The 2009 Colorado Behavioral Health Transformation Transfer Initiative: Final Grant Report

February 2010

submitted to

The State of Colorado
Department of Human Services

on behalf of
Colorado's
Behavioral Health Cabinet
and
Behavioral Health Transformation Council

by

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Executive Summary

From January to December 2009, Colorado carried out a federally-funded behavioral health system transformation planning initiative. The initiative was led by the Behavioral Health Cabinet authorized by Governor Bill Ritter, Jr., and involved the Executive Directors of the Departments of Corrections, Health Care Policy and Financing (the state's Medicaid agency), Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Public Safety; other members included the state's Chief Medical Officer and the Director of the Governor's Office of Policy and Initiatives. With the Department of Human Services as the lead agency and using the recommendations of the 2007 House Joint Resolution 1050 (HJR-1050) Task Force as a blueprint, in late 2008 the BH Cabinet was awarded a Transformation Transfer Initiative Grant (Grant Initiative) by the federal Substance Abuse and Mental Health Services Administration to support this effort. TriWest Group, LLC, and Advocates for Human Potential, Inc., were selected through a competitive process to facilitate the Grant Initiative planning process.

This final report summarizes the accomplishments of that year of planning. Through 2009, the Grant Initiative established a foundation for a multi-year transformation process to develop more coordinated, effective and responsive behavioral health systems. Key to this was the recognition that the implementation plans and broader transformation infrastructure developed in 2009 were only the next of many steps in that process. The Grant Initiative developed a roadmap and supportive infrastructure for continued progress toward transformation of Colorado's behavioral health system by accomplishing three things:

1. A process for ongoing, meaningful input from consumers and other stakeholders through the **formation of a Behavioral Health Transformation Council** to work with the Behavioral Health Cabinet and take responsibility to set priorities to guide behavioral health transformation efforts, define annual objectives to guide implementation, and assemble subject matter experts across multiple work groups to implement system transformation;
2. **Four coordinated implementation plans** to guide the detailed work of integrating Colorado's behavioral health system; and
3. **A multi-year commitment by Colorado's executive, judicial, and legislative branches of government** to ensure that the Behavioral Health Cabinet's planning and implementation efforts are institutionalized and are both ongoing and productive, resulting in true system transformation.

The primary activities carried out through May 2009 centered on building trust and developing a working relationship among stakeholder groups and state government staff. In order to move beyond their traditional roles of advocate and regulator and become partners in the task of system transformation, stakeholders and state agency staff needed both to establish a sufficient level of trust in each other's willingness to work in good faith and to believe that concrete results were attainable. Many of the various levels of partnership that emerged throughout 2009 went beyond the planning stage, including collaboration between the Departments of Human Services and Local Affairs to procure $100 million to develop affordable supportive housing, enhanced connections between Workforce Centers and the BH system to promote employment, efforts to streamline and align required paperwork, and establishment of social/emotional standards for health education.

The BH Transformation Council led the process to develop detailed implementation plans to guide system transformation. To inform the plans, Regional Stakeholder Forums were convened in April and May 2009. Overall, 75 forums were conducted involving 561 participants through in person forums in major urban areas (Denver Metro, Colorado Springs, Grand Junction, Fort Collins, and Pueblo); forums for rural and frontier areas through a network of video conference sites in Craig, Durango, Lamar, Sterling, and Trinidad; and additional telephone conferences for some mountain communities and other areas. Additional forums requested by stakeholders were conducted with American Indian / Native American service providers in the Denver Metro area, caregivers of adults with co-occurring developmental disabilities, and members of the Child Welfare Action Committee. Participants identified 1,149 local issues across 71 areas in 12 overall categories across the forums and used these to rank potential state-level changes. The top state changes prioritized by participants centered on financing reform, streamlined rules and regulations, increased spending on services, the establishment of a behavioral health commission to guide implementation, consumer and family involvement, and workforce development. The BH Transformation Council then convened work group meetings over the summer to develop four coordinated plans to:

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

The four implementation plans focus primarily on changes to formal behavioral health prevention, intervention, and treatment service delivery systems funded and regulated by state agencies (primarily the Colorado Departments of Corrections, Health Care Policy and Financing, Human Services, Public Health and Environment, and Public Safety). Just as critical are the broader sets of non-medical supports essential to the prevention of and recovery from behavioral health disorders, including the employment and workforce development supports of the Colorado Department of Labor and Employment and the housing and community development resources of the Colorado Department of Local Affairs. Key supports from the Colorado Department of Education and the Colorado State Judicial Branch were also incorporated. The implementation plans place a premium on data and evidence of effectiveness, emphasizing the use of evidence-based, promising and best practices wherever feasible, building on existing efforts, and coordinating with interagency collaboratives, so as to both honor and make use of the work that preceded this initiative. Throughout the Fall of 2009, all of the implementation plans were vetted with all involved stakeholders to ensure the broadest possible consensus for implementation, and both the BH Cabinet and BH Transformation Council have endorsed these plans. Under the leadership of the Behavioral Health Cabinet and the Behavioral Health Transformation Council, a consensus-based framework to support that process across the years is now in place, ready to be built upon and ultimately to be transformed through the ongoing process of responding to the needs and strengths of people across Colorado involved in the delivery and receipt of behavioral health services.

Introduction and Background

In the winter of 2007, Governor Bill Ritter, Jr., called an unprecedented meeting of his relevant Cabinet members to discuss the cross-system impacts of mental health and substance abuse services (i.e., behavioral health) in Colorado. Out of this meeting, the Governor authorized the creation of a Behavioral Health Cabinet led by the Executive Directors of the Departments of Corrections, Health Care Policy and Financing (the state's Medicaid agency), Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Public Safety; other members included the state's Chief Medical Officer and the Director of the Governor's Office of Policy and Initiatives.

Beginning early in 2008, the Behavioral Health (BH) Cabinet began the long process of understanding each department's role in the provision of behavioral health care services and related funding streams. The BH Cabinet also reviewed recent efforts that included the recommendations of the 2007 House Joint Resolution (HJR) 1050 Task Force and the Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System.

While the Cabinet was able to make joint recommendations and support each other's efforts, it was understood that increased coordination with advocacy and stakeholder groups was vital to the success of behavioral health transformation. With the Department of Human Services as the lead agency, in late 2008 the Cabinet was awarded a Transformation Transfer Initiative Grant (Grant Initiative) by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to support this effort. A national request for proposals of interest was carried out in late 2008 and TriWest Group, LLC, of Boulder, CO, (TriWest) and subcontractor Advocates for Human Potential, Inc., of Sudbury, MA and Albany, NY, (AHP) were selected through a competitive process to facilitate the Grant Initiative planning process.

The Grant Initiative planning process was initiated in late January 2009 and continued through December 2009 to review the work completed to date by the HJR-1050 Task Force and other stakeholders to develop a roadmap for continued progress in three areas:

1. Developing a process to secure ongoing, meaningful input from consumers and other stakeholders on decisions, implementation plans and system changes proposed by the Behavioral Health Cabinet;
2. Facilitating the establishment of an implementation process for the Behavioral Health Cabinet, and its departmental staff group, to approach the integration of the behavioral health system, using the recommendations of the HJR-1050 Task Force as a blueprint; and
3. Securing ongoing funding (including state, federal or local grant funding) and other necessary support to ensure that the Behavioral Health Cabinet's planning and implementation efforts are institutionalized and are both ongoing and productive, resulting in true system transformation.

This final report summarizes the key steps involved in achieving those goals and documents the primary work products developed in the course of their achievement. The progress overview and final products are grouped by the three primary goal areas just noted. Through these steps, the Grant Initiative has helped set a foundation for a multi-year transformation process to develop more coordinated, effective and responsive behavioral health systems at the state level. All planning participants recognized that the implementation plans and the commitment to the broader transformation framework developed in 2009 were only the next of many steps in that process, building on the foundation of past initiatives, such as the HJR-1050 Task Force, and looking forward to ongoing collaboration, effort, and reevaluation. The transformation of such complex and important systems cannot happen all at once and instead must involve an iterative and dynamic process to improve continually over time. Under the leadership of the Behavioral Health Cabinet and the Behavioral Health Transformation Council, a consensus-based framework to support that process across the years is now in place, ready to support continuing work to transform and integrate multiple behavioral health delivery systems to serve people across Colorado.

Stakeholder Involvement Process Development

The Grant Initiative planning process was kicked-off in late January 2009 with a day of joint meetings with the Behavioral Health (BH) Cabinet and stakeholder representatives. The proposed work plan was reviewed and information was shared from the lessons learned by other states undergoing transformation of their behavioral health systems over the last four years, with a particular emphasis on how those states involved stakeholders in their process (see Appendix One for a summary of those efforts). The primary activities carried out over the next four months centered on building trust and developing a working relationship among stakeholder groups and state government staff to develop the stakeholder involvement process. This relationship development and trust building occurred through formal meetings, as well as through numerous one-on-one and small group interactions among the BH Cabinet members, stakeholder leaders, and senior state agency staff. While the formal meetings are highlighted below, the additional informal meetings were among the most critical steps in developing the functional process in place by the end of the grant period. Trust in each other's willingness to work in good faith and a belief that concrete results were achievable were both necessary achievements enabling stakeholders and state agency staff to move beyond their traditional roles of advocate and regulator to become partners in the task of system transformation.

The various levels of partnership that emerged led to results throughout 2009 that went beyond the establishment of future-directed processes and implementation plans. A variety of near term opportunities to transform local and state BH systems were pursued, including:

- Grant support coordinated through the Colorado Department of Local Affairs (DOLA) for the continued operation of the Colorado West Regional Mental Health Center

psychiatric facility in Grand Junction to provide inpatient services west of the Continental Divide.

- Collaborative funding by DOLA and the Colorado Department of Human Services (CDHS) of federal Homeless Prevention and Rapid Rehousing programs funding under the American Recovery and Reinvestment Act (ARRA) and a Temporary Aid for Needy Families (TANF) grant to support wraparound services for families in the Metro Denver area at immediate risk of homelessness.
- Collaboration between CDHS and DOLA to procure $100 million in financing to develop affordable supportive housing for persons with disabilities, including mental illness and substance use disorder issues.
- Work through the Colorado Department of Labor and Employment to build more connections between Workforce Centers and the BH system to enhance employment opportunities for people with BH needs.
- A statewide planning process coordinated by the Governor's Office and funded by The Colorado Health Foundation to support statewide and community-level planning to stabilize the state's dwindling acute psychiatric inpatient capacity.
- Collaboration between the Colorado Department of Health Care Policy and Financing (HCPF) and CDHS to develop capacity in acute care hospital systems to address BH needs in emergency rooms and increase inpatient psychiatric capacity. This includes working with The Children's Hospital and Denver Health Medical Center to strengthen inpatient and outpatient services for children with severe BH needs.
- Joint effort by HCPF and CDHS to work with nursing home providers, behavioral health organizations (BHOs) managing regional Medicaid BH networks, and community mental health centers to increase community capacity to serve geriatric and other consumers in nursing home settings with behavioral health needs, and with residential providers of children's mental health services to assess ways to improve community-based residential treatment options for children in the child welfare system.
- Cooperation by the Colorado Department of Public Health and Environment (CDPHE) and HCPF to develop new licensure categories for behavioral health facilities to expand residential supportive services options, including work with the Legal Center and BH providers to expand host home and other less restrictive housing options for adults with disabilities.
- Formation of a collaborative workgroup to streamline and align required paperwork for publicly-funded BH providers, with membership from HCPF, CDHS, behavioral health organizations managing regional Medicaid BH networks, community mental health centers, substance use disorder provider organizations and their regional intermediaries, and federally qualified health centers.
- Establishment of social/emotional standards for health education by the Colorado Board of Education in December, in response to a request from the BH Cabinet and in support of work by the Colorado Department of Education (CDE), CDPHE, and a coalition of existing collaborative groups including Colorado LINKS for Mental Health and the Colorado Mental Health Planning and Advisory Council.

These and similar collaborative efforts unfolded across the grant period, increasing in the second half of the year in direct relationship to the formal and informal efforts to build multiple levels of working relationships among BH Cabinet members, stakeholder leaders, and state agency staff. The major milestones by month in the development of these relationships are described below.

