a pandemic, children and youth are often isolated and have a reduction of interactions with helping professionals. When those interactions stop, there must be other avenues by which children and youth in need can be identified. In addition, with less professionals engaged in a child's life and a lack of school time, there grows a concern the incidence of identification of behavioral health needs decreases. There needs to be a public health strategy to educate children, youth and families on the social/emotional implications that children are experiencing as a result of COVID-19 (e.g., fear of contracting the disease; advising parents not to go to the playground; avoiding contact with other kids; wearing a mask; and avoiding doctor offices and hospitals) as this could affect their development. The strategy should provide information to parents/guardians/caregivers on how to speak to their children or provide information to youth about the pandemic and how to help them identify a youth that needs help (e.g., what you should look for and what to do if you are concerned). Consider youth both as an audience and a mechanism to spread valuable public health information.

RECOMMENDATION 14

The state agency responsible for public health should coordinate with child-serving agencies and educational institutions to prepare a public education strategy to respond to the social/emotional implications that children are experiencing as a result of COVID-19.

As a result of increased isolation and the risk of increased behavioral health symptoms, widespread screening should occur in settings such as childcare, primary care, educational settings, the home, and other non-traditional venues where children might be. The ability to identify children and youth in need becomes increasingly important for children who lost a parent, family member, or loved one to Covid-19 or were hospitalized themselves for COVID-19. Children and youth's grief and long-term behavioral impact from the pandemic have to be addressed. This includes coordination by all agencies and professionals responsible for ensuring services are provided to the children and youth in need.

RECOMMENDATION 15

Develop new strategies and processes to identify and screen children and youth for their behavioral health needs.

RECOMMENDATION 16

Ensure evidence-based preventative measures that decrease suicide and other behavioral health concerns are adequately resourced in schools.

RECOMMENDATION 17

Ensure there is a strong balance of local and state alignment to have consistent and centralized access to information and coordinate available services between these agencies and educational institutions (i.e., "no wrong door" approach).

CHILDREN IN FOSTER CARE

Children in foster care are more likely to have experienced trauma related to abuse and neglect, distrust of adults, and the removal from peers or schools. Foster youth bring histories that are complicated by prior trauma, as well as potential fracturing of parental, family and sibling relationships related to out-of-home placement, termination of parental rights or post-termination adoption of siblings. In the current pandemic, many youth also experienced an interruption of regular visitations with parents, siblings and other important family members. In all of these circumstances, bereavement may become more complex and require specific interventions to assure children and youth can process and deal with the unexpected death of a sibling, family member or parent. This makes them more vulnerable in a pandemic such as COVID-19.

Without proper identification and support of behavioral health conditions (e.g., psychotherapy, psychiatry, family meetings, outings, support groups, and respite care), child or youth symptoms can escalate, and caregivers can experience burnout. As a result, identifying these children and youth and caregivers at the onset of a crisis and implementing flexible services and supports are necessary. Supportive services should both recognize the unique behavioral health needs of this population and provide targeted assistance for foster families. Preventative or timely caregiver training, telehealth, consistent family meetings, and safe activities are needed to reduce anxiety, depression, isolation, caregiver burnout, and other harmful repercussions.

RECOMMENDATION 18

The State, in conjunction with counties, should ensure that foster children and youth have the behavioral health services they need to successfully navigate the pandemic, specifically:

- Develop a process to identify children and youth in foster care who are receiving mental health therapy or substance use disorder treatment to allow for easy identification for mobile crisis and prioritization of other supportive services.
- Consider developing a protocol that defines youth in foster care as a specific subpopulation of children/youth in need of particular supportive services when dealing with the loss of a parent, family member or sibling.
- Develop virtual foster youth support forums to help mitigate isolation for foster youth.
- Develop a process to identify those youth who will "age out" of the foster care system during times of public health emergencies to assure adequate linkage to adult mental health, SUD, housing and other supportive services when a change of provider is required. Particular attention should be given to navigation and mentoring supports to help these young adults navigate the system and also to decrease isolation.

FUNDING FOR CHILDREN AND YOUTH SERVICES

The initial and prolonged changes that occur during a pandemic can cause sudden and unforeseen consequences for families. This can include but is not limited to economic hardship, family strife, domestic violence, substance misuse, and mental health degradation for one or more members of the family. Families who are commercially insured, under-insured, or non-insured often express in surveys that they go without services because of affordability. There is a need for funders of direct and support services to adopt flexible funding strategies that ensure all individuals and families can access all levels of behavioral health services regardless of their ability to pay. This should also include basic needs such as food and shelter, childcare, respite, crisis interventions, communication, and other necessities.

RECOMMENDATION 19

As it relates to a pandemic or State emergency, funding agencies of direct and support services for families should adopt flexible funding strategies that ensure all families can access all levels of whole person care and behavioral health services.

Given the existing limited number of providers who can provide child and adolescent specific behavioral health care that meets their level of need, it is important that in the current economic environment hindered by the pandemic.

RECOMMENDATION 20

For children's services, the State should assess which crucial community provider organizations are in jeopardy of closing or laying off their workforce or closing their program altogether. Efforts should be made to connect these providers with known resources, federal/state funding, and/or pandemic business loans.

Older Adults

In addition to children and youth, the behavioral health impacts of a pandemic like COVID-19 on older adults can be significant. Because older adults were identified as higher risk for contracting and dying from the virus, proactive measures such as reducing visitors and encouraging social distancing were established to protect these individuals. However, these practices can also lead to social isolation, difficulty engaging in services, and worsened behavioral health symptoms for older adults.

ACCESS TO TECHNOLOGY-BASED SERVICES

During COVID-19, when providers increased their usage of technology-based services, older adults were less able to engage in such services compared to younger populations. Older adults were more likely to have limited access to devices or often experienced difficulty utilizing technology-based services due to lack of skill related to the technological platforms.

Without access to technology-based services, older adults may lack accessible services which might result in the escalation of behavioral health symptoms. Thus, the tele-behavioral health recommendation [Recommendation 1(g)] to create a proactive outreach plan to identify and reach the most vulnerable populations should give consideration to this population.

SOCIAL ISOLATION

As older adults are a vulnerable population for contraction and severe consequences from COVID-19, many of them have experienced increases in social isolation as a result of staying home to reduce contact with others. As a result, many older adults may feel isolated from others and lack access to social engagement. This is exacerbated by the aforementioned difficulties with engagement in technology-based services, as it may be more difficult for older adults to participate in virtual social activities.

Furthermore, due to social distancing guidelines and attempts to keep older adults safe from contracting COVID-19, older adults may experience less support such as reduced contact with caregivers or home-based service providers. Professionals and others should be vigilant in checking in with older adults and probe for behavioral health concerns related to isolation.

In summary, the needs of vulnerable and underserved populations should be a priority in a future crisis. Once the most vulnerable populations are identified, determining how best to support them -- to meet them where they are -- is critical. Furthermore, given the limited data available to assess the disparities that exist in accessing behavioral health care during the pandemic, it is safe to assume that the inequities that existed prior to a pandemic, disaster, or State emergency, exist or are exacerbated during such an event.

RECOMMENDATION 21

Assess and rectify inequitable access for all Coloradans within children, youth and adult behavioral health services during the current pandemic and in future State emergency responses. This includes those factors resulting from structural/institutional racism.

Emergency/Disaster Behavioral Health Response

Colorado must maintain, and enhance, a coordinated behavioral health emergency disaster response and ensure the permanency of robust resources for preparedness. During the COVID-19 pandemic response, some disaster behavioral health response protocols were clearly established as a result of previous state of emergencies and disasters, such as forest fires and floods. However, there were a large number of protocols that were not as clear and required problem solving in the moment. There needs to be a "playbook" of crisis/emergency best practices that should be created and accessible to providers in a centralized location who may activate or have activated crisis standards of care. During a crisis, situations evolve quickly, and a decision tree (as well as the process of creating one) would help providers understand the range of situations that have currently occurred and what could/should be done next. Creating policy decisions now will reduce the confusion and stress during future emergencies.

Communication in an Emergency

During a time of crisis/state of emergency, it is critical for all state agencies to communicate and educate providers on new and evolving policies. While Colorado was quick to distribute relevant updates, the process of communicating information was a learn-as-you-go model. The Provider Survey indicated that the best way to communicate with their clients was to ensure that providers deliver updated information about their services through their website, email communications, and other forms of direct contact with clients.

Many state agencies were quick to establish centralized communication websites for the latest information on COVID-19. CDPHE understood that behavioral health communication was, and is, essential. In particular, under the integration of behavioral health in the joint information center, several web pages, guidance and other communication products were developed, including but not limited to:

- Promotion of the Colorado Crisis Services phone line across the State COVID-19 webpage
- Promotion of the Crisis Counseling Program
- Promotion of behavioral health coping materials
- Guidelines for behavioral health leaders

CDPHE's Emergency Response Protocol

The Colorado Department of Public Health and Environment (CDPHE) is charged with addressing the behavioral health components of the State's emergency preparedness, response, and recovery activities (see Attachment 5). Behavioral health is a critical component of any adequate emergency response plan, and preparedness efforts are enhanced by the inclusion of all behavioral health partners. For comprehensive response to be adequate, behavioral health must be included in the public health mission of addressing population needs, especially following a community crisis. For community behavioral health organizations to be successful contributors in responding during and after a crisis, they must be adequately valued and reimbursed for the role they have in supporting community resilience.

RECOMMENDATION 22

Formalize the role of community behavioral health organizations with the capacity and capability to actively participate in CDPHE's emergency preparedness, response, and recovery activities. This includes:

- Supporting behavioral health disaster response teams as a core service within the provider mission, with funding to allow for:
  - Sustainability through funding.
  - The creation of adequate reimbursement methods within state agencies for community resilience activities and community emergency response activities, which are not tied to individual services.

STATE AGENCIES IN COVID-19 RESPONSE

During the COVID-19 pandemic response, at a minimum, five different state agencies were involved in issuing guidance and updates. These agencies (CDPHE, DORA, HCPF, CDE and CDHS-OBH) had separate mechanisms for communicating with providers. Furthermore, multiple state agencies were independently attempting to secure federal funds without completely strategically aligning efforts. The creation of this Committee did result in an increased coordination across state agencies that proved to be beneficial. If there is a creation of a Behavioral Health Administration in Colorado, as suggested by the Behavioral Health Task Force, that agency may want to review with the aforementioned state agencies' opportunities to better coordinate and align behavioral health efforts.

RECOMMENDATION 23

The State should review the roles of the various state agencies involved in the pandemic response as it impacts behavioral health service delivery and coordinate and align state agencies for emergency responses in meeting the behavioral health needs of individuals and communities.

Funding and Regulation Flexibility

Funding and regulation flexibility for providers is critical during a state of emergency. During the COVID-19 pandemic, providers highlighted the critical benefit that funding and regulation flexibility had in their ability to provide behavioral health care in a rapidly changing environment.

Associations representing Colorado's behavioral health providers reported that when strictly funded in a fee-for-service environment and billable encounters are down, or when 24/7 facilities have to reduce the number of clients served, the cost to run those programs does not also decline. They reported that without adequate base funding for the behavioral health safety net there may not be enough elasticity in the system to have the ability to stay viable and supportive to the clients and community throughout the length of a crisis. In addition, there was concern that the pandemic has stretched already thin resources and without the necessary funding to support the system during such client fluctuating participation in services.

Several state agencies provided funding flexibility for providers. OBH issued Emergency Funding Flexibility guidelines that allowed providers to continue to deliver direct services. Providers were permitted to acquire supplies and tools that were not anticipated at the time of contract budgeting, such as PPE, additional cleaning supplies, and technology/devices for telehealth. In addition, the State Medicaid agency (HCPF) secured state and federal flexibility that focused on eligibility (coverage and processes), provider enrollment, telemedicine, and long-term care services administration and supports. Specific to telemedicine flexibility, in March 2020, HCPF passed emergency rules that allowed a wider array of providers to bill on a fee-for-services (FFS) basis and added new modes including telephone and live chat. (SB 20-212 made these emergency provisions permanent). These telemedicine provisions allowed Medicaid community mental health centers and pediatric behavioral health providers to bill their in-person rates for FFS benefits. Regional Accountable Entities followed suit and liberalized their existing telemedicine policies.

Additionally, Governor Polis ordered the temporary suspension of certain statues to expand the use of telehealth services. The order directs the Colorado Department of Regulatory Agencies' (DORA) Division of Insurance (DOI) to issue emergency rules requiring health insurance carriers regulated by the State to permit providers to deliver clinically appropriate, medically necessary covered services using telehealth services. In early April, DORA released Emergency Regulation 20-E-05 addressing the reimbursement of telehealth services using non-public facing audio or video communication products during the COVID-19 nationwide public health emergency.

The flexibility of funding guidelines and the adjustment of rules and regulations ensured that Coloradans in need of services were able to access them in a timelier manner. In preparing for the next statewide emergency, these steps should be considered and incorporated into plans to enable a more agile response. Maintaining funding flexibility when possible affords providers and the persons receiving care the ability to determine the best mode of treatment.

