

Roadmap to Colorado's Behavioral Health System for Children, Youth and Families:

4-YEAR STRATEGIC PLAN



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Colorado is in the midst of a children's behavioral health crisis.

The National Picture

Colorado is not alone in this crisis. Across the U.S., **13%** of youth between 8 and 12 years old live with mental illness severe enough to cause significant impairment in their day-to-day lives. This figure jumps to **21%** in youth 13 to 18 years old¹. It is not widely recognized that childhood and adolescence are critical periods of risk for the onset of mental health challenges. But in fact, half of all lifetime cases of mental illness begin by age 14 and three quarters by age 24². Despite these statistics, there is too little attention on early identification and intervention -- which could improve outcomes for children and youth before these conditions become far more serious, costly, and difficult to treat. Sadly, data show an average delay of eight to 10 years between the onset of symptoms and intervention; these are critical developmental years in the life of a child³. Foundational weakness is at the core of the problem. Health systems are typically built around adult needs, while children's needs are a lower priority. The same is true for behavioral health systems, where treatment models are designed for adults, and the importance of children's behavioral health needs are an afterthought. This has to change. Neglecting the critical needs of children with mental health challenges is a failure that not only leads to suffering for the individuals, including school and social difficulties and increased risk of pervasive mental and physical illness, but also has a devastating impact on family functioning. Not surprisingly, the longer-term impact comes at a great cost to society through loss of productivity, greater burden on our social services and justice system, and loss of life. This is both tragic and preventable.

Where Colorado Stands

Findings from the 2018 KIDS COUNT in Colorado!⁴ report offers hope in many areas of children's physical health. In 2016, Colorado's infant mortality rate was nearly half of what it was 25 years before. Teen birth rates plummeted by nearly 70%, and uninsured rates for children are at record lows. These improvements are the result of meaningful policy changes that catalyze change for the better. Unfortunately, trends are moving in the opposite direction for children's behavioral health. Based on the 2018 State of Mental Health in America Report³ for children and youth specifically, Colorado currently ranks 48th in the country when analyzing several indicators including the prevalence of mental illness and access to care. Among the most disturbing statistics is that suicide is the leading cause of death among Coloradoans between 10 and 24 years old⁵. That alone should stop us in our tracks. Over the past decade, the Emergency Department at Children's Hospital Colorado has seen a more than six-fold increase in admissions following a suicide attempt⁶. Nearly one in three Colorado high school students reported experiencing sadness or hopelessness that impacted their usual activities for at least two weeks⁷. Among U.S. states, Colorado ranks 47th for the prevalence of youth with major depression, and is last for rates of youth alcohol dependence and illicit drug use³.

Social Determinants of Health and Health Disparities

Many children in Colorado experience the cumulative burden of numerous risk factors, including poverty, trauma, low resourced or violent neighborhoods, and housing insecurity. Children with these risk factors are much more likely to experience mental health challenges. This burden is more than

any child should be expected to overcome without significant support, yet support is often difficult to access. Access to and utilization of mental health services is also a prominent need for other health disparity groups including those from ethnic and racial minority groups. LGBTQ (Lesbian, Gay, Bisexual, Transgender, or Queer/Questioning) youth report high levels of anxiety, depression and substance use problems⁷, yet often resist seeking treatment due to feelings of stigma and isolation.

We know that youth in one or more health disparity groups are overrepresented in ‘deep end’ services including child welfare, juvenile justice and corrections, and more intensive and restrictive treatment settings such as residential care⁸. It is critical to recognize that these disparities and unfortunate sequelae are often the result of policies and practices that create barriers to health and wellness for children and families. This must be changed.

What to Do About It?

Colorado’s mental health crisis is not due to a lack of expertise, dedication or effort aimed at reform and improvement. There are valuable efforts in progress across Colorado in many state and community systems. Currently, a number of groups are working in a variety of directions, and the result has been gradual progress. However, if we come together with a unified vision, a clear strategy and specific goals, we can make greater change for the children and families of Colorado. To reach this unified vision, Partners for Children’s Mental Health (PCMH) facilitated a strategic planning process for the State of Colorado. Each of six workgroups met for six 90-minute sessions between June and September 2018. Each workgroup was charged with developing actionable goals specific to the workgroup topic, including Governance, Finance, Care Coordination and Care Management, Quality Improvement and Outcomes, Service Array, and Access, Screening and Assessment.

A Call to Action

If you are passionate about contributing to the solutions, there are many ways to get involved. Reach out and join the Child Health Champions, a grassroots advocacy network of people who care about kids' health and wellbeing and want to make a difference. Visit <https://cqrcengage.com/childrenscolorado/childhealthchampions>. Share your experiences and learn more about our plans for moving these efforts forward at PCMH@childrenscolorado.org.

The Roadmap Purpose

The Roadmap purpose was to develop and promote a four-year strategic plan, which identifies and prioritizes a series of goals focused on improving quality and expanding access to needed behavioral health services and supports for all of Colorado’s children, youth and their families. We emphasize *behavioral* rather than *mental* health in order to be intentional in our effort to recognize and address the substantial and growing need for substance use services for our Colorado children and youth. Through the engagement of community stakeholders, we developed a series of guidelines to help frame and focus the strategic planning approach.

Overarching Guidelines

- Build upon strengths and successes in our current systems and services.
- Identify, strengthen, and expand best practices across the children's behavioral health system.
- Seek stakeholder alignment across child serving entities and regions of Colorado.
- Engage families and youth with lived experience in children's behavioral health services.
- Coordinate our efforts with current promising initiatives.
- Deploy available resources.
- Advocate for children, youth and families in every aspect of our work.
- Honor and operationalize System of Care values and principles.

Building Broad Community Engagement

With considerable input from state and local collaborators, PCMH created an outreach list of more than 600 community stakeholders who were invited to a kick-off event. These individuals represented more than 260 different organizations, including:

- State departments and offices (Government, Mental Health, Education, Children and Families, Juvenile Justice/Corrections, Welfare, Public Health, Safety, Housing)
- County, regional, and municipal entities
- Hospitals
- Residential treatment agencies
- Outpatient treatment agencies
- Crisis services
- Care coordination services
- Professional membership organizations
- Policy development and advocacy organizations
- Family mentoring/support/advocacy organizations
- Peer (youth) mentoring/support/advocacy organizations
- Legal and judicial entities
- Charities and foundations
- University-based entities

On May 17, 2018, PCMH hosted the kick-off event. This was a call to action where the *why, what and how* of the strategic planning process was unveiled. Following the outreach efforts and kick-off, 117 individuals committed to participating in one or more Roadmap workgroups. We tasked those who attended to reach out to families they work with and colleagues in their sphere of influence to encourage them to participate in the Roadmap strategic planning process.

The Roadmap process was guided by the framework of Systems of Care. This framework is the only approach that has shown demonstrated success in building effective, collaborative, integrated services and supports, leading to improved outcomes for children and youth facing behavioral health challenges.

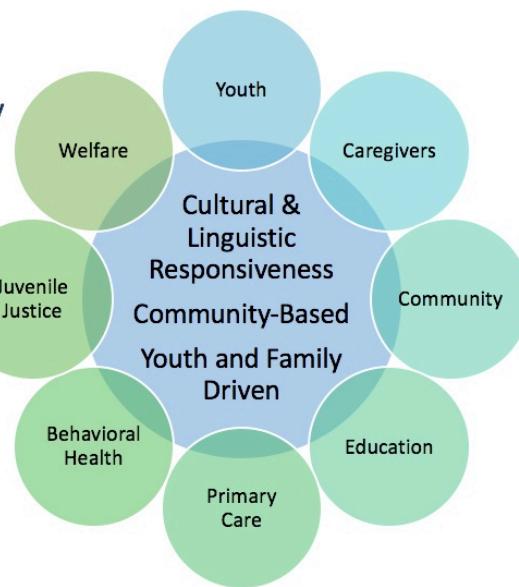
The Systems of Care Framework

The System of Care framework has evolved over the past 40 years, stimulated by the recommendations of the Joint Commission on Mental Health of Children. The congressionally appointed body completed a four-year national study and reported that millions of children were not receiving needed mental health services⁹. During the mid-1980s, there were national and state-level efforts to establish community-based mental health services that included participation by families and youth consumers in their design considerations. During this period, care management entities were introduced in the System of Care framework as a mechanism for ensuring that families with complex needs were served appropriately. In the following decade, legislative support for Systems of Care strengthened further and became more aligned with its values and principles by emphasizing individualized, strengths-based services planning, intensive care management, partnerships with families and youth, and cultural and linguistic competence.

Since the original definition of System of Care was published¹⁰, the conceptual framework evolved to address a wider population of children, youth, and their families who are either involved, or at a high risk for involvement with multiple services and systems. *Building Systems of Care: A Primer*, published by Sheila Pires¹¹ ("Primer"; 2nd Ed., 2010), currently defines System of Care as "a broad, flexible array of effective services and supports for a defined multi-system involved population, which is organized into a coordinated network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management, and policy levels, has supportive management and policy infrastructure, and is data-driven." Since 2006, System of Care has become federal policy and legislation, and has provided funds to improve and expand community-based services and supports so that most children, youth, and families can have their needs met within their homes, schools, and communities.

Systems of Care

- Comprehensive service array
- Individualized services
- Least restrictive
- Natural supports
- Integration
- Coordination
- Strengths-based
- Flexible funding



In order to accomplish our goals within a four-year timeframe, PCMH, along with our advisors, defined the Roadmap's population of focus as school-aged children and youth, 5 to 21 years old. With this decision came the recognition that if an effective System of Care is designed and built, future

efforts to expand the work to additional populations (e.g., dually diagnosed children, children younger than five years old needing early intervention, youth transitioning from adolescence to young adulthood), would be a straightforward process.

Workgroup Domains

Based on the Primer, there are certain functions that need to be structured and defined at onset. The Primer lists several functions system builders can add to and adapt based on their experiences. Based on these functions, we selected six priority areas as a frame for the workgroups including: Governance, Finance, Quality Improvement, Care Coordination and Care Management, Service Array, and Access, Screening, and Assessment.

The **Governance** workgroup's charge was to focus on decision-making at a policy-level that has legitimacy, authority, and accountability. The key issues for governing bodies are to have the authority to govern and clarity about what it is governing; to be representative; to have credibility and capacity to govern; and to assume shared liability across systems for the population of focus. The Governance workgroup also encompassed system management, or day-to-day operational decision-making.

The **Finance** workgroup tackled the financing structure, including what funds will be used to finance the children's behavioral health care system and how they will be utilized and managed. Finance strategies and structures can include redeployment of existing dollars, refinancing to maximize federal match dollars, raising new revenue, and the creation of new financing structures altogether. This includes exploring pooling (or blending or braiding) various types of funding to reduce inefficiency, fragmentation, and duplication of services. It also includes examining parity and payment rates, contracting and accountability, and utilization management.

There is increasing emphasis on building accountability at the treatment level and recognition that system builders cannot achieve desired outcomes without improving the quality of clinical interventions. As such, the **Quality Improvement** workgroup considered behavioral health outcomes and indicators, evidence-based practices, continuous quality improvement, and evaluation.