February/March: Initial Interviews. Interviews were conducted with dozens of stakeholder, state agency, and executive branch representatives to inform the development of a collaborative process to involve the BH Cabinet, representatives of key stakeholder groups, and existing collaborative / interagency commissions, task forces and work groups. Early on, stakeholder and state government informants emphasized the importance of building on existing initiatives and fostering synergy among them, as opposed to just developing yet another layer of meetings for people to attend. As a result, in addition to involving representatives of key state agencies and major stakeholder groups such as consumers, family members, and service providers, representatives of existing interagency task forces, work groups, commissions and other collaborative bodies were also involved.

March/April: Sharing Perspectives and Building Consensus. The input from the initial interviews was then summarized and shared with representatives of the key stakeholder groups and interagency task forces / work groups involved. Key events during this period included:

- Webinar and in person presentations to stakeholders in mid-March to review findings and solicit comment;
- Presentations to and planning with existing interagency groups, including the Colorado Commission on Criminal and Juvenile Justice and the Child Welfare Action Committee;
- Additional outreach to stakeholder groups that felt left out of prior planning, including substance abuse provider agencies and youth; and
- Monthly meetings with the BH Cabinet to update them on progress, review the input of stakeholders and interagency groups, and begin building consensus on implementation activities.

April/May: Initiating a Formal Stakeholder Involvement Process. In mid-April, representatives of stakeholder and interagency groups gathered for the first formal meeting to carry out planning for the Grant Initiative process. At this meeting, participants developed a preliminary statement on Values and Vision and began to develop the outline of a formal process for ongoing stakeholder involvement. The group met again twice in May and once in June, working through differences, clarifying priorities, and identifying additional membership. In early July, the group finalized a framework for an ongoing Behavioral Health (BH) Transformation Council (see Appendix Two for a summary of the BH Transformation Council's charter and original membership established under the Grant Initiative).

The role of the BH Transformation Council centers on supporting collaboration between stakeholders and state agencies. The Council has three primary tasks within that role:

- Setting priorities to guide behavioral health transformation efforts,
- Defining annual objectives to guide implementation, and
- Assembling subject matter experts across multiple work groups to implement transformation.

To the extent possible, these work groups will build on and coordinate with existing interagency collaborative efforts. The BH Transformation Council will ensure that needed stakeholders and subject matter experts are included in these efforts, and will coordinate with the BH Cabinet to ensure that state agency efforts are optimized. BH Transformation Council members commit to streamline and coordinate their individual agencies' efforts in alignment with the decisions made by the Council.

To carry out this role, the responsibilities of the BH Transformation Council are as follows:

- Each participating organization commits to participate in a common priority setting and planning process for behavioral health transformation within the following parameters:
  - Each participating organization commits to support the common priority setting process, to "do no harm" when they have competing priorities, and to at all times maintain healthy working relationships to support the work of behavioral health system transformation.
  - Each participating organization maintains its autonomy and remains responsible for its own budget, policies, purchasing, monitoring, compliance, and legislative strategy.
  - The Behavioral Health Cabinet is responsible to Governor Ritter and recommendations involving state agencies are subject to the Governor's authority.
- To participate, stakeholder organizations must represent larger groups of stakeholders.
- Each organization has one official representative who commits to attend all meetings, plus a deputy who also attends in order to be able to act in the official representative's absence.
- In between meetings, each participating organization is responsible for communicating with groups they represent to keep stakeholders informed and obtain ongoing input.
- The BH Transformation Council will develop actionable proposals for consideration by the BH Cabinet within the parameters of the state's defined governmental, budgetary and legislative cycles.

Beginning in July 2009, the BH Cabinet and BH Transformation Council began regular, coordinated meetings, including joint meetings in July, November, and the final Grant Initiative meeting in December.

Transformation Implementation

The second Grant Initiative goal involved the development of implementation plans to facilitate transformation of state and local behavioral health care delivery systems. This effort began

with the 2007 recommendations of the HJR-1050 Task Force as a guiding document, and project work centered on developing achievable and substantive plans to carry them out.

It should be noted that the BH Cabinet meetings held throughout the planning process, the stakeholder interviews leading to the creation of the BH Transformation Council, and the BH Transformation Council's meetings and subcommittee meetings were the primary forums for planning all implementation activities. To help prioritize opportunities for advancing the HJR-1050 recommendations, the Grant Initiative planning process began with information gathered from stakeholders across Colorado in April and May 2009.

April/May: Regional Stakeholder Forums. Regional Stakeholder Forums were convened to prioritize "entry opportunities" among the 11 HJR-1050 Task Force Recommendations developed in 2007 (see Appendix Three for a summary of these recommendations). At the forums, participants engaged in two overall activities. First, they developed a list of changes they would like to see in their local behavioral health care delivery systems. After discussion, they were asked to prioritize their top three changes. Participants then reviewed the 11 HJR-1050 recommendations, which focus on state level changes, in an effort to identify those state changes most likely to result in the local changes they had prioritized. Participants were also allowed to identify recommendations for more funding for specific types of services and to generate additional state changes not included in the HJR-1050 priorities. After this, participants ranked the "top three" state changes they believed most likely to result in transformation. Participants also provided demographic information.

TriWest and AHP worked closely with the stakeholder representatives involved in the BH Transformation Council and state agency leaders to identify stakeholders for involvement. Because behavioral health needs affect the lives of so many different kinds of people, forums were conducted in each community with a wide range of groups. To the extent possible, TriWest and AHP met with each group separately in order to focus on their unique needs, but several times stakeholders from different groups attended other meetings because a given time worked better for them. The primary groups targeted for involvement in the forums included:

1. Adult consumers of mental health and substance abuse services,
2. Youth and young adults,
3. Parents and caregivers of children receiving BH services,
4. Family members of adult consumers of BH services,
5. Child welfare, juvenile justice, and education system leaders,
6. Criminal justice system leaders,
7. Community leaders,
8. Mental health providers,
9. Substance use disorder treatment and prevention providers,
10. People interested in early childhood issues,
11. People interested in primary care and behavioral health Integration, and
12. People interested in private insurance issues for behavioral health.

Overall, 75 forums were conducted involving 561 participants (this count included duplicates, as some participants attended multiple forums). Forums in major urban areas (Denver Metro, Colorado Springs, Grand Junction, Fort Collins, and Pueblo) were conducted in person and forums in rural and frontier areas were conducted using a network of video conference sites in Craig, Durango, Lamar, Sterling, and Trinidad. Some mountain communities and other areas requested telephone conferences as an alternative to the in person and video options in order to involve more local stakeholders; in all cases these requests were accommodated. Additional forums requested by stakeholders were conducted with American Indian / Native American service providers in the Denver Metro area, caregivers of adults with co-occurring developmental disabilities, and members of the Child Welfare Action Committee.

For some subsets of stakeholders in some areas, no participants were identified. However, overall attendance was quite robust across the state and included participants reporting that they lived in the following areas:

- Denver Metro: 201
- Colorado Springs: 41
- Rural / Frontier areas: 128
- Western Slope (Grand Junction): 57
- North Front Range (Fort Collins): 53
- South Front Range (Pueblo): 30
- Those reporting their community of interest as “statewide” or not reporting it: 41

Participants identified 1,149 local issues across 71 areas in 12 overall categories across the forums and used these to rank potential state-level changes. The top state changes prioritized by participants are summarized in the following table; a fuller presentation of the forum results is provided in Appendix Four.

State-Level Change Rankings (n=558)	
Recommendation	**Overall Ranking**
Financing reform	1
Streamlined rules and regulations	2
Spending more money on services	
Establish a Behavioral Health Commission	
Consumer and family involvement	3
Work force development	
Shared outcomes across state agencies	4
Aligned service areas	
Joint budget planning	
Other (respondent identified)	5
Electronic data sharing	6
Cultural competency	7
Joint auditing/oversight	8

June/July: Prioritizing Action Items for Implementation. The stakeholders and state agency leaders participating in the BH Transformation Council then set about the work of prioritizing areas of action, using the forum results and additional input and guidance from the constituents and agencies they represented. The BH Cabinet and the BH Transformation Council jointly developed decision criteria (phrased below as questions) to guide the prioritization of actions for implementation:

1. Will the item lead to a positive impact on the quality of life for people served?
2. Does the item allow for consumer and family involvement across time?
3. Does the item promote cultural competence and a focus on disparities in access to behavioral health care across implementation planning?
4. Does the item fit with the HJR-1050 recommendations and the priorities identified through the community forums?
5. Does the item fit with Governor Ritter's policy priorities (including health care reform, education, child welfare reform, justice reform, and economic improvement/stability)?
6. Is the item actionable?
7. Is the item transformative and bold?
8. Are the actions cost neutral?

In July, the BH Transformation Council convened work group meetings around emerging priority areas to develop initial frameworks for implementation plans. These frameworks were reviewed at a joint meeting in mid-July at which the BH Cabinet and BH Transformation Council identified four areas in which implementation plans would be developed:

- Prevention and intervention for children, adolescents, youth, and young adults;
- Criminal and juvenile justice system;
- Continuity of care and finance reform; and
- Sustainability of the behavioral health system transformation process.

August/September: Develop Implementation Plans. Implementation plans were then developed in each of the four priority areas, aligned with the decision criteria. The BH Transformation Council held an intensive two-day retreat in August and follow-up work groups in September to develop the plans. The August retreat included a thorough review of the transformation implementation efforts of other states (see Appendix Five for this summary). Through this process, existing interagency collaborative groups were engaged to the extent possible. For example, to develop the implementation plans for prevention and intervention with children, Colorado LINKS and the Mental Health Planning and Advisory Committee's Youth and Young Adult Transitions Committee led the planning process. For criminal and juvenile justice, planning was led by a joint work group convened in collaboration with the Colorado Commission on Criminal and Juvenile Justice and the Legislative Oversight Committee for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System.

The four sets of implementation plans focus primarily on changes to the publicly-funded behavioral health prevention, intervention, and treatment service delivery systems funded and

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

The implementation plans that were developed place a premium on data and evidence of effectiveness, emphasizing the use of evidence-based, promising and best practices wherever feasible, building on existing efforts, and coordinating with interagency collaboratives so as to both honor and make use of the work that preceded this initiative. Finally, all of the implementation plans have been vetted with all involved stakeholders to ensure the broadest possible consensus for implementation, and both the BH Cabinet and BH Transformation Council have endorsed these plans. This process included a statewide webinar in August in which the results of the stakeholder forums conducted in April and May and the prioritized content areas for implementation planning were shared with forum participants and other concerned stakeholders. Email addresses had been gathered from all forum attendees interested in receiving a copy of the results, and these stakeholders, as well as additional advocacy groups (such as the Colorado Cross-Disability Coalition), were invited to participate.

The final four Grant Initiative implementation plans are included in Appendix Six. The appendix includes a summary of short and longer term outcomes for each of the four plans, followed by a description of major steps, involved parties, and proposed timelines:

- Action Plan One: Continuity of Care and Finance Reform Implementation Plan (Appendix 6, page 2),
- Action Plan Two: Criminal / Juvenile Justice (Appendix 6, page 6),
- Action Plan Three: Under 21 Prevention and Intervention (Appendix 6, page 8), and
- Action Plan Four: Sustaining Behavioral Health System Transformation in Colorado (Appendix 6, page 13).

Ongoing Resources and Support

The third and final goal of the Grant Initiative planning process was to secure ongoing funding (including state, federal or local grant funding) and other necessary supports to ensure that the Behavioral Health Cabinet's planning and implementation efforts are institutionalized and are both ongoing and productive, resulting in true system transformation. While resources for transformation are always a challenge to secure, the national and state-level financial crises, and associated dramatic drops in state government revenue beginning in 2008 and continuing throughout the Grant Initiative planning process, posed a particular challenge to sustainability.

In order to move the work of transformation forward in such an environment, all of the implementation plans were developed on the premise that there would be no changes in state agency funding related to behavioral health transformation in the remainder of Fiscal Year (FY) 2009-10 and that any changes in FY 2010-11 would need to be both cost neutral and in line with budget plans already finalized for that year. Furthermore, the resources available to support the work of transformation would be limited to existing state agency staff and the participation from involved stakeholder groups, recognizing that all participating agencies and organizations are undergoing staffing cuts and funding reductions that for many are unprecedented.