RECOMMENDATION 24

Maintain flexible policies to provide services by telephone and videoconferencing.

When considering funding flexibility, reimbursements should take into account that facilities provide significant support to providers working remotely. Additionally, the following should accompany reimbursement considerations for tele-behavioral health:

- Provide further clarification on specific funding waivers and exceptions.
- Provide clarification on where/what/how to be flexible in a pandemic or crisis and state that explicitly
- Create a list of services that could be turned "on" (approved) in a pandemic/crisis.

There may also be options for the state to petition waivers from the federal government on funding regulations. During the COVID-19 pandemic, several federal agencies, including that for Medicare and Medicaid, issued regulatory waivers to ease the access to care and reimburse providers for tele-behavioral health services. There may be an opportunity during a future crisis, to quickly expand the workforce if additional federal regulations were waived.

RECOMMENDATION 25

Explore with the federal Medicaid agency on expanding the pool of Medicaid providers by allowing non-contracted Medicaid providers to provide services to Medicaid recipients quickly.

Funding flexibility alone will not ensure that there is an adequate amount of services available for those in need. Budget cuts for behavioral health direct care services result in less resources available during the current and future State emergencies. Minimizing these cuts increases the ability of the State to respond with a sufficient level of behavioral health services to mitigate the impact of pandemics and disasters.

A Healthy Behavioral Health Workforce

The provision of quality behavioral health care is inextricably linked to the health of the workforce. The onset of COVID-19 necessitated rapid change in organizational operations, resulting in significant impacts on behavioral health care workers. Almost immediately, providers were required to alter their approach to delivering care, frequently through the use of technological solutions or, sometimes, cutting back or eliminating services entirely. To complicate matters, changes in care delivery coincided with an increased need for services. Feedback from providers stated that employees engaged in direct client care voiced increased compassion fatigue and feared contracting, or spreading, the virus. The initial lack of personal protective equipment compounded this fear, as did structural issues which limited the ability to maintain social distancing standards. The workforce further struggled with the same personal stressors facing the rest of the nation, such as balancing childcare demands and caring for sick loved ones.

Services for frontline healthcare workers and first responders

Ensuring the identification of, and access to, confidential care is vital for the behavioral health workforce. Information about primary prevention tools and confidential treatment options should be made available. Standardized assessments can prove useful for assessing burnout and other dimensions of well-being (e.g., stress, work-life integration, meaning/purpose in work) in workers. Peer assistance programs offer in-depth assessments, referrals, and sometimes direct treatment, for individuals struggling with behavioral health or medical problems. Using federal funds, OBH was able to contract with the University of Colorado, School of Medicine to provide behavioral health supports for medical professionals, front line workers, and first responders to COVID-19.

Conclusion

A strong, accessible behavioral health system is critical to meet the demands for substance use and mental health care during a crisis. The initial phase of the COVID-19 response offers many key lessons that should not only inform future disaster planning, but also guide behavioral health system reform over the coming years. Providers and stakeholders across Colorado were quick to adapt the provision of services, and their quick responses likely helped thousands of Coloradans. We also learned what we need to do better in terms of emphasizing behavioral health assistance as an essential service, and reaching the most vulnerable and underserved populations. There are opportunities to enhance outpatient, inpatient and SUD services. Tele-behavioral health can be a powerful mechanism to provide timely services when in-person meetings are not an option; however it should never be the only option. Caring for the workforce will help to deliver high-quality services. As is the case with all services available during a crisis, they need to be resourced. This should be considered during the economic downturn and how that impacts the ability to fund direct services and implement the recommendations of this report.

This Committee had a limited timespan of five months to make recommendations to address the impact of COVID-19 pandemic on Coloradans and identify opportunities to improve the behavioral health system in response to future state disasters or emergencies. With that said, there are undoubtedly topics and subject matter areas that were not addressed and need further exploration. For example, although important, this Committee was not able to address the social determinants of health or the use of the Adverse Childhood Experiences Survey as it relates to the pandemic. Strengthening Colorado's behavioral health system, as laid out and recommended in the Governor's Behavioral Health Task Force blueprint (of September 2020), will result in better behavioral health care in times of a pandemic, disaster, or state emergency.

Integrating the recommendations reflected in this report into the implementation plan of the Behavioral Health Task Force will better prepare Colorado for its response during any potential future crisis.

APPENDICES

Appendix 1. Acronyms

ADA	Americans with Disabilities Act
ASAM	American Society of Addiction Medicine
ASC	Ambulatory Surgical Centers
CDE	Colorado Department of Education
CDHS	Colorado Department of Human Services
CDPHE	Colorado Department of Public Health and Environment
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
COVID-19	2019 Novel Coronavirus
DOI	Colorado Division of Insurance
DORA	Colorado Department of Regulatory Agencies
FDA	Food and Drug Administration
FSED	Free Standing Emergency Departments
GEEERC	Governor's Expert Emergency Epidemic Response Committee
HCPF	Colorado Department of Health Care Policy and Financing
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IMD	Institution for Mental Disease
KFF	Kaiser Family Foundation
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MAT	Medication Assisted Treatment
OBH	Office of Behavioral Health
PPE	Personal Protective Equipment
SB	Senate Bill
STAR	Support Team Assisted Response
STW	Safe to Wait Services
SUD	Substance Use Disorder
The Committee	The COVID-19 Special Assignment Committee
The Task Force	The Behavioral Health Task Force

Appendix 2. Voting Record

COVID-19 Special Assignment Committee

7/22/2020 Tele-Behavioral Health Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Recommendation 1	18	18	0	0
Recommendation 2	18	18	0	0
Recommendation 3	18	18	0	0
Recommendation 4	18	18	0	0
Recommendation 5	18	18	0	0
Recommendation 6	18	18	0	0
Recommendation 7	18	18	0	0

9/17/2020 COVID-19 Special Assignment Committee Report				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
COVID-19 Special Assignment Committee Report	16*	16	0	0

***Note that one person did not support recommendation #4**

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Attachments

Attachment 1: COVID-19 Behavioral Health Access Client Survey Results

COVID-19 Behavioral Health Access Client Survey Results

Background and Methods

In July 2020, the Colorado Department of Human Services, Office of Behavioral Health (OBH) conducted a survey in partnership with the Colorado Department of Health Care Policy and Financing (HCPF) to examine **how COVID-19 impacted factors related to mental health or substance use treatment in the state**. The survey addressed four domains: 1) change in mental health and substance use; 2) behavioral health concerns for children; 3) behavioral health care access; and 4) alternative approaches to behavioral health and outreach.

Some survey respondents helped contextualize the results during a community forum in August. OBH used a convenience sample of individuals who received publicly-funded health care through a contact list managed by HCPF. The sample consisted of **375 respondents**. The majority of respondents identified as female (n=292, 78%), Caucasian (n=240, 64%), and had a combined family income of less than $30,000 (n=214, 58%). Respondents lived across Colorado, but primarily resided in urban counties (n=331, 88%).

OBH examined responses for the entire sample and for group differences by race and ethnicity, income, rural location, and caregiver status. Few differences existed among groups, which is highlighted in the results. Importantly, the absence of significant differences may be due to the lack of diversity among respondents, which does not fully represent the true demographic distribution related to gender identity or the race/ethnicity of all Coloradans.

Key Takeaways

Mental Health and Substance Use: Respondents said they experienced anxiety and stress “often” at the onset of the pandemic; depression and anxiety increased significantly between March and July.

Behavioral Health Concerns for Children: The majority of caregivers were concerned about a variety of issues related to the dependent’s behavioral health, and over one-third were uncertain that children could receive behavioral health care if school was closed.

Behavioral Health Care Access: The majority of respondents reported “no change” in their ability to pay for behavioral health services. Medication cost may have been a driving factor among those respondents who saw increased payment difficulties. Many respondents expressed support for using technology to receive care.

Alternative Approaches to Behavioral Health and Outreach: The majority of respondents supported alternative means to improve behavioral health, including the use of mobile vans and virtual gatherings.

Results

Mental Health and Substance Use

Respondents reported the frequency in which they experienced certain mental health problems (depression, anxiety, stress, feeling alone, anger, and suicidal thoughts) at the start of COVID-19 (March 2020) and in July using a scale of “never” “rarely” “often” or “always” (0-3 points).

Regardless of time period, the highest rated problems were anxiety and stress, with respondents reporting that they experienced these "often" (anxiety July average=1.6, stress July average=1.8). **Over time, respondents reported small, but statistically significant, increases in depression** (March average=1.1; July average=1.3, p<.001) **and anger** (March average=1.0; July average=1.1, p=.005), although both problems were reported, on average, "rarely." Some community forum participants said that increased anger stemmed not only from the pandemic, but also the unrest over racial injustice during the same time. Approximately 11% (n=42) of respondents believed that they used drugs or alcohol "too much" to help them cope with COVID-19.

> I probably would have been better off if I had already been established with a therapist rather than trying to reach someone during the pandemic when the phone lines were overwhelmed."- Survey respondent

Behavioral Health Concerns for Children

Nearly half of respondents cared for dependents under the age of 18 in their home (n=167, 45%). Of these, the majority were concerned about children missing major milestones (n=96, 58%), feeling alone or isolated (n=95, 57%), children's mental health (n=92, 55%), online schooling (n=91, 55%), and adapting to new routines (n=86, 52%). **Notably, more than one-third of respondents** (n=58, 35%) **were uncertain that children in their home could receive behavioral health care if school was closed**.

Respondents reported the degree to which they were concerned about issues impacting children using a scale of "not at all worried," "a little worried," "fairly worried," or "very worried" (0-3 points). **Participants who made less than $30,000 were significantly more concerned about being able to meet children's basic needs, such as food or housing, compared to higher-earning respondents** ($30,000 and below average=1.6; above $30,000=1.2, p=.014). Additionally, participants who identified as Caucasian were more likely to worry about their children's general mental health compared to individuals who identified as BIPOC or multiracial (Caucasian average=1.80; BIPOC or multiracial average=1.42, p=.02).

Behavioral Health Care Access

In the year before the pandemic began, 164 (44%) respondents received behavioral health care. **Paying for care was "somewhat" or "much" harder for one-third of these respondents** (n=55, 33%) **after COVID-19, but the majority reported no change in their ability to pay** (n=105, 64%).

Community forum participants noted that payment difficulty was primarily due to the cost of medications. Approximately one-quarter (n=93, 25%) of respondents used behavioral health services since COVID-19 began. Treatment was not always available for some individuals; 12% (n=46) of respondents tried to get an appointment after the pandemic began, but were unable. Individuals who sought treatment after COVID-19 received care via technology, such as video or telephone (n=71, 76%) or a combination of technology-based and in-person services (n=14, 15%); **most believed the care was "good" or "very good"** (n=72, 85%).

Colorado Crisis Services offers a variety of supports across the state, including a phone or chat line, walk-in centers, mobile response, stabilization units, acute treatment units, or respite care. While only 6% (n=23) of survey respondents used Colorado Crisis Services since COVID-19 began, 61% of these were first time users.

Respondents identified behavioral health care "silver linings" that resulted from the pandemic. Benefits included reduced travel (n=134, 36%) and wait times for scheduling appointments (n=38, 10%) or waiting for a scheduled appointment to begin (n=47, 13%). **Some respondents felt that it was easier to share information with their provider** (n=46, 12%) **and believed their care was "better" (n=43, 11%) using technology.** Community forum participants stressed the need to continue offering technology-based care "after things returned to normal".

Alternative Approaches to Behavioral Health and Outreach

Mobile health units are vehicles (typically vans) that travel to different communities to provide medical or mental health services, offering individuals a more convenient way to receive care than traditional brick and mortar offices. While the majority of respondents had access to reliable transportation (n=314, 84%), **over half** (n=219, 58%) **expressed interest in using mobile units to receive their behavioral health care if units were available locally.**

> "Some people find their church practitioners helpful, some people find alternative methods helpful like animal therapy. Only allowing psychologists or psychiatrists to provide care is limiting people desire to seek help." – Survey respondent

Virtual gatherings are events where people use technology to participate at the same time from different locations. The majority of respondents said that they have joined a virtual get-together previously (n=267, 71%) and believed that it could be a good way to feel less lonely. **Over half** (n=197, 53%) **of all respondents expressed interest in virtual get-togethers sponsored by community organizations.**

Understanding how people get health care information helps the State effectively reach consumers. Respondents most frequently received information about behavioral health services from providers via conversations (n=137, 37%), websites (n=133, 35%), or email (n=106, 28%), followed closely by family and friends (n=110, 29%) and human services websites (n=86, 23%). Understanding service availability was the most frequent suggestion for improving behavioral health emergency response (n=22, 6%). Community forum participants suggested that the State provide information about how to advocate for statewide change in behavioral health care.