Children, youth, and families who have multiple issues and stressors in their lives and involvement with multiple agencies often need and want support to manage and coordinate their involvement with many systems and providers. Care managers work with only a small number of families who have multiple, complex needs, have the authority to convene child/family team as needed, and often have control over resources. The **Care Coordination and Care Management** workgroup considered care management structures within and across the children's behavioral health system.

A key principle of an effective service delivery system is the benefit design needs to incorporate a broad array of services and supports. The **Service Array** workgroup considered the role of provider networks or whoever will provide needed services and supports in the system. Providers and support staff must have requisite skills. Human resource development should encompass a broad set of activities, including planning and evaluation, workforce management, recruitment, retention, and staff distribution, education and training, and regulations such as standards and licensure.

The sixth and final workgroup centered around **Access, Screening, and Assessment**. It is essential to provide a more organized pathway to services and supports for the population of focus. System builders must make strategic decisions about whether to create multiple entry points or a single access point. Screening is usually the first step of an ongoing process to determine a child's need for services. As such, the key functions of this workgroup were to consider universal screening, standardized assessments, system entry, public education, and crisis management.

Previous Recommendations and State Models for Effective System Reform

With the assistance of several stakeholders, PCMH collected more than 30 sources of previously documented needs and recommendations related to reforming and strengthening Colorado's behavioral health services and supports for children and youth. These documents ranged from reports from councils, committees, and taskforces to legislation, grants and policy papers. PCMH built a database of goals and recommendations drawn from these documents, organized by workgroup topic. The database of previous recommendations was used as a content guide throughout the workgroup and goal development process. This guide honored the substantial body of work that came before this effort, capitalized on lessons learned by previous stakeholders in Colorado's system reform, and avoided duplication of efforts that were currently underway and showing promise.

Additionally, we selected several state models of successful Systems of Care to serve as foundational frameworks for goal setting in several workgroups. We also sought guidance from national experts and utilized documentation available through the National Technical Assistance Network for Children's Behavioral Health (TA Network; <http://theinstitute.umaryland.edu/our-work/national/network>), to support our process.

Seeking Input from Families, Youth, and Community Stakeholders

An essential step in building an effective service delivery system is to gain a clear understanding of the barriers and challenges families face when they need access to effective behavioral health services. Family members who have firsthand experience guiding children to appropriate help share many of their most frustrating challenges. Family advocates, including family support partners and family navigators, echo these challenges. Paramount among them is the need for greater cultural and linguistic alignment and responsiveness in children's behavioral health systems, including the clinical workforce. It is clear that an optimal health care system would be one where providers are reflective of the populations they serve.

Family Voice

PCMH held two focus groups with family members who have lived experience with parenting a child with behavioral health challenges to gather feedback and perspectives on the most pressing needs and priorities for strengthening Colorado's children's behavioral health system. Most of these parents are now part of the behavioral health workforce serving as peer specialists and advocates for other families across Colorado. Highlights of the family focus group discussions are below:

- All system reform efforts should aim to simplify the children's behavioral health system, not add complexities and layers.

- System builders should keep the families' needs as their top priority.
- Success hinges on families receiving the right service, at the right place and the right time.
- Colorado's family support partner* workforce needs to be expanded.
- Family support partners and advocates need accessible training and ongoing support.
- Behavioral health provider turnover must be reduced in order to improve consistency in the family's experience.
- Family voice and guidance are essential during all phases of treatment.
- System leaders need education and support in order for peers (e.g., family support partners, and youth peers) to reach their potential as key members of the care team.
- Children- and youth-focused substance use treatment services need to be expanded.
- Families need creative solutions to assist them with transportation to services.
- Mobile response services (not limited to crisis response) are essential for meeting families' needs, especially in rural communities.
- Regularly scheduled (short- and long-term) respite is critically important for families.
- Health homes where behavioral health services are integrated will increase access.
- Families need more rapid assessment and diagnosis so that appropriate care is not delayed.

* *Family Support Partners are parents and other caregivers with lived experience raising a child with mental health challenges are trained to serve as family peer specialists and advocates.*

Youth Voice

PCMH also partnered with Kippi Clausen, COACT Technical Assistance Contractor and one of Colorado's leaders in engaging youth who have experienced behavioral health challenges. Many of these youth have both received support from their peers and have provided support to other youth in need. During the Roadmap process, she conducted a brief survey of youth. Key findings are highlighted below:

- 33% asked for help before their first contact (with services), but did not receive it.
- 93% said if they needed mental health supports, they would know where to go for help.
- 54% said they delayed asking for help because of cost.
- 80% said they delayed asking for help because of stigma.

Below are the most commonly reported barriers that youth face when trying to access care:

- Difficulty locating the needed resources near the transportation available to them.
- Limited options for youth to learn about behavioral health and wellness.
- Asking for help often carries stigma or requires youth commit to ("signing-up") for something.
- Family members can be roadblocks.

PCMH also engaged with the Colorado Youth Advisory Council (COYAC) to better understand some of the youth-identified behavioral health needs and priorities. COYAC was created by Colorado State Legislature (Youth Advisory Act in House Bill 08-1157) in 2008 and is charged with discussing and evaluating the issues most relevant to Colorado youth and helping inform policy decisions. COYAC is made up of 40 young people, representative of Colorado's 35 state Senate districts. PCMH attended COYAC's quarterly meeting on September 22, 2018, to gather input on the current state of behavioral health in Colorado.

At the meeting, there was a resounding awareness of Colorado's poor behavioral health ranking and that suicide is the leading cause of death amongst this age group. The group expressed a deep concern for Colorado's current state of behavioral health and identified three major concerns/barriers: 1) stigma; 2) lack of public education on what to do when someone you know is struggling with a behavioral health issue; and, 3) lack of access, especially in rural communities. The discussion themes centered around a general lack of awareness on how to engage *with* youth, significant shortage of school counselors, and a "large gap" between how adults and youth view mental illness/wellness (e.g. "the mental health system for young adults is unapproachable"). In addition, the group recognized other pressing issues such as bullying, lack of LGBTQ and culturally responsive care, youth substance use, the role of social media, high pressure academic environments, and a disconnect between a school's promotion of behavioral health and suicide prevention strategies and available intervention options. PCMH greatly appreciated the opportunity to hear some of the current youth behavioral health challenges and will engage with COYAC moving forward to consult on implementation of Roadmap goals.

Public Comment

Before finalizing the roadmap goals for this strategic plan, we sought feedback from a large number (>1,000) of stakeholders across many disciplines and communities across Colorado. Draft goals were presented through an online survey with an opportunity for respondents to either state: "I support this goal," "I support this goal with the following conditions," or "I do not support this goal." For the latter two response categories, respondents were asked to provide comments on either their conditions for supporting the goal or the reason(s) they would not support the goal. Over a two-week comment period, 124 stakeholders completed the survey. Responses were considered as 'supportive' if the comments were either suggestions for small semantic edits to the goal language or were implementation considerations that will be captured in the foundational materials being developed for the implementation phase of the Roadmap process. Of the 29 goals surveyed, 23 had at least 90% support (either full support or conditional support). Across those 23 goals, the proportion of responses offering unconditional support ranged from 61% to 86% (average was 76%). Across the six goals receiving lower levels of support, the average percent of responses indicating they did not support the goal was 14%. Additional details of the comments provided by those completing the public comment survey were described in the section entitled: Roadmap Goals -- Full Details. It is noted where any goals were not fully developed until after the public comment survey was launched.

Roadmap Workgroup Sessions

Facilitator and Chair Roles

Chairs: Subject matter experts were recruited to serve as chairs/co-chairs for each workgroup. The chairs' role was to initiate discussions, elicit input from all participants and ensure that the workgroup honored the values and principles set forth. Chairs committed to leading each workgroup session as well as meeting with chairs from the other workgroups (between sessions) to debrief on the previous session, plan for the next workgroup session topic area, address any overlap or duplication of goal material between groups, and identify any conflicting material.

Facilitators: Team members from PCMH and Colorado's Trauma Informed System of Care (COACT) team from the Office of Behavioral Health served as facilitators for the workgroup sessions. The facilitators' role was to introduce the session topic, be responsible for timekeeping, note taking and general support of the group process to ensure the day's agenda was completed. In addition, they were responsible for compiling foundational content and sharing it with attendees. The content included previous recommendations, current statistics, and the charter. Finally, the process facilitators were responsible for sharing ongoing progress updates across all six workgroups.

Workgroup Session Activities and Output

Between June 27 and September 12, 2018, six workgroup sessions were held for each workgroup topic (a total of 36 sessions). Workgroup members were provided with three tools to assist them in developing SMART (Specific, Measurable, Achievable, Relevant, and Time-sensitive [i.e., feasible within a 4-year timeframe]) goals for each workgroup topic area. These were: 1) a summary of the needs and priorities identified by the group participants; 2) highlights from previous recommendations and lessons learned; and 3) a worksheet guiding them through the drafting, evaluating, and revising of goals process. Participants were divided into small (typically four to six member) breakout groups and tasked with developing goals on the topics outlined above. In order to assist participants in being specific, they were asked to consider the type of change proposed, who would be impacted by the recommendation, who would drive the change, what were the expected benefits of the recommendation, and what resources were needed to accomplish the goal. PCMH put forth a set of group norms during the first workgroup session. The purpose was to set the tone for open, thoughtful, respectful, and productive participation. Group norms were proposed to workgroup participants, discussed, and then consensus was reached.

Primary Themes Guiding our Work

Throughout the workgroup sessions, the following overarching themes emerged, were debated, and continued to resurface during goal setting activities and group discussions. Most of these themes are relevant to multiple goals across the workgroups and deserve particular attention in setting the tone and context of the strategic plan.

System Level

- Colorado needs a statewide behavioral health system designed specifically for children.
- Innovative and effective solutions are happening in siloes around the state. A lack of communication and collaboration prevents successful initiatives from being scaled up. Without coordinated efforts, we risk duplicating efforts. In doing so, we increase the burden on both providers and families and wasting precious resources including expertise, time and funds.
- System builders must take the time to review the history of previous System of Care efforts, identify lessons learned, and capitalize on previous strengths and successes.
- A pressing challenge is to ensure diversity, inclusion, equality, and equity at all levels of system building and implementation.
- Colorado needs data-driven planning, solutions, and monitoring. Process, quality and effectiveness are not measured with consistency at the system or service levels. This gap negatively impacts communication and collaboration across agencies, and weakens quality improvement efforts.
- Colorado's behavioral health system is fragmented. Services are offered across many settings by multiple, uncoordinated provider networks with no central authority providing oversight related to quality or to equitable reimbursement rates and benefits.
- Colorado's child/youth behavioral health systems implemented within adult systems, rather than designed based on the unique needs of the children and youth (e.g., developmentally appropriate strategies, family focused interventions, school engagement, etc.).
- We must strive for statewide institutionalization of System of Care values and principles in how we conduct business at all levels. Family voice and needs should be the anchor point for decision-making and prioritizing.

