# The Status of Behavioral Health Care in Colorado

**ADVANCING COLORADO'S MENTAL HEALTH CARE**

*2011 Update*

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In 2003, a group of Colorado grantmaking foundations came together to fund *The Status of Mental Health Care in Colorado*, a report that, for the first time, collected and reported information about Colorado's many overlapping, fragmented, and underfunded systems for providing mental health services.

In response to this report, Caring for Colorado Foundation, the Colorado Health Foundation, The Colorado Trust and The Denver Foundation created Advancing Colorado's Mental Health Care (ACMHC) in 2005. This five-year, $4.25 million project provided joint support to six different community collaboratives to bring together human services agencies, mental health care providers, and other local partners to address the tremendous needs facing our state in the mental health arena. The project also worked with TriWest Group to develop an updated, broader assessment of both mental health and substance use disorder (SUD) care in the state.

*The Status of Behavioral Health Care in Colorado* provides critical information on evolving mental health and SUD treatment needs, funding, progress made in the coordination and integration of behavioral health services since 2003, continued barriers to care, and long term recommendations for the state. Both the needs and opportunities facing the state in these areas are greater than ever.

The ACMHC funders plan to use the findings of this report to inform future mental health grantmaking efforts. It is our hope that those working to improve mental, behavioral and broader health care in Colorado will also use this analysis to review the current gaps in behavioral health care, and address the various recommendations for the state.

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# Executive Summary

**In 2003, a group of Colorado foundations came together to fund The Status of Mental Health Care in Colorado, a report that brought together for the first time information about Colorado's many overlapping and fragmented systems for providing mental health services.**

In response to the 2003 *Status Report*, four foundations – Caring for Colorado Foundation, the Colorado Health Foundation, The Colorado Trust and The Denver Foundation – created Advancing Colorado's Mental Health Care (ACMHC). This five-year (2005-2010), $4.25 million project provided joint support to community collaboratives bringing together human services agencies, mental health care providers, and other local partners to address the tremendous needs detailed in the 2003 report.

This report updates the 2003 results as of early 2011 at the advent of many important transitions for Colorado's mental health, substance use disorder (SUD), and broader health care systems. The goals of this 2011 update are similar to those of the original study: to better understand the strengths and weaknesses of mental health and SUD service delivery systems in Colorado across populations and identify opportunities to strengthen these systems. Both the needs and the opportunities facing Colorado are greater than ever.

**KEY FINDINGS FROM 2011 INCLUDE THE FOLLOWING:**

• Three in 10 Coloradans need treatment for mental health or SUD needs each year – more than 1.5 million people.

• Colorado's national ranking for public sector mental health spending fell one place to 32nd in 2007; data on SUD spending shows rates one-third the national average.

• About 1 in 12 (about 425,000) have a severe condition; 1 in 30 (more than 170,000) are adults with a severe mental illness (SMI); 1 in 100 (60,000) are adults with severe SUD without SMI – an important, underserved group; and more than 1 in 50 (90,000) are children and adolescents with serious emotional disturbance (SED).

- Nationally, 40.5 percent of those with severe needs receive care. In Colorado, many more with severe needs in poverty receive care: about 61 percent of people with SMI/SED and 64.8 percent of people with severe SUD needs in need of public services.

- Most mental health/SUD care is delivered through primary care (just over 50 percent), and Colorado is a leader in promoting integrated mental health/SUD in primary care settings.

- For mental health, more people are served in the community, fewer are served in hospitals of any kind, and Colorado's acute psychiatric inpatient capacity ranks among the lowest nationally.

- Public sector SUD service delivery has increased, but service levels remain well below need, due to a history of limited funding and marginalized capacity too often stretched too thin.

- The primary challenge remains uncoordinated care, as those with the highest cross-system mental health/SUD service use experience poor physical health status that drives more costs than their mental health/SUD needs, arguing for more wholistic treatment and specialized supports.

- Important steps to reduce fragmentation since 2003 include integration of mental health and SUD oversight through the Division of Behavioral Health (DBH), expanded medical homes for children, system reform efforts by the House Joint Resolution (HJR) 07-1050 behavioral health task force, and formation of the Behavioral Health Transformation Council (BHTC).

- Of the $887 million in known expenditures spent on behavioral health in 2010, just over 53 percent was spent through the formal public behavioral health system; the rest (47 percent or nearly $413 million) was spent in other systems.

- More than $93 million was spent on behavioral health needs in the criminal justice system. This amount represents more than one-tenth of total known behavioral health expenditures. It is also more than one-fifth higher than the amount spent through the formal public behavioral health system.

- For Colorado Medicaid populations, overall health spending is 124 percent higher per person for those with any mental health diagnosis than for those without, with 73 percent of this difference driven by increased physical health and prescription costs.

- Involvement with other human services systems exacerbates these differences. The DBH identified the top 267 people in terms of cost who had accessed five or more different types of state agencies (inclusive of mental health care in all cases). Just over half (51 percent) had Medicaid claims, and simply the cost of their behavioral health and medical claims was more than $30,000 per person, nearly 10 times the cost of typical Medicaid medical costs.

- There are also too few mental health and SUD providers of the types needed who are willing to serve priority populations. Systematic approaches to integrate mental health and SUD treatment with primary care is essential to leveraging available providers to meet growing demands.

- As level of training (number of years of graduate-level training) and specialization increases, behavioral health providers are found disproportionately in the Denver and Colorado Springs areas. Six hundred nineteen of the 753 practicing psychiatrists (82 percent), 86 percent of child psychiatrists, and essentially all psychiatrists specializing in SUD treatment (95 percent) and in geriatrics (100 percent) practice in the Denver and Colorado Springs areas.

- The evidence base for peer support for both mental health and SUD needs is substantial and growing.

This report used multiple methods that built on each other to describe Colorado's many service systems for mental health and SUD services at two broad levels. The first level was quantitative, updating the 2003 data with (1) broader data on SUD services, and (2) data from major reports of which we were aware or which stakeholders brought to our attention. The second level involved interviews with 89 formal and informal leaders actively involved in Colorado and national mental health and SUD services systems. We also augmented the report with targeted literature citations addressing key issues addressed throughout the report. Another major influence throughout the report development was the interactive guidance of the ACMHC project group, including the ACMHC funders, evaluator, and

communications firm. A draft of the report was also shared in the summer of 2011 with all of the stakeholders who participated in interviews to ensure that key points from the interviews were incorporated, and that issues of concern were framed in ways congruent with stakeholder perspectives. All input received was incorporated.

**IN SUMMARIZING THE UPDATED RESULTS, WE REVISITED THE SEVEN OBSERVATIONS FROM THE 2003 STUDY AND UPDATED THEM AS FOLLOWS:**

1. Coordination and integration of services are improving, but they are needed more than ever.

2. Despite gains and the hope of health reform, many people still cannot access needed care.

3. Funding for mental health services is still low, funding for SUD services and prevention is even lower, but the situation is somewhat better than before.

4. Health care costs continue to increase, and bending the cost curve depends on better integration of health, behavioral health, and human services.

5. More than ever is known about what works, and what works is somewhat more available.

6. There are still too few providers – and the need is growing.

7. Prioritization of resilience and recovery is still needed.

Under each observation, the report offers focused recommendations for improvement.

# OBSERVATION #1
## COORDINATION AND INTEGRATION OF SERVICES ARE IMPROVING, BUT THEY ARE NEEDED MORE THAN EVER

There is still not an integrated system in Colorado for delivering mental health and substance use disorder (SUD) care. And there has never been one, in Colorado or anywhere in the nation. This is because health and human services systems are in a continuous state of ongoing development, and they have been for more than 100 years, as people across Colorado time and again have committed to build new systems to address unmet needs. Well-intended and positive efforts have unintentionally resulted in an incredibly complicated array of systems and providers serving a range of needs across diverse and overlapping groups of people. Health care's primary challenge is to find ways for multiple systems to work better together for people with complex needs, given Colorado and national evidence of high costs and poor outcomes. Current systems are multiple and varied by

funding source, focus of care (primary, specialty mental health/SUD, prevention), and geography. They also include an array of additional human services that deliver their own mental health/SUD services (education, child welfare, juvenile justice, state and local adult corrections) or offer other critical support services to people with mental health/SUD needs (housing, employment).

Most mental health/SUD care is delivered through primary care (just over 50 percent). Colorado is a leader in promoting integrated mental health/SUD in primary care settings. The Colorado Behavioral Healthcare Council is nationally recognized and involved in about 100 integration projects statewide.

In the public sector, a 72 percent increase in Medicaid members from State Fiscal Year (SFY) 2002 to SFY 2010 has driven mental health service use increases. More people are served in the community, and fewer people are served in state psychiatric hospitals (3,484 in SFY 2002 to 2,425 in SFY 2010 – a 28 percent drop), reflecting both capacity reductions (24 percent) and improved access to community services. Fewer people are served in hospitals of any kind since 2003, and Colorado's acute psychiatric inpatient capacity ranked 49th among states in 2006.

Public sector SUD service delivery has increased with the expansion of DBH state and federal block-grant funded services, as well as the addition of the Medicaid SUD services benefit in 2008. SUD service levels, however, remain well below need. Stakeholders emphasized multiple limitations in SUD service networks related to a history of limited funding and marginalized capacity too often stretched too thin. Unlike the public mental health system, the emphasis has been on short term stabilization and treatment rather than longer term follow-up and intensive, recovery-oriented supports.

Less explored frontiers involve prevention, and evidence is growing that intervening earlier is more cost-effective. Research on Adverse Childhood Experiences (ACEs) clearly shows that maltreatment of various kinds and levels of intensity is associated with poor health and behavioral health outcomes.

Despite progress, the primary challenge remains uncoordinated care. Among those with the highest cross-system mental health/SUD service use, poor physical health status drives more costs than does high mental health/SUD need, arguing for more wholistic treatment and specialized behavioral health supports.

**COLORADO MENTAL HEALTH AND SUD HEALTH SYSTEMS HAVE TAKEN IMPORTANT STEPS TO REDUCE FRAGMENTATION SINCE 2003, INCLUDING:**

- Integration of mental health and SUD oversight through the DBH,

- More integrated systems of care for children with intensive needs under House Bill (HB) 04-1451,

- More medical homes for children eligible for Medicaid and Colorado's Child Health Plan Plus (CHP+) through Senate Bill (SB) 07-130,

- System reform efforts initiated by HJR 07-1050 through a behavioral health task force,

- Creation of the Behavioral Health Cabinet in 2007 by Colorado Governor Bill Ritter, Jr.,

- Formation of the BHTC through SB 10-153, and

- Recommitment to the BHTC by Governor John Hickenlooper and his cabinet in 2011.

As a result, state agencies with a core mission to deliver mental health and SUD services (the Office of Behavioral Health (OBH) and DBH within the Colorado Department of Human Services, the Department of Health Care Policy and Financing, and the Colorado Department of Public Health and Environment) are working better together, coordinating with other agencies that deliver mental health and SUD services as part of a different core mission (corrections, public safety, and youth corrections and child welfare within CDHS), and are better aligned with other state agencies that play an important supportive role (labor/employment, local affairs, housing/community development, vocational rehabilitation). These efforts have clearly demonstrated that meaningful change in health and human services integration is always incremental. The actual work of integration involves the careful knitting together of regulations, purchasing efforts, service standards, data collection protocols, information systems, and the myriad structures that comprise state regulatory oversight and purchasing.

Transformation is also more cultural than structural, given the need to build an integrated culture focused on common service delivery goals across the existing cultures of the agencies integrated. The test of transformation is whether or not it improves the quality, access to and costs of the actual delivery of services.

**RECOMMENDATIONS TO PROMOTE INTEGRATION AND REDUCE CONTINUING FRAGMENTATION INCLUDE:**

1. Integrate deliberately. Integration efforts need to focus more on the complex details of true integration rather than simply reorganization, though thoughtful reorganization can be a powerful tool.

2. Rely on the BHTC as the lead resource to coordinate planning for publicly funded mental health/SUD services, and recognize that it needs resources to function well.

3. Address behavioral health and local human services integration within Regional Care Collaborative Organizations (RCCOs) by: (1) formally incorporating behavioral health care-delivery performance indicators within the RCCOs to ground system changes in improved access, cost and quality and to measure progress with a core set of outcomes and (2) formally involving counties to leverage their broader human services resources and to reduce costs in jails and other adverse impacts.

4. Beyond Medicaid, look for opportunities to consolidate state-level delivery and financing for behavioral services across agencies, to align benefits and maximize access to federal funds, particularly for community-level corrections, juvenile justice, child welfare, and education.

# OBSERVATION #2
## DESPITE GAINS AND THE HOPE OF HEALTH REFORM, MANY PEOPLE STILL CANNOT ACCESS NEEDED CARE

Updated national studies show that 3 in 10 Coloradans need treatment for mental health or SUD needs each year – more than 1.5 million people. Among these:

- Just over 1 in 10 (more than 580,000) have SUD of some kind (alcohol/drug abuse/dependence).

- Just over 1 in 10 (between 550,000 and 700,000) have a mild condition, about 1 in 11 (nearly 450,000) have a moderate condition, and about 1 in 12 (about 425,000) have a severe condition.

- About 1 in 30 (more than 170,000) are adults with a SMI that substantially impairs their functioning; about 100,000 of these people also have co-occurring SUD. About 125,000 have low incomes (at or below 300 percent of the federal poverty level).

- About 1 in 100 (60,000) are adults with severe SUD without SMI, a major underserved group.

- Over 1 in 50 (90,000) are children and adolescents with SED. Nearly two-thirds of these individuals have low incomes, and many adolescents have SUD needs.

Based on national data, access to care varies by level of need (and the estimate varies sometimes a lot by study): between 11.3 percent to 23.0 percent of those with mild needs receive care, 26.3 percent to 37.2 percent of those with moderate needs receive care, and 37.1 percent to 40.5 percent of those with severe needs receive care. In Colorado, many more with severe needs receive care: about 61 percent of people with SMI/SED and 64.8 percent of people with severe SUD needs also in need of public services.

Coloradans living in rural and frontier areas have similar needs, but much lower levels of care. Critical supports such as prescribers, acute care facilities (inpatient and detox), and intensive community supports are often more than 100 miles away. Often even primary care access is limited. Rural and frontier communities face additional challenges in 2011, given population losses, transient populations in recreational areas, undocumented residents in agricultural areas, and the disproportionate effects of the recession on jobs in small towns and rural areas. In response, payers and providers in rural areas have developed integrated care models and multi-agency partnerships to address growing needs with limited supplies of providers.

Other needs include Colorado's high and growing suicide rate, as well as the many unmet and growing needs of veterans and members of the armed forces, including those Coloradans among the 2 million nationally who have served in Afghanistan and Iraq since 2001. These veterans suffer rates of suicide two-to-four times those of same age civilians, elevated rates of trauma-related disorders and depression, untreated traumatic brain injury, and disproportionate rates of unemployment, divorce, substance use, homelessness, and chronic (often acute) pain – needs that are too often unmet. Despite this, behavioral health supports for veterans are among the most innovative.

Updated national data shows that persons of color receive far fewer mental health services, with African Americans overall only 50 percent as likely to receive care and Hispanic populations only 60 percent as likely. When they do receive care, African Americans are 90 percent more likely and Hispanics 50 percent more likely to receive care in public human services settings, including child welfare, juvenile justice, and corrections. Colorado informants emphasize the continued concern that youth and adults of color (particularly African American and Latino) are disproportionately served in correctional settings. Data on race and ethnicity are not reported on a relatively large proportion of Medicaid members (13.8 percent), substantially impeding the ability of the system to track progress on health disparities.

People who are lesbian, gay, bisexual, or transgender (LGBT) also suffer health disparities, with clear links between high rates of experienced discrimination and behavioral health needs. Suicide risk is two-to-three times higher, particularly earlier in life and in adolescence. Colorado stakeholders emphasized that the leading concern regarding LGBT behavioral health is access to services from organizations sensitive to LGBT concerns, developmental issues, and needs.

People with developmental disabilities are at higher risk for mental health need and victimization than the general population, and their mental health care continues to be particularly fragmented. Autism spectrum disorders (ASD) have become more widely recognized; Colorado's rate per 1,000/population was 7.5, below the national average of 9.0 and in the middle of the national range. People with hearing, mobility, and vision disabilities are at greater risk for depression, and continue to experience a wide range of physical, linguistic, and cultural barriers to care.

MEDICARE SPENDING HAS INCREASED DRAMATICALLY (MORE THAN FOUR TIMES SINCE 1986 FOR MENTAL HEALTH AND MORE THAN DOUBLE SINCE THEN FOR SUD). MEDICARE PLAYS AN IMPORTANT ROLE IN SHAPING HEALTH POLICY AND PARTICULARLY AFFECTS THE DELIVERY OF SERVICES TO OLDER ADULTS.

**RECOMMENDATIONS TO IMPROVE ACCESS TO MEET UNMET NEEDS INCLUDE THE FOLLOWING:**

1. Employ more refined indicators of need for planning and investment. Break down populations into key groups to better monitor progress in meeting priority needs. Recommended priorities include:

   - The "few" with high needs and high involvement with state systems inclusive of services across state systems: Adults with SMI, severe SUD, and severe co-occurring disorders, as well as children with SED and those involved with multiple state agencies, and

   - The "many" needing better routine access to mental health/SUD care across all health settings.

2. Focus more on challenges in rural areas that have fewer providers and lower funding, and that experience a disproportionate impact from the recession (especially job losses) and funding cuts.

3. Reduce health disparities in access/outcomes for racial, ethnic and linguistic minorities, sexual minorities, and people with disabilities. Given major gaps in data on race, ethnicity, and language in current data sets, an initial priority would ensure that data on each individual person's race, ethnicity, and spoken and written language is collected in health records and regularly updated.

## OBSERVATION #3
### FUNDING FOR MENTAL HEALTH SERVICES IS STILL LOW, FUNDING FOR SUBSTANCE USE DISORDER SERVICES AND PREVENTION IS EVEN LOWER, BUT THE SITUATION IS SOMEWHAT BETTER THAN BEFORE

Even though the recession of 2008 was much worse than the recession of 2001, the Ritter Administration maintained Colorado's investment in mental health and SUD services. Colorado's national ranking for public sector mental health spending fell one place to 32nd in 2007; data on SUD spending shows rates one-third the national average.

Nationally over the past two decades (1986 to 2005), spending grew more slowly for SUD (4.8 percent) and mental health (6.9 percent) than for all health spending (7.9 percent). In 2005, spending on SUD treatment was 1.2 percent of all health spending; mental health spending was 6.1 percent. Medicaid remains the largest payer, growing from 17 percent in 1986 to 27 percent in 2002 to 28 percent in 2005. Unlike overall health spending, public spending has always been the primary payer. Medicare spending has increased dramatically (more than four times since 1986 for mental health and more than double since then for SUD). Medicare plays an important role in shaping health policy and particularly affects the delivery of services to older adults.

Spending on public mental health treatment in Colorado rose substantially from SFY 2002 to SFY 2009, resulting in increases in spending from multiple perspectives: Per capita based on the overall Colorado population ($62 to $84), per estimated person in need ($1,665 to $2,256), and per person living at/below 300 percent Federal Poverty Level ($129 to $158). These increases were driven by dramatic increases for Medicaid (up 82 percent) and state-funded community mental health (54 percent). Spending on SUD treatment in Colorado has risen substantially, with per capita funding reaching a high point of $9.44 per capita in SFY 2009, falling back somewhat following cuts in SFY 2010. Acute care hospital spending increased at nearly five times the rate as state hospital expenditures (a 55 percent increase versus just under 11 percent, respectively) from 2002/2003 to present. More than $53 million was spent on prevention of SUD by the DBH in SFY 2010.

Although data are not available for all behavioral health spending in Colorado, they are available for a wide array of public agencies and inpatient care. Available data for the most recent available year show:

- Of the $887 million in known expenditures spent on behavioral health in 2010, just over 53 percent was spent through the formal public behavioral health system.