Appendix - Client Survey Questions

(reformatted for brevity)

1. What did you feel or think when COVID-19 started in Colorado in March 2020? Never, Rarely, Often, Always
   Depressed, sad or hopeless /Anxious, fearful or nervous / Stressed / Alone / Angry /I thought about ending my life
2. What do you feel or think now?
3. Do you think you are taking drugs or alcohol to cope with COVID-19 too much? Yes No
4. Do you care for children ages 3-18 years in your home? Yes No
5. >>*If yes,* How worried are you about the following? Not at all worried, A little worried, Fairly worried, Very worried
   Children getting used to new routines / Child care / Meeting children's basic needs such as food and housing / Children's mental health / Children feeling alone or isolated / Children missing out on major milestones, like graduation or a birthday party / Doing distance or online learning at home
6. Can your child(ren) still get behavioral health care, such as counseling or medications, if their school is closed in the Fall? Yes No I don't know N/A
7. *In the year before* the COVID-19 outbreak (March 2019 to March 2020), did you get care for mental health or substance use at least once? Yes No
   >>*If yes,* Has your ability to pay for this care changed since COVID-19 began? Much Easier, Somewhat Easier, Somewhat Harder, Much Harder, My ability to pay hasn't changed
8. Have you had or tried to get counseling services for mental health or substance use since COVID-19 began in March 2020? Yes, and I had an appointment, I tried but did not get an appointment, No
   >> *If yes and had an appointment,* How did you go to your appointment? Using phone or video (telemedicine) / I went in person / I have used phone or video AND gone in person
   >>*If used phone or video, or both phone/video AND in person,* How was your visit using phone or video?? Very bad, Bad, Good, Very good
9. Do you have reliable transportation to get to mental health or substance use care? Yes No
10. Some communities don't have a place to get mental health or substance use care. If a mobile mental health and substance use clinic came to your community, would you be interested in using it? Yes No
11. Have you used any Colorado Crisis Services since COVID-19 began? This includes calling or texting the Colorado Crisis Line or going to a crisis walk-in center, crisis mobile response, crisis stabilization unit, crisis acute treatment unit, or crisis respite care. Yes No
    >> *If yes,* Was this your first time using Colorado Crisis Services? Yes No
12. How do you get information about mental health and substance use services where you live? (multiple options provided)
13. Has anything been good about getting mental health or substance use care during COVID-19? (multiple options provided)
14. Do you have a reliable way to use the internet at home? Yes No
15. Do you own a computer, smartphone or tablet that is reliable to use on the internet? Yes No
16. Have you had a virtual get-together with people, such as on a video chat using an app like Zoom, FaceTime or Skype? Yes No
17. >> *If yes,* Do you think virtual get-togethers are a good way for people to feel less lonely right now? Yes No
18. Are you interested in going to a virtual get-together with community organizations? Yes No
19. What could you have known before COVID-19 that would have made getting mental health or substance use care easier?
20. Is there anything else you want to tell us about making mental health and substance use care better during emergencies like COVID-19?
21. What's your age?
22. Are you _____? (Gender identify question - multiple options provided)
23. Are you of Hispanic, Latinx, or Spanish origin? Yes No Prefer not to answer
24. What was your total family income last year before taxes? (multiple options provided)
25. Which race do you most identify with? (multiple options provided)
26. What county do you live in? (multiple options provided)

Attachment 2: COVID-19 Behavioral Health Impact Evaluation

COVID-19 Behavioral Health Impact Evaluation:

A Report to the Behavioral Health Task Force COVID-19 Special Assignment Committee

Prepared by the Colorado Department of Human Services,
Office of Behavioral Health

July 2020

COLORADO
Office of Behavioral Health
Department of Human Services

Acknowledgements

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Table of Contents

Executive Summary

The Office of Behavioral Health (OBH) Evaluation Team conducted an evaluation to understand the impact of COVID-19 on behavioral health and behavioral health service provision in Colorado. Data were collected via key informant interviews, focus groups, and an online survey. Respondents were representatives from organizations that provide direct care to clients with behavioral health needs or from organizations that provide other forms of assistance (e.g., housing, advocacy, after school programs) to this population.

Key Takeaways

Needs of Clients

- The COVID-19 pandemic affected the behavioral health needs of Coloradans, leading to the prevalence of stress, anxiety, social isolation, and financial hardship accompanied by a concurrent demand for behavioral health services and support.
- Older adults (65 years and over) and individuals who are homeless were most frequently mentioned as being particularly impacted by the COVID-19 pandemic, followed by adolescents, young adults, and individuals in congregate housing/residential care.

Organizational Response

- Organizations turned to, or scaled up, the use of technology to provide remote-based services to meet the behavioral health needs of Coloradans.
    - Technology solutions' uptake and impact varied. For some clients, particularly adolescents, technology improved engagement. Others faced more difficulties using technology (i.e., clients with substance use disorders, severe and persistent mental illness, Intellectual or Developmental Disorder, Autism Spectrum Disorder; justice-involved populations [e.g., sex offenders]; those lacking reliable internet access or devices; clients with lower levels of technological literacy; older adults, and those experiencing homelessness).
- Assistance provided by the State and other entities empowered organizations to continue service provision.
    - The State's expanded telehealth reimbursement structure allowed reimbursement for more provider types and types of telehealth modalities (e.g., telephone-based assessments).
    - The State enabled more flexibility in how organizations could spend funds. This was particularly advantageous in situations where providers needed to purchase new technologies in order to continue services.
    - Entities such as the Federal government, technology companies, non-profits, and private foundations provided grants, equipment, and other resources that allowed organizations to more quickly and effectively adjust their services and provide behavioral health care to clients.

Respondent Recommendations

Recommendation 1: Expand the State's Support for the Use of Technology-based Services

- Expand technological infrastructure (equipment, software)
- Support/expand telehealth reimbursement (service modalities, provider type)
- Provide flexible funding for technology purchases
- Support technology training for behavioral health staff (e.g., how to use equipment/software, allowable billing and coding information)
- Expand broadband/internet capabilities in rural areas, reservations

Recommendation 2: Improve Behavioral Health Preparedness and Communication

- Develop standard operating procedures for behavioral health emergency planning and response
    - Develop and coordinate among State agencies and behavioral health partners
    - Share distribution and training plans
- Make policy decisions now to reduce confusion and stress during emergencies
- Build personal protective equipment stockpiles now - at minimum: masks/respirators, gowns, gloves, and footwear (different items may be needed for other emergencies)

Recommendation 3: Ensure a Healthy Workforce

- Implement a worker-first (also) mentality; the workforce must be healthy to provide good care
- Improve efforts to reduce compassion fatigue, burnout, isolation, and turnover
- Provide hazard pay as a morale booster/show of appreciation for clinical and frontline workers in times of crisis
- Implement public health measures to ensure a safe workplace

Additional Respondent Considerations

- Continue organizational communication efforts from the State to providers through the end of the COVID-19 pandemic
- Recognize the behavioral health needs of and provide support for clients, their families, and caregivers
- Acknowledge and explicitly address the differential impact of the COVID-19 pandemic on vulnerable populations

Background

In May 2020, Governor Jared Polis created the COVID-19 Special Assignment Committee within the Behavioral Health Task Force to evaluate the behavioral health crisis response in Colorado to COVID-19 and provide recommendations on improvements to behavioral health services for any future crises. To assist members of the COVID-19 Special Assignment Committee in decision-making, the Office of Behavioral Health (OBH) conducted an evaluation to understand how COVID-19 impacted behavioral health needs, how organizations responded, and how the State can improve behavioral health responding in the future. Feedback was collected via key informant interviews, focus groups, and an online survey.

The evaluation centered around three main research questions:

1. What behavioral health needs emerged or were amplified by the COVID-19 pandemic?
2. What operational changes were made within organizations to address these challenges?
3. What should the State do to support agencies in their continued response to the COVID-19 outbreak and in future emergency situations?

Data collection was conducted using three methodologies: key informant interviews, focus groups, and an online survey. **Survey responses provided insight into the scope of the problems, whereas key informant interview and focus group data were primarily used to contextualize and understand the nuances of survey responses. All frequencies detailed in this report reflect survey response data, unless otherwise noted. Responses do not represent the true distribution and frequency for which needs and response occurred throughout the State.**

Potential respondents were identified as representatives of organizations who provide direct care to clients with behavioral health needs or to those who provide other forms of assistance (e.g., housing, advocacy, after school programs) to this population. The COVID-19 Special Assignment Committee and OBH staff compiled a list of potential respondents, with a particular focus on reaching organizations that served marginalized or disproportionately affected populations. **A total of 197 respondents participated, representing 161 unique behavioral health organizations.** More information on the Methods and respondents can be found in Appendix A.

Findings

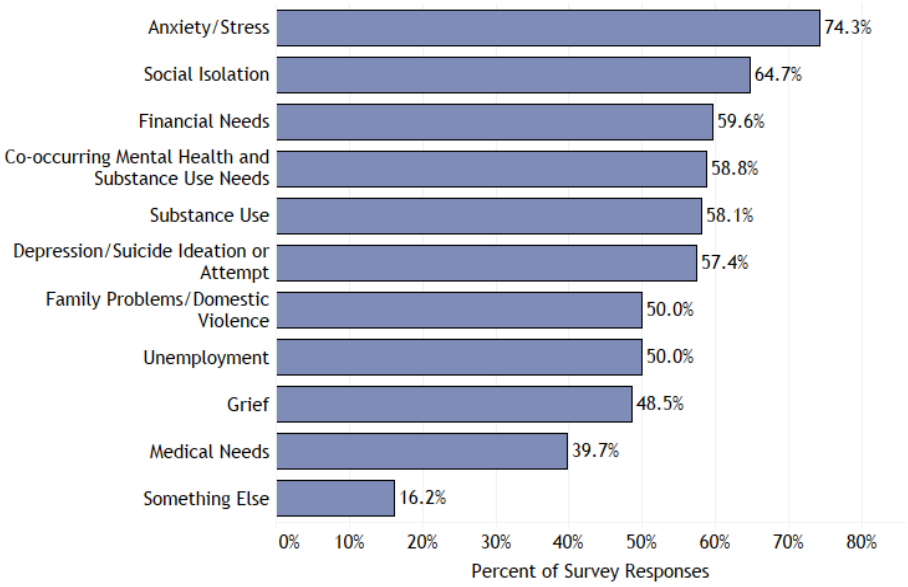
Statewide Behavioral Health Needs

KEY TAKEAWAY: The impact of COVID-19 on behavioral health is varied and far-reaching. Anxiety/stress and social isolation lead the list of reported client stressors, but the impact of COVID-19 goes much deeper. Clients had difficulty knowing whether services were available or how to obtain care. Many respondents noted a lack of safe housing options for clients. Organizations had difficulty keeping some services open, particularly group-based care and drop-in services. Wait times for some service options increased. Organizations struggled with financing care and maintaining sufficient staff. Organizations further struggled with a workforce that, like many community members, were scared about catching or spreading the virus; the lack of personal protective equipment compounded this issue. Compassion fatigue impacted many working in the behavioral health arena.

Client Stressors and Barriers to Behavioral Health Services

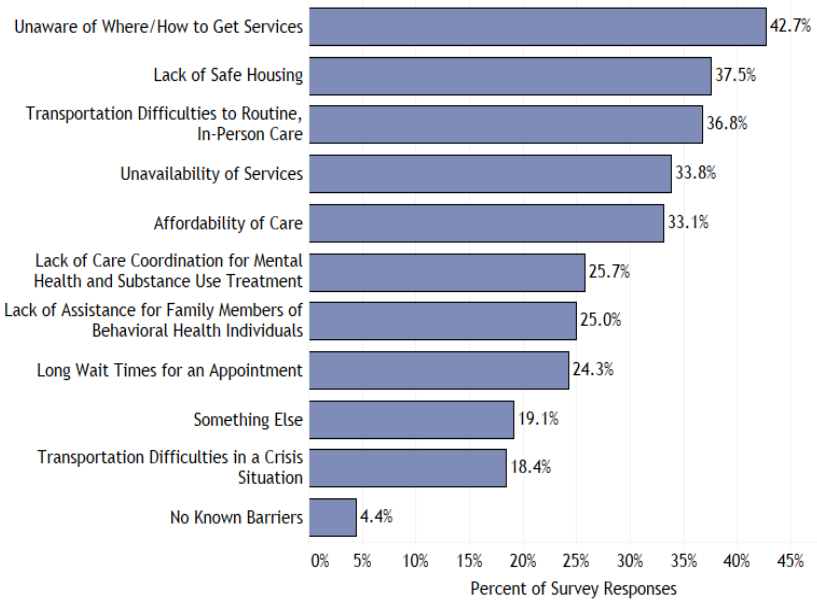
All survey respondents observed behavioral health stressors in the clients they serve as a result of COVID-19. The most commonly reported stressors were anxiety/stress (74.3%), social isolation (64.7%), and financial needs (59.6%) (Figure 1). Anxiety and stress often stemmed from social isolation and relative lack of contact with clients' usual support systems. Providers reported the prevalence of co-occurring mental health and substance use needs, substance use, and depression/suicidal ideation or suicide attempts. Unemployment was an additional stressor respondents identified that clients experienced as a result of COVID-19, and subsequently some organizations shifted their focus to help meet the basic needs of clients. Financial challenges/unemployment was the most frequently reported stressor related to basic needs. Some respondents voiced concerns for client's access to MAT services as well as childcare/school engagement needs for clients with children.