Service Level

- Clinical workforce challenges are about more than simple numbers. Too few providers possess the skills needed for treating complex cases (e.g., comorbidity, intellectual/developmental delays + behavioral health issues, multi-generational behavioral health and trauma issues), working in culturally diverse communities needing linguistically appropriate service providers, and working in rural communities where clinics may be a long distance from families' homes.
 - Colorado has a severe lack of cultural diversity in its workforce and cultural responsiveness in how services and supports are delivered across the continuum.
 - Lack of accountability is often referred to as the 'blame game,' where fault is deflected and responsibility is passed on; results in children falling through the cracks when their needs (and therefore funding streams) don't fall squarely in one system or another.
- In order to be successful in many of our goals, we must find the right balance between state-level authority and accountability and local authority and accountability.

Roadmap Goals – In Brief

Governance

Goal 1: Governing Body. Establish a centralized governing body with authority, clarity, capacity, and credibility to govern the Colorado children's behavioral health system.

Goal 2: Systems Management. Identify, formalize, and fund a systems management entity, which will serve as the locus of management accountability for our target population(s) within Colorado's children's behavioral health system.

Finance

Goal 1: Financial Map. Create a financial map for the children's behavioral health system to understand the system in relation to prevalence, need, utilization, and cost.

Goal 2: Blending and Braiding Pilot. Execute a pilot project that blends and braids funds of relevant child serving systems into a joint funding venture.

Goal 3: Facilitate Buy-In for Blending and Braiding. Develop a communication and engagement package to facilitate buy-in of stakeholders – inclusive of state and local entities and families – for blending and braiding of funds.

Goal 4: Statewide Essential Health Benefits. Work in collaboration with the Colorado Division of Insurance to define essential health benefits for children's behavioral health.

Goal 5: Contracting for Wraparound. Establish legislation that a) directs HCPF to exercise the optional scope of work in the Regional Accountability Entities' contracts to support Wraparound and Family Support Partners during the current contracting cycle, and b) establishes support for Wraparound and Family Support Partners in future contracts.

Goal 6: Value-Based Contracting: Linkage to process and outcomes. Refine value-based contracting models that directly link financial incentives to improvements in process measures and outcomes with consistent metrics across systems.

Goal 7: Utilization Management- Standard Protocol. Establish standardized (best-practice) Utilization Management guidelines for determining the optimal dose and duration of behavioral health treatment.

Quality Improvement

Goal 1: Core Indicators and Outcomes. Across Colorado's child serving agencies, consensus must be reached on a core set of indicators and outcomes (i.e., data points, not measures) that will be assessed as children/families enter or exit any child serving system.

Goal 2: Training and Incentives Aimed at Sustaining High Quality Providers and Best Practices. Develop and Implement a comprehensive set of strategies to support evidence-based practices and core competencies.

Goal 3: Strengthen and Scale-up Evidence-Based Practices. Implement PracticeWise (details at: www.practicewise.com) in a select set of communities with sufficient funding to allow for time to implement and evaluate outcomes with the expectation that, in the case of effective results, communities will commit to scaling and sustaining PracticeWise for a set number of years.

Goal 4: Shared Data Infrastructure. A quality taskforce will be formed and charged with designing and building system-wide support for a secure data infrastructure that will store and control access to quantitative data (core metrics and system-level service utilization data) and qualitative data such as integrated care/case/treatment plans (e.g., behavioral health, education, welfare, medical) and crisis plans, as appropriate.

Goal 5: Provider Quality Incentives. The quality taskforce will develop a set of metrics, which will assess and monitor whether providers meet eligibility criteria for value-based contracting. Metrics will center on patient/family satisfaction (e.g., services are meeting the child/family needs; a provider that is culturally/linguistically responsive), and measured outcomes such as family functioning, school attendance, and clinical improvement.

Goal 6: Continuous Quality Improvement (CQI). Develop and utilize a CQI process with an integrated data system that, in addition to assessing child and family outcomes, monitors and provides feedback on fidelity, acceptability, and feasibility of care, at the child and family level, practice level, and system level.

Care Coordination

Goal 1: Statewide Tiered Care Coordination Model. Establish a statewide tiered care coordination model that relies on data to determine the needed intensity of care coordination and defines the model of care coordination for each tier.

Goal 2: Establishing Care Management Entities. The governing body for children's behavioral health should establish regulations and appropriate funding to support the development of statewide, locally operated care management entities (CMEs) to administer care coordination to children, youth, and families.

Goal 3: Authorization of Services by Care Coordinators (or CMEs). Allow care coordination teams to define medical necessity to a degree by developing a service package for each tier of care coordination, which is informed by other state models and Colorado state data.

Service Array

Goal 1: Network Adequacy Metrics. Improve the data metrics for measuring and reporting Colorado's network adequacy.

Goal 2: Colorado Service Array Assessment. RAE's, state agencies and private managed care companies to conduct a uniform service array assessment on a reoccurring basis that includes a portion where families and youth report on their experience of the service array. RAE's, state agencies, and privately managed care companies to report out on the service array assessment results.

Goal 3: Core Set of Strategies. Develop an agreed-upon set of core service strategies (i.e., a range including services, resources, coordination, and supports) to be made available across the state.

Goal 4: Cultural and Linguistic Responsiveness. The children's behavioral health governing body will form a taskforce, representative of child serving system stakeholders, charged with establishing agreed-upon standards for culturally and linguistically responsive engagement/outreach, assessment, and services.

Goal 5: Workforce Development: Recruitment and Retention. Identify a set of strategies that support the recruitment and retention of clinical staff in order to address the Colorado workforce shortage.

Goal 6: Statewide Core Competencies. Establish a taskforce charged with developing a set of core competencies for all providers of behavioral health services.

Goal 7: Wraparound and Care Coordination Workforce Development. Fund and implement a centralized resource hub to train, coach, and credential care coordinators and family and youth peer support specialists statewide.

Access, Screening, and Assessment

Goal 1: Establish Universal Screening. Establish a universal screening procedure for developmentally appropriate childhood/youth behavioral health risks and symptoms; establish statewide utilization of the tool by Colorado's child-serving agencies following training and implementation support

Goal 2: Standardized Assessment Tool. Establish a standardized approach to child/youth behavioral health assessment that also assesses youth and their families for the social determinants of health.

Goal 3: System Entry. Establish a "hybrid" model of system entry with 'no wrong door' access points as well as a centralized 'wellness' help-line.

Goal 4: Outreach, Engagement and Referral. Develop, staff, and sustain the centralized access point for children and families with 'family navigators' and 'support partners' to answer calls and follow the family through linkage and engagement of services.

Goal 5: Whole Person/Family Wellness. Design and deliver a 'whole-person wellness' curriculum (adapted from SAMHSA's "Eight Dimensions of Wellness") for children and families that will address how different system stakeholders can support whole family, whole child/youth wellness.



Who We Are

Partners for Children's Mental Health (PCMH) is a newly developing Children's Mental Health Center of Excellence. PCMH is designed to serve as a statewide resource to increase the capacity, access, and quality of mental health services for children, youth, and families.

The **vision** of PCMH is to be a nationally recognized leader in children's mental health, advancing Colorado's ranking to one of the top 10 places to receive services in the nation.

Our **mission** is to bring communities together to improve mental health outcomes for children and families. There are five foundational **values** of PCMH: cultivate partnerships, provide humble expertise, engage in boundless creativity, be responsive and accountable, and turn knowledge into action.

Our **scope of work** includes the following: 1) provide training, technical assistance and coaching on evidence-based practices; 2) consult on program design, change management, implementation and sustainability of such evidence-based practices; 3) develop key partnerships in service of children's mental health issues; 4) evaluate implementation processes and mental health outcomes; 5) build and manage an information clearinghouse/portal for children's mental health statewide; 6) support policy development; and, 7) bridge and coordinate children's mental health initiatives across Colorado.

Workgroup Chairs

Governance

Susanna C. Snyder – Colorado Department of Health Care Policy & Financing, *Maternal Child Health Policy Specialist*

Finance

Kevin J.D. Wilson – Children’s Hospital Colorado Child Health Advocacy Institute, *Senior Policy Coordinator, Strategy & External Affairs*

Care Coordination

Lisa Brody – Signal Behavioral Health Network, *Chief Operating Officer*

Quality Improvement

Jessica Malmberg – Children’s Hospital Colorado, *Clinical Director of Outpatient Services Child and Adolescent Psychologist & Assistant Professor of Psychiatry*

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Service Array

Monique Germone – Children’s Hospital Colorado, *Psychologist & Assistant Professor*

Access, Screening, and Assessment

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Workgroup Facilitators

Antonia Airozo – PCMH, *Training Director*

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Chris Meyer – OBH, *COACT, System of Care Project Director*

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A full list of Roadmap Workgroup Participants can be found in the Appendix.

Roadmap Goals – Full Details

Below is the comprehensive description of the proposed Roadmap Goals. The content is structured as follows: 1) previous recommendations (and historical efforts), 2) current identified needs and priorities by workgroup participants, 3) goal intent, 4) goal implementation considerations, and 5) consensus including both internal workgroup participant consensus and external public comment survey consensus.

Governance and System Management

Structure of the Governing Body

A. Previous recommendations

A total of eight different reports put forth recommendations on governance structure and management of systems serving children, youth, and families struggling with behavioral health challenges. Among these, several called for the adoption of System of Care values and principles into Colorado's children's behavioral health service delivery systems¹². Two reports propose a centralized, and statewide governing body^{13,14}. There was a common call from stakeholders to identify solutions that need to be addressed through state-level leadership, vision, coordination, and collaboration, as well as through formalized linkages across state, regional, and local entities, which could streamline administrative, fiscal, and management functions for children's behavioral health^{15,16,17,18}. Top priorities include efforts to reduce duplication and redundancy of work as well as strategies for addressing a widespread problem of fragmentation and siloed systems¹⁹. The lessons learned from previous reform efforts emphasize the importance of collaboration and joint accountability among child and youth serving systems²⁰. Finally, previous guidance specified that the governing body should be designed to address the needs of both Medicaid and non-Medicaid eligible children, youth and families.

B. Current needs and priority areas

Many of the workgroup participants echoed the priorities identified in previous reports, including:

- Improved collaboration and communication among child-serving systems.
- Centralized oversight (“behavioral health backbone”) and shared accountability to the children and families needing services and supports, taxpayers, behavioral health providers, and other community stakeholders.
- Streamlined and integrated payment systems.
- Statewide consistency and alignment.
- Maintaining local authority, customization and flexibility.
- Integrating family voice in all planning activities.

Goal 1: Governing Body

Establish a centralized governing body with the authority, staff, clarity, capacity, and credibility to govern Colorado's children's behavioral health system.