The Grant Initiative planning process included a review of federal, state, and local funding opportunities. The possibility of another round of major federal system transformation funding was identified, but at the time of the completion of this report, no definitive federal funding opportunities had been released. In addition, discussions in the summer and fall of 2009 were carried out with Colorado foundations focused on health policy; targeted resources in support of some transformation activities may be pursued, recognizing that Colorado foundations already support a wide range of cross-agency planning and policy development activities upon which new efforts can build.

October/November: Finalizing process recommendations. The planning activities through the end of the formal Grant Initiative planning process focused on sustainability of transformation efforts. Key achievements to align resources in support of continued activities included:

- The members of the BH Cabinet and BH Transformation Council committed to a specific schedule to continue the work of transformation. Beginning in December 2009, a 12-month cycle of joint meetings was established, involving both groups (scheduled through February, April, June, August, and October 2010) and working meetings of just the BH Transformation Council (scheduled through January, March, May, July, September, and November 2010). The joint meetings begin with a one-hour separate meeting of each group, followed by a two-hour joint meeting where implementation progress is reported, state agency and stakeholder actions in support of transformation discussed, and decisions made. The working meetings of the BH Transformation Council coordinate and track implementation of the priority transformation activities described in the next section of this report.
- A website resource was established through e-Colorado.gov, supported by the Department of Labor and Employment and maintained by Department of Human Services staff, in order to provide a common set of information and schedule information for BH Cabinet and BH Transformation Council participants.

The fourth implementation plan, centered on developing options for a sustainable public-private partnership to guide Colorado's behavioral health transformation efforts, identified four sets of activities to continue to align resources around the work of transformation. This plan and associated language for draft legislation was developed across multiple work group meetings from September through December 2009 involving most members of the BH Transformation Council. As noted in the detailed implementation plans provided in Appendix

Six, this effort may include legislation and written commitments from the executive and judicial branches of government that could include one or more of the following provisions:

- Recodification of existing statute to consolidate behavioral health related statutes where appropriate.
- Establishment of a commitment from each of the three branches of government to work together to carry out the goals, objectives and values of the behavioral health policy framework. This process would be established to ensure that consumers, families and other stakeholders provide meaningful involvement, and would designate that the Commissioner of Education, State Court Administrator of the Colorado Judicial Branch, and Executive Directors of the Departments of Corrections, Education, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Public Safety would dedicate staff to assist with the fulfillment of the behavioral health policy framework.
- Implementation of specific provisions of the Transformation Transfer Initiative implementation plans as appropriate.
- Beginning a process for aligning the myriad groups, task forces, and commissions that are working on some aspect of behavioral health care in order to consolidate and strengthen transformation efforts, and focusing on the development of joint priorities across the groups and building consensus as to which items move forward and are implemented in legislation and practice.

The potential legislation that could flow from this process and the broader commitment to joint action across a multi-year transformation process together comprise the next step in Colorado's efforts across the years to develop an effective and responsive behavioral health care system. It would broaden plans from the Grant Initiative centered on the executive branch to include the legislative and judicial branches of Colorado State Government and provide a firm policy foundation for the implementation efforts coordinated by the BH Transformation Council in 2010.

All Grant Initiative planning participants recognized that the implementation plans and the commitment to the broader transformation framework developed in 2009 were only the next of many steps in a multi-year transformation process. When asked how long they thought the process of behavioral health system transformation was likely to take, over 60% of community forum participants endorsed the option with the longest timeframe (over three years). This underscores that transformation will not happen all at once and instead must involve a continuous, iterative and dynamic process to improve services and systems. Under the leadership of the Behavioral Health Cabinet and the Behavioral Health Transformation Council, a consensus-based framework to support that process across the years is now in place, ready to be built upon and ultimately to be transformed itself through the ongoing process of responding to the needs and strengths of people across Colorado involved in the delivery of behavioral health services.

Appendix One

Involvement of Stakeholders in the Transformation Activities in Other States

Colorado's work on the Transformation Transfer Initiative is dedicated to consumer involvement and stakeholder input. The state received input on successful strategies from the Transformation Workgroups of the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation State Incentive Grant awardees, including Connecticut, Hawaii, Maryland, Missouri, New Mexico, Ohio, Oklahoma, Texas, and Washington. As part of their recommendations, these workgroups suggested engaging stakeholders in meaningful and powerful ways, managing expectations, developing win-win actions, building on relationships, and creating visible changes. Each of the nine states provided detailed information on how they are meaningfully engaging stakeholders and giving their voices a powerful role in transformation activity. The following are brief overviews of each state's approach to involving stakeholders in the planning and execution of mental health transformation in their state.

Connecticut

Connecticut has created a detailed, specific and measurable set of principles, policies and procedures that ensure the meaningful and powerful participation of consumer, youth and family members, which have been codified in a formal charter. The Consumer, Youth and Family Council (CYF Council) decides its own membership, develops its role within the larger transformation efforts, and has a formal management plan and timeline. As part of their duties, the CYF Council designates representatives to subcommittees; previews all pilot projects, major decisions and resource allocations prior to full development or insertion in the larger plan; and reviews and modifies final plans. In addition, they work closely with the Oversight Committee in determining resource allocation.

Maryland

In an effort to develop a recovery oriented system, the Maryland Transformation Workgroup (TWG) has increased consumer representation on committees that affect policy development and program implementation, hired a consumer affairs specialist and restructured the TWG as an "open community meeting" with opportunities for feedback and guidance to the process.

Maryland's specific activities dedicated to supporting consumer participation have included providing WRAP training to 58 people and implementing the Consumer Quality Team (CQT) that interviews consumers and conducts program site visits. They are also developing a Self-Directed Care Project and a State hospital Consumer Interview Project designed to reach out to consumers who have been hospitalized one year or more, with a goal of identifying needed community resources.

The state has also been focused on services for children, youth and families. Maryland has established the Children's Mental Health Institute (which is grounded in EBPs and promising practices), implemented a wraparound service model pilot project in four sites, and has

partnered with Coalition of Families to recruit and hire family navigators in 19 of 24 jurisdictions. The state has also launched Place Matters, a family preservation program, and worked with the Children's Cabinet to create and release the Ready by 21 action agenda.

Missouri

The Missouri TWG has supported a number of stakeholder initiatives. The state is currently exploring the development of a Youth Leadership Initiative and providing support for the "Real Voices" conference held in August of 2009. They have also developed a series of RESPECT Seminars, with seventeen seminars held in 2008, and implemented the Mental Health First Aid training program, which is a twelve hour course. In addition, Missouri has developed support for "Procovery," which is "an approach to illness based on the understanding that sometimes healing has little to do with health; sometimes recovery in the traditional sense is not an option; and often we need to rewrite the scripts of our lives and reach forward to the largely unknown rather than backward to the familiar."

New Mexico

New Mexico has developed the Behavioral Health Planning Council, which advises the state level Collaborative, and includes consumers, family members, Native American Tribal representatives, and other advocates. The state has also developed a network of local collaboratives, made up of consumers, families, providers, and advocates, that are the communities' voice to the TWG. In addition, New Mexico has Restructured CAFÉ, a program through the state's Office of Consumer and Family Engagement that trains peer specialists as service providers, evaluators and active participants in local processes.

Ohio

The Ohio TWG has been proactive in involvement of consumers, families and youth. They have conducted town hall meetings throughout the state, led by the Multiethnic Advocates for Cultural Competence (MACC). In addition they have developed a 24 member Statewide Advisory/Planning Team as part of MACC to provide feedback on cultural competence. The state has also developed curriculum and trained case managers in the use of consumer outcomes data for shared decision making and collaborative development of individual plans of care, and developed a peer consultant advisory group that is incorporated into the MHT SIG process and included in a monthly cross-system forum.

Hawaii

Hawaii's Transformation Workgroup has developed seven sub-groups, including a working group titled "Consumers and Families as Drivers".

Oklahoma

Oklahoma has focused on specific activities to enhance consumer and family voice. These include appointing a consumer representative to the Governing Board of OK Department of MHSA, drafting standards for consumer involvement, and creating new positions for Recovery

Support Specialists and training them. The state has also planned to apply for funding to provide leadership training programs.

Oklahoma has also launched the Children's Behavioral Health Initiative, which is built on a previous issue-driven partnership that included representatives from families, Oklahoma Health Care Authority, the Oklahoma State Department of Health, Department of Human Services, Office of Juvenile Affairs, Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma Commission on Children and Youth, the Department of Rehabilitative Services, the State Department of Education, and two legislators.

Texas

The Texas TWG has formalized and adopted consumer and family driven guiding principles and characteristics. They have also developed seven local community collaboratives, with requirements for local participation of consumers and family members. In addition, they have developed a training plan to support that activity within the local collaboratives. Texas DSHS and the Hogg Foundation for Mental Health are also collaborating on the development of a Texas Mental Health Training Institute.

Washington

The MHT SIG staff in Washington have provided formal training and technical assistance to increase the capacity of larger numbers of consumer and family members, including board training for a new statewide consumer network. The state has also provided support for the development or expansion of Youth in Action, Statewide Action for Family Empowerment (SAFE-WA), and a statewide consumer network. In addition, they have supported development of certification standards for consumer/family-run organizations; established the Self-Help Empowerment and Evaluation Alliance to provide TA to support consumer, family and youth-run organizations; and provide mini-grants to develop capacity. Washington has also implemented three (3) pilot projects that integrate consumers into community mental health clinical teams, and explored Self-Directed Care options. Finally, the state has created a web-based cultural competency training and organizational assessment, and convened a public health and prevention summit.

Appendix Two

Behavioral Health Transformation Council Charter and Membership

Goal: Colorado Transformation Transfer Initiative (TTI) Goal #1: "Develop a process to secure on-going, meaningful input from consumers and stakeholders on decisions, implementation plans and system changes proposed by the Behavioral Health Cabinet."

Process to Develop this Process:

- On May 14 and 29, stakeholder and State agency representatives met and agreed on the following process for stakeholder involvement for the TTI process.
- On June 19, Governor Ritter's Behavioral Health Cabinet endorsed creation of the Behavioral Health (BH) Transformation Council.

Values and Vision Established on April 14 by Stakeholders and Agency Staff

- Commitment to true transformation of Colorado's behavioral health systems
  - Bold changes
  - High visibility
  - Multi-year commitment
- Commitment to building trust among stakeholders
- Commitment to a vision grounded in:
  - System of care and recovery principles:
    - Consumer voice
    - Belief in recovery
    - Youth-guided, family-driven services
    - Community based care
    - Culturally and linguistically competent care
    - Public awareness and education regarding behavioral health
    - Accessible and effective services
  - Commitment to helping people live full and successful lives in livable communities
  - Commitment to incorporate broader goals related to:
    - Behavioral health across the developmental span (from "cradle to grave")
    - A full continuum of mental health and substance abuse services, from prevention to intensive treatment
    - Integration of behavioral health within the broader physical health care service delivery system and primary care
    - Meeting the range of behavioral health needs, from low level to severe
    - Supports for jobs, housing, transportation, basic needs, social connections
- Commitment to doing something, taking initial steps, learning from them, and ultimately working through the nuts and bolts to get things done
- Commitment to a forum where all can share their knowledge and experience
- Commitment to equality in decision-making in carrying out the BH Transformation Council's work
- Commitment to involve "more than just the usual suspects"
- Bottom Line: Real changes in the lives of people served that improve their lives

Role of the Behavioral Health (BH) Transformation Council

- **Collaboration** between stakeholder and State Agency representatives to:
    - **Set priorities** to guide behavioral health transformation efforts
    - **Define annual objectives** to guide implementation
    - **Assemble subject matter experts** across multiple work groups to implement transformation