Figure 1. Client Stressors Due to COVID-19 Crisis (Survey Responses)



A number of barriers impacted clients' ability to receive care (Figure 2). Many clients were unaware of where or how to get services at the start of the pandemic (42.7%). Among survey respondents, lack of safe housing (37.5%), transportation difficulties to routine, in-person care (36.8%), unavailability of services (33.8%), and affordability of care (33.1%) were reported as notable barriers to clients. Key informants echoed that their ability to provide transportation services for clients to routine, in-person care were significantly reduced, which served as an additional service provision barriers for individuals in need of transportation.

Figure 2. Client Barriers to Accessing Behavioral Health Services during COVID-19 Crisis (Survey Responses)



Organizational Impacts

Service operations among organizations were severely impacted by the COVID-19 pandemic, most notably for traditional face-to-face services. The number and types of services were restricted, increasing the wait time for some services (particularly residential). Providing group therapy/group-based services, drop-in services, and community-based services was difficult for organizations, especially among those serving populations who were homeless or living in shelters. Whereas some respondents noted that client engagement suffered, others noted improvement in this area, such as among youth who were offered telehealth options.

Administrative operations further suffered in the face of the COVID-19 pandemic. Without consistent revenue streams, organizations faced many financial concerns and constraints. Some were unable to keep services open, purchase new and necessary equipment, or pay staff (who, consequently, had to be laid off). Structural issues included workplace configurations which did not allow for social distancing, thus reducing the number of clients who could be served in-person. The impact on personnel was widespread. Staff expressed concerns about contracting (or spreading) the virus, a fear compounded by the lack of personal protective equipment (PPE) in organizations. Respondents discussed the growth of compassion fatigue and increased burdens on workers. Staff members were required to stay up-to-date with rapidly changing information and processes, work longer hours; adjust to working remotely, and cope with stress related to their household's health while still trying to provide quality care. One

> "*We have folks who are homeless and suddenly didn't have a place where they could get a shower or charge their phone because there were no in-person churches, or places they would typically go for those basic needs weren't allowed to have them in*."

interview respondent described staff members' feelings as, "guilt around not being able to do everything". Lastly, family considerations also impacted staff; those with children may have lacked adequate childcare, and staff worried about exposing members of their household to the virus.

Population-specific Differences

Numerous groups of people were adversely impacted by the COVID-19 pandemic. The impact on **older adults (65+)** included a lack of access to technology (devices or skill) that prevented engagement in technology-based services, increased social isolation, lack of stimulation and routines that contributed to increased behavioral health concerns, and reduced contact with caregivers or home-based services providers. **Homeless individuals** no longer had access to regular services to help them meet basic needs, feared contracting COVID-19 based on their living situations, experienced social isolation when placed in hotels for recovery from COVID-19, and had increased difficulty accessing meal services.

Other groups differentially impacted included adolescents, young adults, and individuals living in congregate care, among others**. Adolescents (12-17)** were impacted by the transition to online learning (leading to negative educational outcomes), increased social isolation and barriers to accessing meals, and reduced contact with non-household adults who provide guidance and oversight (e.g., identifying and reporting abuse). **Young adults (18-25)** experienced disruption to their life plans due to the pandemic, which resulted in feelings of "being stuck". Individuals who lived in **congregate housing** were not able to have visitors, resulting in social isolation and worsened behavioral health symptoms. Similarly, care for individuals who were **incarcerated** was limited (or eliminated) due to the implementation of social distancing measures. Those with **severe mental illness** were predisposed to having disproportionately larger effects from the transition of services (e.g. the pandemic situation fitting into paranoia of some clients, concerns about being watched through technological devices), resulting in increased difficulty engaging this population in services. Additionally, individuals who are **not fluent in English** struggled with accessing translation services on technological platforms and individuals in the **deaf and hard-of-hearing community** were unable to participate in services offered over the telephone or in-person with masks. Many **individuals with intellectual or developmental disabilities** experienced acute isolation and disruption in routine because day programs were closed.

Statewide Behavioral Health Response

KEY TAKEAWAY: By and large, organizations turned to, or scaled up, the use of technology to provide remote-based services to meet the behavioral health needs of Coloradans. The use of technology worked better for adolescents but not as well for clients with certain behavioral health conditions, living situations, or those unfamiliar with computer-based systems. State flexibility on telehealth reimbursement and spending enabled organizations to continue service clients.

Organizational Adaptations

Surveys indicated that the most common organizational response to COVID-19 was the development of new policies and procedures that enabled them to continue services, such as procedures around client assessment and discharge (41%), client referrals (30%), food services or deliveries (27%) or "other" (52% - federal and other regulatory procedural changes). Organization further "adapted" by closing or restricting services (31%) and reallocating funds or reducing spending (27%). Some respondents described how their agencies attempted to increase communication with community members through creative means such as text messaging, socially distanced home visits, and even writing letters.

> *"People have really been thinking outside the box because they're dedicated, passionate, and compassionate and want to serve our clients... From basic needs to therapeutic services, how do we do that and continue to serve?"*

To help with COVID-19 transitions, organizations received assistance from multiple organizations. The State or other entities provided assistance in the form of rule or policy changes/modifications to 59% of survey respondents who received outside help. Additionally, 48% of these organizations received assistance with contracts and financing changes, 47% were allowed to adapt requirements/procedures, 43% reallocated funds, and/or 40% reported data or deliverable changes. Rule and policy changes include changes allowing virtual consent and expansion of the use of telehealth services (e.g., the types of providers that can be reimbursed, the types of delivery mechanisms eligible for reimbursement). Other entities, such as the Federal government, technology companies, and non-profit foundations, provided grants, equipment, and other resources.

> *"There has been a lot of adjustment and learning how to do things, including how to communicate in this way. In the beginning, it feels so stilted and weird… You get a little more accustomed to it and learn the etiquette and all that. But it is exhausting to have to do everything in this kind of a venue."*

Transition to the Use of Technology-Based Services

A large number of survey respondents (72%) reported that their organization turned to the use of technology, such as telephone, video-based platforms accessible via computer or smartphone, social media platforms, and smartphone apps, to provide behavioral health services (Table 1). Technology offered several benefits by allowing for the continuation of services that would otherwise need to be shut down completely. Survey respondents reported that technology increased clients' use of or adherence to services (38%) and increased efficiency for staff (35%), allowing them more flexibility in scheduling and

> *"Our no-show rate decreased immediately...typically 20% across all programs; we are down to ...7% no-show rate for new client intakes."*

reduced no-show rates (Table 2). One respondent highlighted the essentiality of technology, calling it a "lifeline." Telephone-based service provision was vital for populations with limited, or no, broadband access, or among clients who were uncomfortable using video. Adolescents and young adults, as well as families with young children, were particularly accepting of technology-based services, due, in part, to the new flexibility of services.

"It's been kind of remarkable that if you're talking about [services including] mental health… sometimes families that were not reliable in engagement are suddenly reliable …via Zoom or other methods.

Table 1. Use of Technology in Response to COVID-19 (Survey Responses)

	#	%
Conduct assessment, treatment, or discharge on a technology-based platform	75	56%
Provide other services (e.g. classes, interactive games)	56	42%

*multiple responses possible

Despite the frequent use of technology, barriers were noted for some populations or situations (Table 2). Some clinicians found it difficult to read body language and non-verbal cues from clients, making it easier to potentially hide or mask issues, and more difficult for clinicians to perform assessments. The lack of broadband/internet availability was a substantial barrier for rural areas (27%) and lower-income households (40%), for older adults who lacked internet/computer knowledge (27%), among clients or organizations that lacked adequate technological devices (44%), and in households that lacked privacy or a safe space to engage (28%). As mentioned above, clients not fluent in English struggled with accessing translation services on technological platforms and individuals with severe mental illness had concerns about being watched through technological devices, resulting in increased difficulty engaging this population in services. Further, individuals who were not fluent in English had difficulty engaging in technology-based services due to the lack of translation services or problems learning the new online platforms. Further, individuals in the deaf and hard-of-hearing community were unable to participate in services offered over the telephone.

Table 2. Benefits and Barriers of Providing Services via Technology (Survey Responses)

	#	%
Benefits		
Increased use of/adherence to services	51	38%
Increased efficiency for staff	47	35%
No benefits that I am aware of	14	10%
Removed transportation barriers to care (i.e., logistically, financially)	8	6%
5% or fewer responses: Client satisfaction, improved service provisions, safely provide services for clients with high COVID-19 risk)		
Barriers		
Lack of available and/or adequate technological devices (e.g., smart phones, tablets)	59	44%
Lack of broadband/internet availability for lower income households	54	40%

Lack of internet/computer knowledge for older adults	49	36%
Individual refusal to engage in technology-based services	42	31%
Lack of privacy or safe space to engage	38	28%
Lack of broadband/internet availability in rural areas	36	27%
Decreased efficiency for staff	23	17%
No barriers or challenges that I am aware of	16	12%
5% or fewer responses: Lack of equipment for organizations, some services not possible via technology		

*multiple responses possible

Lessons Learned

Organizations varied in their opinions of what "went well" in COVID-19 responding. Positive experiences primarily included organizations overall ability to use technology (39%), their use of social distancing and other health precautions (13%), and the reduction in "red tape" (11%) (Table 4). Several respondents complimented the speed at which internal adjustments were made, and the flexibility of their staff to those adjustments. These changes were facilitated by increased collaboration between organizations around Colorado and the increased communication from the State and other expert bodies governing various organizations.

"This being the first time that we've been through a challenge of this size does not work well because it's a first time learning experience -- if this thing ever happens again we'll have lessons to draw on."

Table 3. Successes in COVID-19 Responding (Survey Responses)

	#	%
What Went Well		
Use of technology-based services	52	39%
Implementing social distancing and other health precautions	17	13%
Increased flexibility/reduction in barriers or "red tape" (ex: virtual consent forms, some service provision by telephone, and changes in medications doses for MAT)	15	11%
Prioritizing new/evolving client needs	11	8%
Communication from leadership or other authority (e.g. local health department)	9	7%
5% or fewer responses: Early planning and preparation, Collaboration with partner organizations, Staff/employees supporting each other, Providing additional pay to staff in residential facilities		

*multiple responses possible

Specific challenges in COVID-19 responding noted in the survey include:

- General inability to provide in-person treatment or resources to those who need in-person services (10%).
- Learning, training, and assistance for clients and staff in using technology-based services (8%).

- Policy updates and communication. Interview respondents specifically called out guidance provided by the State and other governing/oversight agencies in remaining HIPAA compliant during transitions of services.
- The need to improve communication between state agencies.

Table 4. Challenges in COVID-19 Responding (Survey Responses)

	#	%
What Was Challenging		
Inability to provide in-person treatment or resources to those who need in-person services	13	10%
Telehealth learning/training/technical assistance for staff and clients	11	8%
Staff issues (e.g. stress, staff illness, lack of adequate staff, lack of childcare, lack of hazard pay)	9	7%
Telehealth causing lack of engagement for specific client populations (including: substance use/sobriety monitoring, SPMI clients, non-tech-savvy, homeless, sex offender clients)	9	7%
5% or fewer responses: Last minute updates/inconsistencies on policies; acquiring PPE or other supplies (e.g., technological equipment); difficulty with referrals/accessing inpatient treatment, residential services, or housing, isolation; telehealth causing general lack of client engagement; enforcing social distancing or other protective measures; lack of comprehensive approach; transportation unavailable/difficult		

The Road Ahead: Recommendations to the State

KEY TAKEAWAY: Respondents suggestions for improving the State's behavioral health response, focused on expanding technology-based service provision, improving emergency preparedness with a standard operating procedure, and implementing measures to ensure a healthy workforce. Supplementary data collection efforts across the State (Appendix B) support the recommendations derived from survey responses.

Respondent Recommendations

Recommendation 1: Expand the State's Support for the Use of Technology-based Services

- Expand technological infrastructure (equipment, software)
- Support/expand telehealth reimbursement (service modalities, provider type)
- Provide flexible funding for technology purchases
- Support technology training for behavioral health staff (e.g., how to use equipment/software, allowable billing and coding information)
- Expand broadband/internet capabilities in rural areas, reservations

Recommendation 2: Improve Behavioral Health Preparedness and Communication

- Develop standard operating procedures for behavioral health emergency planning and response
    - Develop and coordinate among State agencies and behavioral health partners
    - Share distribution and training plans
- Make policy decisions now to reduce confusion and stress during emergencies
- Build personal protective equipment stockpiles now - at minimum: masks/respirators, gowns, gloves, and footwear (different items may be needed for other emergencies)

Recommendation 3: Ensure a Healthy Workforce

- Implement a worker-first (also) mentality; the workforce must be healthy to provide good care
- Improve efforts to reduce compassion fatigue, burnout, isolation, and turnover
- Provide hazard pay as a morale booster/show of appreciation for clinical and frontline workers in times of crisis
- Implement public health measures to ensure a safe workplace

Additional Respondent Considerations

- Continue organizational communication efforts from the State to providers through the end of the COVID-19 pandemic
- Recognize the behavioral health needs of and provide support for clients, their families, and caregivers
- Acknowledge and explicitly address the differential impact of the COVID-19 pandemic on vulnerable populations

Appendix A: Evaluation Methodology

Respondent Characteristics

A total of 197 respondents participated, representing 161 unique organizations in behavioral health. There were 15 key informant interviews, 16 focus groups (consisting of 46 respondents total, and 135 surveys completed. The survey was issued to 422 people, yielding a response rate of 32%. Data collected from each of the three methods were analyzed separately. Open-ended questions were examined using content analysis and a coding schema to identify themes in responding. Descriptive analyses were used to provide counts and percentages for survey responses.