Intent: Address current challenges in child, youth, and family systems:

- Unsuccessful services are applied repeatedly to meet a system goal or when an individualized service more targeted to the need is not readily available. This results in reliance on invalid success markers and results in multiple failures, and increased severity and trauma to child and family (sometimes repeating over years of service involvement).
- There is no system to identify the need for the development of new service approaches and to respond to gaps, particularly between local systems and service providers and state leaders and policy makers.
- Due to bifurcated funding streams, children, youth, and families are often waiting for services while payors debate whom should pay for care.
- There is limited and inconsistent coordination and communication across systems, resulting in increased family burden, poor outcomes, inconsistencies in care and information, the inability to engage in effective cross-system utilization management, duplication of services and reporting, problems with access, increased reliance on deep-end services and out-of-home placements, which leads to increased cost.
- There is currently an inadequate investment in an effective children's behavioral health system, which ensures that children, youth, and families receive the right services at the right time. As a result, access to care can be delayed, leading to increased severity and complications, higher utilization of deep-end services, higher costs, and poor long-term outcomes of children and youth.
- Poorly enforced requirements and supports for the provision of evidence-based services leads to inconsistencies in quality, effective care, and poorer outcomes.
- Without a structure for multilevel cross-system quality standards and a mechanism for sharing data across systems, system leaders are unable to track the effectiveness of programming or family outcomes. There remains an inability to continuously improve care across systems or engage in effective utilization management. The result is duplication of services, suboptimal placement in treatment (based on intensity of type), poorer outcomes, and higher costs.
- There exists insufficient standardization in screening and assessment, resulting in placement in treatment (based on intensity of type) that is misaligned and ineffective for children, youth, and family needs, resulting in poor outcomes and higher costs.
- Current child, youth, and family crisis service systems/strategies do not meet the range of needs, resulting in barriers to care, over-utilization of deep-end services, and poorer long-term outcomes of children and youth.

Aspirational Aims

- Build a best practice continuous quality improvement process that ensures effective communication between state and local systems, service providers, and consumers for valid understanding of efforts and outcomes, effective decision-making and resource utilization for maximum impact.
- Improve the overall outcomes of children, youth, and families/caretakers [within scope set by governing body].
- Ensure services are appropriate to individual need for the effective use of resources and the best outcomes for children and families.
- Ensure services provided reflect best practices.
- Invest in children and caretakers by acting as good stewards of entitlement programs and other funding sources [within scope of the governing body] by reducing duplication and increasing efficiencies and effectiveness across agencies.

Operational Aims

- Create a structure that allows continuous input from consumers, service providers and local systems to ensure evidence-based decision making, accountability and meaningful quality improvement.
- Ensure an array of accessible services across Colorado meets the needs of children, youth, and families in a timely manner.
- Increase accountability at provider, system management, and state levels to deliver high quality behavioral health services and supports through a defined quality assessment and improvement plan.
- Establish policy-guided mechanisms for blending and braiding of funds.
- Institutionalize System of Care values and principles in all child and family-serving systems.

Implementation Considerations:

Legislatively appoint and form a commission responsible for determining how best to structure the governing body in a way that:

- Coordinates alignment of efforts and goals across systems and state and local entities and communities.
- Engages in multi-system integrated problem solving.
- Develops and drives strategies, implementation and evaluation of best practices coordinated at the state, county, and local levels.
- Reduces silos and duplicative efforts.
- Aligns and connects systems, stakeholders, functions, and initiatives related to the target population and functions.

- Determines outcomes that authentically align with family, children, and youth needs.
- Develops a mechanism to inform stakeholders about Medicaid, CYMHTA, and other relevant policy revisions and updates.
- Institutionalizes System of Care values and principles within state, county, and local levels.
- Establishes formal and informal methods for gathering and implementing input from children, youth, families, service providers, and local systems in to evaluation, evidence-based decision-making, accountability, and continuous quality improvement processes.
- Includes national best practices (SOC Primer) in the design and development of governing body components:
 - Administrative home that is politically neutral and protected from partisan influences.
 - Staffing solely dedicated to the governing body.
 - Core membership representative of Colorado including state and provider agencies, diverse individuals and communities, children, youth, and families.
 - Accountability structure representative of Colorado stakeholders, government and legislators that is organized around and driven by quality improvement methods.
 - Clear scope of work that address cross-system functions and target population.
 - Duties defined by needs of target population and cross-system functions.

Consensus:

- Workgroup participants: During the first workgroup, three small groups were asked to develop a goal to resolve Colorado challenges in relation to governance structure. All three groups proposed a governing body to address challenges. This initiated a working group with strong alignment and consensus around a goal for a governing body. Throughout sessions the group debated ways to find balance between effectively addressing problems, eliminating conflicts of interest due to administrative home, increasing accountability, and avoiding development of needless infrastructure or wasting of resources. By the last workgroup, full consensus was reached on the development of a governing body, focused on a target population and cross-system functions. Consensus was not achieved around how the group should be designed; however, it was evident from discussions that underlying concerns were far more generalized among participants. It was therefore determined that establishing a commission would be an important first step to ensuring a governing body is developed in a way that will successfully address the implementation considerations, goals, and Colorado challenges identified by the group.
- Public comment: Though 95% of respondents supported the governance goal, it received among the largest percentage of conditional support (33%), with only 5% of respondents saying they would not support the goals. The conditions for support

centered on five primary themes. First, respondents expressed concern that the governing body could create additional fragmentation, silos, or unnecessary complexity. Second, several respondents emphasized the importance of meeting the differing needs of different regions of the state, including rural, urban, and frontier as well as the specific needs of our diverse population. Respondents also urged appropriate representation on the governing body, including family members and youth who have experienced the behavioral health system, as well as a balance of state leaders (from within each child serving agency) and ‘front line’ providers. Several concerns were focused on whether the governing body would have the spending authority needed to make the intended impact, while not drawing funds away from essential services. Last, multiple respondents argued for the expansion and strengthening of the Collaborative Management Program or other locally controlled entities, in lieu of a new governing body.

System Management

The Primer outlines the importance of a system management structure for successful execution of governing body vision and goals, and to ensure outcomes set forth by that body.

A. Previous recommendations

- Ensure services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.¹⁶
- Communities are encouraged to build on existing cross-system collaborative processes and infrastructure such as Collaborative Management Program, Oversight Interagency Group (OIG), Individual Service and Support Team (ISST), Senate Bill 94, and juvenile services planning committees to reduce duplication and system fragmentation.^{13, 12}
- Currently identified System Management Infrastructure (agencies, programs, entities) across Colorado includes:
 - Collaborative Management Program (CMP)
 - Communities that Care
 - Colorado Youth Detention Continuum
 - Regional Accountability Entity contracts
 - Children and Youth Mental Health Treatment Act
 - Creative Solutions
 - Colorado Commission on Juvenile Justice
 - Early Childhood Leadership Commission

B. Current needs and priority areas

- Clear reporting relationships:
 - CMP reporting is not well defined and accountability is low. Each participating county defines and interprets their outcomes differently.

- Final decision-making authority is not clear.
 - Many reporting requirements overlap or contradict one another, which can limit funds allocated to direct services.
 - Challenges with local control.
 - Need to institutionalize reporting that measures and tracks: a) policy outcomes; b) management performance; c) training activities; d) whether individual services are meeting the needs of those they serve; and, e) continuous quality improvement.
- Clear expectations and outcomes
 - Applicable to all three levels: system, service provision, and consumer.
 - Mechanisms for joint accountability.
 - Address conflict and inconsistencies in core measured outcomes across systems.
 - Broad alignment in expectations across systems.
- Sufficient technical and staff capacity
 - Staff providing technical assistance (TA) should be independent of any single department or agency.
 - CMP needs to be strengthened with sufficient TA and staff capacity.
 - Training to build adequate clinical, supervisory and administrative staff levels.
 - Technical and front-line staff charged with addressing needs and barriers to access.
- Credibility with stakeholders
 - Must serve equitably across all systems and stakeholders.
 - Increased consistency in implementation for CMP across counties.
 - Increase credibility through increased (and demonstrated) efficiencies.
 - Leadership roles and responsibilities should be statutorily mandated.
 - All stakeholders must be valued, heard, and respected.

Goal 2: System Management

Identify, formalize, and fund a systems management entity, which will serve as the locus of management accountability for our target population(s) within Colorado's children's behavioral health system.

Intent: To complement the functional aims of the governing body by focusing on the day-to-day decision making and operational aspects of the governance of the children's behavioral health system.

Implementation Considerations: The system management entity should ensure adherence to System of Care principles of child and youth-guided and family-driven care in provider agencies and organizations.

Consensus:

- No public comment available.

Finance

Blending and Braiding of Funds

A. Previous recommendations

A previous recommendation regarding funding is to embed specific children's behavioral health services and financing in the Colorado Medicaid system²¹. This should include dedicating Medicaid funding for a minimum service package that includes high-fidelity wraparound, peer support, flexible funds, and intensive in-home services^{21,22}. It was deemed necessary to develop community infrastructure to blend funding across agencies and implement a statewide care delivery system for both Medicaid and non-Medicaid eligible children and families in Colorado that includes: case management using the wraparound approach, intensive in-home services, peer support for families, and flexible funds²⁴.

B. Current needs and priority areas

- Financial map (especially eligibility criteria for different funding streams).
- Lower administrative burden for authorization of services and reimbursement.
- Equal financial support for under-resourced regions of Colorado.
- Value-based payment.

Goal 1: Financial Map:

Create a financial map for the children's behavioral health system to understand the system in relation to prevalence, need, utilization and cost.

Intent: The results will demonstrate children and family needs in comparison to expenditures and whether what is being spent aligns with utilization and need. It is important to collect data across as much of the lifespan, from birth to 21 years old, as possible based on system willingness and availability of data. This will inform future efforts to address funding considerations.

Implementation considerations:

- Financial map should delineate budget and expenses from the local, state and federal government.
- Identification of service needs for children/youth, from birth to 21 years old, using available data sources and prevalence estimates.
- Potential sources and tools for developmental (mental health) screening include: Ages and Stages Questionnaire (ASQ) and the Adverse Childhood Experiences (ACE) questionnaire.
- Utilize the financial map to inform opportunities for blending and braiding of funds (refer to Blending/Braiding Pilot goal).

Consensus:

- Workgroup participants expressed full consensus in supporting this goal. Suggestions related to implementation considerations are included above.
- Public comment: Of the 29 comments, 26 (90%) are in favor of the goal. The large majority of input can be categorized as implementation considerations and will be provided in their entirety to the organization leading implementation. There were no responses that recommend a fundamental change to the goal itself. Two respondents indicated reasons not to move forward with the goal. Though most comments were unique, two themes emerged: 1) suggestions that this goal should include working within existing systems; and 2) four comments noting the current funds are limited and a desire to avoid moving these funds away from other vital services or programs.

Goal 2: Blending and Braiding Pilot

Execute a pilot project that blends and braids funds of relevant child serving systems into a joint funding venture.

Intent: The purpose of this goal is to develop a test model for blending and braiding that can then be centralized across system structures for children and youth served by multiple systems.