BH Transformation Council Members

- Members Primarily Representing Consumers and Families
    - Advocates for Recovery
    - Colorado CURE
    - Federation of Families for Children's Mental Health
    - NAMI Colorado
    - WE CAN! Colorado
- Members Primarily Representing Providers
    - Colorado Behavioral Healthcare Council
    - Colorado Multi-Ethnic Cultural Consortium
    - Colorado Providers Association
    - University of Colorado Denver School of Medicine Department of Psychiatry
    - University of Colorado Denver School of Medicine Department of Family Medicine
    - One representative for the following professional organizations:
        - Colorado Psychological Association
        - Colorado Psychiatric Society
        - National Association of Social Workers
        - Additional groups of professionals over time, such as the Colorado Association of Infant Mental Health Providers and the Society of Addiction Counselors of Colorado
- Members Representing Multiple Stakeholders
    - Mental Health America of Colorado
    - Mental Health Planning and Advisory Council
    - Silverprint Colorado (older adults)
    - Group representing veterans – TBD
- Members Representing State Agencies and the Governor's Office
    - Office of Governor Bill Ritter Jr.
    - Colorado Department of Corrections
    - Colorado Department of Education
    - Colorado Department of Health Care Policy and Financing
    - Colorado Department of Human Services
    - Colorado Department of Labor and Employment
    - Colorado Department of Local Affairs
    - Colorado Department of Public Health and Environment
    - Colorado Department Public Safety
- Members Representing Multi-Stakeholder Initiatives and Task Forces
    - Blue Ribbon Policy Council on Early Childhood Mental Health
    - Child Welfare Action Committee
    - Colorado Commission on Criminal and Juvenile Justice
    - Colorado Commission on Indian Affairs
    - Colorado Community and Interagency Council on Homelessness
    - Colorado LINKS

- Legislative Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System
- Prevention Leadership Council
- Youth Partnership for Health (YPH) / Youth Development Team (CDPHE)
- Other Initiatives and Task Forces as Needed

Responsibilities of the BH Transformation Council

- Each participating organization commits to participate in a common priority setting and planning process for behavioral health transformation within the following parameters:
    - Each participating organization commits to support the common priority setting process, to "do no harm" when they have competing priorities, and to at all times maintain healthy working relationships to support the work of behavioral health system transformation.
    - Each participating organization maintains its autonomy and remains responsible for its own budget, policies, purchasing, monitoring, compliance, and legislative strategy.
    - The Behavioral Health Cabinet is responsible to Governor Ritter and recommendations involving state agencies are subject to the Governor's authority.
- To participate, stakeholder organizations must represent a larger group of stakeholders.
- Each organization has one official representative who commits to attend all meetings, plus a deputy who also attends in order to be prepared to act in the official representative's absence.
- Each participating organization is responsible for communicating with the groups they represent in between meetings in order to keep stakeholders informed and obtain ongoing input.
- The BH Transformation Council will develop actionable proposals for consideration by the BHC within the parameters of the state's defined governmental, budgetary and legislative cycles:
    - **Tier One Proposals**: Governor Ritter delivers his State of the State address in approximately six months, so proposed actions to be achieved by then must either address policy only or already be in the state budget.
    - **Tier Two Proposals:** Proposals that are budget neutral or generate a cost-savings could be considered by the Executive Branch for the Fiscal Year 2011-12 budget.
    - **Tier Three Proposals:** Proposals to increase funding cannot realistically be acted upon until state revenue improves, but can be developed with implementation dates "to be decided."

BH Transformation Council List of Representatives and Alternates as of July 23, 2009

Organization	Representatives	Alternates
Advocates for Recovery	Don Rothschild	Not Identified (NI)
Blue Ribbon Policy Council on Early Childhood MH	Claudia Zundel	NI
Child Welfare Action Committee	George Kennedy	NI
Colorado Behavioral Healthcare Council	George DelGrosso	Doyle Forrestal
CO Commission on Criminal and Juvenile Justice	Diane Pasini-Hill	NI
Colorado CURE	Kathie Izor	Dianne Tramutola
Colorado Department of Corrections	Joanie Shoemaker	NI
Colorado Dept. of Health Care Policy and Finance	Marceil Case	NI
Colorado Department of Human Services	Janet Wood	Charles Smith
Colorado Department of Labor and Employment	Booker Graves	Peggy Herbertson
CO Dept. of Public Health and Environment (CDPHE)	Shannon Breitzman	José Esquibel
Colorado Department of Public Safety	Jeanne Smith	Diane Pasini-Hill
Colorado Governor's Office – Policy and Initiatives	Leslie Herod	NI
Colorado Governor's Office of State Planning and Budgeting	Ann Renaud	Jana Locke
Colorado Multi-Ethnic Cultural Consortium	Monica Griego	Deborah Ward-White
Colorado Provider Association	Carmelita Muniz	David Murphy
Federation of Families for Children's Mental Health	Tom Dillingham	Tracy Kraft-Tharp
Mental Health America of Colorado	Jeanne Rohner	Stephen Kopanos
MH Planning and Advisory Council (MHPAC)	Ty Smith	NI
Silverprint Colorado (Older Adults)	Vicki Rodgers	NI
NAMI Colorado	Lacey Berumen	Phoebe Norton
Prevention Leadership Council	José Esquibel	Stan Paprocki
Professional Provider Associations: ▪ Colorado Psychiatric Society ▪ Colorado Psychological Association ▪ National Association of Social Workers	Renee Rivera	Karen Wojdyla
Univ. of CO School of Medicine – Family Medicine	Frank deGruy	NI
Univ. of CO School of Medicine – Psychiatry	Thomas Crowley	Julie Krow
WE CAN!	Amanda Kearney-Smith	Jillian Mukavetz
Veteran's Group Representatives	NI	NI

Appendix Three

Summary of HJR-1050 Recommendations

In 2007, the Colorado Legislature passed House Joint Resolution (HJR) 07-1050, creating a task force to study behavioral health (mental health and substance abuse) funding and treatment in Colorado. The HJR-1050 Task Force developed 11 recommendations the State could follow to improve behavioral health services. The following outline was used to summarize the HJR-1050 recommendations for participants in the Transformation Transfer Initiative (TTI) forums held in April and May 2009:

1. **Establish a Behavioral Health Commission** – This would be an official governmental body with authority to bring together State government leaders, adult and youth consumers, parents, caregivers, families, providers, other local agencies, communities, and others to guide changes and promote development of integrated behavioral health systems in Colorado.
2. **Shared outcomes across State agencies –** Different State agencies trying to help people with mental health and substance abuse needs would agree on shared goals (often referred to as "outcomes") that they all would work together to try to achieve. Shared goals would be developed for both how systems work and how helpful they are to people served.
3. **Aligned service areas –** Colorado is a big State, and State agencies divide the State into regions in order to organize their services. Different State agencies divide it up in different ways, everything from the State's 64 counties, to its 22 judicial districts, to its 5 Medicaid behavioral health regions, to its 4 youth corrections regions. One idea to improve State services is to better align service areas so systems are less confusing.
4. **Joint auditing/oversight –** Different State agencies often oversee or audit the same programs. For example, a Medicaid provider would have to comply with requirements from the Departments of Health Care Policy and Financing and Human Services (often multiple subdivisions within DHS), as well as requirements for specialty programs through other department (such as Corrections and Public Safety), local school districts, local departments of health, and other agencies. As a result, providers have to prepare for, host and respond to multiple audits whose requirements often overlap or conflict. One idea is to have State agencies work together on these audits so programs spend less time on audits and more time on services.
5. **Joint budget planning –** Dozens of different State agencies provide funding for mental health and substance abuse services, and it makes it confusing and difficult for providers to even know about, let alone make use of, so many funding streams. If State agencies developed joint budgets, providers could spend more time providing services and less time sorting through requirements. Also, the State could possibly better address shared needs and make better long term plans.
6. **Streamlined rules and regulations –** With so many different State agencies providing oversight, programs and clinicians spend a lot of time figuring out how to follow the rules. One idea would be to simplify, streamline and integrate rules.
7. **Financing reform –** Currently, funding levels are not equal across different parts of the State or for people with different needs. This came about because programs and services grew at different rates, and because some needs were recognized and addressed and others were not. One idea would be to try to make funding fairer, raising it for some regions and groups of people in need, but also lowering it for others. This is different than spending more; it means spending money differently.
8. **Electronic data sharing –** Often people get services from different parts of State government. Many people believe that if it was easier for State agencies to share information with each other, they

could do a better job coordinating services. Ideas range from electronic health records that follow people across providers to State agencies sharing information on services used and outcomes. Confidentiality safeguards are a critical consideration, and confidentiality would need to be protected.

9. **Cultural competency –** Colorado is a diverse state in terms of race, ethnicity, the languages people speak, where people live, and how people live their lives. Developing standards and requirements to make sure that mental health and substance abuse services respond appropriately and fairly to people's diverse strengths and needs could improve the quality of services. This is sometimes referred to as "cultural competency."
10. **Consumer and family involvement –** The term "consumer" is sometimes used to refer to people who receive mental health and substance abuse services, and this includes children, youth, adults, and older adults. Also, families are often very involved in the services provided to their family members, especially for parents and caregivers of children. Many believe that the State could do more to solicit, value and be responsive to the input and guidance of people and families receiving services by developing standards and requirements to support their active (and welcomed) involvement.
11. **Work force development –** It can be hard to find the right people to provide services. Doctors, nurses, therapists and other professionals are in high demand, especially for children, diverse cultural groups, people who speak languages other than English, and people who live in rural/frontier areas. Many believe the State can help build behavioral health work forces.

Appendix Four

Regional Stakeholder Forum Results

Summary of Forum Process

- Number of forums completed: 75
- Number of participants: 561 (this count included duplicates, as some participants attended multiple forums)
- Regional Breakdown:
  - Denver Metro: 201
  - Colorado Springs: 41
  - Rural / Frontier: 128
  - Western Slope (Grand Junction): 57
  - North Front Range (Ft. Collins): 53
  - South Front Range (Pueblo): 30
  - Statewide / Missing: 41
- Focus #1: Ratings of HJR-1050 State Level Changes
- Focus #2: Local change priorities (Number of local issues identified: 1,149 issues across 71 areas in 12 overall categories)
- Methodology:
  - Focus on "Top 3" Rankings: #1 gets 3 points, #2 gets 2 points, #3 gets 1 point
  - Calculated scores
  - Reported primarily as cumulative rankings, with scores within 10% considered a tie

Summary of Forum Results

State-Level Change Rankings (n=558)	
Recommendation	**Overall Ranking**
Financing reform	1
Streamlined rules and regulations	2
Spending more money on services	
Establish a Behavioral Health Commission	
Consumer and family involvement	3
Work force development	
Shared outcomes across state agencies	4
Aligned service areas	
Joint budget planning	
Other (respondent identified)	5
Electronic data sharing	6
Cultural competency	7
Joint auditing/oversight	8

Regional Rankings						
State Recommendations	**Colorado Springs**	**Denver**	**North**	**Rural/Frontier**	**South**	**Western Slope**
1. Establish a BH Commission	4	1	4	4	2	5
2. Shared outcomes across state agencies	5	5	8	7	2	4
3. Aligned service areas	7	4	6	5	5	4
4. Joint auditing/oversight	10	8	7	9	7	7
5. Joint budget planning	6	4	3	7	2	7
6. Streamlined rules and regulations	3	3	2	2	5	2
7. Financing reform	2	2	1	1	1	4
8. Electronic data sharing	9	6	9	8	8	6
9. Cultural competency	8	6	9	9	4	8
10. Consumer and family involvement	3	2	2	5	4	3
11. Work force development	4	3	5	3	3	2
12. Spending more money on services	1	1	3	4	6	4
13. Other-- respondent identified	7	7	5	6	NR	1

Rankings by Race/Ethnicity							
State Recommendations	**African American / Black (n=19)**	**Asian American (n=6)**	**Hispanic / Latino American (n=42)**	**Native American / American Indian (n=45)**	**White (n=417)**	**Biracial / Multiracial (n=14)**	**Other (n=6)**
State Population	**3.8%**	**2.8%**	**19.6%**	**0.9%**	**83.1%**	**2.6%**	**6.7%**
Sample Proportion	**3.4%**	**1.0%**	**7.5%**	**8.1%**	**74.7%**	**2.5%**	**1.1%**
1. Establish a BH Commission	4	1	1	1	2	1	3
2. Shared outcomes across state agencies	6	6	5	5	5	2	4
3. Aligned service areas	7	4	4	5	4	5	4
4. Joint auditing/oversight	8	6	8	7	7	NR	1
5. Joint budget planning	5	5	5	6	4	6	5
6. Streamlined rules and regulations	3	6	2	4	2	7	5
7. Financing reform	1	6	1	1	1	2	2
8. Electronic data sharing	6	2	7	6	6	4	NR
9. Cultural competency	1	NR	3	2	8	3	3
10. Consumer and family involvement	2	NR	1	3	3	3	5
11. Work force development	5	2	2	3	3	2	6
12. Spending more money on services	7	3	4	2	2	2	NR
13. Other-- respondent identified	NR	3	6	6	5	3	NR