- Nearly half (47 percent or nearly $413 million) was spent in other systems.

- More than $93 million was spent on behavioral health needs in the criminal justice system. This amount represents more than one-tenth of total known behavioral health expenditures. It is also more than one-fifth higher than the amount spent through the formal public behavioral health system.

- Expenditures for the vast majority of privately paid care are unknown (only private acute inpatient expenditures were identified for this report).

A single spending recommendation is offered: While it is understood that state revenue is still recovering in 2011 from the effects of the 2008 recession, it is strongly recommended that as revenue recovers and funds allow, Colorado public sector payers invest more in mental health service delivery and substantially more in SUD treatment and prevention services.

## OBSERVATION #4
### HEALTH CARE COSTS CONTINUE TO INCREASE AND BENDING THE COST CURVE DEPENDS ON BETTER INTEGRATION OF HEALTH, BEHAVIORAL HEALTH, AND HUMAN SERVICES

Nationally, the key organizing construct of health care reform is the "Triple Aim," a three-fold simultaneous goal: (1) Improve the health of the population, (2) Enhance the patient experience of care (including quality, access, and reliability), and (3) Reduce, or at least control, the per capita cost of care.

The U.S. spends more per capita on health care than any other nation, and suffers more preventable deaths per 100,000 population than any developed country. Chronic health conditions among U.S. children, including SED and other behavioral health conditions, are on the rise, increasing from 12.8 percent in 1994 to 26.2 percent in 2006. U.S. adults with SMI are dying, on average, at age 53, of largely preventable causes. This average life expectancy is comparable to that of sub-Saharan Africa. Rates of respiratory disease are five times higher; diabetes, cardiovascular disease, and infectious diseases are 3.4 times higher; lung cancer is three times higher; and stroke among people under age 50 is two times higher.

Research conducted by Colorado Access has replicated the national findings for Colorado Medicaid populations, with overall health spending 124 percent higher per person for those with any mental health diagnosis as for those without, with 73 percent of this difference driven by increased physical health and prescription costs. Involvement with other human services systems exacerbates these differences. DBH identified the top 267 people, in terms of cost, who had accessed five or more different types of state agencies (inclusive of mental health care in all cases). Just over half (51 percent) had Medicaid claims, and simply the cost of their behavioral health and medical claims was more than $30,000 per person, nearly 10 times the cost of typical Medicaid medical costs.

**IN LIGHT OF THIS, THE FOLLOWING RECOMMENDATIONS ARE OFFERED TO LEVERAGE BEHAVIORAL HEALTH CARE TO BEND THE COST CURVE:**

1. In the short term (2012 and 2013), continue to emphasize integration of local and regional service delivery systems without losing past gains made through discrete delivery systems such as Behavioral Health Organizations (BHOs) and SUD Managed Service Organizations (MSOs). BHOs and MSOs should be integrated as partners into the evolving regional delivery system, building on their achievements, rather than starting anew.

2. In the longer term (targeting 2014), integrate and expand Medicaid mental health and SUD benefits within the broader health system, taking the following steps:

   • Work systematically toward funding stream integration for mental health and SUD services within the evolving accountable care structure of the Medicaid program, with a target of 2014; however, do not rush into integrated funding and take steps to help local delivery system structures get ready.

   • In the mean time, take incremental steps now to align financial risk, resources, incentives and accounting for all health care funding with the Triple Aim. At the very least, behavioral health and broader health systems should work together to monitor mental health and SUD expenditures. In addition, joint efforts to "hot spot" could both reduce costs and increase outcomes in the short term, and inform longer term planning.

- Post-integration, maintain discrete accounting and performance incentives for behavioral health funding separate from physical health, to ensure that behavioral health needs are adequately funded and performance aligned with broader outcomes of the Triple Aim. Accounting and performance monitoring should include discrete tracking for mental health, SUD and prevention services, since each subcomponent of behavioral health care delivery requires accountability over time.

# OBSERVATION #5
## MORE THAN EVER IS KNOWN ABOUT WHAT WORKS, AND WHAT WORKS IS SOMEWHAT MORE AVAILABLE

The empirically based approaches outlined in the 2003 *Status Report* are still among the most valid available. Thus, the 2011 report focuses on:

- Analysis of the change in availability of evidence-based approaches since 2003, and

- An overview of two additional sets of research-based practices not covered in the 2003 report: Integrated behavioral health and primary care and practices to reduce health disparities.

Successful evidence-based practice (EBP) promotion begins with an understanding of their real world limitations. One major limitation is that the literature prioritizes randomized clinical trials that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. Research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking. Major concerns center on culture, with wide consensus held that too little research has been carried out to document the differential efficacy of EBPs. There are strategies to adapt EBPs cross-culturally. Efforts to promote a wide range of EBPs have begun to be subjected to systematic study, and typically involve a multi-state process of development involving a complex interplay of organizational capacities, technical expertise, and quality improvement over time.

In Colorado, implementation of Therapeutic Foster Care, Multisystemic Therapy, and Functional Family Therapy is tracked. Only 5 percent of all children served received any of the three EBPs in SFY 2009, falling to 3 percent in SFY 2010. For adults, Supported Housing, Supported Employment, and Assertive Community Treatment are tracked. In SFY 2010, 10.5 percent of adults served received any of the three. Family Psychoeducation, Integrated Treatment for Co-occurring Mental Health/SUD, Illness Self-Management, and Medication Management were also tracked, with 18 percent receiving any of the four in SFY 2010.

Correctional agencies are also helping lead. The Colorado Department of Public Safety (CDPS) and the Colorado Commission on Criminal and Juvenile Justice (CCCJJ) together secured a $2.1 million two-year Justice Assistance Grant in October 2009 used to fund EBP training in Motivational Interviewing, cognitive behavioral approaches, and Mental Health First Aid in five demonstration sites. In 2009, the Colorado Division of Youth Corrections won a $1.8 million federal Justice Assistance Grant to fund nine county-level Collaborative Management Programs to use the Colorado Juvenile Risk Assessment, an actuarially derived criminogenic risk assessment process, as well as a second EBP such as multi-systemic therapy (MST) and cognitive behavior therapy. Colorado has expanded problem-solving courts, doubling the number statewide in the past four years to a total of 64 mental health, SUD, and veterans courts that emphasize diversion and treatment alternatives.

In terms of best practices in behavioral health and primary care integration, the Colorado Behavioral Healthcare Council initiated an Integrated Care Mapping Project to disseminate information on nearly 100 programs across the state offering integrated behavioral health and primary care. A primary emphasis across Colorado is on Person-Centered Medical Homes (PCMH) to promote higher quality, better coordinated health care that addresses problematic health-related behaviors and chronic conditions.

Collaborative care is a model of integrating mental health (but also SUD, in some applications) and primary care services in primary care settings, to: (1) treat the individual where he or she is most comfortable, (2) build on the established relationship of trust between a doctor and

person served, (3) better coordinate mental health and medical care, and (4) reduce the stigma associated with receiving mental health services. Primary challenges center on the behavioral health/primary care consultant work force. Collaborative care requires a different set of skills, knowledge and attitudes than traditional roles.

Regional Care Collaboratives are a model states are pursuing to integrate specialty health plans into the broader health system ("reconnecting the head to the body"). The Colorado Regional Integrative Care Collaborative has early evidence of lower costs, less use of hospital and emergency room care, and increased use of outpatient services. In December 2010, the Colorado Department of Health Care Policy and Financing (HCPF) awarded contracts to seven Regional Care Collaborative Organizations (RCCOs) to implement its Accountable Care Collaborative (ACC) Program. The ACC is a hybrid model blending characteristics of a regional Accountable Care Organization (ACO) within a network rather than a single organization. Start-up for the RCCO contracts began in February 2011. While not required, all RCCOs have partnered with their local BHOs and most with their local SUD MSOs. Critical to the success of the RCCOs will be the health information exchange (HIE) infrastructure being developed under the leadership of a nonprofit organization, the Colorado Regional Health Information Organization (CORHIO).

Health Care Neighborhoods take accountable care to a broader level by adding human services partners to the health service framework for people in restrictive human services settings such as adult corrections, juvenile justice, or child welfare, or who have complex needs such as homelessness.

### PRACTICES TO ADDRESS HEALTH DISPARITIES INCLUDE:

- Cultural competence standards. The most well-known national standards to address health disparities are the National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards). They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence.

- Cultural brokers are advocates between groups of differing cultural backgrounds; for health care settings, these individuals help span the boundaries between the culture of health care delivery and the cultures of the people served. National guidelines focus on the development of programs within health care organizations to expand availability of cultural brokers for specific communities served.

**RECOMMENDATIONS TO IMPROVE ACCESS TO EMPIRICALLY BASED CARE INCLUDE THE FOLLOWING:**

1. Continue to expand access to evidence-based care across the board (while remaining mindful of the limitations of current evidence), and

2. Put a priority on expanded access to person-centered health/medical homes that integrate behavioral health and primary care using strategies for specific subgroups of people:

   • For the "many," health/medical homes should be in all primary care settings, and

   • For the "few," health/medical homes should either be in the settings where people receive most health services (for example, community mental health centers for adults with SMI) or through specific evidence-based models such as Integrated Duel Disorders Treatment and Wraparound that can serve as temporary (one-to-two year) health homes, to knit human services and natural supports together to improve health outcomes, avoid or minimize use of restrictive service settings, and facilitate longer term health care delivery in more natural settings.

# OBSERVATION #6
**THERE ARE STILL TOO FEW PROVIDERS – AND THE NEED IS GROWING**

Colorado continues to have a relatively good supply of mental health practitioners and certified addictions counselors, but has critical shortages of particular subgroups of providers:

• Psychiatrists and other prescribers,

• Any providers trained in empirically based approaches, and

• Those specializing in the care of children, older adults, people living in rural areas, minority cultures, and people who speak languages other than English.

There are also too few mental health and SUD providers of the types needed who are willing to serve priority populations, given current reimbursement levels. As a result, the types of systematic approaches to integrate mental health and SUD treatment with primary care resources discussed under the previous section are essential to leveraging available providers to meet growing demands expected under health reform.

The number of mental health and SUD practitioners in Colorado has increased since 2003 from 10,564 to 14,217; the increase of nearly 35 percent has more than kept pace with overall population increases of about 10 percent. Changes in the number of psychiatrists and psychologists relative to the Colorado population, however, have been modest, even slightly decreasing for psychiatrists per capita by 4 percent.

• There have been dramatic increases in the number of licensed masters-level practitioners and licensed/certified addictions counselors of 29 percent to 32 percent by category.

• The role of certified peer-support specialists and family advocates was emphasized by multiple stakeholders, and there was general consensus that current needs outstrip the available supply.

• For SUD prevention providers, there is a movement in Colorado to develop a certification process for SUD prevention professionals. In addition, the DBH established International Certification and Reciprocity Consortium (ICRC) certification in the spring of 2011 for prevention specialists.

While there is geographical disparity across nearly all behavioral health practitioner groups, the disparity is most pronounced for the professions that require the most training. As level of training increases (number of years of graduate-level training), behavioral health providers are found disproportionately in the Denver and Colorado Springs areas. Psychiatrists across all sub-specialties are predominantly located in the Denver metro area and El Paso County. Six hundred nineteen of the 753 practicing psychiatrists (82 percent) were located in Denver and El Paso Counties alone. An even higher percentage of child

psychiatrists (86 percent) was located in those two urban counties, and essentially all psychiatrists specializing in SUD treatment (95 percent) and in geriatrics (100 percent) were in the Denver and Colorado Springs areas.

**RECOMMENDATIONS FOR THE BEHAVIORAL HEALTH WORKFORCE INCLUDE:**

1. Focus workforce development on mental health/SUD and primary care integration skill development and care delivery models, to leverage resources optimally to address provider shortages that cannot be resolved in the short-to-medium term (and likely never will be resolved).

2. Target workforce-expansion efforts in two areas:

   • Access in communities beyond the Denver metro and Colorado Springs areas, and

   • Access in specialized areas of need: trained prescribers (particularly for SUD and child populations), geriatric and child specialists, and culturally and linguistically competent specialists.

# OBSERVATION #7
## PRIORITIZATION OF RESILIENCE AND RECOVERY IS STILL NEEDED

Recovery is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Resilience refers to an individual's capacity for adapting to change and stressful events in healthy and flexible ways.

The evidence base for peer support for both mental health and SUD needs is substantial and growing.

The consumer and family advocacy movement dates back to at least 1845. Colorado has two leading organizations representing the voices of people with mental health needs: WE CAN! (which receives administrative support from the advocacy organization Mental Health America of Colorado), and the Colorado Cross-Disability Coalition (CCDC). Colorado also has a strong peer voice for people with SUD needs through Advocates for Recovery and Peer Assistance Services.

The National Alliance on Mental Illness (NAMI) had its beginnings in the early 1970s. NAMI Colorado supports 16 affiliates across the state and is the leading voice for family members of people with severe mental health needs. Founded in 1990, NAMI Colorado has more than 200,000 members.

The development of family peer-to-peer support for parents and caregivers of children and youth with SED took a critical step in 1989 when the Federation of Families for Children's Mental Health (the Federation) was incorporated. The Federation's Colorado Chapter has taken a lead in advocacy for children with SED and their families.

The development of youth involvement in mental health systems of care formally dates back to 2000. In Colorado, the Mental Health Planning and Advisory Committee's Youth and Young Adult Transitions Committee has taken a lead in advocacy for youth and young adults with mental health needs. The Colorado Department of Public Health and Environment (CDPHE) supports the Colorado Youth Development Team to promote positive youth supports across the state.

Peer-run organizations are entities that emphasize self-help as their operational approach, and that are owned, administratively controlled, and operated by people who receive and/or need mental health or SUD treatment services or their families.

## DEDICATION OF SPECIFIC RESOURCES TO FUND TECHNICAL ASSISTANCE TO DEVELOP PEER-RUN ORGANIZATIONS ACROSS THE STATE AT MULTIPLE LEVELS OF DEVELOPMENT INCLUDE:

- Dedicated funding for start-up of new organizations and the enhancement of existing organizations to expand;

- Development of regulatory requirements to certify peer-run organizations to allow those organizations ready to seek expanded state and Medicaid funding to do so; and

- Ongoing funding and evaluation of peer-run supports to document their benefits, costs, and potential cost-savings to the broader system.

## RECOMMENDATIONS TO SUPPORT BROADER PROMOTION OF RECOVERY AND RESILIENCE INCLUDE:

1. Increasing access to peer support, employing skills of people with real life experience, and

2. Expanding the role and development of peer-run organizations to help individuals, groups and communities take more responsibility for solutions in their lives. Such help is modeled on successful efforts, such as grass-roots support networks for returning veterans and their families, as well as the many programs across Colorado promoting peer-support in mental health and SUD systems through the Medicaid BHO program, community mental health clinics (MHCs), and programs such as Access to Recovery.

# Introduction

## BACKGROUND AND APPROACH

In 2003, a group of Colorado foundations[1] came together to fund *The Status of Mental Health Care in Colorado*,[2] a report that brought together for the first time information about Colorado's many overlapping and fragmented systems for providing mental health services.

In response to the 2003 *Status Report*, four foundations – Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and The Denver Foundation – created *Advancing Colorado's Mental Health Care (ACMHC)*. This five-year (2005-2010), $4.25 million project provided joint support to community collaboratives that brought together human services agencies, mental health care providers, and other local partners to address the tremendous needs detailed in the 2003 study. This project funded the following integration initiatives:

- Two projects integrating mental health and substance use disorder (SUD) services, one in Larimer County (Fort Collins) and one in El Paso County (Colorado Springs);

- Two projects integrating mental health and primary care services, one in Mesa County (Grand Junction) and one in Summit County; and

- Two projects integrating mental health services in school settings, one with Denver Public Schools and one in Prowers County.[3]

The lessons learned and achievements realized through the investment in these six communities, and the hard work of all the community members involved over the last five years, in many ways reflect the broader opportunities for system improvement emerging

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1    Caring for Colorado Foundation, The Colorado Trust, Daniels Fund, The Denver Foundation, First Data Western Union Foundation, HealthONE Alliance (now known as The Colorado Health Foundation), Rose Community Foundation, and Rose Women's Organization.

2    TriWest Group. (2003). The Status of Mental Health Care in Colorado. Mental Health Funders Collaborative: Denver, Colo. See http://www.coloradotrust.org/attachments/0000/2200/MHCCfinalreport.pdf to view the report.

3    Two grantees (Prowers, Summit) also implemented coordination of multi-agency support for children/families.

to different degrees across Colorado. Accordingly, the experiences of those communities helped inspire, inform, and guide the findings of this broader report.[4]

This report updates the 2003 results as of early 2011 at the advent of many important transitions for Colorado's mental health, substance use disorder (SUD), and broader health care systems. This report includes:

- **Updates to the data and status of the 2003 *Status Report* findings**, summarizing progress and ongoing challenges in each area of the original findings.

- **Analysis of current and proposed policies affecting the delivery of mental health and SUD services**, including the status and projected impact of health care reform nationally and in Colorado, the impact of federal mental health parity legislation, the work of the Colorado Behavioral Health Cabinet and BHTC, and current funding and policy trends more broadly affecting mental health and SUD service delivery systems, as well as related health and human services.

- **Integration of results from the ACMHC grantees**, incorporating key findings and lessons learned from the Final Grantee Report.

- **Recommendations for the future development of Colorado's systems** of care for delivering mental health and SUD services.

The goals of this 2011 update are similar to those of the original study: to better understand the strengths and weaknesses of mental health and SUD service delivery systems in Colorado across populations and identify opportunities to strengthen these systems. Both the needs and the opportunities facing Colorado are greater than ever.

Many stakeholders have understandably strong feelings about the mental health and SUD services on which they, their loved ones, and so many of their neighbors and fellow Coloradans depend. Often those feelings carry over into opinions about language, and it is difficult to find universally supported terms for some important concepts. As such, here are some terms we have used in this report, and what we mean by them:

- **People in need of care and their families.** People who need and receive mental health and SUD services can be referred to by a wide variety of terms: client, consumer, patient, ex-patient, survivor, and many others. In this report, unless we need to preserve accuracy in following the convention of a source we are citing or agency we are referencing, we will try to use the term people. We will also refer often to the families of people in need of care, using that term in its broadest sense to talk about people related to the person receiving care, whether biological family or other relatives, either legally or by cultural convention. Sometime we will focus on an important subset of families, such as parents and other caregivers (such as legal guardians or kin) responsible for the care of children in need of mental health or SUD services.

- **Mental health and SUD services.** We will usually refer to the health care services provided to address mental health and SUD by referencing one or both sets of the disorders they treat. In doing so, we are referring to the entire range of prevention, early intervention, treatment, and self-help services paid for as medical services under each specialty. We will also often refer to the broader sets of supports available to people with mental health and substance use disorder needs, referring to these as either human services when delivered by a public agency or natural supports when delivered by a community organization, private organization, or individual person.

- **Behavioral health.** The term behavioral health often is used as shorthand to refer to mental health and SUD services. In this report, we will use this term primarily when referring to the entire range of specialty health services that encompass mental health and SUD treatment, intervention, and prevention services. We will also use this term when following the convention of a source we are citing or agency we are referencing. In doing so, we recognize that many stakeholders have concerns about this term given its inherent vagueness and because, to some people, the term implies the ability to merge or somehow transcend discrete expertise in the delivery of mental health and SUD services. This report recognizes that these disorders, while often interrelated, are also complex and often require multiple conceptual models and discrete sources of expertise to understand and treat them. Because of this, we will often refer to mental health and SUD treatment specifically, to call attention to those specific sets of clinical expertise and treatment focus.

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4    Appendix Three of this report includes a summary of the experiences of those grantees and lessons learned.