Among all respondents, 43% worked for an organization that provides both mental health and substance use treatment or support, 28% worked in mental health only, and 12% in substance use only. Respondents reported that their organization provides population-specific care for adolescents (38%), older adults (38%), clients experiencing homelessness (34%), and rural populations (34%). Organizations serving every county across the state were represented.

Table 5. Number of Respondents by Data Collection Method

	Key Informant Interviews	Focus Groups	Online Survey	TOTAL
Number of Respondents	16*	46 (16 groups)	135	197
Unique Organizations Represented	15	38	118	161**

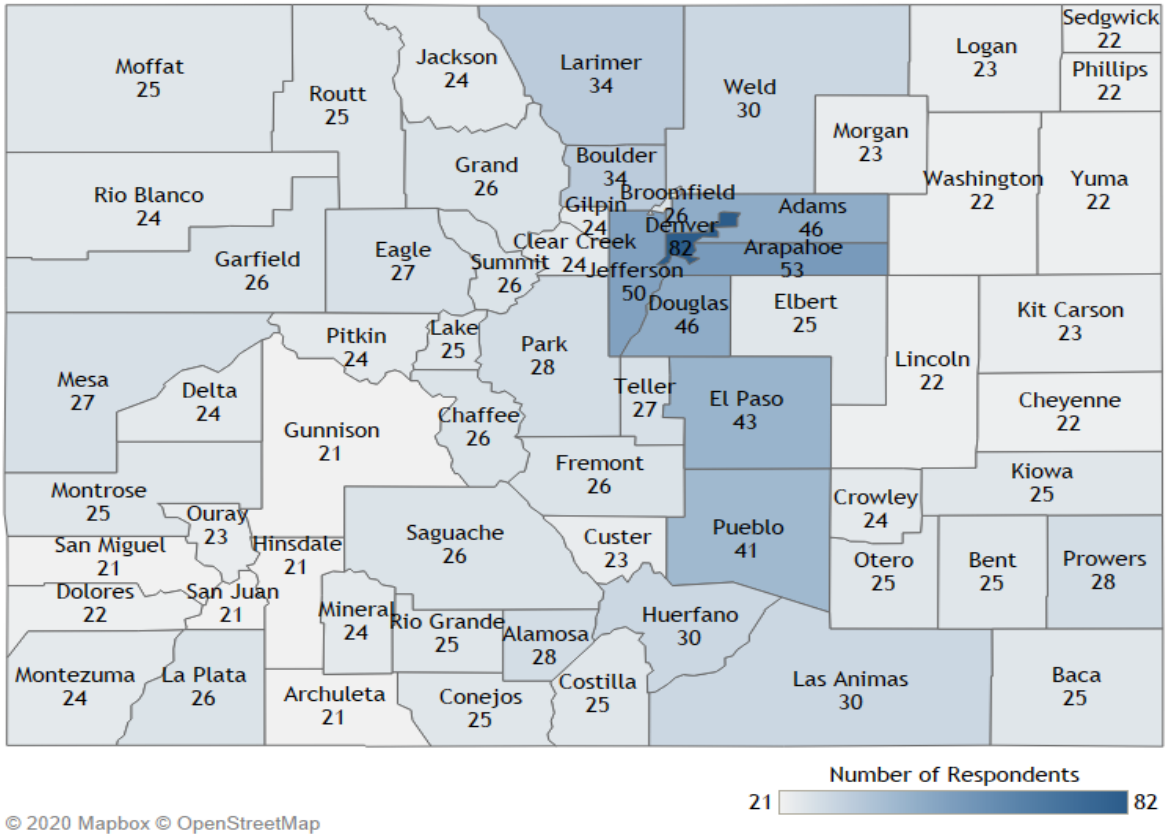
*One key informant interview was conducted with two people from the same organization. Although two respondents are represented in this count, the data collected was combined into one interview response interview.
**Five organizations provided feedback in multiple data collection methods.

Data Collection and Analysis

Over the course of three weeks, evaluators carried out data collection efforts using three methodologies: key informant interviews, focus groups, and an online survey. Each effort assessed 1) how COVID-19 impacted behavioral health needs and services across the State, 2) how organizations responded, and 3) how the State can improve [emergency responding for] behavioral health in the future. Key informant interviews and focus groups followed a semi-structured interview guide. **Survey responses provided insight into the scope of the problems, whereas key informant interviews and focus groups data was used, primarily, to understand the nuances.**

Evaluators made a concerted effort to seek out representative voices to speak to a diverse array of populations and conditions. However, respondents selected for this group represent a convenience sample and, therefore, do not constitute a full representative sample of behavioral health work across the State. Survey results do not represent the true distribution and frequency for which service options occur throughout the State.

Figure 3. Geographic Distribution of Behavioral Health Respondent Organizations, by County



Appendix B: Supplementary Information

In addition to this survey, OBH and other Colorado-based organizations carried out other activities to document the impact of COVID. This Appendix provides a brief overview of some of these efforts. By and large, the results of these efforts support the key takeaways and respondent recommendations mirrored in this report.

ASO, MSO, and CMHC Administrative Responses

At the onset of the COVID-19, OBH surveyed crisis organizational entities contracted to provide and manage behavioral health services in the state of Colorado to ascertain the impact on services and organizations. Administrative service organizations (ASO), managed service organizations (MSO), and community mental health center (CMHC) staff were asked to complete a survey to indicate the impact of COVID-19 on service provision and service delivery. Additionally, the survey allowed these entities to submit accommodation and/or deliverable extension requests if needed.

Administrative Service Organizations (ASO)

ASO providers reported the majority of services were transitioned to telehealth or telephonic services to continue service delivery. Crisis services remained available via telehealth or via in-person services with PPE and additional medical screenings. Crisis stabilization units and respite services saw reduced capacity due to the environment being difficult to socially distance in and lack of referrals from other services. ASOs also utilized peer and case management staff to increase phone engagement during the onset of the pandemic to meet the clients' needs. Additionally, ASO providers reported having to limit care to telephonic services due to lack of internet available in rural areas.

ASOs provided additional funding to community mental health centers and programmatic partners for the purchase of PPE, telehealth expansion, and mental health center management. The State's waiver for phone assessments was a significant help to providing these additional service accommodations. Going forward, ASOs request additional contract or funding support going forward to work through reimbursement and sustained operations.

Managed Service Organizations (MSO)

MSO providers reported they were able to successfully transition many outpatient services to telehealth to continue service provision while ensuring client safety. Many services, such as withdrawal management, medicated-assisted treatment, and residential programs continued to be provided in-person with PPE and social distancing practices. Most programs were modified to align with safety protocols and continued to be available to clients throughout the pandemic.

One barrier MSOs reported was a lack of infrastructure available for some clients to access telehealth services. Many clients did not have equipment or internet available to them to participate in telehealth sessions. MSOs reported that the inability to engage with some clients via telehealth and

reduced referrals from other providers or services will likely result in reduced volume. Involuntary commitment services also saw a reduction in petitions and difficulty placing clients at treatment centers due to the restrictions of the pandemic. Additionally, substance use disorder services were transitioned to curbside service for medication dosing but required additional security to ensure safety when providing services.

MSOs request contract and funding flexibility to meet the needs of their modified service deliveries and additional PPE costs. MSOs have implemented additional policies and billing processes to meet the demands of the COVID-19 pandemic and request ongoing OBH support to manage these situations moving forward.

Community Mental Health Centers (CMHC)

The onset of COVID-19 modified a significant portion of CMHC-based behavioral health services; however, the majority of services continued with limited closures. Most CMHC providers reported transitioning to telehealth platforms to continue service delivery. Services such as outpatient therapy, medication management, jail-based behavioral health, Assertive community training, Individual placement and support programs, and case management were provided via telehealth. Crisis services remained operational for all CMHCs, provided largely by telehealth, with some in-person services continuing with the use of PPE (depending on availability and state/county regulations).

Inpatient services—such as withdrawal management, acute treatment units, crisis stabilization, and respite—were significantly affected. Many CMHCs reported decreased capacity due to social distancing and COVID-19 regulations, diversion due to suspected illnesses, or closure of services until safety could be ensured in a few cases. Additionally, group-based services, educational classes, and community services were restricted or temporarily stopped to meet social distancing requirements.

CMHCs reported decreased volume, staffing changes via telecommuting or turnover, reduced referrals to services, having to reallocate funds for PPE and telehealth, monitoring staff well-being, and the need for flexibility as they work through the issues presented by the pandemic. CMHCs request clear guidance from OBH on next steps and reimbursement for non-traditional services to allow them to continue service delivery in modified ways.

Prevention Survey

The Center for Effective Philanthropy (CEP) surveyed organizations receiving Substance Abuse Block Grant funds through OBH to conduct substance abuse/misuse prevention work in the state of Colorado grantees to obtain input and advice regarding the impact of the COVID-19 pandemic on their organizations. CEP received 33 responses (70% response rate) between May 10 and June 19. The most common experiences reported by these grantees was moving to a virtual working environment (100%), adding a new service/project to focus on a COVID-19 response (91%), experiencing an increase in demand for programming and services (79%), halting or delaying some services/projects (76%), and

experiencing a decrease in contributed revenue (e.g., grants or donations; 75%), an important source of funding since nearly all of the organizations receiving these OBH grants are non-profit organizations.

When probed about OBH's response to the COVID-19 outbreak, most organizations agreed with statements that portrayed OBH's response positively. However, responses indicated continued need for addressing the most vulnerable during the pandemic. Tables 6 & 7 display full responses to the items on this assessment, first regarding experiences of the providers during the COVID-19 pandemic and second regarding their characterization of OBH's response to COVID-19.

Table 6. Impact of COVID-19 on OBH-Funded Prevention Organizations

	Yes	No (but expect to happen)	No (don't expect to happen)	Don't know/ N/A
As a result of the COVID-19 pandemic, has your organization experienced - or is it experiencing - any of the following?				
Moved to a virtual working environment at one or more location(s) or facility(ies)	100%	0%	0%	0%
Added new services or projects to focus on a COVID-19 response	88%	3%	9%	0%
Experienced an increase in the demand for your programs and services	58%	21%	18%	3%
Halted or delayed some services or projects	73%	3%	21%	3%
Experienced a decrease in contributed revenue (e.g., foundation grants, individual donations, etc.)	30%	45%	21%	3%
Experienced a decreased in earned revenue (e.g., fee for service, contracts, etc.)	42%	27%	18%	12%
Tapped into reserves (e.g., rainy day fund, board designated reserves)	42%	27%	24%	6%
Re-allocated funding from existing services or projects to focus on a COVID-19 response	45%	18%	33%	3%
Shifted staff from other services or projects to COVID-19 management efforts	55%	6%	39%	0%
Experienced reduced capacity (e.g., staff or volunteer)	30%	30%	36%	3%
Reduced staff levels (e.g., conducted layoffs)	30%	21%	48%	0%
Experienced a decrease in demand for programs/services	19%	19%	59%	3%

Table 7. Characterizations of State (OBH) Response to COVID-19

	Strongly disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Strongly agree
Did any of the following characteristics describe your experience of OBH's response to COVID-19?					
Is clear	0%	18%	11%	39%	32%
Is rapid enough to allow the continuation of our most important work	6%	6%	12%	38%	38%
Addresses ways in which this pandemic can disproportionately affect historically vulnerable or marginalized populations	0%	12%	30%	30%	27%
Allows my organization to address the needs of those at greater risk as a result of COVID-19	6%	19%	22%	31%	22%
Communicates a willingness to hear from my organization	3%	9%	6%	6%	76%

Regional Health Connectors Survey

The Regional Health Connector (RHC) Workforce in Colorado participates in surveys every two weeks to illustrate regional responses to COVID-19, including observed needs, actions to address needs, and observed impact of such activities. The June report documented an increase in requests for the social determinants of health, resources to help patient social needs, communication and messaging around public health, and coordination across the state. Meanwhile, requests for contact tracing and follow-up help were down, while requests for access to testing and treatment remained stable. These results suggest that the community is starting to shift from the direct management of COVID-19 and onto the behavioral and social consequences of the disease. A major request from the community, and focus of the RHCs, was on increasing collaboration among community partners to build better access to resources to address social needs.