Implementation considerations:

- This pilot should allow enough time to fully implement and then evaluate progress. A range of three to seven years was discussed by participants.
- Pilot success will depend on clear outcome benchmarks for both implementation and evaluation of model outcomes.
- Pilot direction would come from the governing body to ensure alignment.
- The pilot will be executed in both an urban and rural area with sufficient funding to allow for time to implement and evaluate outcomes with the expectation that, in the case of effective results, communities will commit to scaling and sustaining the model for a set number of years.
- Pilot design needs to be scalable and sustainable.
- Effective results will include partnership and alignment of state and local policy and processes, including funding policy and process, to allow for sustainability of the effort according to its goals and purpose

Consensus:

- Workgroup participants expressed full consensus in supporting this goal. Suggestions related to implementation considerations are included above.
- Public comment: 88% of respondents were supportive (18% conditionally), and 12% did not support this goal. Multiple respondents expressed concern about the feasibility of a project involving blending and braiding of funds, including the limitations within federal regulations as well as the risk of taking limited funds away from needed services and reducing flexible funds. One additional concern was that with the recently implemented ACC Phase II, the ideal time for this pilot may not be now, but instead after the impact of

the new policies are evaluated. Second, respondents felt this effort could be done through the Collaborative Management Program, as there are statutory requirements in place about reducing duplication of services. One additional concern was the need for careful evaluation of the pilot and response to the findings.

Goal 3: Facilitate Buy-In for Blending and Braiding

Develop a communication and engagement package to facilitate buy-in of stakeholders – inclusive of state and local entities and families – for blending and braiding of funds.

Implementation considerations:

- Recommended elements of package include: cost of doing nothing (data-driven evidence).
- Argument for a culture shift. education on how to blend and braid funding; opportunities to help with larger statewide design via testing in communities; and clarity on the return on investment that stakeholders will get in return for participation.

Consensus:

- Workgroup participants expressed full consensus in supporting this goal. Suggestions related to implementation considerations are included above.
- Public comment: Among survey respondents, 92% stated they supported this goal (15% conditionally), with only 8% stating they would not support it. Among the comments were a number of questions regarding how the blending and braiding would be managed, which stakeholders would be involved, how well the potential risks and benefits associated with blending and braiding of funds are understood, and what is meant by a communication package.

Parity and Payment Rates

A. Previous Recommendations

Previous recommendations include utilizing federal, state, and local funding sources (e.g. Medicaid, CMH block grants, CMP, SB-94, school districts, and city government) to develop and implement a case rate to utilize multiple funding services¹². Also, it was recommended that Medicaid be expanded to increase reimbursement rates which might encourage more health professionals to accept a broader set of both private and public insurance plans³.

B. Current Needs and Priorities

- Parity in reimbursement rates for behavioral health.
- Greater attention to building integrated care.
- Streamlined and integrated payment systems.

Goal 4: Statewide Essential Health Benefits

Work in collaboration with the Colorado Division of Insurance to define essential health benefits for children's behavioral health.

Intent: Ensures all Colorado children and youth have statewide access to a minimal level of coverage for behavioral health services, regardless of whether they have public or private insurance.

Implementation Considerations:

- Update the Colorado Mental Health Parity Bill to include cost sharing enforcement.
- Advocate for the Department of Insurance to enforce reimbursement rates to improve access.
- Granular assessment of behavioral health plans.

Consensus:

- Workgroup participants: Workgroup participants expressed full consensus in supporting this goal. Suggestions related to implementation considerations are included above.
- Public comment: Among survey respondents, 90% stated that they supported this goal (18% conditionally), with only 10% stating that they would not support it. Several comments focused on whether legislation is needed, or whether stakeholders could work with the RAEs to implement this process. Multiple respondents noted that care coordination/management should be included in the 'essentials' list.

Contracting and Accountability

A. Previous recommendations

Implementation of a children's behavioral health system should be value-based and outcomes-driven to ensure accountability. It is recommended outcomes be directly related to the types of services used, child, youth, and family functioning, and behavioral health. Examples of appropriate outcomes include: reduced out-of-home placements and hospitalizations resulting in decreased costs; improved mental health functioning and school attendance; reduced school disciplinary actions, juvenile justice involvement, and teen pregnancy; reduced child welfare involvement and caregiver stress; and decreased use of psychotropic medications. Performance measures should be tracked to assess fidelity to the wraparound process, and increased youth and family satisfaction with services¹³.

B. Current needs and priority areas

- Value-Based Payment.
- Medicaid support for high quality care coordination.
- Use data leverage increased funding for high quality care.
- Stable funding for expansion of provider network.

Goal 5: Contracting for Wraparound

Establish legislation that a) directs Healthcare Policy and Financing (HCPF) to exercise the optional scope of work (Option) in the RAE contracts to support Wraparound and Family Support Partners during the current contracting cycle, and, b) establishes support for Wraparound and Family Support Partners in future contracts.

Implementation considerations:

Contract language will include options to implement based on collaboration between Colorado Department of Human Services (CDHS) and local direction, or in cases where Option is not initiated, Option will be directed by the state. Legislation needs to have a fiscal note, which appropriates funding to do the work.

Consensus:

- Workgroup participants expressed full consensus in supporting this goal. Suggestions related to implementation considerations are included above.
- Public comment: Support for this goal was very strong, with 97% support (including 18% conditionally) and only 3% non-support. The primary theme emerging from the conditional comments was the importance of fully funding (through the RAEs or otherwise) this work including Wraparound and Family Support Partners.

Goal 6: Value-Based Contracting: Linkage to process and outcomes

Refine value-based contracting models that directly link financial incentives to improvements in process measures and outcomes with consistent metrics across systems.

Implementation Considerations:

- Establish expectations for contractors to implement, track, and reward process incentives and one outcome on a set percentage of accurate prescribing for the first two years (e.g. accurate prescribing of psychotropic medications at or above 90%).
- Recommended *process* (i.e., the way in which service is delivered) incentives: institutionalization of System of Care values and principles and establishing an appropriate network. (https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf)
- Review existing value-based structures to determine if we have effective/appropriate incentives

Consensus:

- Workgroup participants expressed full consensus in supporting this goal. Suggestions related to implementation considerations are included above.
- Public comment: Support for this goal was very strong (93%), though more than one third of them were conditional support. There were a number of themes within the comments for this goal. These included a concern about punitive methods and unintended

consequences, and a concern that an outcome for accurate prescribing would not account for the complexity of individuals.

Utilization Management

A. Previous recommendations

For utilization management, it is recommended that there is continuous accountability and quality improvement mechanisms. Quality improvement mechanisms would be designed to track, monitor, and manage the achievement of system delivery goals; fidelity to the System of Care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level¹⁶.

B. Current needs and priority areas

- None specified.

Goal 7: Utilization Management- Standard Protocol

Establish standardized (best-practice) utilization management guidelines for determining the optimal dose and duration of behavioral health treatment.

Intent: Standardize utilization management criteria across all payors, geographies, and settings, which will ensure that regardless of where treatment is delivered, all children and youth receive effective treatment.

Implementation Considerations: This design will likely require a process of analyzing historical utilization data to identify ‘typical course’ and ‘outlier’ cases.

Consensus:

- Workgroup participants: With the exception of one participant, who expressed concern that in situations where a child, youth, or family needs more time (i.e., *dose* of treatment) based on their provider’s clinical judgment additional treatment will not be supported, the workgroup participants expressed full consensus in support of this goal.
- No public comment available.

Considerations for Future Finance Goal Development

Value-Based Contracting: Payor risk for unavailable services

Payors to provide families with the service needed (“the right service, at the right place, at the right time”). In the event a service is not available, the payor should cover a higher-level of service that is available immediately or in a timely manner

Utilization Management - Family Request for Review

Establish a mechanism for families to utilize for requesting a case review when, a) needed services have not been made available, or, b) services provided are not effectively addressing a child's needs.

Quality Improvement

Behavioral Health Outcomes and Indicators

A. Previous recommendations

It is recommended that outcomes be directly related to the types of services used, child, youth, and family functioning, and health¹³. Examples of appropriate outcomes include: reduced out-of-home placements and hospitalizations resulting in decreased costs; improved mental health functioning and school attendance; reduced school disciplinary actions, juvenile justice involvement, and teen pregnancy; reduced child welfare involvement and caregiver stress; and decreased use of psychotropic medications.

B. Current needs and priority areas

- More useful outcomes measures.
- Standardized measures.

Goal 1: Core Indicators and Outcomes

Across Colorado's child serving agencies, consensus must be reached on a core set of indicators and outcomes (i.e., data points, not measures) that will be assessed as children/families enter or exit any child serving system.

Intent: Reduce burden of duplicative assessment, and increase consistency of information across agencies and systems.

Implementation considerations: These core metrics will be housed and made accessible through the data infrastructure described in Quality Improvement Goal 4.

Core domains that will drive the selection of the core indicators/outcomes will be reflective of current research-based evidence and *could* include:

- Family functioning
- Social adjustment
- Emotional and behavioral issues (including substance use)
- Cognitive functioning
- School functioning
- Stability of living situation
- Trauma or ACES
- Community involvement
- Natural and community supports

- Extent of system involvement
- Developmental milestones (including social and emotional)
- Physical health
- Youth/family satisfaction with care plan

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations detailed above.
- Public comment: This goal received excellent support from survey respondents, with only 3% stating that they would not support the goal. There were several comments about the methods for selecting the core indicators and outcomes, including the importance of: 1) alignment and collaboration across child serving agencies; and, 2) utilizing research evidence and best-practices guidance when developing the array. A second theme that emerged among the concerns was that the collection of core data would increase burden among providers and administrative staff.

Evidence-Based Practices

A. Previous recommendations

Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of delivery system goals; fidelity to the System of Care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level¹⁶. Performance measures should track fidelity to the Wraparound process, and increased youth and family satisfaction with services²². Evidence-based practices (EBP) should provide ongoing provider training by partnering with state colleges and universities¹⁵. It is also recommended to develop and implement trauma informed care trainings for all child-serving systems, including schools¹⁴. Overall, it is necessary to employ evidence-based approaches to mitigate the effects of adverse experiences and environments that impact the wellbeing of children, including toxic stress¹⁸.

B. Current needs and priority areas

- Use data-driven tools to support clinical practice (support the use of EBPs).

Goal 2: Training and incentives aimed at sustaining high quality providers and best practices

Develop and implement a comprehensive set of strategies to support EBPs and core competencies, including (but not limited to) the following:

- Increase reimbursement rates and value-based contracting for demonstrated use of EBPs and core competencies and for demonstrated positive patient-level outcomes.
- Establish a workforce development hub for statewide access to free or low-cost training, coaching, credentialing, technical assistance, and ongoing consultation and support of core competencies and EBP's.

- Make available scholarships, tuition reimbursement, and salary supplementation to assist in developing (educating), recruiting and retaining a more diverse clinical workforce.
- Develop a clear set of criteria for measuring successful outcomes of these strategies.

Intent: Solve the problem of a workforce that is under-developed, transient (e.g., moving out of community mental health after receiving licensure or specialized training), underpaid, and lacking diversity.

Implementation considerations: It would be advantageous to collaborate with graduate training programs (e.g., social work, psychology) in recruiting diverse trainees and strengthening core competencies (i.e., those most useful for community-based treatment settings) that are offered within graduate curricula.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations detailed above.
- Public comment: This goal received excellent support from survey respondents, with only 4% reporting they would not support it. Among the comments provided was a theme regarding the need to make certain that the design of the training and incentive programs is feasible in rural and other small community settings where the clinical workforce is limited. A second theme that arose was a caution against duplicating efforts already in place. Last, several respondents urged implementation that takes a wider view of how evidence-based practices are defined, including non-traditional methods and practices that are evidence-based, but not necessarily strictly regulated, costly, manualized treatment models.