## REPORT METHODS

This report used multiple methods that built on each other to describe Colorado's many service systems for mental health and SUD services. The project involved two broad efforts. The first was quantitative, centering on updating the data from the 2003 report and supplementing it with (1) broader data than in the previous report on SUD services, and (2) data from major reports of which we were aware or which stakeholders brought to our attention. The second level of effort involved dozens of interviews with formal and informal leaders actively involved in Colorado's mental health and SUD services systems. The 89 leaders who spoke to us are listed in a table in Appendix One of this report. We used the following approach to identify these leaders:

• We began in late 2010 with the members of the Behavioral Health Cabinet and BHTC initiated under Governor Ritter. These two important groups, discussed in more detail in the first set of findings for this report, led efforts to coordinate the delivery of public mental health and SUD services across state agencies in Colorado. Members of the Behavioral Health Cabinet under Governor Ritter included the past Executive Directors of the Departments of Corrections, HCPF (the state's Medicaid agency), Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Public Safety, as well as Colorado's Chief Medical Officer and the Director of the Governor's Office of Policy and Initiatives. The membership of the BHTC was defined by Senate Bill (SB) 10-153 to include representatives of the executive, judicial and legislative branches, as well as representatives of the broader group of people in need of care, advocates, providers, and other stakeholders. A key purpose of the Council is to provide a single representative body to advise state government on matters related to mental health and SUD services; therefore, this report began with that body as a starting place.

- We then branched out from this initial representative group to talk with other leaders across the state, identified through our initial interviews and data collection. We made a particular effort to reach out to additional people in need of services and providers representing underserved rural, cultural, and demographic groups, as well as providers and researchers involved in health care reform and primary care integration efforts.

- Following the change of administrations with Governor John Hickenlooper in January 2011, we also invited the incoming executive directors of each of the agencies involved in the Behavioral Health Cabinet to be briefed on the report and to provide input on how our emerging findings fit with Governor Hickenlooper's plans and priorities.

We also incorporated findings from several recent major reports authored by others, including:

- The independent evaluation of the six ACMHC grantee communities noted above, conducted by Heartland Network for Social Research to measure changes in the integration of services in these communitywide efforts over time, as well as related barriers and facilitators to system integration.[5]

- The Final Grant Report of the 2009 Colorado Behavioral Health Transformation Transfer Initiative, which included results from 75 forums involving 561 participants across the state that identified 1,149 issues of concern across 71 topic areas in 12 categories, and used these results to rank potential state-level reforms.[6]

- The Western Interstate Commission for Higher Education (WICHE) Mental Health Program's 2010 report on The Behavioral Healthcare Workforce In Colorado, with additional analysis by the Colorado Health Institute (CHI).[7] Both WICHE and CHI were extremely helpful and gracious in allowing us to reproduce some of the geomaps contained in the WICHE report, and in helping us update and explore some of the workforce data in more detail.

- The WICHE Mental Health Program's 2009 estimates of people in need of public mental health services in Colorado,[8] augmented with additional data from Chuck Holzer at the University of Texas, who monitors these epidemiological trends over time.

We also augmented the report with targeted literature citations addressing key issues addressed throughout the report. These are cited across the report, and they offer a wealth of additional information and guidance regarding the findings of this report.

Another major influence throughout the report development was the interactive guidance of the ACMHC project group, including the ACMHC funders, evaluator, and communications firm.[9] TriWest Group participated in monthly meetings with the ACMHC project group to review and guide report findings, including a day-long retreat to shape the major findings of the report. The study process concluded with the ACMHC project group's review of two draft reports. A draft of the report was also shared, in the summer of 2011, with all of the stakeholders who participated in interviews as part of the report development to solicit their input and comment on the draft. The goal of this review was to be sure that key points from the interviews were incorporated and that issues of concern were framed in ways congruent with stakeholder perspectives. All input received was incorporated.

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5    Demmler, J. and Coen, A.S. (2011).

6    TriWest Group. (February, 2010).

7    Western Interstate Commission for Higher Education (WICHE) Mental Health Program. (December 2010). The Behavioral Healthcare Workforce In Colorado: A Status Report. WICHE: Boulder, Colo. Retrieved from http://www.wiche.edu/info/publications/bhWorkforceColorado2010.pdf. The WICHE report was funded by The Colorado Health Foundation. Colorado Health Institute analysts assisted TriWest in conducting further analyses and data checks of the workforce data reported by WICHE (numerous personal communications, January 2011).

8    WICHE Mental Health Program. (2009). Colorado Population in Need 2009. McGee, C. and Flory, M. WICHE: Boulder, CO. Report was funded and directed by DBH.

9    The ACMHC Funders include Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust, and The Denver Foundation. The independent evaluator for the ACMHC project is the Heartland Network for Social Research, in collaboration with Focus Evaluation. The communications firm for the ACMHC project is The Bawmann Group, Inc.

## STORIES OF COLORADO PEOPLE IN NEED OF BEHAVIORAL HEALTH CARE

**Underlying each statistic and finding in this report are real people with real lives. The following examples are fictional composites based on real-life situations faced by people in Colorado with mental health and SUD needs. We will refer back to these stories to illustrate key findings throughout the report.**

### Adults with insurance visiting a primary care practice

#### Barbara & Steve

Steve is a consultant working for a health care policy firm. The company that employs him is small, but it provides a basic health insurance plan for him, and he purchases additional coverage for his spouse and two children. Steve's spouse, Barbara, is 28 and currently stays at home as primary caregiver for their children, ages 3 and 6. Barbara has been sleeping poorly, acting intermittently irritable, and feeling very sad for a few weeks. Their primary care physician prescribed an antidepressant six days ago and recommended that they follow up with a psychiatrist. Since then, they have called six psychiatrists on their insurer's provider list and found that all six were either not taking new patients or could not schedule an appointment with Barbara for more than a month.

For the last two days, Barbara has not slept at all. For the last 24 hours, she has been driving around the city continuously and has called the house six times to see if the President has called and if any packages have arrived for her. Steve was frantic trying to find her until he received a call from the police at the local hospital emergency room. The police brought her there after she ran her car into a tree.

When Steve arrived at the hospital, he saw that Barbara was upset, did not remember what happened with the car accident, and wanted to go home. She denied that she

was suicidal. Steve wanted her to stay at the hospital. He called their insurer, who gave him another number to call for their separately administered behavioral health benefits. After working through a series of automated messages, Steve connected with a utilization review nurse who was quite helpful, but determined that, since Barbara did not seem to pose an imminent danger to herself or others, payment for hospitalization could not be authorized.

The nurse did recommend a clinic in their area that could take urgent cases, but Steve would have to go down there to wait with Barbara until she could be seen. When they arrived at the clinic, they waited all day until eventually Barbara was seen by a psychiatrist, who changed her medications, and a social worker, who did a thorough assessment and recommended outpatient treatment. Soon after, Barbara stopped taking her medication. While her erratic behavior had subsided with the right medication, her depression continued and worsened after she stopped the medication. Steve now wonders how he can continue his hectic pace at work, support Barbara, and juggle time with his parents and other social supports to care for their children.

## Joan & Dave

Joan and Dave are teachers. Both are in their late thirties, with two children, ages 12 and 9. Dave has struggled with anxiety since adolescence, including worries about performance, social anxiety that has made it difficult to develop friendships, and repetitive habits that come and go as life events and Dave's level of stress change. Dave sometimes jokes that he never would have made it through college without frequent and often heavy alcohol use. Since having children, Dave's drinking has rarely gone past being "social," but in the past few months, he has started drinking more – at least three beers a night after work and even more on the weekends. Joan has tried to talk with Dave about this, but it always ends in an argument. She is particularly worried about their younger son, who has always been close with Dave and a good student and athlete, but increasingly has been getting into fights at school and causing more trouble at home. He and Dave used to regularly practice baseball in the evenings and

on weekends, but Dave has avoided this more and more as his mood has deteriorated. Joan thinks this may have something to do with Dave's reassignment to a new school last year because of staff cuts in his district, but she is not sure and Dave will not talk about it.

Dave had an appointment with his primary care physician this past week, whose practice is co-located with a behavioral health practice group. Prior to the appointment, Dave filled out some paperwork that asked about his alcohol use, which he answered honestly. When his primary care physician met with him, she first discussed more general health concerns, then asked Dave how he was doing. Dave mentioned that things had been more difficult at work this past year since his school reassignment – he feels like he is starting over. His doctor asked Dave if he would agree to having one of the behaviorists from the co-located practice join them. The three talked together further about how Dave was doing, and the behaviorist and Dave then met for an additional 30 minutes to complete an initial assessment. The behaviorist had received training in the past year in motivational interviewing, and was able to help Dave connect his desire to improve the situation at work with the need to address his substance use. Dave was also offered a prescription that day for an antidepressant with an anti-anxiety component. While he declined the medication, he did agree to try some of the relaxation techniques they discussed to help him sleep, cut back on alcohol consumption, and come back in to see the behaviorist a week later.

When they next met, Dave had not been able to stop drinking, and was now facing disciplinary action at work for arriving late a third day this semester. He and the behaviorist talked candidly about his concerns regarding medication, again tying this option to Dave's goals around work. This time, Dave decided to give the medication a try. Another primary care practitioner was able to join their session, and give Dave a prescription immediately. A couple weeks later, Joan joined Dave for a session with the behaviorist where they focused on changes to make at home and as a couple. Two months later, Dave was feeling much better, had reduced his alcohol consumption dramatically, and was doing better both at home and work. He and the behaviorist have

been meeting monthly to maintain and extend his gains.

## An adult with serious mental illness

### Bob

Bob is 61 years old and was diagnosed with schizophrenia when he was 28. Currently, Bob also frequently uses whatever alcohol or drugs he can come across. He had been in and out of the Colorado Mental Health Institute at Fort Logan (one of Colorado's two state-funded psychiatric hospitals) throughout his life, and was hospitalized for eight years when he was in his 30s. During the past several years, Bob has primarily used the emergency room for medical issues, as he has been living on and off the streets and in various shelters in the Denver metro area during this time. He does not take his medications or have a place to live because he does not have a job or other resources. He also does not qualify for Medicaid because he is a single adult without children, and was not successful in his recent attempt to be declared disabled (while filling out the application for disability, the person helping him did not know about Bob's history at Fort Logan and focused instead on his substance use – addictions cannot qualify for a disability under Medicaid). Bob has been told that he could work with a lawyer to address this issue. He was also told, however, this could take a long time and he has otherwise never wanted to go through this process. Ironically, when Bob is homeless, he typically has better access to services, as he often stays at shelters connected with various mental health and co-occurring disorder outreach teams through local community mental health centers. Over the years, Bob has developed hepatitis C, but is not treating it currently, as he does not know of any doctors to see, and he is not bothered much by any symptoms at present. Bob has been told that drinking is a particular problem given his medical condition, but he finds it hard to get through the day without using alcohol or other substances.

## John

Bob has a friend named John. John is about Bob's age and suffers from schizoaffective disorder. Like Bob, John also has a problem with substance use. Bob and John met at Fort Logan several years back, and they sometimes see each other now at a local consumer drop-in center. Unlike Bob, John currently receives Medicaid through assistance he was able to get from a local consumer advocacy group to qualify as disabled based on his mental health condition. John is now living in supported housing and receiving services through a team that provides Integrated Dual Disorder Treatment (IDDT) to address both his mental health and substance use concerns. John has also been doing much better since he started taking an atypical antipsychotic, which Medicaid also covers. John has expressed concern about developing type 2 diabetes, as he is 50 pounds overweight and has a family history of the disorder. He has also gained 20 pounds over the past year after switching to a new, more effective antipsychotic medication. Next week, he has an appointment with a primary care practitioner from the local federally qualified health center that is now seeing people two days a week at the site of his IDDT provider. The IDDT team has told John that the plan for the doctor visit is to address his weight gain on the medication and concerns about developing diabetes. John's psychiatrist from the IDDT team is going to join that meeting, since it is happening onsite.

## Two youth and their families

## Gabriela & Rosa

Gabriela is 14 years old. Her parents moved to the U.S. from El Salvador before she was born. Gabriela grew up speaking both English and Spanish, but now says she will only speak English and prefers to be called "Gabby." Her mother, Rosa, earns nearly $13 an hour with tips, but her employer does not provide health coverage. Rosa is bilingual in Spanish and English, prefers to speak Spanish, but can speak a limited amount of English.

Gabriela lives with her mother and two sisters; her father suffered a fatal heart attack last year. Gabriela was recently suspended from school for three days because of inappropriate language and behavior toward a teacher. She and her mother are arguing many times each day, sometimes with much shouting and vague threats of harm. After several attempts to treat Gabriela with medication and individual counseling, local community mental health center staff recommended intensive family-based treatment for Gabriela. Because this treatment is home-based and intensive, the only payer that will cover it is Medicaid. However, since her mother makes too much money, Gabriela does not qualify for this funding. And, since this treatment costs more than $1,000 a month, the family cannot afford to pay for it themselves. Even if they had insurance, it would only cover clinic-based outpatient services, not home-based treatment. Because of this, no funds were available to purchase the recommended treatment from the mental health center.

Because of the escalating situation at home, Gabriela moved out to a local runaway shelter, which has 24-hour staffing, but provides little in the way of treatment. After placement there, an interagency staffing team was convened to try to come up with a plan for Gabriela and her family. Gabriela's mother was present, as was staff from the runaway shelter, mental health center, probation department, school, and child welfare department. None of the agency staff on the team spoke Spanish and no interpreter was available, but Gabriela's mother agreed to hold the meeting in English.

Again, the team initially discussed intensive family-based treatment for Gabriela. Someone on the team then suggested that charges be pressed against Gabriela for an incident at school, allowing the juvenile court to place Gabriela under the jurisdiction of the district probation department, which could fund a placement with a local Multisystemic Therapy (MST) team, an intensive family-based treatment, with rigorous evidence for its effectiveness, designed for youth in the juvenile justice system. The probation representative noted that an MST placement would be unlikely, with this being Gabriela's first offense. Someone else suggested a plan that involved the runaway shelter discharging Gabriela,

her mom refusing to pick her up, and the shelter staff calling the child abuse and neglect hotline to report the abandonment, which would result in child welfare taking custody of Gabriela and helping her access treatment. While this was seen as less desirable, all of the agency staff agreed that this was the best available way for Gabriela and her family to gain access to needed treatment.

Gabriela's mother had been quiet during most of the meeting, seemingly understanding and deferring to the ideas discussed by the agency staff. When the child welfare discussion began, she became visibly more concerned and said that she was not sure she understood all of the implications of the child welfare involvement, especially since people were talking about "child abuse," "neglect" and "abandonment," noting that this was not true and conflicted with the importance she placed on family. Staff reassured her that it would work out and that this was really the only option. Rosa still was not sure she understood, but she was too tired and discouraged to discuss the issue further and agreed to the plan. Still, despite the "discharge" that initiated the child welfare involvement, Gabriela remained at the shelter for 60 more days, delayed by the child welfare investigation, the court process, and the waiting lists for a female residential placement in Colorado.

## Assefa & Amira

Assefa is also 14 years old. He is the only son of Amira, who emigrated from eastern Africa to Colorado with Assefa's father before Assefa was born. Amira has a minimum-wage job that does not include health coverage. Amira prefers to speak a Sudanese dialect of Arabic at home, but also speaks a sufficient amount of English to get by at work. Assefa sometimes uses Arabic at home with his mother, but increasingly insists that they speak English at all times.

Assefa's father died about a year ago, and since then Assefa has been skipping school, and spending time with peers with whom he has had some run-ins with law enforcement. He and his mother used to be quite close, but now he rarely speaks with her. On a couple of occasions, Assefa has met with the counselor at his high school's school-based health center. He has indicated that he trusts his counselor, but also

stated that he feels best when he is with his friends.

This past week, Assefa was arrested with some of his peers after a local convenience store had been robbed at gunpoint. Assefa claimed that he was not part of the robbery, that his friends had simply picked him up in their car afterwards, and that he had not known about what happened until they picked him up. Amira had been at work when Assefa got out of school, so she did not know whether Assefa's story was true or not. After his arrest, given the seriousness of the charges, Assefa was taken to a local juvenile detention center where he received a standardized assessment using the Colorado Juvenile Risk Assessment (CJRA). The CJRA showed significant mental health needs related to Assefa's situation. Assefa was held for five days at the detention center, but was discharged home, based on the assessment findings and his mother's agreement to take off a few days from work to monitor him at home.

Fortunately, the county in which Assefa lives has funded Wraparound Planning through its 1451 interagency planning process, and Assefa qualifies since he was placed out of home. Amira and Assefa both attended the first Wraparound Planning meeting, along with Assefa's probation officer, the school-based health center counselor, and a friend who attends a local mosque with Amira (from initial conversations with detention center staff who assessed Assefa, and an initial visit at home with Amira, the Wraparound facilitator had learned about Assefa's relationship with the school-based health center counselor and Amira's friend from the mosque).

At the first meeting, it became clear that Amira had difficulty following all of the discussion in English, so at the second meeting the Wraparound facilitator arranged for an interpreter who spoke Arabic to attend. While the interpreter did not speak the same dialect as Amira, she was able to help bridge the language gap. At that meeting, Amira shared her sense of powerlessness and inability to manage Assefa's behavior. She shared that she had heard about residential treatment and wondered if Assefa could qualify. She was particularly interested in this because she and Assefa had been fighting frequently since he had come home. Furthermore, she had already taken four days off from work, and was worried that she

would lose her job if she had to continue to stay home to supervise Assefa.

The Wraparound team worked together to address Amira's concern. While residential care was an option, the placement process would likely take a couple of weeks, and the family needed an immediate alternative. The school-based health center counselor was sure that he could get approval for Assefa to return to school if Assefa was willing to meet with him daily for a brief check-in and two times a week for a longer meeting, given that, other than skipping school, Assefa had generally behaved well at school. Also, since Amira has to leave for work many days before Assefa goes to school, and often does not get home until after he returns from school, the other concern of the team was monitoring Assefa when Amira was at work. Amira's friend agreed to watch Assefa in the mornings and was sure she could work with others at the mosque to help during the week. Also, since Assefa qualified for Medicaid, the local Behavioral Health Organization was willing to fund respite over the coming weekend to given Amira and Assefa some time apart to cool down from their most recent argument.

Three months later, Assefa has remained in school and at home. The Wraparound team has met eight times, and team members have helped Assefa enroll in a martial arts class that meets three days a week right after school. On the other nights, Assefa goes to the home of a family from Amira's mosque; this family has two sons around Assefa's age with whom Assefa has become friends. Amira and Assefa have had a couple of subsequent serious arguments, but respite was available to give them time apart for the situation to settle down, and Assefa has not needed any more restrictive out-of-home placement. It has now been more than six weeks since their last serious conflict, and Amira has begun meeting with Assefa and the school counselor once every other week to talk together about their grief over the loss of Assefa's dad, and ways they can help each other work through that grief. At the last Wraparound team meeting, Assefa's probation officer shared with the team that he was confident that Assefa would be sentenced to three more months of probation at his hearing the following week.

## Older adults living in a rural area

### Nadine

Nadine is 73 years old and lives in a small town in northwestern Colorado. She has a high school education and worked as a bank teller for more than 30 years before she retired eight years ago. Nadine had been living with her husband, Ned, for 51 years before Ned died of a long-term illness one year ago. Since Ned's death, Nadine has been very depressed. She has no family members who live nearby. Nadine was recently hospitalized in a community hospital in a larger city on the Western Slope (but still more than 100 miles away from home) after family members grew alarmed following phone calls with her, in which she made references to her own death and noted she was giving away valued belongings. She had also been very forgetful of late.

While Nadine was in the hospital, staff determined that she was experiencing progressive dementia and helped her family to arrange for an assisted-living placement. Nadine was given a prescription for an antidepressant medication and discharged to an assisted-living facility in a small western Colorado town. Her family lives out of state, so she has had few visitors, and she has been increasingly withdrawn and incoherent in the last two months. She has had frequent urinary tract infections that coincide with increased confusion, which at times seems to involve delusions and hallucinations. Because of rules limiting care available at the assisted-living facility, Nadine is frequently taken by ambulance to the local hospital.