Crisis Standards of Care Plan

The Crisis Standards of Care (CSC) Plan developed by the Governor's Expert Emergency Epidemic Response Committee (GEEERC) lays out actionable standards for modified practice by behavioral health care providers during times of crisis, defined by declaration of a state of emergency by the governor, in order to address healthcare gaps resulting from the disaster. This plan enables such actions as expansion of telehealth services and other practice adaptations to meet increased need during a time when some providers may be unavailable. The document outlines how demand for behavioral health services change in conventional and crisis times. In particular, the plan explains that there may be service outages during crisis; including circumstances when there may be little to no outpatient behavioral health care services available, non-functioning inpatient facilities, and insufficient substance abuse testing sites open which would compromise a provider's ability to monitor and serve clients with substance use issues. "Best practices," such as follow-up care, are often unavailable during times of

crisis; the report recommends that inpatient resources be reserved for those with severe psychiatric decompensation.

Appendix C: Organization Information

Table 8. Number of Respondents Providing Services by Data Collection Method

Services by Response Type*	KII	FG	Survey
Crisis services	3	16	53
Mental health treatment or support	9	30	74
Other direct services for clients with behavioral health needs	8	13	53
Provides emergency response (e.g., law enforcement, co-responder, other first responder)	4	10	26
Provides medical treatment	3	12	27
Provides other forms of assistance (e.g., housing, transportation, after school programs)	7	15	47
Services: Substance use treatment or support	9	26	74
Other: My organization does not provide direct services to clients with behavioral health needs	1	5	22

*multiple responses possible

Table 9. Number of Respondents Serving Population by Data Collection Method

Population Served by Response Type*	KII	FG	Survey
Adolescents	9	15	64
BIPOC (Black, Indigenous, or Persons of Color) populations	7	14	38
Healthcare workers	4	7	27
Homeless clients	8	15	44
Older adults	8	17	50
Rural populations	7	15	44
Other	4	14	26

*multiple responses possible

Appendix D: Survey Instrument

(Key Informant Interview and Focus Group Guide available on request)

COLORADO
Office of Behavioral Health
Department of Human Services

Impact of COVID-19 on Colorado's Behavioral Health System

In the wake of COVID-19, many Coloradans are experiencing new or elevated levels of behavioral health problems. The purpose of this survey is to understand how behavioral health needs changed and how providers and the larger healthcare system responded.

With this information, we will gain insight into areas that the State needs to improve now, and how we can respond more effectively in the future.

This survey may take 30 minutes to complete. Your answers will remain confidential and we will remove any identifying details that could tie your answer to your specific organization when sharing survey results.

The survey deadline is Monday, June 15 at 5:00pm. No responses will be collected after this cutoff date. Thank you for your time!

1. Please complete the information below.
   - Name _____
   - Organization Name _____
   - Your Role _____
   - Organization County _____
   - Other Counties (if applicable) _____

2. How does your organization serve clients with behavioral health needs?
   - ❑ Mental health treatment or support
   - ❑ Substance use treatment or support
   - ❑ Crisis services
   - ❑ Provides other forms of assistance (e.g., housing, transportation, after school programs)
   - ❑ Provides medical treatment
   - ❑ Provides emergency response (e.g., law enforcement, co-responder, or other first responder)
   - ❑ My organization does not provide direct services to individuals with behavioral health needs
   - ❑ Other direct services for individuals with behavioral health needs (please specify)

3. Does your organization provide specific behavioral health services for any of these populations?
   - ❑ Adolescents
   - ❑ Older adults
   - ❑ Homeless individuals
   - ❑ BIPOC (Black, Indigenous, or Persons of Color) populations
   - ❑ Rural populations

- ❑ Healthcare workers
- ❑ My organization does not provide specific services for any of these populations.

4. To begin, think about the behavioral health needs of the individuals your organization works with. What behavioral health stressors have those individuals experienced due to the COVID-19 crisis?

- ❑ Anxiety/Stress
- ❑ Depression/suicide ideation or attempt
- ❑ Grief
- ❑ Substance use
- ❑ Co-occurring mental health and substance use needs
- ❑ Medical needs
- ❑ Financial needs
- ❑ Unemployment
- ❑ Social isolation
- ❑ Family problems/domestic violence
- ❑ No behavioral health stressors related to COVID-19
- ❑ Something else (please specify)

5. What barriers to receiving behavioral health services have those individuals experienced?

- ❑ Long wait times for an appointment
- ❑ Unavailability of services
- ❑ Unaware of where/how to get services
- ❑ Affordability of care
- ❑ Lack of care coordination for mental health and substance use treatment
- ❑ Transportation difficulties to routine, in-person care
- ❑ Transportation difficulties in a crisis situation
- ❑ Lack of safe housing
- ❑ Lack of assistance for family members of behavioral health individuals
- ❑ None that I'm aware of
- ❑ Something else (please specify)

6. Which specific services have been most affected by the COVID-19 crisis in your organization, and how were those services impacted? (If none or not applicable, respond “n/a”)

7. In your experience, how have certain client groups been more adversely affected than others? (Please describe for all populations affected, leave blank if you didn’t see difference in a given population.)

Children (0 - 11) _____
Adolescents (12 - 17) _____
Young adults (18 - 25) _____
Older adults (65+) _____
BIPOC (Black, Indigenous, Persons of Color) _____
Persons with disabilities _____
Healthcare workers _____
Front line/essential workers _____
Caregivers/single parents _____
Homeless individuals _____
Incarcerated individuals _____
LGBTQIA+ _____
Not fluent in English _____

Undocumented residents _____
Veterans _____
Rural _____
Other population (please specify) _____
Not applicable _____
No population differences apparent at this time _____

8. In what other ways has your organization been impacted by COVID-19?

- ❏ Lack of personal protective equipment (PPE)
- ❏ Problems with staffing or staff health concerns
- ❏ Lack of stock/supplies
- ❏ Difficulty engaging with individuals served
- ❏ Workplace configuration does not allow for social distancing
- ❏ Workplace makes adhering to protective measures challenging (e.g., hand washing protocols)
- ❏ None that I'm aware of
- ❏ Something else (please specify)

9. If your organization had staff issues related to COVID-19, what were those issues?

- ❏ Staff concerned about coming to the workplace
- ❏ Staff out sick/scheduling issues
- ❏ Staff member(s) are part of a vulnerable population
- ❏ Living with or care-giving for a family member who is part of a vulnerable population
- ❏ Lack of childcare options
- ❏ My organization did not have staff issues
- ❏ Something else (please specify)

10. What changes did your organization make to address these staff issues?

As you know, effective service delivery is directly related to an organization's ability to respond. Now we'd like to understand what your organization did to continue operations as the COVID-19 crisis unfolded.

11. We know that many organizations turned to the use of technology to continue providing services to individuals with behavioral health needs. Did your organization turn to (or expand) your use of technology in this way? Yes No

12. How did your organization adopt or expand the use of technology?

- ❏ Conduct assessment, treatment, or discharge on a technology-based platform
- ❏ Provide other services (e.g. classes, interactive games) using a technology-based platform
- ❏ Something else (please specify)

13. Were there particular barriers or challenges that prevented you from making modifications or using technology to meet the behavioral health needs of individuals?

- ❏ Lack of broadband/internet availability in rural areas
- ❏ Lack of broadband/internet availability for lower income households
- ❏ Lack of internet/computer knowledge for older adults
- ❏ Lack of available and/or adequate technological devices (e.g., smart phones, tablets)
- ❏ Lack of privacy or safe space to engage
- ❏ Individual refusal to engage in technology-based services
- ❏ Decreased efficiency for staff
- ❏ No barriers or challenges that I am aware of
- ❏ My organization did not use technology-based services
- ❏ Something else (please specify)

14. Did you notice any particular benefits with the use of technology- based services?

- ❑ Increased use of/adherence to services
- ❑ Increased efficiency for staff
- ❑ No benefits that I am aware of
- ❑ My organization did not use technology-based services
- ❑ Something else (please specify)

15. Have you received assistance from external organizations to support building infrastructure for your technology-based services?

Yes No N/A

16. (If "Yes" selected above) You said that you received assistance from external organizations to build or expand your technology-based services. What organizations have you worked with? What type of help did you receive?

Other than the use of technology, let's talk about ways in which your organization responded to COVID-19 in order to meet the behavioral health needs of clients.

17. What other mechanisms did you use to continue service delivery?

- ❑ Developed new procedures for referring individuals
- ❑ Developed new procedures for assessing and/or discharging individuals
- ❑ Developed other policies/procedures
- ❑ Changed policies around food services or deliveries
- ❑ Closed or restricted service options
- ❑ Reallocated funds/reduced spending
- ❑ No other mechanisms
- ❑ Something else (please specify)

When responding to any unforeseen situation, some things work well and some things could be improved. We'd like to understand the lessons learned as it relates to COVID-19 preparedness and response.

18. What procedures or changes worked well in your organization's response to the COVID-19 crisis? (If none, write N/A.)

19. What procedures or changes did not work well in your organization's response to the COVID-19 crisis? (If none, write N/A.)

20. In what ways did your organization receive assistance from the State or other entities to ensure continued operations despite the unique challenges of COVID-19?

- ❑ Rule and policy changes/modifications (e.g., virtual consent)
- ❑ Contracts and financing changes/modifications
- ❑ Other organizations provided more frequent communication
- ❑ COVID-19 related meetings
- ❑ Other organizations developed new public media campaigns about COVID-19
- ❑ Other organizations helped to improve coordination across multiple agencies
- ❑ Technical assistance
- ❑ No assistance from State or other entities
- ❑ Something else (please specify)

21. If your organization received assistance from the State or other entities related to contracts and financing, what type of assistance did you receive?

- ❑ Reallocation of funds
- ❑ Requirements changes (e.g., individual numbers/population served)

- ❑ Data or deliverable changes
- ❑ Elimination of tasks/deliverables
- ❑ Technology purchases
- ❑ No assistance received
- ❑ Something else (please specify)

We'd like to understand how the State can offer further support.

22. How can the State improve our response to emergency situations?

- ❑ Assist with material resources and provision (e.g., PPE)
- ❑ Expand supports for the use of technology-based services
- ❑ Improve resources and information to individuals and their families during crisis
- ❑ Improve response to demands on clinician workforce (e.g., hazard pay, emergency training)
- ❑ Expand Standard Operating Procedures for emergency planning
- ❑ Improve coordination with medical healthcare system
- ❑ No improvement necessary
- ❑ Something else (please specify)

23. What technology-related support from the State would help your organization?

- ❑ Expand the types of services that can be reimbursed for technology-based services
- ❑ Expand the types of providers that can be reimbursed for technology-based services
- ❑ Ensure that out-of-state providers can practice in Colorado (i.e., interstate licensure)
- ❑ Expand training
- ❑ Flexible funding to purchase electronic devices to provide services to individuals
- ❑ Support expanding existing technological infrastructure (e.g., equipment, software)
- ❑ Support expanding broadband/internet capabilities in rural and/or reservation areas
- ❑ My organization would not benefit from State support for technology
- ❑ Something else (please specify)

24. Considering your previous responses, what would you consider to be the top 2 priorities that the State should focus on in the next 6 months to 2 years?

25. Are there specific efforts that the State can make to improve behavioral health services overall (beyond emergency response)?

26. Is there anything else you would like to share related to the impact of the COVID-19 crisis on Colorado's behavioral healthcare system?