Stakeholder Type Rankings				
State Recommendations	**Consumer (n=103)**	**Parent / Caregiver (n=63)**	**Family Member of Adult (n=87)**	**Provider (any type) (n=214)**
1. Establish a Behavioral Health Commission	2	2	1	2
2. Shared outcomes across state agencies	4	6	6	6
3. Aligned service areas	6	8	8	6
4. Joint auditing/oversight	9	9	9	7
5. Joint budget planning	6	6	6	4
6. Streamlined rules and regulations	5	5	5	2
7. Financing reform	2	2	2	1
8. Electronic data sharing	8	8	9	7
9. Cultural competency	7	7	7	8
10. Consumer and family involvement	1	1	1	5
11. Work force development	3	3	4	3
12. Spending more money on services	3	4	3	1
13. Other-- respondent identified	7	7	5	5

Rankings by Forum Interest Area						
State Recommendations	**Early Childhood (n=70)**	**Criminal Justice (n=60)**	**SA Providers (n=72)**	**MH Providers (n=39)**	**CW / JJ / Education (n=57)**	**Primary Care (n=24)**
1. Establish a Behavioral Health Commission	5	4	3	3	2	5
2. Shared outcomes across state agencies	7	9	5	7	3	5
3. Aligned service areas	5	5	6	5	4	8
4. Joint auditing/oversight	10	7	7	9	6	7
5. Joint budget planning	7	4	4	5	2	6
6. Streamlined rules and regulations	6	3	2	1	3	3
7. Financing reform	2	2	1	2	1	4
8. Electronic data sharing	11	8	8	8	4	2
9. Cultural competency	9	9	9	6	4	No Ranking
10. Consumer and family involvement	4	10	7	7	5	8
11. Work force development	1	6	6	4	4	2
12. Spending more money on services	3	1	4	4	2	7
13. Other-- respondent identified	8	6	10	3	5	1

Statewide Local Issue Rankings (n=558)	
Local Issues	**Total Score**
Funding Related	**735**
41--More MH Funding	28
42--Access To / Funding for SA Services	108
43--More BH Funding / Access	260
44--Access for Uninsured / Underinsured / Undocumented	158
45--More Medicaid Providers / Better Rates / Problems with Medicaid BHOs	92
46--Expand Medicaid Eligibility / Presumptive Eligibility / Leaving Correctional Settings	19
47--Underinsurance	7
48--Rural Access / Funding	63
Integrated Care	**477**
21--Integrated MH / SA	115
22--Blended Funding / Silos / Coordinated State Budgets / Rules Coordinated	172
23--BH / PC Integration	190
High End, Multi-Agency Involved	**339**
11--Collaboration Across Agencies / Community Focus	124
12--Homeless Services	10
13--Vocational Supports	16
14--EBPs / ACT / IDDT	18
15--Weekend / Evening Access	5
16--MH Courts / Diversion / Specific Correctional / Jail Services	65
17--Intensive / Home-based Child and Family Services	34
18--Youth Corrections Services-Specific	10
19--Child Welfare Services	13
201--Coordination of Care / Continuity of Care	44
Consumer and Family Related Issues	**337**
71--Peer Services / Support	87
72--Education About Medication	4
73--Navigation / Access to Public Benefits / Linkages to Services	70
74--Support of Consumer Advocacy / Family Involvement in Advocacy / Youth Voice	30
75--Combat Stigma	81
76--Promote Recovery / Basic Respect	13
77--Community Education / Public Education	33
78--Less Involuntary Care	6
79--Individualized Care	13
Continuum of Services for Children and Youth	**287**
31--Services for Adolescents	24
32--Family-Centered Services / Multigenerational	37
33--Early Childhood Services / Supports	98
34--Prevention / Early Intervention	85
35--School-Based Services / Supports	27
36--Integrated Children's Continuum	12
37--Transition Age Youth	4

Statewide Local Issue Rankings (n=558)	
Local Issues	**Total Score**
Acute Care Continuum	**274**
91--Access to Acute Care / Crisis / Inpatient / Respite / Residential / Detox	122
92--Aftercare Following Intensive Services / Continuum of Care / Alternatives	145
93--Medication	7
Workforce	**235**
81--BH Workforce	103
82--Access to Prescribers	56
84--Primary Care Access	12
85--Workforce Development / Training	64
Basic Needs	**161**
61--Access to Housing	71
62--Transportation	64
63--Meet Basic Needs	26
Specific Populations	**134**
101--Specific Veterans Services	0
102--Services for Deaf / Hard of Hearing	0
103--Autism Services	1
104--Older Adult Services	20
105--TBI / Organic Disorders	0
106--Address Disparities for People of Color / Culturally Competent Services	110
107--Frontier / Mountain Cultures	3
Other Funding	**55**
51--Private Insurance Limitations / Parity	35
52--Specific Reimbursement Limitations to Address	3
53--Role of Insurance Commissioner	8
54--Collaborate with Private Foundations	1
55--Lack of Accountability for Expenditures	3
56--Broader Health Care Reform	5
Information / Technology Related	**21**
111--Information Sharing	16
112--Telemedicine / Technology	5
Other	**33**
202--Local Control / Input / Rural Especially	11
203--Faith-Based / Spiritual Supports	0
204--Guardian Related Issues	0
205--Improve Quality / Outcomes	2
206--Urban Access	0
207--Involuntary Care	6
208--Legislative Advocacy	1
209--Long Term View	6
211--Leadership From State	7

Appendix Five

Summary of the Transformation Implementation Efforts of Other States

SAMHSA awarded nine mental health transformation state incentive grants (TSIG), to Connecticut, Hawaii, Maryland, Missouri, New Mexico, Ohio, Oklahoma, Texas and Washington. Each of these states was required to develop a governor-appointed Mental Health Transformation Work Group (TWG). The TWG mission in each state includes: building an infrastructure to support implementation of evidence-based practices; developing a process for stakeholder input; providing for a continuum of services and supports, including prevention, early intervention, treatment and recovery services; addressing stigma; focusing on performance; and fostering interagency collaboration. Each of these states received between 2.2 and 2.7 million dollars in annual funding for five years, and this document presents information about some of their accomplishments to date.

In an effort to expand system transformation beyond the original nine states, SAMHSA awarded Transformation Transfer Initiative (TTI) funding to 10 states and the Commonwealth of Puerto Rico. The TTI activities are on a smaller scale, although still intended to support "new and expanded efforts to improve the capacity and effectiveness of mental health systems that foster recovery and meet the multiple needs of consumers." The TTI states are Alabama, Florida, Iowa, Illinois, Kentucky, Minnesota, North Carolina, North Dakota, Pennsylvania and Tennessee. Each of these states and Puerto Rico will receive an award for up to $105,000 for one year.

This document summarizes the progress each of the nine TSIG states have made in fulfilling selected goals that were designated as major initiatives. The outlined goals and corresponding actions highlighted here are a *selection* of high-priority initiatives in the TSIG states. The items listed are by no means a comprehensive list of each state's goals and activities. We selected items that are completed or near completion, and that show the wide variety of collaboration and service strategies being enacted among the TSIG states, including (1) expanding mental health services to rural areas, children, families, and other underserved populations; (2) increasing mental health services in the workforce and community support services; (3) providing more culturally competent services that reduce stigma, involve consumers in decision-making roles, and utilize EBPs; (4) collaboration of state and local agencies, advocates and stakeholder organizations; and (5) increasing education, awareness, and funding for these services areas encompassed in transformation. The information below was gathered by interviewing TSIG coaches (including AHP's Carol Bianco), research into each state's plan and reporting, as well as our professional experience working directly with the states.

The table below shows that the nine TSIG states have had varied degrees of success. While some have shown progress and great potential for impacting consumers' lives, others are still in the development stage. Connecticut is an example of one state that has done a great deal with the funding provided. They have strengthened the workforce serving those with mental health issues by creating training curricula, some grounded in evidence-based practice, and developing

a model for supervision standards that is web-based and provides learning modules guided by a supervisor. They have also implemented an initiative that trains and mentors those in recovery to obtain permanent jobs in the behavioral healthcare field, and provides consultation and support to employers for all new employees. Connecticut has also strengthened collaboration among state agencies serving those with mental health issues by assessing demographic data used by state departments, and have created an interoperability workgroup that includes partnership with three state agencies. Another area in which the state has shown progress is in using a marketing approach to reduce discrimination and promote awareness of mental health needs. To date, Connecticut has identified Executive Business Sponsors for their Network of Care website, as well as developed a project staffing structure with defined roles for the Implementation Advisory Committee. They have also completed an anti-stigma media campaign that included several public television documentaries and ad placements in national magazines, and passed legislation requiring public school students to have health assessments earlier in their high school careers, in addition to assessments administered in grade 6 or 7.

Ohio is another example of a state that has made progress in working toward the strategic goals of the TSIG grant. In an effort to make services more culturally competent, they have developed a 24-member Statewide Advisory/Planning Team as part of Multiethnic Advocates for Cultural Competence, as well as developed a curriculum and trained 47 case managers in demonstration projects to teach adult consumers and their providers how to use consumer outcomes data for shared decision-making and collaborative development of individual plans of care. Ohio has also increased the use of evidence-based practices by developing a statewide Employment Toolkit for consumer-operated services and formalized state-local partnerships between the Rehabilitation Services Commission and community mental health providers. The state also has six programs that have implemented Wellness and Recovery Action Plan programs and increased the number of consumers participating in this emerging evidence-based practice. Ohio has also made progress in the area of early childhood services by training 193 teachers and 123 early childhood professionals in the use of Incredible Years, an award-winning parent, teacher, and child training program. They have also trained 163 early childhood providers in the use of the Devereux Early Childhood Assessment, which evaluates the effectiveness of individual child and program-wide interventions, provides developmentally appropriate strategies to foster resilience, screens for emotional and behavioral concerns, and emphasizes a team approach among professional and family members.

As previously mentioned, there are also states that are still in the beginning stages of activity. Hawaii is an example of a state that has made limited progress since their grant began in 2002. To date, they have trained their workforce on service improvements, including a two day workshop on trauma-informed care completed by 615 professionals, providers and staff working with youth with mental health issues who are involved with the juvenile justice system. They also had 236 mental health and forensic providers complete trainings on trauma-informed care, the STARR project, and women's forensic experiences. They also made strides in increasing the number of consumers and family members in consumer-run networks. To date, 10 members of local consumer, family and youth-operated organizations have formed a new

consumer, family, and youth alliance and participated in an MHTSIG-funded leadership development training given by Laverne Miller, a national consultant for consumer, family and youth networks.

Oklahoma is another state that has shown restricted success. They have adopted legislation to increase funding, including new legislative funding supports for therapists providing co-occurring disorder treatment in state prisons; an agreement between Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and Department of Corrections (DOC); and a policy change between DOC and ODMHSAS increasing funding for Re-entry Intensive Care Coordination Teams (RICCT) in Oklahoma City and Tulsa. They have also worked to improve access through technology, which includes implementing Telemedicine in 60 Community Mental Health Centers and satellites, and moving Innovation Center staff to a position within ODMHSAS to maintain the Telehealth system.

Overall, the nine TSIG states have shown modest amounts of improvement when considering the $11-13 million provided to each state over the course of the 5 year grant period. Their initiatives, some of which were discussed above, are summarized in the following table in an effort to draw comparisons to the work being done and the initiatives finalized in Colorado, which has received just over $100,000 and has, in some respects, exceeded the efforts of these TSIGs.