Given her increasing medical needs, the assisted-living facility is recommending that she be discharged to a nursing facility if she is hospitalized again.

## Sally

Nadine's high school friend, Sally, is also 73 and lives in Grand Junction, where she has resided since she graduated from high school. Sally's husband, Carl, died within the past year after years of dementia. Like Nadine, Sally has felt very depressed since her husband's death. In fact, her symptoms are very much like Nadine's, including thoughts of death, difficulty concentrating (which results in increased forgetfulness), and impulsively giving away possessions to acquaintances. Unlike Nadine, Sally receives care from a local primary care practice that has integrated behavioral health staff on site from the local community mental health center. She had also been going regularly to a local senior center with her husband as part of the daily activity recommended by Carl's primary care physician. After Carl's death, Sally continued to go to the senior center, and shared with a staff member her concerns about her loneliness, depression, and memory problems. The staff member encouraged her to bring this up with her doctor and helped Sally get in touch with her primary care practice, which set up an appointment for her the next day. At the primary care practice, she was diagnosed with depression, prescribed an antidepressant medication (the behaviorist from the mental health center answered her questions about medications and helped her decide which one to take), and later that week attended a weekly depression support group with other older adults. In addition, an outreach counselor from the senior center has been coming to her house weekly to check in on her. After two months in the group and taking her medication, Sally continues to live at home and has reported feeling better.

Keeping the experiences of Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally in mind, this report focuses on seven sets of observations about Colorado's behavioral health services and systems, with recommendations for improving their effectiveness for the people of Colorado.

# Observation #1
## Coordination and Integration are Improving, but Needed More Than Ever

## Snapshot of Key Findings
## Regarding the Need for Coordination and Integration

### Why are services fragmented? Is the system broken?

▸ **The system is not broken – it is still in development and has been for more than 100 years.** Efforts to help people with mental health and SUD needs have spanned decades as people across Colorado, time and again, commit to build new systems to address unmet needs.

▸ **Well-intended and positive efforts have unintentionally resulted in an incredibly complicated array of systems** and providers serving a range of needs across diverse and overlapping groups of people.

▸ **Health care's primary challenge is to find ways for multiple systems to work better together for people with complex needs**, given state and national evidence of high costs and poor outcomes.

▸ **Current systems are multiple and varied** by funding source, focus of care (primary, specialty mental health/SUD, prevention), and geography, and they also include an array of additional human services that deliver their own mental health/SUD services (education, child welfare, juvenile justice, state and local adult corrections) or offer other critical supports to people with mental health/SUD needs (housing, employment).

## Public Service System
## Organization and Service Delivery in 2010

‣ The Division of Behavioral Health (DBH), within the Office of Behavioral Health (OBH), within the Colorado Department of Human Services (CDHS) oversees **state-funded and federal block-grant funded community mental health and SUD services**:

  ▾ 17 community mental health centers (CMHCs) and seven specialty clinics that served 85,841 people (including 46,816 people who were without Medicaid at some point in the year), and

  ▾ An array of SUD services for 50,844 people delivered through four Managed Service Organizations (MSOs) coordinating contracts for SUD treatment services and 331 licensed SUD treatment providers (42 of which subcontract with the MSOs). DBH also oversees certification of addictions counselors (3,137 in 2010) and 50 SUD prevention services providers.

‣ The Mental Health Institutes Division within OBH/CDHS oversees **two state psychiatric hospitals** serving 2,425 people.

‣ The Department of Health Care Policy and Financing (HCPF) oversees the following **health services**:

  ▾ Managed **Medicaid mental health services** by five Behavioral Health Organizations (BHOs) for 67,989 people,

  ▾ Fee-for-service **Medicaid SUD services** (outpatient and detoxification services) for 4,398 people,

  ▾ Fee-for-service **Medicaid psychiatric residential treatment** facility (PRTF) benefit for children,

  ▾ Fee-for-service Colorado Child Health Plan Plus (CHP+) mental health services,

  ▾ The **Medicaid physical health benefit** also covers care for a broad array of mental health and SUD needs, and

  ▾ **Mental health and SUD services for people with long-term care needs** through 11 different Home and Community-Based Services (HCBS) waivers managed in partnership with CDHS.

‣ The Colorado Department of Public Health and Environment (CDPHE) oversees **prevention programs and licensing of health facilities**.

‣ The Department of Regulatory Affairs (DORA) licenses individual medical, mental health and SUD providers and health insurers.

‣ **Federally qualified health centers** (FQHCs) are a major sources of primary care-based mental health and SUD treatment in Colorado. There are 15 FQHCs in Colorado operating 123 clinic sites in 33 counties. Many offer integrated behavioral health treatment, often in collaboration with community mental health providers.

‣ **Primary care is a particularly important resource in rural areas of the state**. Colorado rural and frontier counties rely on 51 rural health centers distributed across 14 of Colorado's 23 frontier counties, 16 of 24 rural counties, and underserved areas of two partially urban counties.

‣ **Additional mental health and SUD service purchasing for children, youth, and families involved in the child welfare and juvenile justice systems** is carried out, respectively, by the Division of Child Welfare and Division of Youth Corrections within the Office of Children, Youth, and Families in CDHS, as well as the Colorado State Court Administrator's Office through both the Division of Probation Services (for youth on probation) and Youth Offender Services (for youth served in the adult system).

‣ **Additional mental health and SUD service purchasing for adults in the correctional system** is carried out by multiple agencies: the Department of Corrections for people in state prisons, the Department of Public Safety for people involved in community corrections, the State Judicial Department (Office of State Court Administrator, Division of Probation and Division of Parole Community Corrections) for community and residential services and regulatory oversight of community providers working with offenders, and local counties for people in jails and in some subsets of probation.

‣ **Mental Health and SUD services for members of Colorado's two American Indian Tribes** (Ute Mountain Tribe and Southern Ute Indian Tribe) are either provided directly by the federal Indian Health Service or purchased and delivered directly by the Tribes using tribal and federal funds. The vast majority of American Indians, Native Americans, and Alaska Natives living in Colorado reside outside of reservations and receive their care through a variety of providers, mostly in the Denver metro area.

## Snapshot of Key Findings
## Regarding the Need for Coordination and Integration – Continued

▸ **Additional mental health and SUD services for veterans and active-duty members of America's armed forces**, including the two million who have served in Afghanistan and Iraq since 2001, are provided through the federal Veterans Administration (VA) and Department of Defense (including TriCare insurance). The VA served 21,715 Coloradans in 2010.

▸ **Critical vocational supports** are provided through the Division of Vocational Rehabilitation within the CDHS Office of Economic Security, as well as through the Department of Labor and Employment.

▸ **Critical housing supports** are provided through Supportive Housing Programs, community development block-grants and other supports through the Department of Local Affairs, local housing authorities, and various county and municipal agencies.

▸ **Critical education supports** are provided in school settings, including 47 school-based health centers in 19 school districts, the Positive Behavioral Interventions and Supports program operating in 742 schools in 70 school districts to promote behavioral health more broadly, social/emotional standards within the health curriculum adopted by the Colorado Board of Education, and Department of Higher Education funded behavioral health services in community colleges and state universities.

### Current Public and Private Service Delivery Trends

▸ **Most mental health/SUD care is delivered through primary care.** Despite funding-stream requirements that complicate care delivery, national data show that most mental health/SUD services are delivered in primary care settings. The proportion of people receiving care in primary care is just over 50 percent.

▸ **Colorado is a leader in promoting integrated mental health/SUD in primary care.** The Colorado Behavioral Healthcare Council is nationally recognized and involved in about 100 integration projects statewide.

▸ **A 72 percent increase in Medicaid members** from SFY 2002 to SFY 2010 has driven mental health service use increases, with more people than ever before served in community settings.

▸ **Fewer people are served in state psychiatric hospitals** (3,484 in SFY 2002 to 2,425 now – a 28 percent drop), reflecting both capacity reductions (24 percent) and improved access to community services.

▸ **Fewer people are served in hospitals of any kind** since 2003 (acute psychiatric inpatient episodes dropped 19 percent; numbers served fell 7 percent; length of stay increased to 6.5 days). Colorado's acute psychiatric inpatient capacity ranked 49th among states in 2006.

▸ **Public sector SUD service delivery has increased** with expansion of DBH state and federal-block-grant-funded services, as well as the addition of the Medicaid SUD services benefit in 2008. Some 74,083 people received SUD services in SFY 2010 through DBH and 4,398 through Medicaid (less than 1 percent of Medicaid members – well below need levels).

▸ **SUD service levels in particular remain well below need.** Stakeholders emphasized multiple limitations in SUD service networks related to a history of limited funding and marginalized capacity too often stretched too thin. Unlike the public mental health system, the emphasis has been on short term stabilization and treatment rather than longer term follow-up and intensive, recovery-oriented supports. Recent efforts by DBH (including federal Access to Recovery grant) are helping to shift this, but the broader need persists. And Colorado has made great strides in promoting Screening, Brief Intervention and Referral to Treatment (SBIRT) to increase screening for SUD needs and access to treatment in primary care settings.

▸ **Less explored frontiers involve prevention, and evidence is growing that intervening earlier is more cost-effective.** Research on Adverse Childhood Experiences (ACEs) clearly shows that maltreatment of various kinds and levels of intensity is associated with poor health and behavioral health outcomes.

▸ **Despite progress, the primary challenge remains uncoordinated care.** Among those with the highest cross-system mental health/SUD service use, poor physical health status drives more costs than does high mental health/SUD need, arguing for more wholistic treatment and specialized behavioral health supports.

### Progress Made Since 2003

▸ Colorado mental health and SUD health systems have taken important steps to reduce fragmentation since 2003, including:

  ▾ Integration of mental health and SUD oversight through the DBH in 2007,

  ▾ Promotion of integrated systems of care for children with intensive needs under HB 04-1451,

  ▾ Promotion of medical homes for children eligible for Medicaid and CHP+ through SB 07-130 and through CDPHE's Colorado Medical Home Initiative since 2001,

  ▾ System reform efforts initiated by HJR 07-1050 through a behavioral health task force,

  ▾ Creation of the Behavioral Health Cabinet in 2007 by Governor Ritter,

  ▾ Formation of the Behavioral Health Transformation Council (BHTC) through SB 10-153 in 2010, and

  ▾ Recommitment to the BHTC by Governor Hickenlooper and his cabinet in 2011.

## Snapshot of Key Findings
## Regarding the Need for Coordination and Integration – Continued

▸ As a result, **state agencies with a core mission to deliver mental health and SUD services** (the OBH and DBH within CDHS, HCPF, and CDPHE) are:

  ▾ **Working better together,**

  ▾ **Coordinating with other agencies that deliver mental health and SUD services** as part of a different core mission (corrections, public safety, and youth corrections and child welfare within CDHS), and

  ▾ **Better aligned with other state agencies that play an important supportive role** (labor/employment, local affairs, housing/community development, vocational rehabilitation).

▸ Key findings across these many efforts include:

  ▾ **Meaningful change in health and human services integration** is always incremental. The actual work of integration involves the careful knitting together of regulations, purchasing efforts, service standards, data collection protocols, information systems, and the myriad structures that comprise state regulatory oversight and purchasing.

  ▾ **Transformation is more cultural than structural** given the need to build an integrated culture focused on common service delivery goals across the existing cultures of the agencies integrated.

  ▾ **Priority needs to be kept on broader system goals.** The test of transformation is whether or not it improves the quality, access and costs of the actual delivery of services.

ADVANCING COLORADO'S MENTAL HEALTH CARE

## Recommendations to Promote Integration and Reduce Continuing Fragmentation

The complex process of integration – integration of mental health and SUD services, between mental health/SUD and physical health services, and between health and various supporting human services for those with the most complex needs – is critical to the success of health reform and is likely the work of years and decades, rather than months. Key recommendations going forward include the following:

1. **Integrate deliberately.** Meaningful progress in health and human services integration is always incremental, transformation is more cultural than structural, and reforms must prioritize broader system goals. Integration efforts need to focus more on the complex details of true integration rather than simply reorganization, though thoughtful reorganization can be a powerful tool.

2. **Rely on the BHTC** as the lead resource in coordinating planning for publicly funded mental health and SUD services and recognize that it needs resources to function well.

3. **Address behavioral health and local human services integration within Regional Care Collaborative Organizations (RCCOs) by:** (1) formally incorporating behavioral health care-delivery-performance-indicators within the RCCOs to ground system changes improved access, cost and quality and measure progress with a core set of outcomes, and (2) formally involving counties, to leverage their broader human services resources and reduce costs in jails and other adverse impacts.

4. **Beyond Medicaid, look for opportunities to consolidate state-level delivery and financing** for behavioral services across agencies, to align benefits and maximize access to federal funds, particularly for community-level corrections, juvenile justice, child welfare, and education.

## OVERVIEW

**The 2003 *Status Report* made the stark claim that "there is no single mental health system in Colorado," and the same was certainly true then for service systems treating SUD. These statements are still true in 2011. Moreover, this has been the case since the first state-run psychiatric hospitals were developed in the mid-19th century nationwide, the period when the Colorado Mental Health Institute at Pueblo first opened, in 1879, as the Colorado State Insane Asylum.[10]**

People often talk about the "system" being "broken" to describe this state of affairs, a metaphor that captures the understandable feelings of many who search for help in often desperate circumstances. Yet, this metaphor is flawed, because, to break something, it first has to be an integrated whole. Unfortunately, this has never been the case for health care in general or behavioral health in particular – the truth is that those seeking to help people with behavioral health needs have had to work for decades simply to build new systems to address previously unmet needs, rather than to re-build systems that once worked well for everyone and no longer do. The primary challenge now in health care is to find new ways for multiple systems to work better together for people with multiple needs.

As in 2003, Colorado in 2011 delivers mental health and SUD services through a complicated array of systems and providers serving a range of needs across diverse and too often overlapping groups of people.

Think back to the stories in the introduction. Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally all had physical-health-treatment needs, some quite severe. Several had a mix of substance use and mental health needs.

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10   For more on the history of CMHI Pueblo, see http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/
     CBON/1251580732414.

Bob and John had housing and employment needs, the youth (Gabriela and Assefa) and elders (Nadine and Sally) had challenges to living at home. The youth also had service needs at school, and were involved in the child welfare and juvenile justice systems.

From the perspective of the people who need, provide, and pay for mental health services, the "system" continues to be experienced as confusing and redundant in many situations and outright unavailable in others. The descriptor that continues to be used too often to describe Colorado's behavioral health services is "fragmented." Yet, despite this, there has been progress, much of it in the last four years.

## MULTIPLE MENTAL HEALTH / SUBSTANCE USE DISORDER SERVICES SYSTEMS

It is possible to categorize systems providing behavioral health services across multiple dimensions:

- **Funding.** The most common distinction is between public systems funded by local, state, tribal, and federal governments and private systems funded by health insurers or people paying for their own care. This report primarily focuses on public systems since so much more information about them is available.

- **Primary focus of health services.** Another distinction can be made between the primary focus of the health care service system providing behavioral health care across three groupings:

  1. Primary care. National studies have demonstrated that most behavioral health services are provided in the context of a primary care visit with a pediatric, family practice, or other primary care provider.

  2. Specialty health care. This is what people typically picture when they think about behavioral health care – the psychiatrists, psychologists, social workers, addictions counselors, clinics, and others that provide mental health and substance use disorder services.

3. Public health and prevention. There are also systems in place to provide services to prevent behavioral health conditions from emerging or lessen their impact when they do.

- **Other human services systems.** The government also provides many other human services, including education, child welfare, juvenile justice, state and local adult correctional services, housing supports, and employment supports. Some of these service systems deliver their own mental health and SUD services (in the case of education, child welfare, juvenile justice, state and local adult correctional services). The other service systems (housing, employment) provide critical supports that help people in need recover and support the resilience of individuals and families who are at risk.

- **Geography.** Ultimately health care is delivered within a specific geographic area, and it is a truism that "all health care is local."[11] As a result, systems of care are needed within specific geographic regions and coordinated with specialized services that may not be available in all regions of the state.

### Public Services System Organization

Colorado's public mental health and SUD service systems are managed at the state government level by multiple state agencies:

- **Primary oversight of policy and funding for community-based mental health and SUD services using state general and federal block-grant funding** rests with the DBH, within the OBH within the CDHS. DBH is designated by the federal government as the Single State Authority (SSA) to oversee distribution of federal block-grants (for mental health services, SUD treatment and substance abuse prevention). Under Colorado statute, DBH also oversees community providers of services, including:

  - 17 community mental health centers (CMHCs) and seven specialty mental health clinics serving 17 single and multi-county catchment areas,

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11    Mauer, B., and Jarvis, D. (June 30, 2010). The business case for bidirectional integrated care: Mental health and substance use services in primary care settings and primary care services in specialty mental health and substance use settings. California Institute for Mental Health. Retrieved at: http://www. cimh.org/LinkClick.aspx?fileticket=FBCYbhoBeg8%3d&tabid=489. Page 16.

- Four Managed Service Organizations (MSOs) coordinating contracts for SUD treatment services across seven multi-county Sub-State Purchasing Areas (SSPAs),

- 331 licensed SUD treatment providers (42 of which subcontract with the MSOs to provide DBH-funded SUD treatment services across the state),

- Certification of addictions counselors, numbering 3,137 in 2010, and

- 50 contract service providers for SUD prevention services.

• **Primary oversight of the two state psychiatric hospitals** (the Colorado Mental Health Institutes [CMHIs] at Pueblo and Fort Logan) resides with the Mental Health Institutes Division, within OBH, within CDHS.

• **Primary oversight of Medicaid funded services and health care purchasing** lies with the Department of Health Care Policy and Financing (HCPF). Services are provided through multiple distinct sets of funding streams that are separately organized and that have different benefit levels:

1. Most mental health services are provided through a managed care system involving five BHOs that serve single (Denver) and multi-county catchment areas (these were referred to as Mental Health Administration and Service Agencies, or MHASAs, in 2003).

2. A fee-for-service SUD services benefit was added in 2008 for outpatient and detoxification services.

3. A fee-for-service psychiatric residential treatment facility benefit funds additional inpatient services in children's residential treatment facilities.

4. CHP+ overseen by HCPF also provides a fee-for-service mental health benefit.

5. The broader physical health benefit provided through managed care organizations (such as Colorado Access and Rocky Mountain Health Plans) and fee-for-service purchasing directly from providers also covers care for a broad array of mental health and SUD needs, even though most direct services are carved out to the BHOs. Given the regulatory separation of the mental health benefit and restrictions on the delivery of mental health services under the physical health benefit, it is not clear how much mental health and SUD service is provided in primary care and other physical health settings. As will be seen later in this report, a disproportionate amount of physical health spending goes to people with mental health and SUD diagnoses.

6. Mental health and SUD service purchasing for people with long-term care needs, including older adults and people with developmental disabilities, is carried out through Medicaid-funded institutional care and community alternatives funded by 11 different Home and Community-Based Services (HCBS) waivers managed variously by the Long Term Care Benefits Division of HCPF and the Developmental Disabilities Division and Regional Centers within the Office of Veteran and Disability Services in CDHS. A recently awarded federal Money Follows the Person grant is being used to expand access and better coordinate care among these waivers through 2016.

These systems comprise the bulk of public financing of mental health and SUD services, which will be described in more detail under Observation #3. The lack of alignment of funding streams, funding approaches, service delivery models, benefit levels, service definitions, information reporting requirements, provider requirements, and other regulatory standards across these four overarching systems, let alone the other public systems described in the following pages, illustrates both the complexity and misalignment of the systems involved. The maps below show how even the geographic regions under which these four systems are administered vary markedly.

**THE MAPS INCLUDE:**

- The 17 DBH community mental health catchment areas and locations for the two state psychiatric hospitals: CMHI-Pueblo and CMHI-Fort Logan,

- Managed Service Organizations (MSOs) seven multi-county Sub-State Purchasing Areas (SSPAs),

- HCPF Medicaid Behavioral Health Organization Regions, and

- HCPF Medicaid Accountable Care Collaborative (ACC) regions and Regional Care Collaborative Organizations for each region.