Goal 3: Strengthen and Scale-up Evidence-Based Practices

Implement PracticeWise (details at: www.practicewise.com) in a select set of communities with sufficient funding to allow for time to implement and evaluate outcomes with the expectation that, in the case of effective results, communities will commit to scaling and sustaining PracticeWise for a set number of years.

Intent: It is hypothesized that PracticeWise is a more practical and effective solution for sustaining evidence-based practice in rural communities and small clinical practices where the number of providers and number of clients per caseload are not conducive to sustaining individual (manualized) evidence-based practices.

Implementation Considerations:

- Providers and supervisors should be offered no-cost training and TA through a neutral party so that providers within child-serving systems will have equal access and engagement.
- Features of PracticeWise that are desired include its ability to:

- Assist clinicians (especially early career and rural clinicians who are more often generalists) in identifying the core elements/techniques of EBP's that are best suited to address the individual needs of a child/youth and their family.
- Allow clinicians to monitor progress throughout treatment process.
- Allow clearer communication of progress between provider and family.
- Measure outcomes of intervention(s) at point of discharge or transition.
- Support communication across child-serving systems.
- Support accountability to state-level entities (OBH, Child Welfare, etc.).

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations detailed above.
- Public comment: Survey responses were combined across two draft goals, both of which reflected a plan to implement PracticeWise in order to support the use of EPBs in clinical practice. The average support of these goals was 90% (with 13% being conditional support). The primary themes among the comments were: 1) the need for vetting of the PracticeWise choice and along with other, comparable, platforms; and, 2) the need to make certain that if effective, the burden of funding and sustaining the use of PracticeWise would not fall to rural providers. Respondents also requested more clarity on the timeframe of implementation.

Continuous Quality Improvement

A. Previous recommendations

Past reports included ample content questioning how quality is measured in Colorado's behavioral health system. The following were determined to be key areas for measuring quality: pre-post assessment, client satisfaction survey, family self-assessment, universal assessment with variance by program area, baseline establishment, measure change, and parents and children need to be part of determining what success means¹³.

B. Current needs and priority areas

- Centralized data repository.
- Quality can be improved through provider support (training, supervision, incentives).
- Data should be shared back to families/youth and providers.
- Communicate purpose of data collected from families, including who can access it.

Goal 4: Shared Data Infrastructure

A quality taskforce should be formed by the governing body and charged with designing and building system-wide support for a secure data infrastructure that will store and control access to quantitative data (core metrics and system-level service utilization data) and qualitative data such as integrated

care/case/treatment plans (e.g., behavioral health, education, welfare, medical) and crisis plans, as appropriate.

Intent: Address the problem of data systems that are developed within individual agencies and are not supporting communication or collaboration across systems. Reduce burden on agencies that often duplicate data entry efforts.

Implementation considerations:

- Access to the secure data records will be granted through an (family-driven) informed consent process where families gain a clear understanding process (i.e., how information is stored, secured and shared).
- Families can access their own information, which is summarized in a culturally and linguistically matched manner.
- The data infrastructure will have capability of building provider dashboards and reports, and will facilitate communication and collaboration across agencies/providers.
- Core metrics are a set of child/family-level indicators and outcomes that will be collected and utilized by Colorado's child-serving systems.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations detailed above.
- Public comment: Among respondents, 94% supported (26% of those conditionally) the data infrastructure goal. Many comments included questions regarding how the infrastructure would be paid for, where it would be housed, who would manage it, and how data privacy would be ensured. These important implementation considerations will be included in the materials provided to the organization executing this effort. Several concerns were also raised about the potential duplication of efforts including data collection as well as data entry/management, which could increase the burden on both families and providers. Several additional comments urged the implementation organization to collaborate and align with current initiatives and systems that have a similar aim. Finally, a call was made for a design that would serve the needs of stakeholders at all levels: family, provider and system, including researchers and evaluators that could access and analyze aggregate data in order to help guide system improvements and new initiatives.

Goals 5: Provider Quality Incentives

The quality taskforce will develop a set of metrics to assess and monitor whether providers meet eligibility criteria for value-based contracting; metrics will center on patient/family satisfaction (e.g., services are meeting the child/family needs, provider is culturally/linguistically responsive), and measured outcomes such as family functioning, school attendance, and clinical improvement.

Intent: Current incentives are only contingent on providers demonstrating that trainings have been delivered. The intent of the current goal is to move away from process (training) and move toward indicators of impact and improved outcomes.

Implementation considerations: State entities that provide incentive payments would need to reach consensus how satisfaction is measured and on which measures must be used to demonstrate positive outcomes.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations detailed above.
- Public comment: Among survey respondents, the vast majority (92%) offered support or conditional support for this goal (22% were conditional). One theme that arose from the comments was the importance of aligning these efforts across state agencies and initiatives in order to avoid conflicting efforts or duplication. A second theme was a call for a balanced weighting between family/patient satisfaction and progress/outcomes, so that providers are not discouraged from working with high-risk, high-need individuals.

Goal 6: Continuous Quality Improvement

Develop and utilize a continuous quality improvement process with an integrated data system that, in addition to assessing child and family outcomes, monitors and provides feedback on fidelity, acceptability, and feasibility of care, at the child and family level, practice level, and system level.

Intent: The primary intent of continuous quality improvement is to build and sustain a data-driven approach to: 1) ensure the children's behavioral health delivery system is meeting the needs of children, youth and families; and, 2) evaluate policies, initiatives, and programs so that we continue to strive for excellence.

Implementation considerations:

- Must achieve buy-in for cross-system collaboration.
- A multi-disciplinary taskforce must design and implement the process.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations detailed above.
- No public comment available.

Evaluation

A. Previous recommendations

State and local stakeholders must determine what types of outcomes data to collect across systems for joint accountability, continuous improvement, and monitoring progress toward collaborative goals¹².

Considerations for Future Quality Goal Development

Data-driven progress monitoring

The quality improvement taskforce, staffed by state and local agency representatives, providers, and family stakeholders, will design an efficient data feedback loop so meaningful treatment information can be more easily shared with families, between treatment team members, and compiled for reporting and policy making.

Care Coordination

Care Coordination Structure

A. Previous recommendations

The Children's Behavioral Health Reform Leadership team recommends a statewide System of Care for Medicaid and non-Medicaid eligible children and families in Colorado that includes case management using a wraparound approach¹³. Whenever appropriate, RAEs would be encouraged to delegate care management to the closest setting of care to the child and family. Case management services provided should be performed in partnership with the Collaborative Management Program (CMP)¹³. It is also recommended that the structure of case management services be integrated at the system level, with linkages between child-serving agencies and programs across administrative, funding boundaries, and mechanisms for system-level management, coordination, and integrated care management²². To further develop case management infrastructure, it is central to support the workforce by providing semi-annual trainings for Wraparound, family advocates, and youth peer support specialists¹⁴.

B. Current needs and priority areas

- A single (tiered) care coordination model across systems that covers multiple levels of acuity.
- Centralized hub/control for care coordination/management.

Goal 1: Statewide Tiered Care Coordination Model

Establish a statewide, tiered care coordination model that relies on data to determine the needed intensity of care coordination and defines the model of care coordination for each tier.

Implementation Considerations

- Care coordination taskforce to make a data-driven determination of the optimal tiered care coordination model, based on previous research and evaluation, Colorado culture, and the model's alignment with Systems of Care values and principles.

- Care coordination should follow the family and not be tied to one particular system. Agreement and alignment of care coordination implementation across all child-serving systems is critical.
- Training and fidelity monitoring are essential for each tier.
- Model should allow for effective transition between tiers as appropriate.
- A clear definition (parameters) are needed for each tier:
 - Top tier with high-fidelity wraparound or model with similar intensity/frequency; provide training, coaching, fidelity monitoring, and certification process for care manager or wraparound facilitator.
 - Middle tier is most challenging: there's a need for clear delineation between middle and top tier. The intensity/type of care coordination could be based on number of systems involved, or other complexities (e.g., family involvement, health or cognitive complications); care coordinator would be a systems navigator for families.
 - Low tier would be similar to case management (in terms of ratios). Must have strong prevention and diversion focus (aiming to keep kids out of other systems). Build on natural and community supports and have consistent follow-up; it is essential for care coordinators to engage schools in their work. Consider Oklahoma model for determining low tier.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the detailed implementation considerations above.
- Public comment: Based on the array of public comments, this goal had strong support (89% full or conditional support). One primary theme surrounded concerns of overlap with existing systems, which might create duplication or parallel systems. Second was a desire to make certain that the robustness of the model be equal across all rural, urban and frontier communities. In addition, respondents brought up concerns in regards to flexibility of the proposed three-tiered model.

Goal 2: Establishing Care Management Entities

The governing body for children's behavioral health should establish regulations and appropriate funding to support the development of statewide, locally operated care management entities (CMEs) to administer care coordination to children, youth, and families.

Implementation Considerations:

- CMEs should have the authority to re-invest funds that are saved through greater efficiencies back into child services such as expansion of care coordination or prevention initiatives.
- CMEs could be a strengthened and standardized version of an existing care management system scaled up to be statewide.

- CMEs will have authority to authorize the appropriate tier of care coordination based on a standardized strength and needs assessment.
- CMEs are accountable both to the governing body for children's behavioral health and to the youth/family advisory council.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the detailed implementation considerations above.
- Public comment: Among the survey respondents, 85% offered either full or conditional support. Concerns focused on adding an additional layer of bureaucracy or administrative burden to the system. Alternatively, respondents suggested doing more work to improve existing care management agencies, such as the Collaborative Management Program (CMP). Those who opposed this goal suggested addressing weaknesses in current programs rather than creating a new one. Additionally, there was concern that care management may not work to serve the needs of the patient and family.

Care Planning, Authorization, Monitoring and Review

Goal 3: Authorization of Services by Care Coordinators (or CMEs)

Allow care coordination teams to define medical necessity to a degree by developing a service package for each tier of care coordination, which is informed by other state models and Colorado state data.

Implementation Considerations:

- If justified, additional services can be authorized to supplement the base care package.
- A successful process should help families avoid a difficult appeal process, avoid duplication of services, and ensure that families are engaged.
- An acceptable alternative to a service package would be to provide a case rate for each youth receiving care coordination that could be used to purchase needed services and supports.
- There needs to be some flexibility built in to assure providers will maintain a level of control over clinical decision-making.

Consensus:

- Workgroup participants: The workgroup participants expressed full consensus in support of this goal with the detailed implementation considerations above.
- Public comment: Among stakeholders offering public comments, 91% (20% conditionally) supported this goal. Several respondents expressed concern about how medical necessity would be defined, and how consistent it would be across care coordinators, agencies and funding sources.

Considerations for Future Care Coordination Goal Development

Utilization Management- Monitoring and Review

Evaluate utilization management process currently used by RAE's and other systems/entities. In partnership with the governing body, identify feasible and optimal models through data collection and analysis in order to increase transparency and consistency.