Table 1: Selected Transformation State Incentive Grant Initiatives				
State	Strategic Goal	Specific Action Items	Year Started	Amount/ Duration
CT	• Strengthen the workforce serving people with mental health needs.	• Finalized training curricula for: ▪ Evidence-based intensive in-home family treatment models ▪ Supervisors training (web-based) ▪ Workforce education and consultation. • Developed supervision standards for staff development model that is guided by the supervisor and augmented by access to Web-based learning modules. • Implemented Consumer Recovery Employment Consultation Services – an initiative to train and mentor people in recovery to obtain permanent jobs in the behavioral health care industry. Consultation to employers to support successful integration of new employees.	2005	$2.7 million per year/5 years Total award: $13.6 million
	• Strengthen collaboration and data-driven decision-making among state agencies serving children and adults with mental health needs.	• Completed an Inventory Questionnaire to determine which demographic variables are currently collected and required by state departments. • Three state agencies have signed MOAs to be involved in the interoperability process through the interoperability workgroup.		
	• Promote mental health awareness and reduce discrimination against children and adults with mental health needs using a public health and social marketing approach.	• Developed a project staffing structure, defined roles/responsibilities of Implementation Advisory Committee, and identified Executive Business Sponsor for the Network of Care website. • Completed an anti-stigma media campaign that included several public television documentaries and ad placements in national magazines. • Passed legislation requiring public school students to have health assessments in either grade nine or 10, instead of grade 10 or 11, in addition to grade 6 or 7.		
HI	• Increase number of persons in the workforce who have been trained	• Two day workshop on trauma-informed care completed by 615 professionals, providers and staff working with youth with mental health issues who are involved in the juvenile justice system.	2006	$2.2 million per

	in service improvements. • Increase the number of consumers and family members in Statewide consumer- and family-run networks.	• Also, 236 mental health and forensic providers completed training on trauma-informed care, the STARR project, and women's forensic experiences. • 10 members of local consumer, family and youth-operated organizations have formed a new consumer, family, and youth alliance and participated in an MHTSIG-funded leadership development training given by Laverne Miller, a national consultant for consumer, family and youth networks.		year/5 years Total award = $11 million
MD	• Integrate three EBPs into fee-for-service system: supported employment, family psycho-education, and assertive community treatment. • Support children with mental health needs and their families. • Use technology to improve communication and education.	• Established new rates for programs delivering EBPs in 2006. Annual reviews are conducted to determine if programs meet eligibility standards for the enhanced rate. • MHA and the state vocational rehabilitation agency are jointly funding supported employment (SE) EBP, with 70 percent of vocational programs now converted to SE. • First state to implement the Mental Health First Aid (MHFA) EBP program, which trains members of the public to support individuals in a mental health crisis. • Established the Children's Mental Health Institute. • Launched Place Matters in 2007 to provide more community-based family preservation services and to use cross-agency data to improve decision-making, accountability, and continuous quality improvement for children and families in the child welfare system. • Developed a crisis response and stabilization model that supports the shift to prevention-oriented systems of care (SOC) principles. • Launched a Network of Care Web-site with access to information on mental health, including a personal Wellness and Recovery Action Plan (WRAP) feature. Available in two counties. • Produced the award-winning documentary, Behind Closed Doors, to highlight the impact of trauma on recovery.	2005	$2.7 million per year/5 years Total award = $13.5 million

MO	• Provide MH consultation and services in early childhood and school settings. • Improve access to Autism treatment services.	• Medicaid policy changes made to cover approved school-based services programs. • Staff provide case management and clinical services to students in the St. Joseph Public Schools. • SB 768 established the Office for Autism and established a 24-member Missouri Commission on Autism and Autism Spectrum Disorders. Commission members have been appointed by the Governor.	2006	$2.2 million per year/5 years Total award = $11 million
NM	• Improve children's services. • Provide clinical home and comprehensive supports. • Training behavioral health providers, primary care providers, APS workers, paraprofessionals, and the lay public in geriatric behavioral health issues.	• Early Childhood Mental Health Summits trained 100 providers and communities statewide. • 17 programs have implemented Success in Schools, which supports children with behavioral health problems in school. • Changed Medicaid State Plan to include new service: Comprehensive Infant Mental Health Treatment Services. • Implemented Clinical Home/Wrap-Around model in 10 child-services provider organizations. • 44 therapists trained in Multi-Systemic Therapy (MST) for the Clinical Home program. • Suicide screening/assessment training completed at 23 Sangre de Cristo Partnership sites (723 people). • 400 providers trained in culturally appropriate services for Native Americans.	2005	$2.7 million per year/5 years Total award = $13.5 million
OH	• Cultural competence and involvement of consumers, families, and youth.	• Developed 24-member Statewide Advisory/Planning Team as part of Multiethnic Advocates for Cultural Competence. • Developed a curriculum and trained 47 case managers in demonstration projects to teach adult consumers and their providers how to use consumer outcomes data for shared decision-making and collaborative development	2005	$2.4 million per year/5 years

	• Increase the availability and use of evidence-based practices. • Provision of early childhood services.	of individual plans of care. • Developed a statewide Employment Toolkit for consumer-operated services and formalized state-local partnerships between the Rehabilitation Services Commission and community mental health providers. • Six programs have implemented Wellness and Recovery Action Plan programs and increased the number of consumers participating in this emerging evidence-based practice. • Trained 193 teachers and 123 early childhood professionals in the use of Incredible Years, an award-winning parent, teacher, and child training program. • 163 early childhood providers trained in use of the Devereux Early Childhood Assessment.		Total award = $12 million
OK	• Legislative policies to increase funding. • Access and coordination of care will be improved through the use of telehealth and other technology.	• New legislative funding supports for therapists providing co-occurring disorder treatment in state prisons; agreement between Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and Department of Corrections (DOC). • Policy change between DOC and ODMHSAS increasing funding for Re-entry Intensive Care Coordination Teams (RICCT) in Oklahoma City and Tulsa. • Implemented Telemedicine in 60 Community Mental Health Centers and satellites. • Moved Innovation Center staff to a position within ODMHSAS to maintain Telehealth system.	2005	$2.7 million per year/5 years Total award = $13.5 million
TX	• New legislation and policy changes, focused on use of technology in delivery and coordination of care, disparity in access to care, and crisis services.	• HB 921 enacted requiring state agencies to include information on IT systems within strategic plans, identify how future technology projects may interact with other agencies, and create a data sharing subgroup for the Health Care Policy Council. • State statute amended extending authorization for a mental health Telemedicine pilot. • Legislature appropriated $82 million for crisis services redesign, and specified policy for allocation of funds, quarterly status reports, and	2005	$2.7 million per year/5 years Total award =

	• Developed community collaboratives to move transformation planning and implementation to the local level.	required the DSHS to develop performance measures in consultation with the Governor and Legislature. • In Fiscal Year 2007, contracts were executed with seven community collaboratives covering 14 counties across urban, rural, and border communities. • Each of the seven collaboratives has developed a strategic plan that addresses the New Freedom Commission goals by including specific activities, interests, and issue areas.		$13.5 million
WA	• Use resources to seed innovation and leverage other investments. • Increase number of persons in the mental health care and related health care and related workforce who have been trained in service improvements.	• Funded UW (WIMIRT-W), which set up 15 consumer and family mini-grant programs. • Awarded a 5-year grant to help high-need Aging and Disabilities Services Administration clients move from institutions into the community, including funding policy changes so that 'money follows the person.' • Four Pilot Programs conducted with primary care providers on the assessment, diagnosis, and treatment of children with mental health disorders have been implemented and evaluated. • 250 public and private MH providers, state agency staff, regional support network employees, consumers, primary care providers, family members, law enforcement, first responders and correctional staff trained in recovery and resilience. • 350 primary care providers trained at the Washington Alliance for Healthy Aging Summit, focused on how the aging, public health, and community planning systems work together to foster healthy aging outcomes.	2005	$2.7 million per year/5 years Total award = $13.5 million

Appendix Six

Final Transformation Transfer Initiative (TTI) Implementation Plans

Cross-Cutting Priorities Across All Implementation Plans

- Ensure consumer and family involvement across all implementation planning.
- Ensure cultural competence and a focus on disparities in access to behavioral health care across all implementation planning.
- Be mindful that these implementation plans represent only the next of many steps in a multi-year transformation process, and that transformation will not happen all at once, but instead must involve a continuous, iterative and dynamic process to improve services and systems.
- Implementation planning should place a premium on data and evidence for effectiveness, emphasizing the use of evidence-based, promising and best practices wherever feasible, building on existing efforts, and coordinating with interagency collaboratives so to both honor and make use of the work that precedes this initiative.
- Implementation plans should be vetted with all involved stakeholders to ensure the broadest possible consensus for implementation.

Approach to Ensure Budget Neutrality for All Implementation Plans

- Initial implementation will focus on what is practically and politically feasible.
- Year One activities will focus on work with existing agency staff and stakeholders to carry out transformation activities.
- A federal system transformation grant will be pursued in January 2010 for potential funding availability in October 2010 that may allow expansion of activities. Expected funding, if successful, would be $1-1.5 million per year for five years.
- Efforts will build on existing funded initiatives:
    - Colorado Children and Youth Information Sharing (CCYIS) initiative,
    - Colorado Commission on Criminal and Juvenile Justice, Justice Assistance Grant (through September 2011), and
    - Race to the Top through the Lieutenant Governor's Office.
- Additional state funds are not anticipated for Year 1 (FY 2009-10) or Year 2 (FY 2010-11) activities.

Action Plan One: Continuity of Care and Finance Reform Implementation Plan

Desired Long-Term Outcomes

- Improve quality of life outcomes and more efficiently use public and private resources for people with the highest needs served by multiple systems.
- Improve outcomes and increase efficiency through the integration of service systems, implementation of processes to enhance continuity of care, and reform of financing approaches across systems.

Desired Short-Term Outcomes

- **Streamline paperwork requirements and data sharing** in the following areas in order to promote coordination of care, reduce administrative burden, and maximize availability of clinical resources:
  - Remove the requirement that releases expire after one year and instead add the option of setting whatever date the consumer chooses (including "until revoked").
  - Establish cross-agency common consent forms.
  - Streamline processes and associated paperwork across systems to: (1) Reform assessment requirements to avoid duplicate assessments in different systems; (2) Develop a common treatment plan across agencies with a greater awareness of referral / admission criteria in different systems; and (3) Develop other uniform intake forms / electronic records across systems.
  - Ensure employment, housing, and local services are appropriately addressed in the core requirements.
- **Identify the "Top 400" utilizers of service across state agencies** to serve as a benchmark for cost effectiveness and quality improvement, as well as to inform efforts to improve continuity of care.
- Identify indicators and develop an initial baseline report for a **performance dashboard across state agencies to track BH transformation,** with at least one key performance indicator per agency and at least one indicator each related to cultural congruence and consumer/family voice.
- **Compile an initial inventory of existing evidence-based practices (EBPs)** and related services that support Recovery, Systems of Care, and Cultural Congruence.
- **Compile an initial inventory of funding silos, gaps, and opportunities for integration** related to the "Top 400" service utilizers.
- **Identify potential indicators for a prevention risk profile** related to the "Top 400" service utilizers.