Appendix E: Respondent Organizations

1. A.B. Counseling
2. Alcohol Counseling and Guidance Services
3. Advancing Dynamic Solutions
4. Alamosa County Public Health
5. AllHealth Network
6. AspenPointe
7. AspenRidge Recovery
8. Aurora Mental Health Center
9. Axis Health System
10. Beacon Health Options
11. Behavioral Health Group
12. Behavioral Treatment Services
13. BEST Counseling
14. Boulder County Jail
15. Boulder County Public Health
16. Boys & Girls Clubs in Colorado
17. Building Hope Summit County
18. Community Alcohol/Drug Rehab and Education Center
19. Carreon Consulting, LLC
20. Colorado Assn for School-Based Health Care
21. Castle Rock Community Response Team
22. Castle Rock Fire and Rescue Dept
23. Castle Rock Police Dept
24. Catholic Charities of Central Colorado
25. Colorado Criminal Justice Reform Coalition
26. Colorado Dept of Human Services
27. CDHS Division of Child Welfare
28. Colorado Dept of Corrections
29. Colorado Dept of Health Care Policy and Financing
30. Colorado Dept of Public Health & Environment -Emergency Preparedness and Response
31. Cedar Springs Hospital
32. Celebrating Healthy Communities
33. Centennial Peaks Hospital
34. Center For Change, LLC
35. Centura Health
36. Chaffee County Dept of Human Services
37. Chaffee County Public Health
38. Children's Hospital Colorado
39. Center for Impaired Driving Research and Evaluation
40. City and County of Denver
41. Coalition for Families of Garfield County
42. Collaborative Management, JI
43. Colorado Assn of the Deaf
44. Colorado Coalition for the Homeless
45. Colorado Dept of Public Health & Environment
46. Colorado Federation of Families for Children's Mental Health
47. Colorado Hospital Assn
48. Colorado Liquor Enforcement Division
49. Colorado Mental Health Institute at Fort Logan
50. Colorado Mental Wellness Network
51. Colorado Society of School Psychologists
52. Community Health Initiatives
53. Comprehensive Behavioral Health Center
54. Correctional Psychology Associates
55. Crossroads Turning Points, Inc.
56. Delta County Memorial Hospital
57. Denver Health
58. Denver Indian Health and Family Services
59. Denver Recovery Group
60. Denver Sheriff Dept
61. Denver Springs
62. Douglas County - Community and Resource Services
63. Douglas County Government
64. Douglas County School District
65. Douglas County Sheriff
66. Colorado State Employee Assistance Program
67. Denver Public Schools - Native American Culture and Education Dept
68. Jim Baroffio, PC & Associates
69. Colorado Division of Vocational Rehabilitation
70. Dwyer Psychological Services, PC
71. Eagle Valley Behavioral Vail-Vail Health
72. Early Assessment and Support Alliance Center for Excellence
73. ECHO Colorado
74. El Paso County Public Health
75. El Paso County Sheriff's Office
76. Every Child Pediatrics - Health and Wellness Center
77. Family & Intercultural Resource Center
78. Family Agency Collaborative/Colorado Cultural Consortium
79. Front Range Clinic
80. Golden Peak Recovery
81. Hands Up Counseling, LLC/About An Alternative
82. Harm Reduction Action Center
83. Healing Life's Pains
84. Health Colorado
85. Health Solutions
86. HealthOne Behavioral Health & Wellness Center
87. Heart Centered Counseling
88. Heritage Outpatient Treatment Services, LLC
89. Highlands Behavioral Health System
90. Hilltop Family Resource Center in Grand Junction
91. Home Ward Alliance
92. IDEA Forum, Inc.
93. Independence House
94. InsideOut Youth Services
95. Jefferson Center
96. Kids First Health Care
97. Kit Carson County Public Health-Single Entry Point
98. La Plata Youth Services
99. Lake County Human Services
100. Larimer County Behavioral Health
101. Larimer County Human Services
102. Life Recovery Centers
103. Luna Counseling
104. Mental Health Center of Denver
105. Mental Health Colorado
106. Mile High Behavioral Healthcare
107. Mindsprings Health
108. Montezuma County OLTC
109. Montrose County - Single Entry Point
110. Mount Saint Vincent
111. NAMI
112. National Institute for Change
113. North Range Behavioral Health
114. One Colorado
115. Otero County DHS - Adult Services Programs
116. P2P Recovery Resources, LLC
117. Park County School District and Platte Canyon School District
118. Parkview Medical Center
119. Peakview Behavioral Health Hospital
120. Peer Assistance Services, Inc.
121. Prowers County Public Health and Environment
122. Prowers County Public Health and Environment/OLTC for Prowers and Baca Counties
123. Public Safety Dept/Community Health & Resilience - City of Longmont
124. Pueblo County Dept of Human Services - Single Entry Point

125. Pueblo County Law Enforcement Assisted Diversion
126. Recovering Spirit
127. RMC Health
128. Rocky Mountain Crisis Partners
129. Rocky Mountain Human Services
130. SafeHouse Denver
131. Salud Family Health Centers
132. San Luis Valley Behavioral Health Group
133. Savio House - King
134. SCL Health and the Colorado Providers Assn
135. Signal Behavioral Health Network
136. Sobriety House, Inc.
137. Solvista Health
138. Southeast Health Group
139. Spero Recovery Center
140. Starting Today
141. Status: Code 4, Inc.
142. The Arc - Arapahoe & Douglas
143. The Phoenix
144. The Place
145. The Resource Exchange
146. Third Way Center
147. Tri-County Health Dept
148. Turning Point Mental Health Services
149. UC Health
150. University of Colorado
151. University of Colorado - Addiction Research and Treatment Services (ARTS)
152. University of Colorado (Colorado Springs) - Aging Center
153. University of Colorado (Denver) - the Evaluation Center
154. University of Denver
155. Urban Peak
156. Ute Mountain Ute Tribe - Behavioral Health
157. Vail Health Hospital
158. West Pines
159. West Slope Casa
160. West Spring Hospital
161. Young People in Recovery

Attachment 3: The Value Proposition of Telehealth in Colorado

The Value Proposition of Telehealth in Colorado

Colorado Office of eHealth Innovation (OeHI)

Final Analysis Plan Submitted by the Colorado Health Institute

AUGUST 4, 2020

OeHI
Office of eHealth Innovation

COLORADO HEALTH INSTITUTE
Informing Policy. Advancing Health.

The Colorado Health Institute (CHI) is pleased to submit this proposed analysis plan, intended to guide research efforts by CHI and funded by the Office of eHealth Innovation (OeHI) related to telehealth in Colorado's Health IT Roadmap. All research examines the value proposition of telehealth services for patients, providers, payers, and the state in light of the COVID-19 pandemic and Colorado's rapid transition to virtual care delivery.

CHI developed this analysis plan to outline the available data and methods proposed to address the guiding research questions identified in CHI's memo "Telehealth Guiding Research Questions — DRAFT" dated June 30, 2020. The analysis plan was informed by discussions with OeHI, its working groups, and four organizations/networks serving as stewards of quantitative data.[1] Table 1 identifies these four organizations/networks and provides a brief description of their data that could be used in this research.

The Telehealth Research Advisory Committee (TRAC) — which was convened on July 24, 2020 — informed the finalization of this plan.

CHI proposes that all analyses be guided by the following principles:

- Apply an equity lens to research activities, acknowledging how historical inequities may affect access to telehealth services among racial and ethnic groups, people living with low incomes, rural residents, and other subpopulations of Coloradans.
- Use complementary qualitative and quantitative methods to allow for elucidation of research topics.
- Leverage existing data and build on other research and stakeholder engagement efforts to mitigate duplication.
- Utilize an iterative discovery process, as some data covering the period of the COVID-19 pandemic are not yet available or may need to be interpreted with caution.

Aligned with these guiding principles, CHI has proposed two phases of research:

- **Phase 1** (June – September 2020) will address questions that can be answered in the short-term, given the rapid time frame and data availability.
- **Phase 2** (proposed for October 2020 – September 2021) will build on Phase 1 findings and expand the questions.

Some questions can be answered preliminarily in Phase 1 and in greater detail and depth in Phase 2. Some questions will only be answerable in Phase 2 due to data availability. For example, complete claims data from the Colorado All Payer Claims Database (APCD) covering the safer-at-home period will only be available in Phase 2 given the lag in finalizing claims.

A proposed timeline of Phase 1 research activities is outlined in Table 2.

[1] Summaries of these meetings and additional information about the data are available in the CHI deliverable titled, "Summaries of Data Steward Meetings," dated June 30, 2020.

Table 1. Description of Data Stewards and Potential Data Sources

Organization	Data Source	Data Source Description
Center for Improving Value in Health Care (CIVHC)	All-Payer Claims Database (APCD)	Public and private payer claims, including Medicaid, Medicare, and 41 commercial payers. The APCD captures 45% of non-federally regulated commercial insurer claims in the state. Some paid claims are available at minimum three months after care is rendered, though many claims take longer.
Colorado Department of Health Care Policy and Financing (HCPF)	Incurred but not reported (IBNR) Medicaid claims data and analyses	HCPF has been doing its own analysis of Medicaid claims during the pandemic. Staff are using an IBNR adjustment method since most claims are not finalized for at least three months. HCPF staff are exploring the possibility of sharing IBNR analyses with CHI.
Colorado Health Observation Regional Data Service (CHORDS)	Electronic health record (EHR) data	Standardized, anonymous EHR data from 12 health care and behavioral health providers in the Front Range. Data are typically available one month after care is rendered.
Colorado Hospital Association (CHA)	Hospital claims data	Complete hospital-based billed facility claims, including inpatient, emergency department (ED), outpatient surgery, and other outpatient care. Data are typically available three months after care is rendered.

Table 2. Timeline: Key Analysis Plan Milestones

Activity	Start Date	End Date
Meet with partners to identify data sources and limitations	6/15/20	6/30/20
Develop and submit queries to CHORDS (Initial queries to be run by 7/15/20)	5/26/20	8/15/20
Finalize research questions	6/30/20	7/20/20
Convene TRAC	6/30/20	7/24/20
Compile quantitative and qualitative data	7/15/20	8/14/20
Analyze focus group findings (and incorporate findings into publications)	7/15/20	8/14/20
Analyze quantitative data (and incorporate findings into publications)	7/15/20	8/31/20
Develop three (3) provider profiles and conduct analysis of provider interview questions	7/15/20	8/31/20
Convene TRAC to review findings and get group's recommendations for Phase 2	8/28/20	9/15/20
Publications drafted and published	8/15/20	9/30/20

Table 3 outlines the analysis plan delineated by the four domains of interest as identified in CHI's scope of work. The plan includes proposed methods, data sources, subpopulations of interest, and a benchmark or comparison group ("comparator") when applicable.

CHI developed the plan with the following considerations:

- Cost-related questions may be included within each of the four domains, though limitations on data availability may require detailed cost analyses be conducted in Phase 2.
- Unless otherwise specified, a temporal component is implied in all research questions to examine the impact of COVID-19 telehealth policy. To date, three time periods will be examined when available and appropriate (bolded terms are used in Table 3):
    - **Baseline**: Pre-statewide stay-at-home orders (March 2019 – February 2020)
    - **Time 1**: Statewide stay-at-home orders (March – May 2020)
    - **Time 2**: Safer-at-home orders (June 2020 and on)
- Research activities are recommended for completion in Phase 1 or Phase 2, based on data availability.
- Analyses will include stakeholder engagement activities with patients and providers as qualitative methods to complement quantitative analysis, unless specified as qualitative-only.

Please contact Nina Bastian at bastiann@coloradohealthinstitute.org with any questions.

Table 3. OeHI Telehealth Research Plan:

Utilization and Access

Key Guiding Research Question: How and why did telehealth utilization rates change over time in Colorado?

Research Question	Analytic Approach	Potential Data Source(s)	Subgroup Analysis	Comparator(s) if Applicable	Timing/Notes
1. How do telehealth users differ demographically from the general population?	• Compare telehealth utilization from baseline to Time 1 and Time 2. • Cross-tabulation by subpopulation characteristics to highlight disparities • Use ACS and CHAS to compare to population characteristics • Qualitative analysis of provider interviews	• CHORDS • Qualitative • American Community Survey (ACS) • Colorado Health Access Survey (CHAS)	• Age • Race/ethnicity • Gender • Insurance status/primary payer	• General population • Groups with greatest use and least use	• Phase 1
2. What factors are associated with the use of different telehealth modalities?	• Phase 1: Profile of patients using video, audio, eHealth, and all other telehealth modalities; qualitative analysis of patient and provider interviews about use and preferences • Phase 2: Regression model (dependent variable = modality; independent variables=demographics, etc.)	• CHORDS • Area Deprivation Index (ADI) • Qualitative	• Patient demographic and geographic characteristics • Insurance status/primary payer • Provider type	• Telehealth modalities	• Phase 2 to include regression analyses • ADI can provide socioeconomic characteristics of geographies
3. How does the location and characteristics of a patient's community affect their access to and utilization of telehealth services?	• Qualitative analysis of providers and patient interviews • Cross-tabulation by geography • Geocoded data using Geographic Information Systems (GIS)	Phase 1: • Qualitative • CHORDS • HCPF (if available) • ADI Phase 2: • APCD • CHORDS • ADI	• Census tract, County, Health Statistics Region • Urban, Rural, Frontier (if HCPF data available)	• State as a whole • Census tracts • Counties	• Phase 1 • Phase 2 may include claims analysis • Can use ADI to examine socioeconomic characteristics of geographies

Research Question	Analytic Approach	Potential Data Source(s)	Subgroup Analysis	Comparator(s) if Applicable	Timing/Notes
4. How has the use of telehealth changed the volume and frequency of specific types of health service utilization? What are potential cost differences?	• Subgroup analysis by diagnosis and/or service type. • Compare baseline to Time1, Time 2. • Quantify the frequency and volume by type of service • Model "savings" from fee schedules and projected volume • Qualitative analysis of provider interviews	Phase 1: • CHORDS Phase 2: • CHORDS • APCD • Qualitative	Service type: • Preventive • Chronic care • Pediatric • Home health • Specialty care • Urgent care • ED • Office visits	• In-person use prior to COVID-19 vs. telemedicine use post-COVID-19	• Phase 1 • Phase 2 may include a cohort approach
5. To what extent did the use of telehealth services increase during the pandemic? Were telehealth services additive or did they replace in-person services? Were additive services primarily follow-up visits?	• Phase 1: Explore feasibility of conducting a cohort approach in Phase 2 • Phase 2 (potential): Longitudinal analysis of patient cohort • Possible difference-in-differences model	Phase 1: • CHORDS Phase 2: • CHORDS • HCPF • APCD	• Condition • Type of provider • By type of visit (e.g. acute, chronic, wellness, refill, follow-up, etc.)	• Comparison over time from Baseline to Time 1 and Time 2	• Phase 1 • Phase 2 may include a cohort or difference-in-differences analysis
6. To what degree do Coloradans have access to telehealth services? What were barriers, if any? To what extent did cost (of devices, phone minutes, etc.) influence access?	• Phase 1: Qualitative analysis of patient and provider interviews • Phase 2: Representative Colorado survey using questions from other state surveys (CHAS)	Phase 1: • Qualitative Phase 2: • CHAS	• Geography • Demographic characteristics	• Inter- and intra-state analyses	• Phase 1 (qualitative) • Phase 2 (CHAS 2021)
7. To what degree did frequent users of emergency department services use telehealth during the pandemic? Why?	• Phase 1: Qualitative analysis of patient and provider interviews • Phase 2: Retrospective cohort analysis	Phase 1: • Qualitative Phase 2: • CHORDS • HCPF • APCD	• Acuity/condition • Demographic characteristics • Geography • Telehealth modalities	• Cohort analysis: Patterns compared between frequent users and the rest of ED patients	• Phase 1 (qualitative) • Phase 2 would include CHORDS or APCD data, would require patient identifiers

Outcomes and Quality

Key Guiding Research Question: How are clinical outcomes affected by increased use of telehealth services?