Service Array

Provider Network: Coverage and Adequacy

A. Previous recommendations

Adequate dollars should be available for a full continuum of care including comprehensive home- and community-based support, and utilizing Medicaid funds²². It is important to be able to expand and evaluate the array of trauma-informed, culturally and linguistically responsive services and supports to ensure high quality behavioral health services²². It is recommended that the state invest in a children's behavioral health benefit package that includes a broad array of essential services such as intensive in-home services, peer support, recovery services, walk-in clinics, crisis response and stabilization, respite care, day treatment (individual, family and group), trauma specific treatment, psychotropic medication management and review, step-down services, as well as investment in prevention³. It is also recommended to integrate mental health services and supports in health care and educational settings through delivery system changes, payment reform and practice transformation^{16,18}. Services must be developmentally appropriate, trauma responsive, and culturally responsive¹³.

B. Current needs and priority areas

- Increases in peer mentoring and advocacy.
- Equal access to providers across entire state.
- Workforce development and increased capacity for:
 - Non-traditional therapies
 - Respite Care
 - In-Home Services
 - Specialized Treatment (DD, Substance, Trauma, TAY)
 - Prevention services

Goal 1: Network Adequacy Metrics

Improve the data metrics for measuring and reporting Colorado's network adequacy.

Intent: Ensure the ongoing collection of current service array adequacy across Colorado's child-serving systems, which could serve to inform future discussions about establishing a single provider pool, thereby reducing competition and enhancing standardization and accountability across system providers.

Implementation Considerations:

- Design data collection and analysis so that burden does not fall on individual agencies; centralize and disseminate all service array assessment data.
- RAEs, state agencies, and private managed care companies to improve the meaningfulness and interpretability of network adequacy metrics.

Consensus:

- Workgroup participants: one dissenting vote stated the goal is unattainable as originally written. In response, a portion of the goal was moved to implementation considerations.
- Public comment: Among survey respondents, 94% supported this goal (13% conditionally), and only 6% did not support it. Concerns were expressed in the comments regarding who would have the authority to enforce the improved metrics, how they would be utilized equally across the state, and how adequacy measures would be measured reliably among both private and public provider agencies.

Goal 2: Colorado Service Array Assessment

RAE's, state agencies and private managed care companies to conduct a uniform service array assessment on a reoccurring basis that includes a portion where families and youth report on their experience of the service array. Require all RAE's, state agencies and private managed care companies to report out on the service array assessment results.

Intent: Ensures current service array data across Colorado's child-serving systems, which will serve to inform future discussions about establishing a single provider pool to reduce competition and enhance standardization and accountability across system providers.

Implementation Considerations: Centralize service array assessment data.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation consideration above.
- Public comment: Consensus was excellent (93%) in support of this goal. Several questions about implementation were posed including who would conduct the assessment, where the data would go (e.g., purpose and intent of findings), and how this effort would be funded. Comments also raised issues about alignment with ongoing efforts to enforce parity (e.g., HB 18-1357).

Evidence-Based practices

A. Previous recommendations

Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families¹⁶. Work with schools to offer suicide prevention trainings for teachers and staff²³. Invest in recovery services, peer and supported employment, and preventative services³.

B. Current needs and priority areas

- Behavioral health workforce development – including both generalists and specialists.

Goal 3: Core Set of Strategies

Develop an agreed-upon set of core service strategies (i.e., a range including services, resources, coordination, and supports) to be made available across the state.

Implementation Considerations:

- Establish a process for regularly reviewing and updating, based on changes in the evidence-base, feedback from providers and consumers, and the potentially changing diagnostic profile of the clinical population.
- Phase 1: Identify the core set of strategies and facilitate a public comment process; engage with child welfare, juvenile justice and Medicaid to ensure agency buy-in.
- Phase 2: Pilot and evaluate set of strategies in *at least* one rural/frontier and one urban area, offering incentives for participation.
- Phase 3: Propose legislation to ensure that capacity for offering core strategies will be built and sustained.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the detailed implementation considerations above.
- Public comment: This goal received one of the highest levels of support (96%) among stakeholders who responded to the survey. Some comments expressed concern about the feasibility of accomplishing this goal in small, rural communities. Other comments focused on the need for collaboration and alignment with other efforts underway in this domain.

Goal 4: Cultural and Linguistic Responsiveness

The children's behavioral health governing body will form a taskforce, representative of child-serving system stakeholders, which is charged with establishing agreed-upon standards for culturally and linguistically responsive engagement/outreach, assessment and services.

Implementation Considerations:

- Deliver no-cost training and commitment on multiple levels; build-in education and supports to promote brave and safe spaces.

- Should include Culturally and Linguistically Appropriate Services (CLAS) standards based on outcomes.
- Assessment developed to evaluate progress toward goals.
- Institute an Office of Cultural Affairs.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations above.
- Public comment: Survey respondents strongly supported this goal (93% includes 20% conditional support). One theme among the comments was a call for proper representation within the taskforce including cultural diversity, inclusion of youth and parents with lived experience in the children's behavioral health system, and a variety of providers from varied disciplines. A second theme was a need for alignment and collaboration with other state and regional agencies working toward similar goals.

Workforce Development, Recruitment and Retention

A. Previous recommendations

Further cultivate the infrastructure supporting behavioral health workforce development, including wraparound facilitators and family and youth peer support providers¹⁴. It is recommended to establish a trainer pool to implement a statewide coaching, credentialing and training system for wraparound facilitators, family advocates, and youth peer support specialists.

B. Current needs and priority areas

- None specified.

Goal 5: Workforce Development: Recruitment and Retention

Identify a set of strategies that support the recruitment and retention of clinical staff in order to address the Colorado workforce shortage.

Implementation Considerations:

Strategies could include:

- Recruit and educate diverse staff in rural areas, such as hiring staff and employing them while paying for their education, so that staff characteristics reflect the service population characteristics in terms of race, gender, language, and others.
- Provide loan forgiveness.
- Enforce payment parity and allow for the increase on parity rates.
- Training and technical assistance for providers regarding vicarious trauma and self-care.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations above.
- No public comment available.

Goal 6: Statewide Core Competencies

Establish a taskforce charged with developing a set of core competencies for providers of behavioral health services.

Intent: These core competencies will establish a baseline for a skilled workforce to increase quality, retention and consistency across Colorado's clinical workforce. Core competencies should be designed with child, youth, and family input. Clinical growth pathways, including built-in incentives for providers to get staff trained, should be part of the model to support retention of a skilled clinical workforce.

Implementation Considerations:

- Early childhood or juvenile justice workforce may serve as models.
- Consider requirements for reflective supervision and leadership training.
- Align core competencies with tiered system of providers with a set of criteria for each tier.
- Build partnerships with relevant stakeholders such as the Department of Labor.
- Establish training and development hubs across the state to ensure sustainability and access.
- Offer scholarships for specialized training.
- Competencies may include family-focused interventions, trauma-informed care, child-adulthood crossover/transitions.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations above.
- Public comment: This goal received strong support, with 93% of respondents offering full (73%) or conditional (20%) support. Several questions were posed about how the core competencies could affect licensure or credentialing. Other respondents urged the taskforce to include youth and family members with lived experience in the system as well as a broad array of providers. An additional theme centered on ensuring alignment with all system stakeholders who offer behavioral health services to children and youth.

Goal 7: Wraparound and Care Coordination Workforce Development

Fund and implement a centralized resource hub to train, coach, and credential care coordinators and family and youth peer support specialists statewide.

Intent: This goal will support the development of care coordinators, and the family and youth peer support workforce while maintaining fidelity and quality of services.

Implementation Considerations:

- Funding sources are encouraged to fund a credentialing and coaching system.
- Middle and bottom tiers of coordination model need to be constructed so that training, coaching, and credentialing of care coordinators.
- Youth and family peer specialists could be aligned with other tiers.

Consensus:

- Workgroup participants: One dissenting vote questioned the reach and feasibility of this goal.
- Public comment: This was among the highly supported goals with 85% full support and 8% conditional support. One theme among the comments provided was concern about the cost involved in implementing and sustaining this effort. Additional comments focused on the need to avoid duplicating efforts that may be underway and the importance of including a wide range of stakeholders including public health and primary care.

Access, Screening, and Assessment

Universal Screening

A. Previous recommendations

Past reports highlight the need to develop and fund a robust infrastructure to support a statewide screening, referral and care coordination model¹⁸. Universal screening (trauma, mental health, developmental disability) is recommended to assess needs irrespective of how client enters the system¹³.

B. Current needs and priority areas identified by workgroup participants

- Using technology to improve access.
- Standardized assessment tools used by providers.

Goal 1: Establish Universal Screening

Establish a universal screening procedure for developmentally appropriate childhood/youth behavioral health risks and symptoms; and establish statewide utilization of the tool by Colorado's child-serving agencies following training and implementation support.

Intent: Standardize system entry through accessing services across the state.

Implementation Considerations:

- Train providers at no cost on the approved screening tools.
- Tie screening requirement to payments and incentives.
- Deliver training and provide technical assistance/coaching for providers on what to do if the youth has a positive screen.
- Screening tools must be standardized, but still allow for a person-centered approach.
- Buy-in must be achieved in order to make this a statewide tool that is indeed universal.

Consensus:

- Workgroup participants: Participants expressed full consensus in support of this goal with the implementation considerations above.
- Public comment: Among survey respondents, 88% supported this goal (18% of those were conditional). Among the comments was a suggestion that this tool be considered an ongoing process, not a single, point-in-time screening. Others call for a tool that is truly culturally and linguistically responsive to the populations being served. Among respondents who did not support the goal was a concern about the duplication of screening efforts already in place and the potential increased burden on providers.

Standardized Assessment

A. Previous recommendations

Shared assessment tools such as the Child and Adolescent Needs and Strengths (CANS) assessment or the Treatment Outcomes Package (TOP) assessment should be utilized statewide to determine level of care and individualized care planning²⁴. Intake, triage, and referral using a centralized assessment center¹³.

B. Current needs and priority areas

- Standardized assessment tools.
- Culturally responsive/inclusive assessments.
- Family-focused and comprehensive needs assessment.

Goal 2: Standardized Assessment Tool

Establish a standardized approach to child/youth behavioral health assessment that also assesses the youth and family for the social determinants of health.

Intent: Standardize system entry through accessing services across the state.

Implementation Considerations:

- Utilize the CANS, a freely available, multi-purpose tool developed for children's services to support decision-making, including level of care and service planning, to facilitate quality improvement initiatives, and allow for the monitoring of outcomes of services.
- Train providers how to conduct the assessment in a culturally responsive way.
- Ensure assessment compiles views from multiple supports connected to the family.
- Require that the tool be available in multiple languages.
- A multi-disciplinary team should be involved in selecting the tool.

Consensus:

- Workgroup participants: Participants expressed full consensus in support of this goal with the implementation considerations above.
- Public comment: There was strong support for this goal with 75% offering unconditional support and an additional 17% offering conditional support. Comments included a need for reassurance that the tool would be appropriate for many levels of severity and complexity. Other comments included the suggestion that some flexibility be built into the use of the CANS, and the recognition that the CANS does not replace the need for a clinical, diagnostic tool. Another respondent recommended cross-system training so that all users and systems understand the purpose of the assessment and are utilizing the information gained in the same ways.