Detailed Implementation Plan

ACTION AREA 1: Data Sharing and Paperwork Reduction

- **Establish process for guiding and carrying out tasks for this Action Item –** Will coordinate through existing initiatives, work with existing agency and stakeholder staff for Year One, including:
  - Develop buy-in into process for each BHC agency and critical cross-agency groups. (Late 2009)
  - Empower cross-agency work group(s) focused on paperwork streamlining and data sharing. (December 2009)
    - For **core behavioral health services** paperwork streamlining: Newly convened joint **Data and Paperwork Streamlining** work group already established by HCPF and DBH in October 2009. Substance abuse providers and federally qualified health clinics will be added to this process. This will ensure continued access to essential data needed for performance management and federal funding stream compliance (Medicaid, behavioral block grants), while reducing duplication, building on efforts such as the multi-year DBH/HCPF joint

    Statewide Mental Health Performance Indicator Matrix and work group on substance abuse indicators.
    - For **data sharing** across behavioral health systems: Build on the Colorado Behavioral Health Council's **Health Information Exchange for Behavioral Health**, coordinating with the CORHIO development efforts and the Governor's Office for Information Technology.
    - For **data sharing** across child/youth-serving systems: **Colorado Children and Youth Information Sharing (CCYIS)** initiative (already established with grant funding).
  - Coordinate with existing initiatives, including the Governor's Office of Information Technology, the Colorado Commission on Criminal and Juvenile Justice (see Action Plan Two below), the Child Welfare Action Committee, the Colorado Collaborative Management Program Statewide Steering Committee (HB-1451), the Regional Council of Governments (leveraging Department of Local Affairs linkages), and employment efforts through the Department of Labor and Employment.
- **Streamline processes and associated paperwork across systems to: (1) Reform assessment requirements to avoid duplicate assessments in different systems; (2) Develop a common treatment plan across agencies with a greater awareness of referral / admission criteria in different systems; and (3) Develop other uniform intake forms / electronic records across systems.** (Timeline: As much progress as possible in Year 1, finishing in Year 2 as needed)
  - Identify streamlined core behavioral health (BH) requirements for: Assessments, treatment planning, and intake documentation.
    - The lead agencies for defining the core requirements are DBH and HCPF.
    - Potentially develop different levels of core BH requirements: (1) Expanded BH requirements for SMI/SED, (2) Core for non-SMI/SED ongoing, and (3) Minimal for outreach / brief contact.
    - Identify additional BH requirements by agency for: Assessments, treatment planning, intake documentation, and linkages to / development of standardized BH screening approaches within agencies (e.g., Colorado Juvenile Risk Assessment in DYC; Screening, Brief Intervention, Referral and Treatment/SBIRT in primary care).
    - Each agency will define its own additional requirements (example of DYC's CJRA BH questions for DYC-involved youth).
    - Ensure employment, housing, and local services are appropriately addressed in the core requirements.
  - Streamline each set of protocols by:
    - Combining assessment requirements where possible across agencies.
    - Coordinating the use of agency-specific requirements when each agency is involved (similar to how statewide High Fidelity Wraparound initiatives in other states have done).
  - Carry this out for the following: Assessments, treatment planning, intake documentation.
  - Implement reformed protocols and processes beginning with focus on most expensive "400", but applying reforms as broadly as possible for mental health and substance abuse services.
  - Coordinate with Electronic Health Records (EHR) development above to ensure that protocol reforms are incorporated.
  - Ensure cultural congruence of assessment protocols, treatment plan requirements, and other intake requirements and protocols.
  - Ensure consumer and family voice in assessment protocols, treatment plan requirements, and other intake requirements and protocols.

- **Develop common consent and data sharing protocols and policies across agencies, including data sharing and protocols for care coordination during transitions between agencies to avoid people falling through the cracks.** (Substantive progress by 2/1010; complete others by end of Year 1; others are contingent on federal grant funding)
  - Progress by 2/10; complete by 6/10:
    - Remove requirement that releases expire after one year and instead add option of setting whatever date consumer chooses (including "until revoked").
    - Establish cross-agency common consent forms.
  - Substantive progress by 6/10:
    - For child-serving systems: Develop definition that builds on concept of family, rather than just individual, incorporating work of Colorado Systems of Care Collaborative (SOC).
    - For adult-serving systems: Need to ensure robust protections for use of information.
    - Streamline record sharing protocols for each participating agency (public and private) within confidentiality and privacy laws. Include coordination of data across families, not just individuals, with multi-generational focus.
    - Develop processes and agreements for each participating agency (public and private) so that assessments follow the person and are made available and used across agencies.
  - Primary efforts will begin after federal grant receipt: Support development of Electronic Health Records (EHR) and broaden support to include behavioral health.
- **Identify top 400 utilizers of services across agencies to inform paperwork streamlining and data sharing efforts.**
  - Establish study group through BHTC to pull together analysis using DBH 2009 Colorado Population in Need study as core data set. (January 2010)
  - Assemble additional existing data from BHTC partners to identify top utilizers with focus on quickly identifying costs across agencies. (January 2010)
  - Incorporate all data available related to health disparities, cultural congruence and consumer and family involvement. (January 2010)
  - Define additional <u>short-term</u> study objectives that can be achieved with existing data and resources. (January 2010)
  - Define <u>longer term</u> study objectives that require new data and resources. (Years 2 and 3)

ACTION AREA 2: Performance and Outcomes Assessment

- **Develop performance dashboard across agencies.** (Year 1)
  - Identify one key performance indicator for tracking success in BH transformation for each agency involved in BH Cabinet.
  - Add at least one indicator related to cultural congruence.
  - Add at least one indicator related to consumer and family voice.
  - Report on indicators quarterly. (Begin with initial report in January 2010 with any variables available then. Have full reporting process in place by Sept. 2010.)
- **Develop uniform outcome measures across departments / eliminate outcomes that are disincentives for people to get better.** (Years 2 and 3)
  - Inventory existing outcome measures across agencies. (Year 2)
  - Identify and/or establish common outcomes across agencies. (Year 2 and 3)
  - Develop incentives and/or graduated sanctions to support achievement of common outcomes across agencies. (Year 3)

ACTION AREA 3: Implement Services / Supports that Promote Recovery, Systems of Care, Cultural Congruence

- **Implement High Fidelity Wraparound (HFW) for the most expensive "400".**
  - Develop statewide implementation plan for HFW across agencies, with the following goals:
    - Initial activities by end of Year 2 (FY2010-11) if federal grant is received.
    - Potential expansion using federal and state funds in Year 3 (FY 2011-12).
  - Include training and fidelity tracking/support in implementation plan.
- **Implement other evidence-based practices (EBPs) that support Recovery, Systems of Care, and Cultural Congruence.**
  - Inventory existing EBPs and related services. (Initial inventory by January 2010 for federal grant application. Revise and expand initial inventory in Year 2 (using federal grant funds if received.)
  - Identify priority effective approaches and EBPs based on results of the "400 study" to be completed by end of Year One. (Year 2)
  - Develop glossary that includes all prioritized EBPs and a description, etc. for each. (Year 2)
  - Develop guide with profile of programs, eligibility, services, etc. (Year 2)
  - Develop implementation plan in Year 2 for focused efforts in Year 3 to increase access to services by using and developing less costly alternatives to emergency rooms and justice system. (Years 2 and 3)

ACTION AREA 4: Finance Reform

- **Establish coordinated cross-system financing approaches that integrate and reform funding (including state-level support and statewide expansion of braiding strategies currently used within local systems of care) to serve people accessing multiple departments.**
  - Inventory funding silos, gaps, and opportunities for integration for the "Top 400" service utilizers. (January 2010).
  - Develop implementation plan in Year 2 to assess current services and develop new benefit design package priorities, including an assessment of Federal waiver strategies, for implementation in Year 3. (NOTE: Link to ongoing activity such as Colorado BRAID – expand these efforts beyond the Under 21 group.)

ACTION AREA 5: Align prevention systems across state agencies, informed by needs of high-risk populations, building on the Prevention Leadership Council (PLC) infrastructure and informed by the "400 study" and other continuity of care and finance reform activities.

- **Develop plan to align prevention programs for systematic implementation and coordination across state agencies and local systems of care related to cost avoidance for the "400" top utilizers.**
  - Develop risk profile based on "the 400".
    - Indicators defined by 2/2010 for federal application.
    - Analysis to be completed in Year One, along with rest of "400 study".
  - Crosswalk risk profile to current practices and needed programs. (Year 2)
  - Develop plan during Year 2 (FY2010-11) using federal funds to integrate prevention programs into systems of care (for initial implementation in Year 3 [FY 2011-12] if federal funds are available).
  - Conduct cost-benefit analysis of these practices and programs in Year 3 (FY 2011-12).

Action Plan Two: Criminal / Juvenile Justice

Desired Long-Term Outcomes

- Improve the availability and quality of behavioral health services for people at risk of and involved in Colorado's criminal and juvenile justice systems.
- Use behavioral health services to reduce recidivism for people involved in the criminal and juvenile justice systems.
- Divert people better served in clinical settings from involvement in the criminal and juvenile justice systems.

Desired Short-Term Outcomes

- Implement **a standardized behavioral health screening process across the adult and juvenile justice systems** and upon admission to city / county jails, probation, community corrections and DOC for individuals charged with a municipal or state offense.
- **Improve access to medications across correctional settings and the service systems that coordinate with them** by finalizing recommendations regarding continuity of care issues as they relate to medication transfer between systems.
- **Develop a comprehensive, evidence-based training model for service providers across systems** serving people at risk of or involved in Colorado's criminal and juvenile justice systems **that creates a cohesive approach to the behavioral health and criminal justice systems**.

Detailed Implementation Plan:

ACTION AREA 1: Identify a standardized behavioral health screening process across the adult and juvenile justice systems and upon admission to city / county jails, probation, community corrections and DOC for individuals charged with a municipal or state offense.

- **Establish a joint subcommittee to address identified tasks in this Action Area.**
  - The group would be jointly responsible to (1) the BHTC, (2) the Colorado Commission on Criminal and Juvenile Justice Behavioral Health Subcommittee, and (3) the Legislative Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System.
  - Obtain executive, county, and judicial level agreement to create this subgroup. (December 2009)
  - Identify chair and co-chair. (January 2010)
- **Identify items to be included on common instrument(s), including both common and diversified elements:**
  - Gather information from Colorado jails identifying current processes used to screen, assess and treat arrestees. (December 2009)
  - Coordinate with Interagency Advisory Committee efforts. (Ongoing)
  - Create a matrix identifying the goals of screening and desired performance expectation criteria. (March 2010)
- **Identify and address barriers to implementation; obtain agreements; identify funding; implement.**
  - Identify barriers to implementing the same screening instrument across systems, including financial constraints for jails to convert to a common process (ensuring strong representation in this process from Colorado jails, coordinated with Arapahoe County Sheriff). (May 2010)
  - Explore solutions to barriers. (October 2010)
    - There should be an emphasis on early identification of needs.
    - Involvement of Sheriffs' departments should start early in the process to identify barriers and assure input.

- This should include both an adult and a juvenile justice emphasis. The juvenile justice emphasis should address the needs of youth in detention centers.
    - The screening process should take steps to ensure that people with mental health needs are not further stigmatized as a result of this process.
  - Obtain necessary agreements for streamlined process. This may ultimately require legislation to enact, in which case legislation will be developed in the next legislative session. (October 2010)
  - Develop any necessary legislative action identified by the subgroup to implement the process. (October 2010)

ACTION AREA 2: Access to medications - study current formularies and compare across the systems.

- **Study current formularies and compare across systems**
  - Convene temporary workgroup to examine formulary and algorithm issues and make recommendations for changes to larger Medications Workgroup. (June 2010)
    - Involve psychologists, psychiatrists, jail staff, insurance companies, state agencies, NAMI, and community stakeholders.
  - Temporary workgroup will identify and make recommendations regarding continuity of care issues as they relate to medication transfer between systems. (August 2010)
- **Identify and address barriers to implementation; obtain agreements; identify funding; implement.** Obtain agreements on any recommendations adopted by stakeholding groups. (Year Two)

ACTION AREA 3: Determine training needs and develop a comprehensive, evidence-based training model to create a cohesive approach to the behavioral health and criminal justice systems.

- **Justice Assistance Grant (JAG) Training Grant Advisory Committee will coordinate and oversee.**
- **Conduct needs assessment**, either by survey or gaps analysis. (January 2010)
- **Create plan and develop comprehensive, statewide training model.** (March 2010)
- **Develop strong evaluation and follow-up component.** (Through end of JAG in September 2011)

Action Plan Three: Under 21 Prevention and Intervention

Desired Long-Term Outcomes

- **Leverage prevention / intervention programs to maximize resources and funding** by expanding Colorado BRAID (Braiding Revenue Across Interagency Departments), an existing online database that identifies federal and state behavioral health program funding primarily for early childhood programs, to include federal and state behavioral health program funding information for all children and youth prevention and intervention programs.
- **Implement social and emotional standards for schools** to contribute to increased academic performance, school retention, increased graduation rates and other positive behavioral outcomes for youth.
- **Establish standards for Early Childhood Mental Health** so that all professionals providing mental health services for young children have standard competencies across departments and disciplines in order to improve the quality of early childhood mental health services, preventing or mitigating long-term negative outcomes.
- **Develop standards to guide system transitions** for youth ages 14 to 25 with behavioral health needs transitioning out of child and youth serving systems in order to enhance opportunities for employment and education, secure adequate housing, and promote sustainability and livability within communities.