**DBH COMMUNITY MENTAL HEALTH CATCHMENT AREAS AND CMHIS**



**MSO SUB-STATE PURCHASING AREAS (SSPAS)**
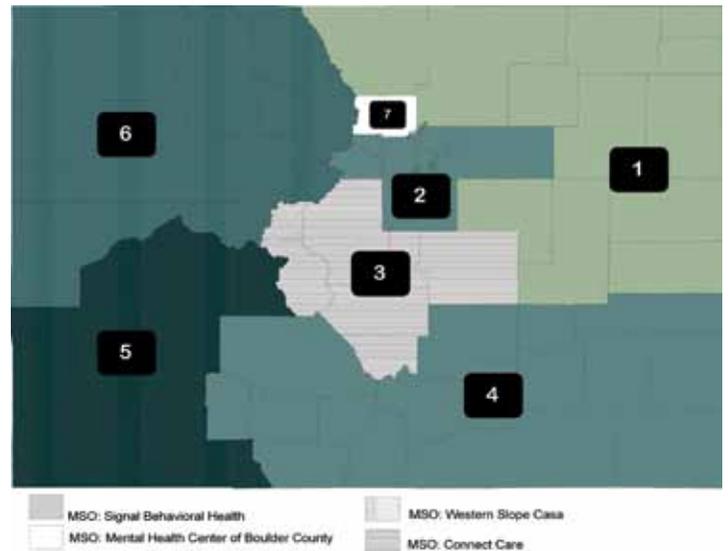


**HCPF MEDICAID BEHAVIORAL HEALTH ORGANIZATION REGIONS**



**HCPF MEDICAID ACC REGIONS AND RCCOS**
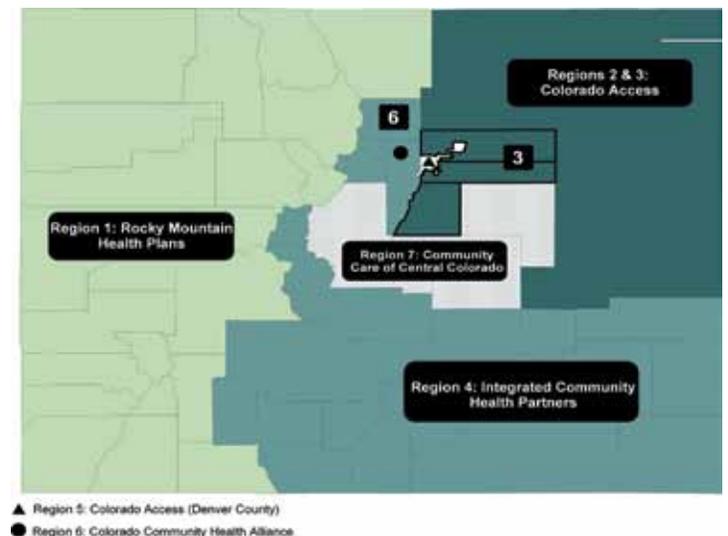
In addition to the primary providers of publicly funded services just described, multiple other state agencies are also involved in the oversight and financing of mental health and SUD services:

- **Primary oversight of prevention programs and licensing of health facilities** rests with the Colorado Department of Public Health and Environment (CDPHE). CDPHE's Prevention Services Division oversees prevention services for children and adolescents through a wide range of school-based services, family resource centers, and specialty programs; targeted coordination, system of care, diagnostic, and referral services for children with special health care needs through a medical home initiative, a network of 10 diagnostic and evaluation clinics, and a broader network of specialty clinics; and statewide efforts to prevent suicide, violence, and a wide range of other health conditions with behavioral components. The Health Facilities and Emergency Medical Services Division oversees all licensing for health facility providers, including hospitals, CMHCs, and other agencies. CDPHE is supported in this role by other state agencies, including DBH, which carries out program reviews and approvals for mental health facilities they fund, and licensing for SUD treatment providers.

- **Primary oversight of licensing for individual medical, mental health and SUD providers and health insurers** resides with the Department of Regulatory Affairs (DORA). This includes oversight of physicians and other individually licensed providers of mental health and SUD services through discrete boards overseeing each provider group.

- **Additional mental health and SUD services for members of Colorado's two American Indian Tribes** (Ute Mountain Tribe and Southern Ute Indian Tribe) are either provided directly by the Indian Health Service (within the federal Department of Health and Human Services) or purchased and delivered directly by the Tribes using tribal and federal funds (as the Southern Ute Indian Tribe took steps to implement in 2009). The vast majority of American Indians, Native Americans, and Alaska Natives living in Colorado reside outside of reservations and receive their care through a variety of providers, mostly in the Denver metro area. Three providers in the Denver metro area specialize in this care delivery: Denver Indian Family Resource Center, Denver Indian Health and Family Services Center, and the Denver Indian Center.

- **Additional mental health and SUD services for veterans and active-duty members of America's armed forces** are provided through federal programs administered by the Veterans Administration and the Department of Defense (including the TriCare insurance program), as well as special allocations and initiatives, many targeted at the approximately 2 million troops who have served since 2001 in Operation Enduring Freedom (Afghanistan theater), Operation Iraqi Freedom (Iraq theater through September 2010), and Operation New Dawn (Iraq theater since September 2010).[12]

- **Additional mental health and SUD service purchasing for children, youth, and families involved in the child welfare and juvenile justice systems** is carried out, respectively, by the Division of Child Welfare and Division of Youth Corrections within the Office of Children, Youth, and Families in CDHS. Additional supports for youth are provided by the Colorado State Court Administrator's Office through both the Division of Probation Services (for youth on probation) and Youth Offender Services (for youth served in the adult system).

- **Additional mental health and SUD service purchasing for adults in the correctional system** is carried out by multiple agencies: the Department of Corrections for people in state prisons, the Department of Public Safety for people involved in community corrections, the State Judicial Department (Office of State Court Administrator, Division of Probation and Division of Parole Community Corrections) for community and residential services and regulatory oversight of community providers working with offenders, and local counties for people in jails and in some subsets of probation.

- **Critical vocational supports** for persons with disabling mental health and SUD needs are provided through the Division of Vocational Rehabilitation within the CDHS Office of Economic Security, along with broader training and job development provided through the Department of Labor and Employment.

- **Critical housing supports** are provided through multiple agencies, including the Supportive Housing Programs, community development block-grants and other supports of the Department of Local Affairs, local housing authorities, and a wide array of county and municipal development agencies.

- **Critical education supports** are provided in school settings to support students' emotional and behavioral health. School-based health centers are a critical provider of behavioral health services, with 47 centers in operation currently across 19 school districts.[13] In addition, the Positive Behavioral Interventions and Supports program is operating in 742 schools in 70 school districts to promote behavioral health more broadly. This is also supported by the Colorado Board of Education's recent adoption of social and emotional standards within its health curriculum. The Department of Higher Education also funds behavioral health services for community colleges and state universities.

The maps on the following pages show the varied regional structures through which most of the supports just described are delivered: judicial districts, Division of Youth Corrections (DYC) regions, counties (which serve as the location for jails, child welfare services, and many criminal justice, community development and other supports), and Colorado school district Regional Service Areas (RSAs). When viewed alongside the four maps shown previously for more generally available publicly funded health care services, one can readily see how people with complex needs across agencies encounter barriers when accessing care simply in determining where to go. It also underscores the challenges to providers in one area of funding that serve people with multiple needs across funding streams – a single BHO in some cases must coordinate with dozens of school districts, counties, judicial districts, and state agency regions.

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12  Armed Forces Health Surveillance Center. Causes of Medical Evacuations from Operations Iraqi Freedom (OIF), New Dawn (OND) and Enduring Freedom (OEF), Active and Reserve Components, U.S. Armed Forces, October 2001- September 2010 Medical Surveillance Monthly Report (MSMR). March 2011; 18(02): 2. Institute of Medicine (IOM). 2010. Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, DC: The National Academies Press.

13  Colorado Association for School-Based Health Care. (May 2011). School-based health centers: Fact Sheet. Retrieved at: http://www.casbhc.org/publications/Fact%20Sheet.pdf.
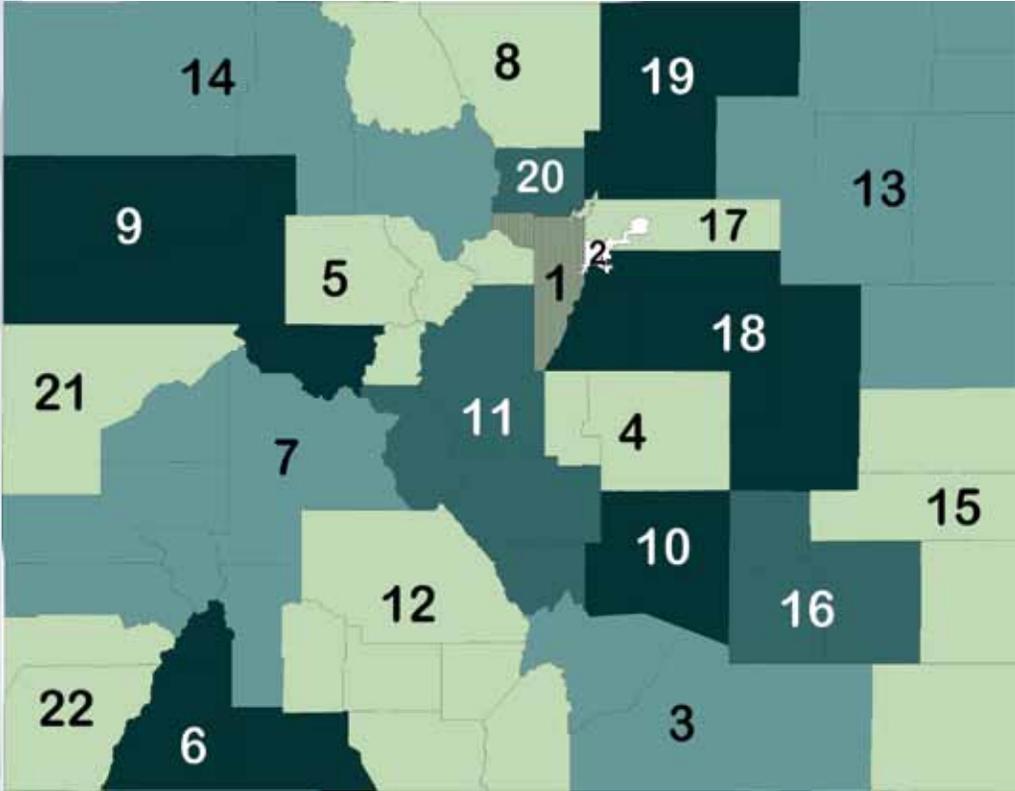
COLORADO COUNTIES (LOCUS FOR JAILS, CHILD WELFARE)

**DYC REGIONS**

**COLORADO SCHOOL DISTRICTS REGIONAL SERVICE AREAS (RSA)**

Taken as a whole, mental health and SUD services and supports in Colorado are delivered through a truly bewildering array of overlapping agencies and structures. It bears repeating, though, that the services described represent an impressive investment by Colorado state and local governments in the behavioral health of Coloradans. The development of these many services and supports was achieved through multiple efforts across many years to better organize, fund, expand access to, and improve the quality and responsiveness of mental health and SUD services. As a single example, the Division of Child Welfare purchases residential supports and community-based services that include mental health and SUD services targeted to children and families with needs related to abuse and neglect. Many of these children and families are also eligible for services through Medicaid, CHP+, state-funded CMHCs, MSOs, and private insurance. The child welfare system purchases services directly, however, to address gaps in covered services (for example, residential care for a child with insurance that does not cover residential care); preferences for services that are more tailored to goals of the child welfare system (such as achieving a permanent placement for a child); and real and perceived barriers in eligibility (an example of the former would be an uninsured parent with major depression who did not meet targeting criteria for CMHC services; an example of the latter would be a child welfare provider unwilling to go through the hassles of enrolling with the local BHO as a Medicaid provider). Thus, redundant-service purchasing by multiple state agencies can be a function of targeted purchasing, as well as uncoordinated purchasing.

Nonetheless, at first glance, public behavioral health services systems in 2011 seem just as fragmented as they were in 2003. In many ways they are, but by 2011, Colorado had also made some substantial progress in improving the organization of the many and varied mental health and SUD services it purchases.

## PROGRESS SINCE 2003

Despite continued fragmentation, Colorado has taken some important steps toward better understanding and coordinating its many discrete behavioral health service systems. The 2003 *Status Report* identified service fragmentation as the biggest challenge confronting

Colorado; this concern was echoed that same year in the publication of the Final Report of the President's New Freedom Commission on Mental Health.[14] Key steps taken since then include:

- Local efforts to build better integrated systems of care within communities, similar to the six ACMHC grant-funded efforts initiated in 2005, were supported by state legislation (most notably HB 04-1451, which promoted collaborative management for children and families involved in multiple state systems, and is currently operational in 30 of Colorado's 64 counties[15]), and a variety of community-level activities. These efforts have grown considerably since 2005, so that Colorado is, in the view of many system leaders, a national leader in local integrated-care system development (for more on this, please see Observation #5).

- 2007 was in many ways a watershed year for system integration:

  - The DBH consolidated the former Division of Mental Health (DMH) and Alcohol and Drug Abuse Division (ADAD) within a single agency.

  - The Colorado General Assembly passed SB 07-130 designating HCPF to collaborate with CDPHE's Colorado Medical Home Initiative (which began its work in 2001) to increase the number of medical homes for children eligible for Medicaid and CHP+.

  - The Colorado General Assembly passed House Joint Resolution (HJR) 07-1050, creating a task force to study behavioral health funding and treatment in Colorado. The HJR-1050 Task Force developed 11 recommendations the state could follow to improve behavioral health services. These recommendations have been critical to integration efforts since 2007 and are summarized in Appendix Two.

  - In late 2007, Governor Ritter called an unprecedented meeting of his relevant cabinet members to discuss the cross-system impacts of mental health and SUD services that led to the creation of the Behavioral Health Cabinet.

- In 2008, the Behavioral Health Cabinet focused on understanding each state agency's role in providing, funding and regulating mental health and SUD

services, carrying out planning and initial collaborative activities that led to an award in late 2008 of a federal Transformation Transfer Initiative (TTI) Grant through the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to support this effort.

- In 2009, the TTI Grant funded a year-long planning process to review the work completed to date by the HJR-1050 Task Force and engage a broad coalition of stakeholders to (1) develop the Behavioral Health Transformation Council as an ongoing process for meaningful input from people receiving mental health and SUD services, as well as other stakeholders, to guide system transformation; (2) develop work plans to further implement system integration based on the HJR-1050 recommendations; and (3) identify ongoing funding for system transformation efforts. The project was successful in the first two goals, but the third goal, hampered by the state's severe economic situation, was limited to assigning existing staff to support the Transformation Council's efforts. Initial work plans focused on (1) improving continuity of care (and ultimately financing of services) for people using multiple and high cost services across state agencies; (2) improving service quality for people with mental health and SUD needs in the criminal and juvenile justice systems; (3) better coordinating prevention and intervention services for children, adolescents, youth, and young adults; and (4) sustaining behavioral health system transformation through joint efforts of the executive, legislative, and judicial branches of Colorado's state government.

- In 2010, the Transformation Council was established in statute through SB 10-153 with representatives of the executive, judicial and legislative branches, as previously noted. SB 10-175 also was passed, consolidating into a single title all statutes governing mental health and SUD services administered by CDHS. The Transformation Council made incremental progress in many additional areas (described further in its January 2011 annual report to the legislature), including completing an initial study of service delivery dynamics among people using multiple-state-agency services (discussed further under Observation #4),

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14  New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, Md.

15  J. Equibel, CDPHE, personal communication, July 7, 2011.

support of various grant-funded initiatives, progress in coordinating supports across agencies for transition age youth, and training to improve service quality for people involved in the criminal justice system with mental health and SUD needs.

• For 2011, multiple state government leaders we spoke with emphasized Governor Hickenlooper's commitment to continuing the work of the Transformation Council. The Governor has integrated the work of the Behavioral Health Cabinet into his broader health reform efforts (discussed in more detail under Observation #4 on health care costs).

In our view, this progress is best described as incremental and significant, reflecting substantial progress across agencies in developing a common vision, shared understanding of resources and needs, and steps toward better coordination of services. The real effects of these efforts at state and local levels will be discussed throughout this report, but for the broader discussion of system organization, the question arises as to whether more comprehensive state-level reform is needed. The 2007 HJR-1050 report recommended establishing a Level Two Commission with the standing of a state agency to coordinate and lead efforts across state government. This was not acted on for various reasons, including concern about adding yet another layer of government structure and statutory limits on the authority of commissions over state agencies.

More recently, industry groups and others among the stakeholders we interviewed for this report have publicly advocated for consolidation of all health care purchasing within a single state agency. Some states have already experimented with such consolidation (for example, Washington, a state with which TriWest has worked). Other stakeholders we interviewed expressed concerns about focusing too much system change effort on reorganizing state government when there is such need to reorganize local systems for delivering care. That being said, many leaders we spoke with also observed that there is never a good time to take on the hard work of government agency reorganization, arguing that Colorado is poised for such change and that the demands of health reform, coupled with the state's ongoing, severe financial challenges, make the near future as good a time as any.

Across these many, often conflicting, opinions among Colorado behavioral health leaders, we were able to discern a few guiding principles:

• **Meaningful change in health and human services integration is always incremental.** In our national work, TriWest has observed multiple agency reorganizations over the past decade, some successful and some less so. TriWest has also observed many incremental change processes led by cross-agency collaborative groups. Across both the major reorganizations and the more incremental changes, the process of actual integration and change has always been incremental. In all cases we have observed, the actual work of integration has been both laborious and detailed (and generally less exciting than a governmental "reorganization" or "reboot"). Such work involves the careful knitting together of regulations, purchasing efforts, service standards, data-collection protocols, information systems, and the myriad structures that comprise state regulatory oversight and purchasing. As witnessed most recently in Colorado in the example of the creation of DBH from the former DMH and ADAD, the simple act of consolidating state agencies does not in and of itself integrate

their functions. A pertinent question, therefore, about large-scale reorganization is whether or not it will support the ongoing, detailed work of system integration substantially better than current structures.

- **Transformation is more cultural than structural.** We spoke with several current and former state agency leaders about the process of integration. These leaders emphasized the importance of building an integrated culture focused on common service delivery goals that bridges the existing cultures of the agencies integrated. One only needs to spend a few minutes in conversation with a mixed group of mental health and SUD service providers to realize that the language, values and priorities of these two groups both differ and overlap in important ways. One group refers to the people they serve as "consumers," the other "clients." One group differentiates among prevention, intervention and treatment services, the other between institutional and community-based supports. One group has learned to function in a managed care environment that is increasingly dominated by Medicaid, and one has learned to function in a much lower-funded environment dominated by federal block-grants. Similar differences can be found when talking with treatment providers and prevention services providers, as well as between primary care and specialty mental health/SUD service providers. These cultural distinctions reflect important differences that must be worked through and integrated to support wholistic care, and such integration is also an incremental process.

- **Keep the priority on broader system goals.** As will be discussed in more detail below in Observation #4 on costs, the "Triple Aim" of health care reform is focused on improving quality, access, and costs, and the consensus of the Colorado leaders and national literature we reviewed is that "all health care is local" and costs are ultimately best controlled in the

medical setting in which they are delivered. The test of reorganization should be whether it improves the quality, access and costs of the actual delivery of services, because that is where the primary challenge resides.

## Overall Service Delivery Trends

One sign of the incremental improvement just described is that in 2011 we have a much better sense of the breadth of behavioral health service delivery. The table that follows summarizes available data on people served across multiple funding streams. The sections that follow provide additional detail on each subset of services.