System Entry and Access

A. Previous recommendations

To improve access to care, it is recommended to ensure services are available to youth in need. This includes a “no wrong door” philosophy, in particular avoiding providing services to only those in crisis^{13,15}. The system should develop a centralized UNIT where the ‘single door’ (e.g., triage) to accessing appropriate treatment is a navigator who completes an initial assessment to determine the tier of care coordination that is needed.

B. Current needs and priority areas identified by workgroup participants

- School-based access to behavioral health services.
- Streamline access point (e.g., crisis line, primary care).
- Services based on needs - not funding streams.
- Using technology to improve access.

Goal 3: System Entry

Establish a hybrid model of system entry with ‘no wrong door’ access points as well as a centralized mental wellness helpline.

Implementation Considerations:

- Assess the behavioral health service access points in order to understand the level of commitment, capacity and training necessary for the effective triage of children, youth, and families.
- Develop an implementation plan that ensures staff at all access points are trained how to triage families and connect them to appropriate care.
- Build-out a decision tree and workflow that identifies which stakeholder groups should utilize a centralized phone number (e.g., police, teachers, coaches), versus those who should be appropriately trained and capable of triaging families (e.g., primary care, behavioral health providers).
- Build on existing systems (e.g., crisis services infrastructure).

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations above.
- Public comment: This goal received strong support with 93% of respondents stating that they would support or conditionally support it. One theme among the comments provided included information about Senate Bill 18-254, which legislates a taskforce to address this work. Similarly, others warned against the possibility of doing duplicative work in this domain. Several comments called for more detail and clarification on what is meant by 'hybrid' and 'centralized'. Other comments emphasize a need for culturally and linguistically responsive services so that the access is equitable across all populations.

Goal 4: Outreach, Engagement and Referral

Develop, staff, and sustain the centralized access point for children and families with 'family navigators' and 'support partners' to answer calls and follow the family through linkage and engagement of services.

Intent: Standardize system entry by accessing services across the state.

Implementation Considerations:

- Develop a centralized line building off the existent crisis line.
- The face of these services/supports could be led through Colorado's Department of Public Health and Environment.
- Reference the Child Health Plan (CHP+) model and create a referral arm covering: embedded funding, line item funding, outreach, engagement with families, up-to-date training for workforce, and incentives for advocates to work together to sustain the workforce.
- We need a collaborative and comprehensive approach that is attached to what already exists that pushes a solidification of family organizations - where sustainability is not dependent on funding.

Consensus:

- The workgroup participants expressed full consensus in support of this goal with the implementation considerations above.
- No public comment available.

Public Education

A. Previous recommendations

Past reports highlight the need for system-level education to reduce stigma related to behavioral health¹⁷. Education of the public and the system around Transition Age Youth (TAY)-specific issues are necessary to ensure support for effective programming¹⁷. It is recommended to increase marketing efforts to raise public awareness¹⁵.

B. Current needs and priority areas

- None specified.

Goal 5. Whole Person/Family Wellness

Design and deliver a ‘whole-person wellness’ curriculum (adapted from SAMHSA’s “8 Dimensions of Wellness”; <https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>) for children and families that will address how different system stakeholders can support whole family, whole child/youth wellness.

Implementation Considerations: Develop a change management implementation plan with a priority for pediatricians as the pilot group to evaluate curriculum’s effectiveness in facilitating culture change.

Consensus:

- Workgroup participants: The workgroup participants expressed full consensus in support of this goal with the implementation considerations above.
- Public comment: Among survey respondents, 93% supported this goal (11% were conditional). Several comments noted the wellness concept and curriculum would need to be carefully developed and implemented in order to gain widespread recognition. Broad, comprehensive (and free) training would be essential. Family input would help with issues including ‘blame’ and a lack of understanding of family systems and the multi-generational nature of many mental wellness challenges.

Crisis Management

A. Previous recommendations

A considerable amount of work has been done recently to both advance and evaluate crisis services in Colorado. Three major reports released recommendations for the system as a whole including several important to children, youth and families. Primarily designed for adults, there remains a lot of opportunity to build out the crisis system for children and youth here in Colorado²⁵. There is a need of funding and resources to establish such a system so that a comprehensive navigation system can be designed to connect caregivers, families and children to resources, including crisis services^{18,25}.

Considerations for Future Access Goal Development

Crisis Services designed for children, youth, and families

Design an accessible (24/7), equitable, and culturally responsive children's, youth and family crisis services system using established best practices for children's behavioral health.

Next Steps – Vision and Plan for Implementation

Establishing these Roadmap Goals marks the beginning of the challenging work ahead to build an effective children's behavioral healthcare system for Colorado. As we prepare for ushering in new State leadership, we begin planning the next steps for moving the Roadmap Goals forward toward implementation. We must strategize which goals are in the scope of PCMH, and which should be moved forward by advocacy, policy and other key stakeholder groups in order to maximize our chances of success.

Ripples of Hope

"Each time a (wo)man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, (s)he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, those ripples build a current which can sweep down the mightiest walls of oppression and resistance."

- Robert F. Kennedy (adapted)

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Appendix

Name	Organization
Laura Patterson	Arapahoe County Department of Human Services
Jamie Falasca	AspenPointe
Betsy Rogers	Aurora Mental Health Center
Kathy Snell	Aurora Mental Health Center
Mara Kailin	Aurora Mental Health Center
David Bonaiuto	Boulder County Human Services
Marya Washburn	Boulder County IMPACT
Sara Boylan	Boulder County IMPACT
Rochelle Galey	CDHS, Division of Youth Services
Andrew Gabor	CDHS, Office of Behavioral Health
Ashley Brock-Baca	CDHS, Office of Behavioral Health (COACT)
Camille Harding	CDHS, Office of Behavioral Health
Chris Meyer	CDHS, Office of Behavioral Health (COACT)
Claudia Zundel	CDHS, Office of Behavioral Health (COACT)
Detre Godinez	CDHS, Office of Behavioral Health (COACT)
Meghan Shelton	CDHS, Office of Behavioral Health
Robert Werthwein	CDHS, Office of Behavioral Health
Stacey Davis	CDHS, Office of Behavioral Health
Allan Hutchenson	CDHS, Office of Child, Youth and Families
Gretchen Russo	CDHS, Office of Early Childhood
Angela Park	CDPHE, Children, Youth and Families Branch
Luis Alvarez	Center for Restorative Programs
Annie Lee	Children's Hospital Colorado, Child Health Advocacy Institute
Ellen Stern	Children's Hospital Colorado, Child Health Advocacy Institute
Kevin Wilson	Children's Hospital Colorado, Child Health Advocacy Institute
Zach Zaslow	Children's Hospital Colorado, Child Health Advocacy Institute
Bruno Anthony	Children's Hospital Colorado, Pediatric Mental Health Institute
Guido Frank	Children's Hospital Colorado, Pediatric Mental Health Institute
Jason Williams	Children's Hospital Colorado, Pediatric Mental Health Institute
Jenna Glover	Children's Hospital Colorado, Pediatric Mental Health Institute
Jessica Malmberg	Children's Hospital Colorado, Pediatric Mental Health Institute
Laura Anthony	Children's Hospital Colorado, Pediatric Mental Health Institute
Monique Germone	Children's Hospital Colorado, Pediatric Mental Health Institute
Shannon Van Deman	Children's Hospital Colorado, Pediatric Mental Health Institute
Sue Williamson	CO Children's Healthcare Access Program
Tiffany Sewell	Collaborative Management Program
Jenny Nate	Colorado Access
Doyle Forrestal	Colorado Behavioral Healthcare Council

Frank Cornelia	Colorado Behavioral Healthcare Council
Moses Gur	Colorado Behavioral Healthcare Council
Kathy Watters	Colorado CASA
Bethany Pray	Colorado Center on Law and Policy
Sarah Barnes	Colorado Children's Campaign
Heather Piernik	Colorado Community Health Alliance
Allison Daley	Colorado Counties Inc (County Commissioners)
Mary Hoefler	Colorado Crisis Services
Lisa Mayer	Colorado Department of Child Welfare
Alejandra Venzor	Colorado Department of Education
Omar Estrada	Colorado Department of Education, Office of Health & Wellness
Justine Miracle	Colorado Department of Health Care Policy & Financing
Susanna Snyder	Colorado Department of Health Care Policy & Financing
Erik Ortiz	Colorado Health Foundation
Jennifer Turner	Colorado Judicial Department
Sarah Heffner	Colorado Management Program Mesa/Hilltop
Kim Erickson	Colorado School Medicaid Consortium
Maria Black	Colorado Springs School District 11
Meg Williams	Commission on Juvenile Justice
Lauren Jassil	Community Reach Center
Corry Robinson	CU School of Medicine- Pediatrics
Scott Utash	Denver Advocacy
Ruby Richards	Douglas County Department of Human Services
Celestene Lyles	Douglas County Wraparound
Patsy Bjork	Douglas County Wraparound
Deborah Ward-White	Family Agency Collaborative
Margie Grimsley	Federation of Families - Colorado Chapter
Bob Dyer	Foothills Behavioral Health Partners
Glenn Ferguson	Health Solutions
Heather White	Health Solutions
Kristie Dorwart	Health Solutions
Lindsay Reeves	Health Solutions
Hillary Jorgensen	Healthier Colorado
Susanna Mizer	Healthier Colorado
Cynthia Meyer	HealthOne
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Amy Engelman	Intentional Impact
Amy Hansen	Jefferson Center for Mental Health
Crystal Christensen	Jefferson Center for Mental Health
Jamie Haskell	Jefferson Center for Mental Health
Kate LaBore	Jefferson Center for Mental Health

Katie Brierley	Jefferson Center for Mental Health
Kristen Anderson	Jefferson Center for Mental Health
Leah Krusich	Jefferson Center for Mental Health
Linda Nordin	Jefferson Center for Mental Health
Maya Garcia	Jefferson Center for Mental Health
Megan Lee	Jefferson Center for Mental Health
Lynnae Flora	Jefferson County Department of Human Services
Angele Fauchier	Kempe Center
Sarah McNamee	McNamee & Assoc.
Lauren Snyder	Mental Health Colorado
Kyle Bixenmann	Mount St. Vincent
Meighen Lovelace	Parent
Erika Retzlaff	Pueblo Charities
Terri Anderson	Reach Collaborative Management Coordinator
Amy Anderson	ReSchool Colorado
Jonathan Muther	Salud Clinic Boulder County
Candice Bailey	Savio Group
Lisa Brody	Signal Behavioral Health
Denise McHugh	Spark Community Foundation
Daryle Conquering Bear	Spirit of the Sun
Kyle Gustafson	State Court Administrators Office/Criminal Justice Programs Unit
Carissa Fralin	State Innovation Model
Tegan Camden	SummitStone Health Partners
Rebecca Dosbahn	Tennyson Center
Kippi Claussen	Youth Move