Desired Short-Term Outcomes

- Support local communities in their efforts to leverage prevention and intervention resources by implementing processes to update and expand available funding information within the Colorado BRAID database, and develop system utilization guidance documents for dissemination to state program managers and technical assistance providers to enhance the use of the database.
- Coordinate with the Lt. Governor's Race to the Top initiative to implement social and emotional standards in education systems.
- Coordinate with the Lt. Governor's Office and Colorado's Early Childhood Framework to develop standards for professionals providing mental health services for young children, defining competencies across departments and disciplines.
- Complete a review of youth transition plans across state and provider agencies to identify principles/values and common elements as standards to guide system transitions for youth in transition, ages 14 to 25.

Detailed Implementation Plan

ACTION AREA 1: Leverage Prevention / Intervention Programs to Maximize Resources and Funding (Colorado BRAID). Expand Colorado BRAID (Braiding Revenue Across Interagency Departments) to include federal and state behavioral health program funding information for all children and youth prevention/intervention programs. The following funding streams are to be included:

- Colorado Department of Education
  - IDEA Part B Preschool
  - IDEA Part B State Grants
  - Title One
  - Colorado Preschool
  - Exceptional Children's Act
  - Senate Bill 101

- Colorado Department of Health Care Policy and Financing
    - EPSDT
    - Medicaid
    - Children's Health Insurance Plan
- Colorado Department of Human Services
    - Child Care Block Grant
    - Community Mental Health Block Grant
    - Core Services
    - Developmental Disabilities-Early Intervention
    - IDEA Part C
    - Family Violence Prevention and Services
    - Promoting Safe and Stable Families
    - Social Services Block Grant
    - Substance Abuse Prevention and Treatment Block Grant Program
    - TANF
    - TANF Transfer
    - TITLE IV-E
    - TITLE IV-B
    - Child Mental Health Treatment Act
    - HB 1297
    - Early Childhood Specialist Program
- Colorado Department of Labor and Employment
    - Workforce Investment Act
- Colorado Department of Local Affairs
    - Community Services Block Grant
    - Gambling –Casino Tax
    - Lottery Funds
- Colorado Department of Public Health and Environment
    - Maternal and Child Health Block Grant
    - WIC
    - Community-Based Grants for the Prevention of Child Abuse and Neglect
    - Health Care Program for Children with Special Needs
- Colorado Department of Public Safety
    - Title V Incentive Grants for Delinquency Prevention
    - Formula Grants
- Colorado Department of Revenue
    - Tax Check Off
- Grants Directly to Local Entities
    - Head Start
    - Early Reading First
    - Early Learning Opportunities
    - Healthy Start

Summary of Tasks and Responsibilities in ACTION AREA ONE:

- BHC appoints 1-2 lead staff to oversee entire project (*estimate 40 hours per year).*
- BHC identifies key Division staff to facilitate updating information and providing information on new funding streams (*estimate 4 hours per year*).

- Yearly, lead staff contacts key Division staff who distribute funding charts to staff of responsible programs (*estimated time 2 hrs per year*), report on new funding streams and return updated information to lead staff.
- Advisory Committee established to oversee project will include representation from state agencies and other non-state agency partners (*quarterly meetings for 2 hrs per meeting – 8 hours per year).*

Key Implementation Plan Steps in ACTION AREA ONE:

- **Assign division / program staff to enter program and funding information into the Colorado BRAID database.** This includes updating information and reporting new funding streams, supported by resources already contributed by the Prevention Leadership Council (PLC).
    - The BHC solicits support of key Division staff to oversee the updating/entering of funding information and reporting of new funding streams. (December 2009)
    - Establish protocols for updating funding information and entering funding information not already in Colorado BRAID. (January 2010)
    - Orientation meeting held for identified people (can be via web conference call). (February 2010)
    - Collect updated information and add other streams. (February 2010)
    - It is recommended that this include an Individual Performance Goal on staff PDQs for updating and entering information. (April 2010)
- **Assign an interagency staff group to develop a database dissemination and utilization plan.** The utilization plan includes a process by which state agencies and local programs can leverage and maximize resources and funding using the information in the database.
    - Appoint lead staff to oversee and administer the Colorado BRAID project. (December 2009)
    - Formally establish an advisory committee to provide guidance to the project and lead staff. (January 2010)
- An informal advisory group is already in place.
- Hold quarterly meetings; include reviewing funding sources and increasing the dissemination and use of the database. (Begin January 2010, then quarterly after that)
- Involve CDHS/DBH, CDPHE/Interagency Prevention Systems, the PLC, Colorado LINKS, OMNI Institute, Early Childhood Councils, Early Childhood Colorado, Collaborative Management Program (HB-1451) State Steering Committee, interested BHTC members, and other non-state partners.
    - Host focus group with selected technical assistance providers and community, county and state partners to develop utilization scenarios. (January 2010)
    - Complete several pilot opportunities with selected communities in partnership with technical assistance providers to test system and inform statewide implementation. (March 2010)
- **Implement the dissemination and utilization plan**.
    - Host web meeting for key division staff, program staff, and technical assistance providers to learn about the utilization of Colorado BRAID. Technical assistance providers will most likely be those using the database with communities. (April 2010)
    - Develop Colorado BRAID utilization guidance documents and disseminate to state program managers and technical assistance providers to enhance the use of the database. (June 2010)

ACTION AREA 2: Social and emotional health for children and youth in the education and other systems. Coordinate with the Lt. Governor's Race to the Top initiative to implement social and emotional standards to contribute to increased academic performance, school retention, increased graduation rates and other positive behavioral outcomes for youth, limited to budget neutral changes and coordination within currently planned activities.

- The basis for implementing Race to the Top and broader educational standards will be a state longitudinal data system to support the P-20 education reform agenda, aligned across the state's education systems and anchored by a common definition of postsecondary workforce readiness that intends to prepare students for postsecondary and workforce participation. This will be developed by the Colorado Department of Education (CDE), working in collaboration with the Governor's Office of Information Technology (OIT), the Governor's Office of Policy and Initiatives, and the Colorado Departments of Higher Education, Human Services, and Labor and Employment.
  - The Colorado General Assembly and the Office of Governor Ritter have made inter-departmental data sharing a state priority by way of legislation that authorizes the development of interdepartmental data sharing and the creation of a state-level data sharing advisory council.
  - The Colorado approach to educational alignment seeks to produce meaningful information on educator and principal effectiveness by mandating the development of the state's first educator identifier system, which will be used to link educators, students, and educator preparation programs for the purposes of individual and program evaluation.
  - Colorado will also expand breakthrough analytical and data visualization tools to support meaningful accountability, transparency and strategic investment. Project SchoolView ™ envisions a flexible enterprise P-20 information and knowledge management system that will equip users to manage and use information for informed decision-making, ensuring all students in Colorado are ready for post-secondary workforce success, addressing the following priorities:
    - Capturing P-20 student-focused data effectively and efficiently across multiple data sources, including student information, programmatic classifications and educator quality.
    - Linking data for effective sharing and exchange across multiple agencies (human services, K-12, higher education, labor, corrections) and levels (district, state, federal) to promote accountability, inform policy and ensure a holistic view of student success.
    - Providing stakeholder users with understandable, timely and reliable information via interactive portals that provide parents/guardians, students, educators, policymakers and researchers access to performance information, online content and collaboration tools to inform and improve student performance.
- Colorado's Race to the Top application will build on this foundation by focusing on increasing the performance capacity of stakeholders to leverage information to inform development, policy, programs and practice to drive increased student performance through professional development, innovative programs and improved instructional practices.

ACTION AREA 3: Establish standards for Early Childhood Mental Health. Coordinate with the Lt. Governor's Office and Colorado's Early Childhood Framework to develop standards for professionals providing mental health services for young children, defining competencies across departments and disciplines.

ACTION 4: Develop standards to guide system transitions for Transitioning Youth, ages 14 to 25. Work with state agency staff to develop a common transition plan for youth in transition, cross-walking elements from existing plans to standardize systems transitions.

- **Assign staff to crosswalk existing transition policies and plans and develop common elements for one plan, one child / youth.**
  - Identify lead staff to coordinate; identify liaisons in service systems that will assist in collecting transition-related information. This position is estimated to need 0.25 FTE dedicated to it in order to coordinate standards development, implementation process and volunteers. The

position would ideally be available through Human Services / DBH and Labor and Employment. If not, the position will be established in Year Two through grant or other funding. (January 2010)
    - Identify additional volunteers and resources (unpaid) to carry out research and technical writing for standards development; research will document relevant policies and practices across youth-serving systems. Possible sources include graduate students on internship / externship or Capstone Projects and Americorps workers. (February 2010)
    - Select participating transitions staff members from each department / division and interested stakeholder groups to participate in the cross-walk development. This is estimated to require two (2) hours of effort per month. This will include, but not be limited to, the following: MH Advisory and Planning Council Youth and Young Adult Transitions Committee, DBH, BHOs, CMHCs, substance abuse service providers, Colorado Dept. of Education, Division of Child Welfare, Division of Youth Corrections, Colorado Dept. of Corrections – Youthful Offender System, Colorado Department of Labor and Employment, Division of Vocational Rehabilitation, University of Colorado Denver/Colorado WIN Partners, Colorado Multi-Ethnic Cultural Consortium, and the Colorado Developmental Disabilities Planning Council. (February 2010)
    - Set up transitions crosswalk meetings on monthly basis. (February 2010 and ongoing, monthly)
    - Review transition plans from all participating agencies; identify principles/values and common elements. (June 2010)
- **Develop and implement processes to support a seamless system of care in order to ease and improve the transition to adulthood for youth and young adults ages 14 – 25 with behavioral and emotional challenges.** (Year Two)
    - Identify existing Behavioral Health Transitions Systems of Care (SOC) approaches, including best practices.
    - Describe principles, values, and elements of their programs; describe/catalogue their SOC supports, community partners, and procedures.
    - Develop a training curriculum outline based on the above; develop full curriculum as funds permit, and/or utilize existing curriculum (e.g. TIP, Person Centered Planning, etc.).
- **Designate a division / program staff as transition specialist to coordinate with other state department transition specialists.** (Year Three)
    - Develop a State Transition Specialist job description.
    - Designate an existing state agency staff member (e.g., DBH, Labor and Employment, other) as State Transition Specialist.
    - Use the Transitions System of Care curriculum to plan and coordinate training for youth/young adult serving agencies.

Action Plan Four: Sustaining Behavioral Health System Transformation in Colorado

Desired Long-Term Outcomes

- Develop options for a sustainable public-private partnership to guide Colorado's behavioral health transformation efforts over a multi-year period.
- Promote collective leadership among the three branches of state government to work together, in concert with stakeholders most impacted by mental health and substance use disorders, in order to improve the quality of life of the citizens of Colorado, to strengthen Colorado's economy, and to continue the responsible management of Colorado's state's resources.
- Build upon the progress made through past efforts and sustain a continual focus on behavioral health as a public policy issue of paramount importance.
- Promote the recognition that no single entity, whether public, private, or non-profit, can address the complexity of behavioral health issues of individuals, families, and communities within Colorado.

Desired Short-Term Outcomes

- Expand the involvement of the State Judicial Branch and the Department of Education in the BH Cabinet and BH Transformation Council processes.
- Potential legislation or written commitments from each branch of government that could include one or more of the following provisions:
  - Set forth a declaration of the vision and intent for comprehensive behavioral health transformation, formally establishing the Behavioral Health Cabinet and directing it to continue the transformation work.
  - Recodification of existing statute to consolidate behavioral health related statutes where appropriate.
  - Establishment of a commitment from each of the three branches of government to work together to carry out the goals, objectives and values of the behavioral health policy framework. This process would be established to ensure that consumers, families and other stakeholders provide meaningful involvement, and would designate that the executive directors of the departments of Corrections, Education, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Public Safety would dedicate staff to assist with the fulfillment of the behavioral health policy framework.
  - Implementation of specific provisions of the Transformation Transfer Initiative implementation plans as appropriate.
  - Beginning a process for aligning the myriad groups, taskforces, and commissions that are working on some aspect of behavioral health coordination across agencies in order to consolidate and strengthen transformation efforts, and focusing on the development of joint priorities across the groups and building consensus as to which items move forward and are implemented in legislation and practice. In this time of scarce resources, behavioral health stakeholders, advocates and state staff are spread thin with the number of groups working on this topic, and improved coordination is needed to maximize efficiency, effectiveness, and transparency across groups.