The table contrasts differences between readily available data[16] in 2003 (SFY 2002 data, usually) and 2011 (SFY 2010 data, usually) in terms of both how many people receive care and what we know about that care. Note that there have been both improvements in both the number served and the detailed information about who was served now widely available to system planners. The table also puts the 2010 service levels in perspective, comparing them to benchmark estimates of need for two overlapping sets of people in need: **(1) Public Sector Need**, defined as those people in any one year with severe mental health disorders or any level of SUD and incomes below 300 percent of the Federal Poverty Level[17] (FPL), and **(2) Overall Need**, the entire range of people in any one year with diagnosable mental health and SUD.[18]

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16  By readily available, we mean the data were routinely accessible to behavioral health planning efforts. While data were generally available within the agency delivering the service in 2002, they were often not known in sufficient specificity, not routinely used, or otherwise not available to system planners, including TriWest and the system leaders we spoke with in 2002. Some specific limitations are noted in footnotes in the table by data set.

17  2009 public-sector mental health need data are from Dr. Chuck Holzer's estimates, with the most recent 2009 300 percent Federal Poverty Level (300% FPL) calculations from the Colorado Health Institute (Colorado Health Institute, personal communication, February 2, 2011) applied to Dr. Holzer's statewide estimates for adults (6.63 percent) and children/adolescents (8.08 percent). The number of adults living at/below 300% FPL was multiplied by Holzer's 6.63 percent and the number of children living at/below 300% FPL was multiplied by Holzer's 8.08 percent. For mental health, severe need includes SMI and SED. Persons in Need (PIN) data for SUDs is not broken out by severe and less than severe, as it is for mental health disorders. PIN data on SUD need is also not available for children and adolescents.

18  The overall need includes all people with any level of mental health need, as identified in the most recent, widely cited and highly regarded psychiatric epidemiological studies, primarily drawing on Kessler, R.C., et al. (2005). Prevalence and treatment of mental disorders, 1990-2003. New England Journal of Medicine, 352, 2515-2523.

| BEHAVIORAL HEALTH SERVICES IN COLORADO – 2002 AND 2010 | | | | |
|---|---|---|---|---|
| CARE SETTING | PERSONS SERVED 2002 | PERSONS SERVED 2010 | COMPARED TO PUBLIC SECTOR NEED | COMPARED TO OVERALL NEED |
| Public Health Care Systems | | | | |
| Mental Health | | | | |
| Non-Medicaid Community Mental Health[19] | 40,031 | 32,355 | 17.8% | 4.6% |
| Medicaid Capitated Mental Health through BHOs[20] | 47,049 | 67,989 | 37.5% | 9.7% |
| CMHIs (State Hospitals)[21] | 3,484 | 2,425 | 1.3% | 0.3% |
| Substance Use Disorder (SUD) | | | | |
| DBH – SUD Programs[22] | Unavailable[23] | 50,844 | 50.7% | 31.2% |
| Medicaid SUD Treatment Benefit[24] | Not Applicable | 4,398 | 4.4% | 2.7% |
| Veterans Administration[25] | Unavailable | 21,715 | 9.6% | 2.8% |
| Private Health Systems | | | | |
| Hospitals (non-CMHIs)[26] | | | | |
| Mental Health | 15,416 | 12,048 | 6.6% | 1.7% |
| SUD | 7,721 | 6,546 | 6.5% | 4.0% |
| Private Health Care System – Outpatient | Unavailable | Unavailable | N/A | N/A |

19  Source for 2002 data were the 2003 Status of Mental Health Care in Colorado report, p. 126; source for 2010 data are personal communication with B. Makonnen, Colorado Division of Behavioral Health, January 2011.

20  Medicaid Capitated mental health through BHOs persons served SFY 2010 data is from personal communication with J. Ware, Colorado Department of Health Care Policy and Financing, January 5, 2011.

21  Data is from personal communication with B. Finn, Colorado Hospital Association, March, 2011. Data are for 2003 and 2009. Note that Persons Served data are actually the number of episodes, and includes duplicated counts.

22  Colorado DBH (2009, 2010). Cost-Effectiveness of SUD Programs in Colorado. Includes people discharged from programs overseen by DBH (SUD treatment and detoxification, but not Driving Under the Influence services).

23  The agency overseeing substance use disorder service delivery in 2002, ADAD, did track data on people served, but this was not included in the 2003 Status Report. This data are available through DBH.

24  M. Case, Colorado Department of HCPF, personal communication, November 24, 2010. Not applicable, as Medicaid did not pay for SUD services in 2002.

25  Veterans Administration North East Program and Evaluation Center. 2010 fiscal year data provided via personal communication by T. Forbes, April 24, 2011. For the need comparison we referenced all adult need (Mental Health and SUD) for those below 300% FPL for the public sector need and all adult need in the Colorado population for overall need.

26  Data are from personal communication with B. Finn, Colorado Hospital Association, March 2011. Data is for 2003 and 2009. Persons Served data are episodes, and includes duplicated counts. Comparisons to need therefore to some extent overstate the level of need met.

| BEHAVIORAL HEALTH SERVICES IN COLORADO – 2002 AND 2010 | | | | |
|---|---|---|---|---|
| CARE SETTING | PERSONS SERVED 2002 | PERSONS SERVED 2010 | COMPARED TO PUBLIC SECTOR NEED | COMPARED TO OVERALL NEED |
| Other Systems | | | | |
| Primary Care Health System (Public and Private) [27] | 260,400 | 286,200 | N/A | 17.3% |
| Criminal Justice System (Adults) | | | | |
| Department of Corrections[28] | | | | |
| Mental Health Programs | Unavailable | Unavailable | N/A | N/A |
| Alcohol and Drug Programs | Unavailable | 7,678 | 7.7% | 4.7% |
| Division of Probation | | | | |
| Offender Treatment and Services (some Mental Health, mostly SUD)[29] | Unavailable | Unavailable | N/A | N/A |
| SB 03-318 (directed to drug courts) | Unavailable | 2,000 | 2.0% | 1.2% |
| Alcohol and Drug Driving Safety Program[30] | Unavailable | 30,000 | N/A | 18.4% |
| Division of Criminal Justice[31] | | | | |
| Mental Health Programs | Unavailable | 172 | 0.1% | 0.02% |
| SUD Programs | Unavailable | 533 | 0.5% | 0.3% |

27  Unlike the rest of this table, which uses actual reported data and estimates of need based on Holzer's data, these estimates are all derived from NCS-R data (Kessler, et al, 2005). Estimates are based on the 32.9 percent overall estimate of 12-month prevalence, 17.3 percent of whom are served in "general medical" settings (what we term "primary care" in this report). Estimates are based on Colorado population figures for 2002 and 2010.

28  Colorado General Assembly Joint Budget Committee (Dec. 20, 2010). Department of Corrections FY 2011-12 Staff Budget Briefing. (p. 119).

29  Offender Treatment Services in SFY 2010-11 included approximately $565,000 in spending on mental health and $2 million on SUD treatment (personal communication, S. Colling, February 3, 2011). Numbers served were not available.

30  Only includes evaluation services, not treatment services.

31  Colorado Commission on Criminal and Juvenile Justice (2010, December). White paper from the Treatment Funding Working Group. Division of Criminal Justice, Department of Public Safety. Table 8, pp. 69 ff.

| BEHAVIORAL HEALTH SERVICES IN COLORADO – 2002 AND 2010 | | | | |
|---|---|---|---|---|
| CARE SETTING | PERSONS SERVED 2002 | PERSONS SERVED 2010 | COMPARED TO PUBLIC SECTOR NEED | COMPARED TO OVERALL NEED |
| Other Systems – continued | | | | |
| County Jails | | | | |
|    Metro Denver County Jails[32] | Unavailable | 5,630 | 4.5% | 0.8% |
|    Other County Jails | Unavailable | Unavailable | N/A | N/A |
| Juvenile Justice System[33] | | | | |
|    Division of Youth Corrections[34] | | | | |
|       Detention, SB 94, Commitment-Only | Unavailable | Unavailable | N/A | N/A |
|       Commitment – Parole-Mental Health[35] | Unavailable | 514 | .09% | 0.8% |
|       Commitment – Parole-SUD[36] | Unavailable | 77 | 0.1% | 0.9% |
| Child Welfare – Core Services[37] | | | | |
| Mental Health | Unavailable | 4,602 | 8.2% | 5.2% |
| SUD | Unavailable | 4,667 | 8.3% | 5.2% |
| School-Based Health Centers[38] | Unavailable | 6,500 | N/A | 7.3% |

32  Spending on behavioral health services was estimated by the Mentally Ill Inmates Task Force of the Metro Area County Commissioners (MACC) for 2009 based on the number of inmates in seven Metro Denver area counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson. For the estimate of people served, data from 2006, 2007 and 2008 was averaged due to missing data in 2009. This was the primary number cited in the MACC analysis, so it is used here. Public sector need included adults with SMI and/ or SUDs. Overall need included all adults with any mental health or SUD problem. For these analyses, the population-in-need data were adjusted to reflect the fact that the Denver metro area counties account for 55.7 percent of the state's population.

33  For the Public Sector and Overall Need comparisons, we use estimates of the number of children/youth with SED, because epidemiology data on SUDs for children/youth is not available.

34  DYC data are from Division of Youth Corrections Management Reference Manual, Fiscal Year 2009-2010.

35  Number served (Mental Health and SUD) data are non-residential served from TriWest's (2010) Continuum of Care Report, re-analyzed by TriWest in February 2011. This analysis of continuum of care youth receiving mental health and SUD services does include some people who were in residential who were waiting for parole through continuum of care services. Some of the services generically classified as mental health services may also have targeted SUD issues, also.

36  These data also come from TriWest's (2010) Continuum of Care Report, re-analyzed by TriWest in February, 2011. The same caveats apply as in previous footnote.

37  TriWest re-analysis of Core Services data on June 20, 2011. For the full report, see TriWest (2010). Core Services Program Evaluation Annual Report, SFY 2009-2010. Colorado Department of Human Services, Division of Child Welfare. (Full report does not include all data reported here.) As with DYC, for the Public Sector and Overall Need comparisons, we use estimates of the number of children/youth with SED, because epidemiology data on SUDs for children/youth is not available.

38  According to the May 2011 Fact Sheet, 27,560 children were served in SBHCs in the 2009-10 school year. According to the 2009-2010 School Behavioral Health Center (SBHC) Annual Survey data (unpublished data provided by S. Moody, July 21, 2011), in the 2009-10 school year, 24 percent of visits involved behavioral health (24 percent mental health and less than 1 percent SUD). To estimate the number of children receiving behavioral health services, we applied the proportion of visits to the number of children served (yielding 6,614) and rounded that number down to the nearest 500 (6,500). While only an estimate, this figure in our judgment allows a reasonable point of comparison. For the need comparison, we only compared children served to the overall need estimate, as it is not known what proportion of children served in SBHCs had SED (note that this still does not include SED prevalence).

# PUBLIC BEHAVIORAL HEALTH SERVICE DELIVERY TRENDS

## Persons Served in Public Mental Health Systems

Not surprisingly, given increases in population, Medicaid enrollment and persons in need, the number of people served in public mental health systems has increased since the time of the 2003 report, in both absolute and relative terms. The chart below shows the number of people served in State Fiscal Years (SFYs) 2002 (the data used in the 2003 report) and 2010 through BHOs (which used to be called Mental Health Assessment and Services Agencies or MHASAs), and through community mental health centers and clinics (CMHCs), which serve as the backbone for the publicly funded outpatient mental health system.[39][40]

BHOs and CMHCs (unduplicated), outpacing Colorado population growth, which was only 10 percent during the same period.[41] Clearly, BHOs and CMHCs have expanded greatly services since 2003 (20 percent), nearly keeping pace with the increase in the number of people living at or below 300 percent of FPL (which grew a little under 25 percent). The rise in the number of Medicaid recipients served through BHOs from SFY 2002 to SFY 2010 (45 percent) reflected to a large degree dramatic increases in the number of BHO Medicaid enrollees over the course of that eight-year period (which increased 72 percent during that period).

The table on the following page compares people served by BHO and CMHC catchment area across Colorado, contrasting SFY 2002 with SFY 2010.

### PERSONS SERVED IN PUBLIC MENTAL HEALTH SYSTEMS



### COLORADO POPULATION VS PERSONS SERVED IN PUBLIC MENTAL HEALTH SYSTEMS



This rate of increase was much sharper than the increase in Colorado's overall population, as the chart to the right illustrates. There was a 20 percent increase from SFY 2002 to SFY 2010 in the number of all people served through

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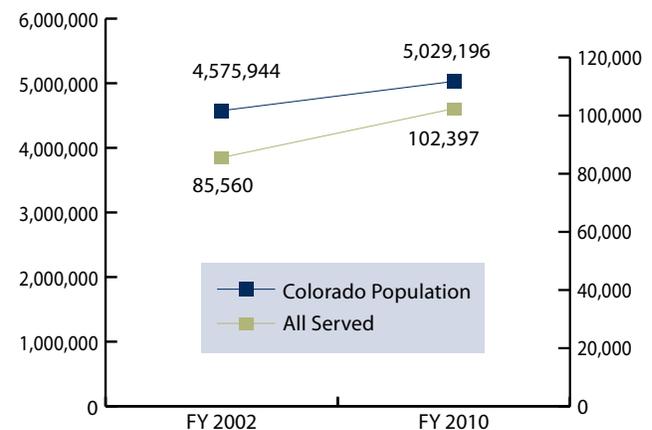
39  FY2002 data are from TriWest (2003). FY2010 data on CMHCs/Clinics are from personal communication with B. Makonnen, DBH, January, 2011. CMHCs/Clinics data includes providers/clinics other than CMHCs; however, 88 percent of the services in FY2010 were provided by the CMHCs. BHO persons served in SFY 2010 is from personal communication, J. Ware, January 5, 2011. Note that most BHO services are provided through CMHCs, so these service figures are duplicated.

40  Note that the BHO and CMHC totals presented partially overlap and do not equal the "All Served," cited further below, which represent unduplicated counts.

41  FY2002 data are from TriWest (2003). FY2010 data are from personal communication with Bruck Makonnen, DBH, January 2011 (number served by CMHCs and Clinics), and BHO enrollees served is from FY09-10-5 Jan2011, personal communication, Jerry Ware, January 5, 2011. The Colorado population data for 2002 was drawn from TriWest (2003) and the 2010 data from the U.S. 2010 Census data – U.S. Census Bureau.

| PEOPLE SERVED BY MHASAs/BHOs AND CMHCs IN COLORADO, STATE FISCAL YEARS 2002 AND 2010[42] | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **BHO (FORMERLY MENTAL HEALTH ASSESSMENT AND SERVICE AGENCY)** | FY 2001-2002 | | FY 2009-2010 | | **COMMUNITY MENTAL HEALTH CENTERS ONLY (NOT SPECIALTY CLINICS)** | FY 2001-2002 | | FY 2009-2010 | |
| | MEDICAID MEMBERS | MEMBERS SERVED | MEDICAID MEMBERS | MEMBERS SERVED | | POPULATION (2000) | PEOPLE SERVED | POPULATION (2010) | PEOPLE SERVED |
| Behavioral Healthcare, Inc. | 55,021 | 6,730 | 118,323 | 13,177 | Community Reach Center | 323,608 | 4,853 | 442,971 | 5,888 |
| | | | | | Arapahoe | 427,589 | 2,937 | 571,598 | 4,662 |
| | | | | | Aurora Mental Health Center | 276,393 | 4,703 | 291,286 | 8,129 |
| Foothills Behavioral Health Partners | 9,851 | 1,573 | 57,145 | 12,895 | Mental Health Partners | 291,288 | 4,405 | 358,023 | 4,190 |
| | 20,255 | 2,965 | | | Jefferson Center for Mental Health | 541,135 | 7,023 | 560,598 | 7,905 |
| Northeast Behavioral Health Partnership | 32,266 | 4,240 | 64,171 | 8,199 | Centennial Mental Health Center | 105,870 | 2,477 | 111,450 | 2,118 |
| | | | | | Larimer Center for Mental Health | 251,494 | 3,479 | 299,284 | 3,940 |
| | | | | | North Range Behavioral Health | 180,936 | 3,765 | 255,496 | 5,207 |
| Access Behavioral Care | 60,981 | 6,052 | 89,258 | 11,465 | Mental Health Center of Denver | 554,636 | 6,846 | 618,650 | 6,285 |
| Colorado Health Partnerships | 33,912 | 7,463 | 174,788 | 22,253 | Aspen Pointe Mental Health Center | 552,007 | 7,097 | 644,360 | 8,259 |
| | | | | | San Luis Valley | 46,190 | 1,806 | 47,950 | 2,121 |
| | 48,262 | 10,881 | | | Southeast Mental Health Services | 52,449 | 1,713 | 50,207 | 1,694 |
| | | | | | Spanish Peaks Mental Health Center | 164,541 | 4,432 | 181,863 | 4,057 |
| | | | | | West Central Mental Health Center | 73,702 | 1,652 | 78,041 | 1,957 |
| | 31,667 | 7,145 | | | Colorado West RMHC | 293,004 | 5,714 | 367,800 | 4,863 |
| | | | | | Midwestern Col Mental Health Center | 86,348 | 1,892 | 102,674 | 2,160 |
| | | | | | Axis Health Systems | 80,071 | 1,770 | 92,277 | 1,953 |
| | | | | | Other/Specialty Clinics | 4,301,261 | 6,389 | 5,074,567 | 10,453 |
| **Total** | **292,215** | **47,049** | **503,684** | **67,989** | **Total** | **4,301,261** | **72,953** | **5,074,567** | **85,841** |

42   SFY2002 data are from TriWest (2003), pp. 23-24. Number served by CMHCs is an unduplicated number of consumers served and includes people with Medicaid. FY 2009-2010 data are from personal communication with Bruck Makonnen, DBH, January 2011.

**Changes in Contractually Required Service Expectations for Colorado CMHCs.** At the time of the 2003 report, CMHCs were contractually required to serve 10,600 non-Medicaid service recipients annually. Contractual requirements in SFY 2010 (which were kept at the same level for SFY 2011) were lower, with CMHCs collectively required to serve 9,522 non-Medicaid persons annually (a decrease of just over 10 percent). However, as can also be seen in the chart below, the lower contractual obligations have not led to fewer people served.[43] The period from SFY 2003 to SFY 2010 saw a 28 percent increase in the actual number of non-Medicaid people served.

**CONTRACTUALLY REQUIRED SERVICE EXPECTATIONS**
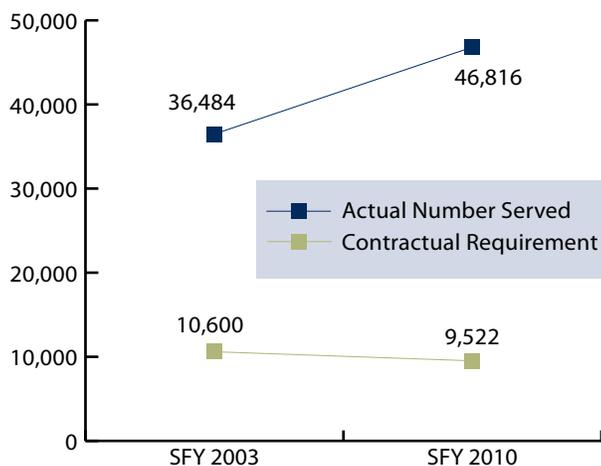


**People served in state-funded psychiatric hospitals.**
Colorado has two state-funded psychiatric hospitals: the Colorado Mental Health Institute at Pueblo (CMHI-Pueblo) and the Colorado Mental Health Institute at Fort Logan (CMHI-Fort Logan). As the name suggests, CMHI-Pueblo is located in Pueblo; CMHI-Fort Logan is located in Denver. As observed in our 2003 report, transformation of the role of state hospitals in Colorado has mirrored national trends over the last 50 years, with dramatic reductions in the use of long-term institutional care. That trend has continued since

2003 and accelerated recently due to further reductions in CMHI capacity driven by the state's budget challenges. While a significant number of people are still served by the two state hospitals each year, the overall number has decreased from 3,484 served in SFY 2001-02 to under 2,500 in SFY 2009-10, a drop of more than 28 percent.[44] Most of this decrease occurred in the last year, with substantial drops in people served through Pueblo's General Hospital unit and in numbers of child, adolescent, and geriatric people served. The chart that follows shows trends across the four major sets of state hospital resources: adults receiving forensic services, adults committed under civil commitment procedures, older adults receiving geriatric civil commitment services, and children/adolescents.