Research Question	Analytic Approach	Potential Data Source(s)	Subgroup Analysis	Comparator(s) if Applicable	Timing/Notes
8. What health conditions or issues are better treated or more poorly treated using telehealth services? What are the short- and long-term impacts of telehealth treatment on effective chronic care management?	• Utilization analysis: Examine changes in administration of lab tests, vitals, and screenings as indicator of possible changes in health as a result of changes in monitoring/screening. • Qualitative analysis of patient and provider interviews	Phase 1: • CHORDS • HCPF (if available) • Qualitative Phase 2: • CHORDS • HCPF • APCD	• Age • Gender • Payer • Procedure • Visit Type • Provider Type • Diagnosis/condition • Labs • Screenings	• Comparison over time from Baseline to Time 1 and Time 2	• Health outcomes, lab scores may not be expected to change over such a short period. Phase 2 analyses will provide greater insights
9. Have certain populations been disproportionately impacted in terms of a disruption in continuity of care due to the transition to telehealth?	• Phase 1: Qualitative analysis of patient and provider interviews • Phase 2: Trend analysis of utilization rates and volume to assess if there was a sudden drop in visits (and among whom), suggesting a disruption in continuity	Phase 1: • Qualitative Phase 2 (if needed): • APCD • CHORDS • HCPF • Conditions: Depression during Pregnancy	• Age • Geography • Select health or behavioral health conditions • Provider type • Conditions: Diabetes, Depression, Anxiety, Mental Health Conditions, Substance Use Disorders, Hypertension, Hyperlipidemia, Asthma, Breast Cancer, Lung Cancer, Colorectal Cancer	• Comparison over time from Baseline to Time 1 and Time 2	• Phase 1 will be limited to qualitative only, although other research questions will provide insights and baseline data to assess in Phase 2

Provider and Patient Experience

Key Guiding Research Question: Are providers and patients satisfied with the shift to telehealth care during the pandemic? Why or why not?

Research Question	Analytic Approach	Potential Data Source(s)	Subgroup Analysis	Comparator(s) if Applicable	Timing/Notes
10. How are patient and provider preferences changing or remaining the same as care transitions back to face-to-face encounters?	• Qualitative analysis of patient and provider interviews	• CHI stakeholder engagement activities • Existing provider-collected surveys of patient/ provider experience	• Provider characteristics: Type of provider, urban/rural, region, size, degree of telehealth adoption • Patient demographics: Income, race/ethnicity, language, age, gender, condition (if available)	• N/A	• Phase 1
11. Do patients feel more or less engaged with providers and their own health when using telehealth?	• Qualitative analysis of patient interviews • Existing data on Patient Activation Measure (PAM)® scores	• Qualitative • Regional Accountable Entities (RAEs)	• Patient demographics: Income, race/ethnicity, language, age, gender, condition (if available)	• National, statewide, or payer-specific scores on the PAM® if available	• Phase 1 will be limited to qualitative only
12. Which telehealth modalities do providers and patients prefer?	• Qualitative analysis of patient and provider interviews • Health system or consumer advocate surveys (if available)	• Qualitative	• Modality: Video, audio-only, email, portal, etc. • Patient demographics: Income, race/ethnicity, language, age, gender, condition (if available) • Geography (urban/rural/frontier)	• Comparison over time from Baseline to Time 1 and Time 2	• Phase 1 • Qualitative • Identify barriers and benefits to each modality
13. What is the patient and provider experience of transitioning behavioral health services to telehealth among patients with behavioral health conditions?	• Qualitative analysis of patient and provider interviews	• Qualitative	• Behavioral health conditions • Patient demographics: Income, race/ethnicity, language, age, gender, condition (if available) • Type of provider • Modality: Video, audio-only, email, portal, etc.	• Comparison over time from Baseline to Time 1 and Time 2	• Phase 1 will be limited to qualitative only

Provider Business Impact

Key Guiding Research Question: To what extent are providers leveraging telehealth visits to grow or sustain their business? How?

Research Question	Analytic Approach (Proposed)	Potential Data Source(s)	Subgroup Analysis	Comparator(s) if Applicable	Timing/Notes
14. What is the impact of telehealth on patient no-show rates?	• Qualitative analysis of patient and provider interviews • Literature review • Provider-level predictive model of factors associated with lowered no-show rates	Phase 1: • Qualitative Phase 2: • APCD	• Type of provider • Region of the state • Physical health vs. behavioral health • Patient demographics: Income, race/ethnicity, language, age, gender, condition (if available) • Modality: Video, audio-only, email, portal, etc.	• Comparison over time of Baseline to Time 1 and Time 2	• Phase 1: Obtain numbers to inform modeling activities • Phase 2: Quantify the additional revenue from reduced no-show rate
15. How has telehealth reimbursement affected providers' and payers' bottom lines, taking into account both revenue and expenses?	• Qualitative analysis of patient and provider interviews • Phase 1: Assessing feasibility of modeling "savings" from fee schedules, using changes in rates and type/volume of services provided	Phase 1: • Qualitative Phase 2: • APCD	• Payer • Specific conditions • Type of visit (e.g. acute, chronic, wellness, refill, etc.) • Type of provider	• Comparison over time of Baseline to Time 1	• Phase 1 • Phase 2 may include financial modeling
16. How has cross-state access to telehealth services impacted providers' competition and business?	• Phase 2 only • Compare patient ZIP code to provider ZIP code to see if there was a change in out-of-state telehealth services	• APCD	• Geography • Type of service	• Comparisons over time of Baseline to Time 1 and Time 2	• Phase 2 (requires claims)

Attachment 4: Children's BHTF COVID Workgroup Recommendations

Children's BHTF COVID Workgroup

New Ideas

1. Evaluate and make some of the emergency rules permanent for telehealth (e.g., telephone in addition to video, equal payment rates as in-person, no need for the patient to be already established, etc.)
2. Invest in rural and frontier access to telehealth by expanding internet, cell, and telephone coverage in those areas
3. Consider approaches to keep crucial community provider organizations viable (i.e., don't allow them to fail) and retain their critical workforce
4. New priority population of children and youth directly impacted by COVID (self, family or loved one)
5. "Hazard pay" for BH providers
6. With the lack of kids in school, we've seen the incidence of identification of behavioral health needs decrease. Develop a strategy to expand settings for screenings, including childcare, educational, and child serving organizations, to identify more youth in need
7. Get out information to parents and youth (to support peers) to help them identify a youth that needs help (e.g., what you should look for and what to do if you are concerned)
8. Minimize budget cuts that support direct care
9. Flexible funds to meet the emergent needs of families at this time is important
10. Strong balance of local and state alignment to ensure consistent access to centralized info source

Attachment 5: Disaster Behavioral Health Recommendations

Disaster Behavioral Health

Recommendations for the Behavioral Health Task Force

Background

There has been recent interest from the executive and legislative branches to formalize the role of Colorado's community behavioral health organizations in the disaster preparedness and response continuum **and** to create avenues for effective and adequate reimbursement for those related activities.

Behavioral health is a critical component of any adequate emergency response plan, and preparedness efforts are enhanced by the inclusion of all Behavioral Health Partners.

- Colorado has a rich history of disaster preparedness, response and recovery efforts across sectors and industries throughout the state.

- Colorado has taken deliberate measures to ensure that disaster response is community-oriented and comprehensively accounts for communities' behavioral health needs.

- Community health organizations, including Community Mental Health Centers (CMHCs) and other behavioral health providers have actively responded to local, state-wide, and national emergencies, critical incidents and disasters for decades, including natural disasters, violence, mass casualty events, public health crises, and tragedy recovery. For example:
    - During the Hepatitis A outbreak, many counties had CMHC staff participate with contract tracing teams, providing proactive outreach to people currently experiencing homelessness and helping to adddress fears and anxieties related to vaccination.
    - With the COVID-19 pandemic, CMHCs will have staff participating with the crisis counseling program and conducting outreach to epidemiologists and contact tracing teams within local public health in order to offer support and education. These teams will also be offering free psycho-education groups for the community on topics such as stress management and parenting in times of crisis.
    - Also during the pandemic, Recovery Support Services have been instrumental in moving services to telehealth.

- There are cost associated with preparedness and planning activities, in addition to the ongoing efforts of response and recovery that often do not have a certain end date. Additionally, many types of community response do not have a FEMA funding stream attached, or other ways to reimburse for staff training or time spent during the response or recovery, which could last years.

3. Susatinability through funding is important:
    a. Disaster behavioral health support team development
    b. Team maintenance, preparedness, and sustained capacity
    c. Ability for behavioral health disaster response to formally integrate into healthcare coalitions

4. Create adequate reimbursement methods within state agencies for community resilience activities and community emergency response activities, which are not tied to individual services.

Current and Future Capability and Capacity Needs for Disaster Behavioral Health Response

The following capabilities and capacity are required elements for eligible community behavioral health organizations to participate in the work of emergency preparedness, response and recovery.

1. Network Development:
    a. Ability and commitment to participate in the regional Healthcare Coalition
    b. Ability and commitment to participate in the biannual Disaster Coordinator's Council
    c. Ability and commitment to participate in the quarterly Colorado Crisis Education and Response Network
2. Planning
    a. Each organization must identify a Disaster Coordinator and two Backups
    b. Each organization must develop Agency/Provider Continuity of Operations Plan
        i. Includes identified Essential Functions of agency/provider
        ii. Includes Actions/Tasks necessary to maintain service to core constituents
    c. Each organization must develop an Agency/Provider Response Plan
        i. Identifies catchment area
        ii. Identifies key community risks
        iii. Identifies probable events and response as well as recovery efforts to those events.
3. Response Strike Team
    a. Each organization must develop an ability to implement any two identified mission sets (defined by CDPHE OEPR)
    b. Team size (depends on agency)
        i. Ideal - 25 to 30 trained members
            1. 1 Licensed Clinician for every 8 non-licensed responders

2. Emphasis should be on paraprofessional capabilities or peer
3. Mix of specialities including children and geriatrics along with trauma and spiritual care/chaplaincy.

ii. Minimum 8-10 trained members

c. Each organization must assure team members always respond in pairs

4. Training – The following trainings are required for the organization
   a. Incident Command System Trainings (Independent Study courses found here)
      i. Core agency and response leadership:
         1. IS 100 (Independent Study)
         2. IS 200 (Independent Study)
         3. ICS 300
         4. ICS 400
         5. IS 700 (Independent Study)
         6. IS 800 (Independent Study)
      ii. Response team
         1. IS 100 (Independent Study)
         2. IS 200 (Independent Study)
         3. IS 700 (Independent Study)
         4. IS 800 (Independent Study)
   b. Disaster Behavioral Health
      i. Colorado Field Response - OR
      ii. ARC fundamentals of disaster mental health
   c. Intervention
      i. Psychological First Aid (not Mental Health First Aid)
      ii. PFA Briefing
      OR
      iii. PrePare (for school based personnel)
   d. Recovery
      i. Crisis Counseling Program Core Content
      ii. Crisis Counseling Program Transition Content
5. Culturally and Linguistically Apppropriate Services: Organizations should be able to meet the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care in delivering disaster behavioral health services into the community.

Conclusions

To ensure that Colorado is fully prepared for future emergencies and crisis, now is the time to:

- Formalize the role of Colorado's community behavioral health organizations in the disaster preparedness and response continuum.

- Create effective and adequate reimbursement for behavioral health disaster preparedness and response initiatives.
- Invest in community resilience initiatives and activities by the behavioral health system.
- Adequately support state and local infrastructure to respond to behavioral health needs following community level crisis and invest in community resilience initiatives and activities.