**PEOPLE SERVED IN STATE-FUNDED PSYCHIATRIC HOSPITALS**



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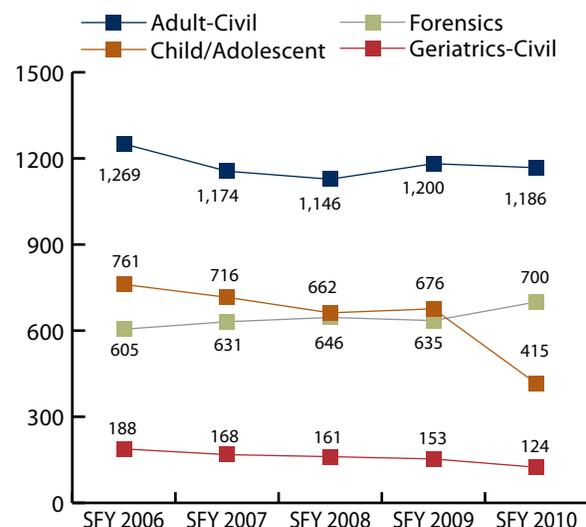
43  FY 2003 data are from TriWest (2003), p. 222. Note that actual number of people served in SFY 2003 in all non-Medicaid community mental health settings (36,484) is lower here than previously cited (40,031), because it only includes the number served by CMHCs, whereas the 40,031 includes Specialty Clinics and other providers. FY 2010 and FY 2011 data are from personal communication, Andrew Martinez, January 21, 2011. The 48,616 people served in SFY2010 include 14,461 people served by BOTH Medicaid and non-Medicaid funds during FY10. The assumption is that these people were at one time served through non-Medicaid funds in FY10, perhaps before they had become enrolled in Medicaid.

44  FY 2002 data is from TriWest (2003). FY 2006 – 2010 data is from personal communication, D. Poulin, CDHS, January 31, 2011. Note that some persons could have been served in more than one inpatient category during the fiscal year, and could be counted in more than one category, so these numbers are duplicated. Nevertheless, the proportionate reduction is the best available estimate of reduced service capacity.

Driving this reduction in use has been a continued reduction in the number of hospital beds at the two facilities, especially notable when examined in relation to Colorado's growing population. Beds per 100,000/population declined for all age groups since 2003, as shown in the table below.[45] The raw number of beds declined for all age categories, except for adults ages 18-64 (Adult Beds), for which the number held steady at 178 beds. There has been a 24 percent reduction in civil bed capacity at the CMHIs from 2003 to 2010, primarily in the last year.

| PUBLICLY FUNDED STATE HOSPITAL CAPACITY (CMHIS) PER 100,000/POPULATION | | | | |
|---|---|---|---|---|
| POPULATION | 2003 BED CAPACITY | CAPACITY PER 100,000 | 2010 BED CAPACITY | CAPACITY PER 100,000 |
| Population | 2003 Bed Capacity | Capacity per 100,000 | 2010 Bed Capacity | Capacity per 100,000 |
| Older Adult Beds | 85 | 19.3 | 40 | 7.7 |
| Adult Beds | 178 | 6.0 | 178 | 5.4 |
| Adolescent Beds | 34 | 10.5 | 20 | 6.0 |
| Child Beds | 16 | 1.9 | 0 | 0.0 |
| **Total** | **313** | **6.9** | **238** | **4.7** |

**PUBLICLY FUNDED STATE HOSPITAL CAPACITY PER 100,000 (2003 VS 2010)**
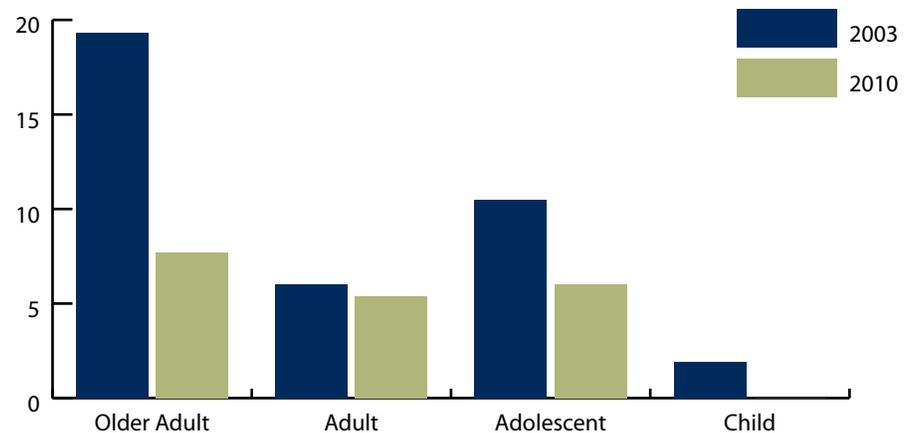


**Other Psychiatric Hospitals.** We obtained data from the Colorado Hospital Association on the number of people served in any acute care psychiatric facility in Calendar Year (CY) 2003 and CY 2009.[46] Trends in episodes, bed days (days in which a person was in a hospital bed), and total charges are summarized in the chart to the right. Note that from CY 2003 to CY 2009 episodes of care in other acute care hospitals dropped by 19 percent and bed days dropped by 7 percent (on average, on any given day in CY 2003, 373 people were in the hospital for a psychiatric or SUD reason; six years later, that number was 346). Note, however, that people are on average staying in the hospital longer (6.5

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45   2003 data is from TriWest (2003). 2010 data is from K. Cole, personal communication, December 2010. Population estimates were drawn from 2003 (4,548,339) & 2010 (5,029,196) – U.S. Census Bureau.

46   Personal communication of analysis completed, B. Finn, Colorado Hospital Association, March 2011.

ADVANCING COLORADO'S MENTAL HEALTH CARE

days on average in CY 2009 versus 5.6 days in CY 2003), a finding consistent with reports from stakeholders that people presenting for acute psychiatric care have more complex conditions and that access to psychiatric acute care is increasingly limited in the state.[47] Meanwhile, total charges increased substantially in other acute care hospitals (by 55.2 percent), reflecting cost increases elaborated upon under Observation #4.

### EPISODES, BED DAYS, AND TOTAL CHARGES IN ACUTE CARE HOSPITALS IN CALENDAR YEAR (CY) 2003 AND CY 2009
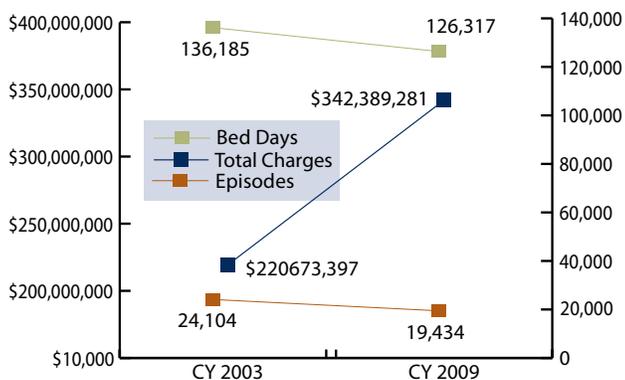


**Overall Inpatient Trends.** Across CMHIs and acute care hospitals, there has been a dramatic drop in the delivery of inpatient care since 2002/2003. This is particularly evident in the chart to the right, showing the drop in the number of bed days across facilities.[48] This combined 19.4 percent drop correlates with a 27.5 percent reduction in bed days through the CMHIs, plus an additional 7 percent reduction in acute care settings. Key informants described a range of efforts related to this reduced use, including system-wide efforts by BHOs for Medicaid and private payers, promotion of recovery-focused and community-based models in community mental health settings, and development

of diversion and step-down programs at the local level, including evidence-based practices described further under Observation #5.

### BED DAYS IN CMHIS AND ACUTE CARE HOSPITALS
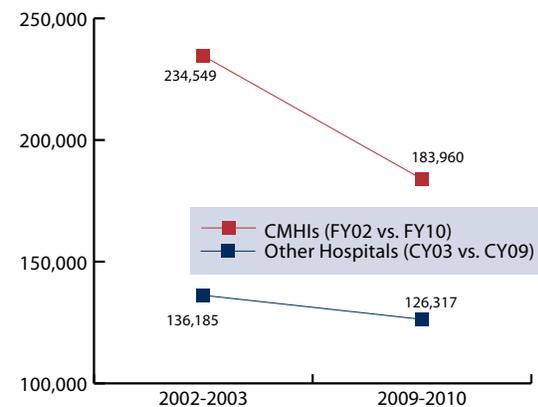


There are also concerns related to recent closings of acute inpatient facilities in the Denver metro area from 2007 through 2010. Key leaders we interviewed noted that capacity is particularly strained for people with complex, co-occurring mental health/SUD needs and medical conditions.[49] The most recent year for which we were able to obtain multi-state comparison data was 2006, and in that year – the year prior to the most recent closings – Colorado ranked 50th among all states and District of Columbia in per capita psychiatric acute care capacity. See the following table for data on Colorado and a cross-section of other states.[50]

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47  From the meeting notes of the December 2009 Colorado Acute Care Capacity Planning Meeting convened by The Colorado Health Foundation and facilitated by TriWest Group.

48  CMHI data is from personal communication with Ken Cole, Mental Health Institute Division, Office of Behavioral Health, CDHS, November 24, 2010. Number of bed days was calculated by multiplying the Average Daily Population for the fiscal year by 365 days.

49  This concern is compounded by recent rulings by the federal Centers for Medicare and Medicaid Services (CMS) requiring services delivered in Institutes for Mental Disease (IMDs – the CMS term applied to state psychiatric hospitals and other psychiatric care facilities). While people with complex needs had often been previously served in state psychiatric hospitals, IMD funding restrictions require the IMDs to pay for all medical care for residents (not just mental health care) and limits their ability to admit them to an outside hospital for medical care paid for by Medicaid. This creates additional access barriers for people with costly, complex medical and mental health/SUD conditions

50  Capacity analysis by D. Jarvis, MCPP Healthcare Consulting, Inc., (September 2009). Analysis conducted for Washington State using American Hospital Association Annual Survey Database.

| STATE | COMMUNITY HOSPITAL PSYCH BEDS FY2006 | BEDS PER 100,000 RESIDENTS | % OF PER 100,000 AVERAGE | PER CAPITA RANK |
|---|---|---|---|---|
| Missouri | 3,189 | 54.6 | 217% | 1 |
| Kansas | 1,284 | 46.5 | 184% | 5 |
| Connecticut | 1,260 | 36.0 | 143% | 15 |
| Pennsylvania | 4,353 | 35.0 | 139% | 16 |
| New York | 5,879 | 30.5 | 121% | 23 |
| Massachusetts | 1,837 | 28.5 | 113% | 27 |
| Maryland | 1,513 | 26.9 | 107% | 28 |
| Virginia | 1,921 | 25.1 | 100% | 32 |
| Ohio | 2,638 | 23.0 | 91% | 37 |
| Arizona | 913 | 14.8 | 59% | 47 |
| Florida | 2,279 | 12.6 | 50% | 49 |
| Colorado | 561 | 11.8 | 47% | 50 |
| Washington | 522 | 8.2 | 32% | 51 |

## Persons Served in the Substance Use Disorder Services System

Substance use disorders (SUDs) among youth and adults constitute a very significant concern in Colorado as well as nationally. We will examine the level of need in Colorado more fully under Observation #2, but stakeholders we spoke with clearly described the severity of their concerns, emphasizing in particular the adverse impact of untreated SUD on criminal justice involvement. The landmark 2009 *Shoveling Up II report* [51] pointed out that, of every dollar that Colorado spent in 2005 on the consequences of SUDs, only three cents went to treatment or prevention, whereas 97 cents were spent on the burden, particularly through the criminal justice system. However, Colorado has increased its investment in treatment in recent years, particularly by adding SUD treatment to its Medicaid benefit.

As recently as 2007, substantial gaps in service were still apparent. In a 2009 DBH funded and directed review, the Western Interstate Commission for Higher Education (WICHE) Mental Health Program estimated that 57 percent of adults with severe SUDs in the general population did not receive treatment. [52] The chart to the right shows, an even higher percentage (84 percent) of those with SUD or co-occurring mental illness and SUD did not receive treatment in 2007.

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51   National Center on Addiction and Substance Abuse at Columbia University. May 2009. Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets. http://www.casacolumbia.org/articlefiles/380-ShovelingUpII.pdf.

52   2007 data is from the DBH funded and directed WICHE Mental Health Program (2009). Colorado Population in Need – 2009. Boulder, Colo.: WICHE.

**ESTIMATED NUMBER OF ADULTS WITH SUD AND CO-OCCURRING SUD/SMI (COD) LIVING AT/BELOW 300% FPL WHO DID AND DID NOT RECEIVE TREATMENT IN 2007**
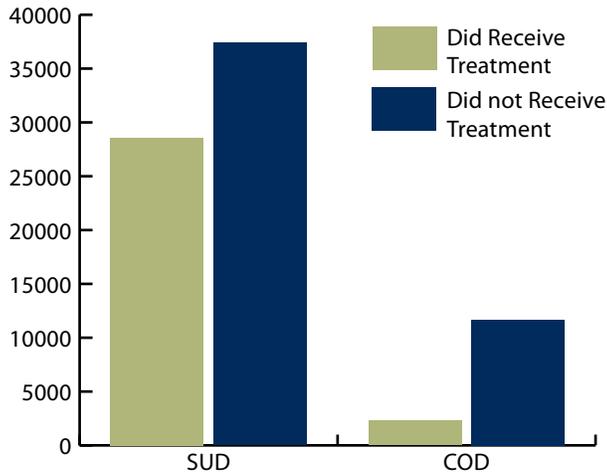


More recent data on services delivered to people with SUDs in Colorado's publicly funded system suggest that larger percentages of people are now being served. As covered more fully in the discussion under Observation #3 on funding, public funding for SUD treatment, particularly through Medicaid, has increased significantly since 2007. In the chart to the right, it can be seen that from SFY 2009 to SFY 2010 the number of people discharged who had been served in outpatient and residential detoxification settings rose by more than 8 percent.

**NUMBER OF DBH-INVOLVED CLIENTS DISCHARGED FROM SUD TREATMENT, SFY 2009 AND SFY 2010[53]**
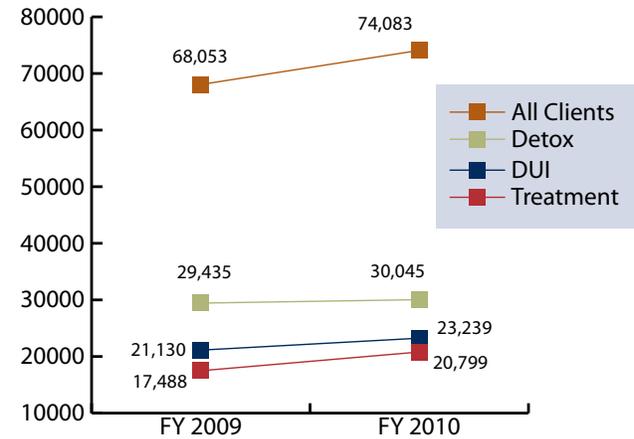


Recent increases in the number of people served through the Medicaid SUD Treatment Benefit rose at an even more impressive rate from SFY 2009 to SFY 2010. As can be seen in the table on the next page, the number of people receiving services increased by 50 percent, from 2,934 in SFY 2009 to 4,398 in SFY 2010.[54]

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53  Colorado DBH (2009, 2010). Cost-Effectiveness of SUD Programs in Colorado. The number of clients with Co-Occurring MI/SUD (COD) in FY10 was estimated, based on the reported percentage of discharged clients with COD.

54  The Colorado DBH completed a new report in June 2011 on service costs in the public SUD system. This report was not available until after completion of the major analyses of this report, so that data is not included. Please contact DBH for access to that report's findings.

WHILE SERVICES
FUNDED UNDER
THE MEDICAID
SUD TREATMENT
BENEFIT INCREASED
SUBSTANTIALLY FROM
SFY 2008 TO SFY
2010, IT SHOULD BE
NOTED THAT THE LEVEL
OF SERVICE REMAINS
RELATIVELY MODEST
COMPARED TO THE
LEVEL OF NEED.

| MEDICAID SUD TREATMENT BENEFIT, SFY 2008 TO SFY 2010[55] | | | |
|---|---|---|---|
| POPULATION | SFY 2007–08 | SFY 2008–09 | SFY 2009–10 |
| Total Clients Served | Not Reported | 2,934 | 4,398 |
| Sessions/ Encounters | Not Reported | 33,663 | 51,602 |
| FTE Medicaid Members | 404,835 | 443,774 | 503,684 |
| Percent of Medicaid Enrollees Served | | 0.66% | 0.87% |

While services funded under the Medicaid SUD Treatment benefit increased substantially from SFY 2008 to SFY 2010, it should be noted that the level of service remains relatively modest compared to the level of need, as discussed further under Observation #2. It should also be noted that Medicaid spending is concentrated in a small number of counties, with 60 percent of the total statewide expenditure in SFY 2010 accounted for by the five top counties: 1) Pueblo, 2) Denver, 3) El Paso, 4) Weld, and 5) Larimer. Furthermore, the Medicaid SUD benefit only covers outpatient counseling and urinalysis testing. It does not cover critical supports, such as medication-assisted therapies.

Stakeholders we talked with emphasized multiple limitations in Colorado's SUD service networks related to its history of limited funding and marginalized capacity that is too often stretched too thin in the view of many:

- The SUD benefit in Colorado had tended to focus on short term stabilization, rather than treatment of what is often a chronic illness.

- Colorado's SUD treatment provider network includes a wide range of relatively smaller providers, in contrast to the larger, more comprehensive treatment providers of Colorado's community mental health network. While this rich array of treatment options is a system strength, many providers lack the infrastructure for more intensive services or follow-up, and funding has not encouraged such practice with its emphasis on short term stabilization and treatment. The Access to Recovery (ATR) program, a five-year, $13 million federal grant to provide expanded recovery-focused supports for people without insurance, is helping shift this, but the history of underfunding and short term focus it has bred persists.

- Concerns about the quality standards for certified addictions counselors were noted by several. One concern was the over-emphasis on addictions, as opposed to the broader range of abuse-related disorders; while important, addictions are only a subset of SUDs. Another was the perception that higher quality standards are needed, but that the cost of certification and growing need for providers counterbalances this need and creates challenges.

- There are also gaps in promoting effective SUD treatments. One example cited by stakeholders was use of addiction medications. Despite a dedicated funding stream to promote their use in SFY 2011, DBH has had difficulty increasing prescriptions. One possible reason is a lack of access to prescribers within SUD treatment settings. Prescribers in mental health settings are reportedly reluctant to take on more care for persons with addictions, and prescribers in SUD treatment programs are minimal

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55    M. Case, HCPF, personal communication, November 24, 2010.

and generally dedicated to methadone or other more traditional treatment programs.

- At the agency level, a lack of capacity to meet the provider requirements for Medicaid billing and a broader lack of experience with more advanced provider requirements (such as electronic billing, participation in managed care networks, quality improvement initiatives, and financial risk management) were both noted by stakeholders, in contrast to community mental health providers that have been involved in Medicaid managed care systems and developing needed capacity for more than a decade.

- Stakeholders also noted a system strength in the close alignment of many SUD treatment options with the criminal justice system, including many offender-specific programs. Many mental health providers have been historically reluctant to work closely with the criminal justice system, though this has changed dramatically in recent years, and numerous CMHC providers have extensive partnerships with their local and state-level justice system partners. Stakeholders noted, though, that there is a lack of engagement and supports for ongoing treatment among SUD providers, given that so many people served historically were court-ordered into care. There is also a lack of specialized programming to address the needs of particular age groups, such as older adults with SUD (either those with earlier onset who have misused substances throughout their lives, and are now older, and often bearing broader health consequences; or those with late onset who do not misuse substances until later in life, often in response to losses, social isolation or cognitive decline). This reflects a developmental need at the broader system level.

- Stakeholders also noted a lack of linkages between SUD treatment providers and broader human services systems, such as housing and employment supports. These were observed to be more robust in community mental health service provision. This is not surprising given the large investment made in case management over the last two decades in Colorado's public mental health system, an investment that has not been made to nearly the same degree for SUD service provision. This was also related, in the view of some, to the lack

of population-based funding for SUD services where health plans or risk-bearing providers take responsibility for care over time rather than simply for payment for a single session or episode of care. Practice developments related to recovery-oriented systems of care and changing requirements in federal block-grants could help drive improvement in this area.

- On a positive side, efforts to improve screening and referral processes in health care settings (for example, the Screening, Brief Intervention and Referral to Treatment or SBIRT efforts[56]) have helped increase awareness, diagnosis, and treatment of SUDs in areas that have successfully embraced the model. Stakeholders noted that improvements have tended to be on the identification and brief intervention side, rather than referral to specialized care.

- Also of concern was the observation that most integration efforts have focused on integrating SUD into primary care and mental health, rather than integrating physical health care and mental health into specialty SUD treatment settings (such as detox and residential care). As discussed further in the integration discussion under Observation #5, there is a need to look at medical/health homes and accountable care in specialty and intensive care settings as well as primary care settings.

- Across all of these limitations, stakeholders expressed concern that, as SUD treatment provision and funding integrates with mental health and primary care treatment provision and funding over time, there is a risk that SUD providers will be further marginalized, and critical SUD capacity and expertise will be lost.

- There is also a concern among many stakeholders that "integration" too often means "assimilation" for SUD treatment resources, with fears that SUD clinical expertise will be glossed over in an effort to promote "behavioral health," and that relatively larger primary care and mental health funding streams will dwarf and ultimately absorb SUD funding if payment pools are integrated. There was consensus that true integration requires a valuing of SUD clinical expertise and its incorporation across care settings.

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56    For additional information on SBIRT and the research literature supporting it, see resources on the Colorado SBIRT website: http://www. improvinghealthcolorado.org/publicpolicy_research.php.

One model of SUD and mental health care integration has been the experience of the merger between Island Grove Regional Treatment Center, a SUD provider, and its community mental health partners in Larimer County (Larimer Center for Mental Health) and Weld County (North Range Behavioral Health), a partnership that has recently been extended to FQHC partners through the Northern Colorado Health Alliance. Planning for the merger (which occurred in 2008) began in earnest more than four years before, and grew out of close coordination between the involved boards and a multi-year series of integration initiatives in the region. For example, Larimer County has worked across multiple initiatives (including one of the six ACMHC integration projects) to integrate its mental health and SUD capacity. This process has involved operational redesign across clinical and administrative functions, including adoption of a strength-based philosophy that validated the importance of both mental health and SUD expertise equally, integrated assessment and medical record processes, alignment of treatment planning requirements (which required waivers from DBH, given six-month requirements for mental health and 90-day requirements for SUD), restructuring of salary structures to put SUD staff on a more equal footing compared to mental health staff, a "no wrong door" policy that involved clinical staffing integration across care settings (from detox to specialized services for people with severe and persistent mental illness, to children's services, to vocational services), and cross-training. The northern Colorado region is now a recognized leader in the state in delivery-system-integration efforts. One unintended challenge to these integration efforts, however, was the recent Medicaid Accountable Care Collaborative initiative (see Observation #5 for additional information on this important project). When the regions for the project were set, Larimer County was included with western Colorado (Region 1) and Weld County was included with northeastern Colorado (Region 2), to balance covered population numbers, thereby functionally splitting Medicaid oversight for this regionally integrated provider.

## Behavioral Health Services in Other Systems

### BEHAVIORAL HEALTH SERVICES THROUGH THE VETERANS ADMINISTRATION

Data on mental health services provided to Colorado residents through the Veterans Administration (VA) were provided by the North East Program and Evaluation Center (NEPEC) for the last three calendar years. These data are summarized in the following table.

| BEHAVIORAL HEALTH SERVICES THROUGH THE VETERANS ADMINISTRATION | | | |
|---|---|---|---|
| | **2008** | **2009** | **2010** |
| Total VA Service Users Residing in Colorado | 66,589 | 70,682 | 75,922 |
| Total Mental Health Service Users | 17,039 | 19,484 | 21,715 |
| Inpatient/Residential Users | 1,073 | 1,184 | 1,136 |
| Outpatient Users | 16,972 | 19,413 | 21,661 |

## BEHAVIORAL HEALTH SERVICES IN CRIMINAL JUSTICE SYSTEMS

As described in more detail under Observation #3, criminal justice systems across Colorado comprise the third largest funding source for public behavioral health services after the Medicaid and DBH-funded systems. The table to the right summarizes data available on the number of people served across Colorado's adult criminal justice systems. While data are not available for all services areas, it is readily apparent that significant resources are being expended in the criminal justice system to serve and incarcerate people with behavioral health disorders. In many cases, numbers of people served were not available, but levels of spending were, so spending is also shown in the table that follows to underscore the substantial investment made.

### BEHAVIORAL HEALTH SERVICES TO PEOPLE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM, SFY 2010 [57]

| PROGRAM | SERVED BY AGENCY | NUMBER SERVED – MENTAL HEALTH | NUMBER SERVED – SUD | TOTAL BEHAVIORAL HEALTH FUNDING |
|---|---|---|---|---|
| Department of Corrections[58] | 32,158 | NR[59] | At least 7,678[60] | $30,288,126 |
| Division of Probation Services[61] | 70,000 | NR | 32,000[62] | $17,046,007 |
| Division of Criminal Justice[63] | NR | 172 | 533 | $7,349,751 |
| Metro County Jails (2009)[64] | NR | 5,630 | | $35,100,021[65] |
| Other County Jails | NR | NR | | NR |
| DBH Offender Services Programs[66] | NR | 2,125 | 5,936 | $10,572,787[67] |

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57   Or the most recent fiscal year that complete data were available; years other than SFY 2010 are noted.

58   Number Served – SUD includes Community-Based Services (4,570 served) and Prison-Based Services (2,216). The latter was calculated using treatment discharges in SFY 2009. This may underestimate the number served, as 2,216 is slightly less than the number of annualized treatment slots (estimate of each facility's annual capacity), which totaled 2,386 in SFY 2009. These SUD programs had a total of $8,187,389 in funding. Total behavioral health funding also includes four programs for which data on numbers served were not available to TriWest: (1) an Institutions mental health budget, which includes a mental health Subprogram with $7,873,357 in funding, and the San Carlos Subprogram, a 250-bed specialized facility designed to provide mental health treatment services to high needs mentally ill inmates, with $13,385,703 in funding, (2) Psychotropic Medication Program ($119,975), (3) Community Mental Health Services ($471,702), and (4) Parole Subprogram ($250,000-FY 2011).

59   Note that data noted as "not reported" in the table were not available in reports accessible to TriWest. It may be the case that some of these data are available in other sources not known to TriWest.

60   This number does not include the number receiving Community-Based Outpatient Services, likely a large category. Through its general fund, the Department of Corrections Parole also allocates money for recovery support services for offenders.

61   This includes the Division of Probation's Senate Bill 03-318 program, which targets prison-bound offenders, with a priority to direct funds toward drug courts and recovery support services for offenders. Offender Treatment Services in SFY 2010-11 included approximately $565,000 in spending on mental health treatment and $2 million in spending on SUD treatment (personal communication, S. Colling, February 3, 2011).

62   This does not include data on the number of people served through the Offender Treatment and Services Fund, but it does include 30,000 people receiving evaluation services through the Alcohol & Drug Driving Safety Program.

63   Mental health services include 160 mental health Beds ($2,713,4100) and 12 slots available through the John Eachon Reentry program ($240,000). SUD services include 208 served through Intensive SUD Residential Treatment ($1,039,334) and 200 served through Modified Therapeutic Community ($2,851,380).

64   Spending on behavioral health services was estimated by the Mentally Ill Inmates Task Force of the Metro Area County Commissioners (MACC) for 2009 based on the number of inmates in seven metro Denver area counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson. For the estimate of people served, data from 2006, 2007 and 2008 was averaged due to missing data in 2009. This was the primary number cited in the MACC analysis, so it is used here.

65   This amount is the estimated cost of incarcerating people with Axis I mental disorders in seven metro area county jails and correctional facilities in 2009.

66   These offender-related programs include several made possible by the Tobacco Litigation Settlement, as well as several programs that received allocations from the State General Fund and the Persistent Drunk Driver Fund to serve people with SUDs. Totals include: (1) SB 07-97: 2,100 receiving mental health services, $3,803,000 in spending; (2) Family Advocacy Program: 50 served (not clear whether mental health or SUD, so the total was split evenly between the two for reporting), $157,000 in spending; (3) STIRRT-Residential: 1,400 receiving SUD services, $2,791,874; (4) STIRRT-Continuing Care: 760 receiving SUD services, $361,536; (5) STIRRT-Ancillary Services: total served not available, $211,000; (6) ARTS/Peer 1/The Haven: 53 receiving SUD services, $321,849; (7) Strategies for Self-Improvement and Change: 566 receiving SUD services, $951,288; (8) Persistent Drunk Driver Fund (detox and education): 3,100, $577,000; and (9) STAR Therapeutic Community: 32 receiving SUD services, $600,000.

67   Funding data is taken from the Colorado Commission on Criminal and Juvenile Justice (December 2010). White paper from the Treatment Funding Working Group. Division of Criminal Justice, Department of Public Safety. Table 8, pp. 69 ff.

## BEHAVIORAL HEALTH SERVICES IN THE JUVENILE JUSTICE SYSTEM

The Colorado Division of Youth Corrections (DYC) also provides a large amount of behavioral health care. In SFY 2007, DYC took an important step toward more systematically identifying youth with behavioral health needs by implementing the Colorado Juvenile Risk Assessment (CJRA), which identifies mental health and SUD treatment needs related to juvenile justice involvement. However, DYC does not specifically keep track of the number of youth receiving behavioral health services. It does track the number of youth that receive mental health and SUD treatment after being discharged from commitment placements. Of the 1,270 committed youth discharged in SFY 2010, 514 (40 percent) received mental health services and 77 (6 percent) received SUD treatment.[68] While many of those receiving mental health services also received SUD treatment as part of that care, it is of interest to note that Colorado Client Assessment Record (CCAR) indicators of need suggest that far more committed youth need SUD treatment (63.5 percent) and relatively fewer needed mental health treatment (22.2 percent). Behavioral health treatment is also provided in detention settings, through community-based detention alternatives funded under the SB94 program, and in residential commitment settings, but specific figures on behavioral health expenditures and numbers served are not reported.

## BEHAVIORAL HEALTH SERVICES IN THE CHILD WELFARE SYSTEM

The Core Services Program within the CDHS Division of Child Welfare (DCW) is statutorily mandated to provide strengths-based resources and support to families when children are at imminent risk of out-of-home placement and/or need services to maintain a less restrictive setting. In SFY 2010, the program spent more than $7.8 million on these services, with 4,602 children and family members receiving mental health services (97 percent of the number estimated to have severe mental health needs) and 4,667 receiving SUD treatment (47 percent of the number estimated to have severe SUD needs).[69] Other behavioral health care purchased by DCW includes an array of out-of-home placements. In SFY 2010, DCW placed six children in residential SUD programs, 2,007 children in Therapeutic Residential Child Care Facilities, and 19 children in psychiatric inpatient settings.[70]

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68    Number served (mental health and SUD) data is from non-residential served in TriWest's (2010) Continuum of Care Report, re-analyzed by TriWest in February 2011. This analysis of continuum of care youth receiving mental health and SUD services does include some people who were in residential settings while being prepared for discharge through continuum of care services. Some of the services generically classified as mental health services may also include treatment for targeted SUD issues.

69    TriWest re-analysis of Core Services data on June 20, 2011. For the full report, see TriWest (2010). Core Services Program Evaluation Annual Report, SFY 2009-2010. CDHS, Division of Child Welfare. (Full report does not include all data reported here.)

70    Colorado Division of Child Welfare; Research, Evaluation and Data Team. Personal communication, K. Powell, June 21, 2011.

The WICHE Mental Health Program did a more extensive analysis of mental health services for children and adolescents involved with DCW in SFY 2007.[71] More than half (51 percent or 14,812) of all children served by DCW received mental health services. The specific agencies providing these services included: 11,187 through DCW, 7,366 through Medicaid BHOs, and 4,532 through DBH. The WICHE analysis found that 4,135 (14 percent) of children served through DCW received SUD treatment, including: 3,963 through DCW, 535 through DBH, and 91 through Medicaid.

## BEHAVIORAL HEALTH SERVICES IN EDUCATION

School-based health centers (SBHCs) offer an important set of services for children and adolescents in 47 schools in 19 school districts.[72] Many of these services are provided in partnership with mental health and SUD providers (for example, CMHCs), so there is overlap in the figures reported here and above. Based on average expenditures of $233,000 in cash per center, overall spending during the 2009-10 school year totaled just under $11 million (plus an additional $2.5 million in in-kind support). The centers served 27,560 children with over 84,000 visits. According to 2009-10 School Behavioral Health Center (SBHC) Annual Survey data, nearly one-quarter (24% percent) of visits in the 2009-10 school year involved behavioral health concerns (24 percent, or 20,021 visits, for mental health and less than 1 percent, or 242 visits, for SUD).[73] Mental health-related visits were the second highest reason among students (primary care was first). Out of the SBHC users during the 2009-10 school year, 12 percent were ages 0 to four, 17 percent were ages five to nine, 27 percent were ages 10 to 14, 40 percent were ages 15 to 19, and one percent were ages 20 years and older (age was unknown for four percent of SBHC users). Geographically, 24,203 SBHC users (69,645 visits) resided in urban communities, while 3,357 users (14,578 visits) lived in rural areas.

Behavioral Health services provided by SBHCs range from addressing minor emotional distress to crisis intervention, including suicide attempts and helping students cope with post-traumatic stress disorder. Behavioral health treatment services offered at Colorado SBHCs are integrated with primary care services and include: mental health assessments crisis intervention; individual, group and family counseling; consultation with educators, parents and students; and assessment and treatment for SUD. In addition, SBHCs also provide prevention services, offering smoking prevention and cessation programming, and violence prevention and intervention services. SBHCs reported the following breakdown of licensed mental health clinicians who provided services during the 2009-10 school year: psychiatrists provided services to eight SBHCs (18 percent), alcohol and drug counselors provided services to one SBHC (2 percent), and licensed counselors/social workers/therapists provided services to 36 SBHCs (80 percent). Seven SBHCs had services provided by unlicensed counselors/social workers/therapists, and none had services provided by psychologists or psychiatric nurse practitioners. Services in SBHCs are guided by quality standards developed by CDPHE in 2009.[74]

Colorado SBHCs provide services to students regardless of their ability to pay, with nearly half of the students who receive services being uninsured. During the 2009-10 school year, 31 percent of SBHC users were uninsured, 42 percent were enrolled in Medicaid, 9 percent had private insurance, 9 percent were enrolled in CHP+, 2 percent were supported by some other government program, and the remaining 8 percent were supported by an unknown funding source. In 2006, the Colorado General Assembly passed HB 06-1396, which supported the creation of a grant program specifically for SBHCs. Grants are awarded for the establishment, expansion and ongoing operations of SBHCs. Centers that serve a disproportionate number of uninsured children or low-income populations (or both) are given priority for these grants.

71   WICHE Mental Health Program (2009). Colorado Population in Need – 2009. Boulder, Colo.: WICHE. Report was funded and directed by DBH.

72   Colorado Association for School-Based Health Care. (May, 2011). School-based health centers: Fact Sheet. Retrieved at: http://www.casbhc.org/publications/Fact%20Sheet.pdf.

73   Unpublished data from the 2009-10 SBHC Annual Survey, with data collection and analysis conducted by the Colorado Association for School-Based Health Care and the Colorado Health Institute. Personal communication, S. Moody, July 21, 2011. Data that follows is from same source, unless otherwise cited.

### BEHAVIORAL HEALTH SERVICES IN PRIMARY CARE

Data from the most widely cited epidemiological studies show that about 17.3 percent of the 32.9 percent of people in need of care every year (in both the public and private sectors) receive services in general medical or primary care settings.[75] The proportion of people receiving care in primary care settings varies by severity as follows:[76]

- Of the 6.8 percent of people with no diagnosable needs who nonetheless receive treatment, 47 percent do so in primary care settings;

- Of the 11.3 percent to 23.0 percent of those with mild conditions who receive treatment, 51 percent do so in primary care settings;

- Of the 26.3 percent to 37.2 percent of those with moderate conditions who receive treatment, 52 percent do so in primary care settings; and

- Of the 37.1 percent to 40.5 percent of those with serious needs who receive treatment, 55 percent do so in primary care settings.

One of the major sources of primary care-based mental health and SUD treatment in Colorado are federally qualified health centers (FQHCs). There are 15 FQHCs in Colorado operating 123 clinic sites in 33 counties.[77] FQHCs are required to provide specialty behavioral health care as part of their treatment array. Key informants underscored the importance of FQHCs in behavioral health care delivery, both through their primary care resources and their increasingly robust integrated mental health and SUD treatment resources.

75    Kessler, R.C. et al. (2005). Prevalence and treatment of mental disorders, 1990-2003. New England Journal of Medicine, 352, 2515-2523.

76    Kessler, et al, 2005. Bilj et al estimated a treatment rate overall as low as one in 10, but the Kessler study is generally viewed as the current benchmark.

77    Colorado Community Health Network. Retrieved at: http://www.cchn.org/health_centers.php.

Under Observation #5, we discuss in detail Colorado's leadership nationally in grassroots development of integrated primary and behavioral health care; Colorado's FQHCs have been leaders in this effort along with community mental health providers through the Colorado Behavioral Healthcare Council (CBHC). As discussed further under Observation #5, CBHC has been a leader nationally in the promotion of integrated care, and its members are involved in integrated initiatives in approximately 100 sites.[78]

Despite this leadership, FQHCs face challenges. While partnerships between Medicaid BHOs, community mental health centers, and FQHCs have increased, there are still tensions when integrating the various funding streams involved in the care, particularly in a time of budget freezes and reductions. The association for FQHCs in Colorado, the Colorado Community Health Network, reported that FQHCs suffered a $20 million funding cut in SFY 2010, despite growth of over 30,000 persons served. Capacity is expected to be further strained as Medicaid coverage expands, and there are concerns as to whether rates paid will be adequate to cover needed expansion. Rural health clinics offer additional capacity in rural and frontier areas of the state (this is described in more detail below in the section on rural and frontier needs under Observation #2). Colorado has also made a major investment in the development of person-centered medical homes, which are described in more detail under Observation #5.

## UNINTENDED CONSEQUENCES OF MULTIPLE, UNCOORDINATED GOOD INTENTIONS: HIGH UTILIZATION OF INEFFECTIVE SERVICES ACROSS MULTIPLE SYSTEMS

One of the problems inherent in the poorly coordinated, discrete systems that provide mental health and SUD treatment is the tendency of people with complex needs to become involved in multiple systems that provide care that is uncoordinated and too often redundant, ineffective, or even counterproductive. Through their intensive planning efforts in 2009, the Behavioral Health Transformation Council (BHTC) identified the "Top 300" users of multiple systems as one of their highest priorities to better understand and learn from. The approach was popularized earlier this year in the *New Yorker* magazine's profile of *hot spotting*.[79] The notion is relatively simple: identify the people using the most care across systems – mental health and SUD treatment, primary care, hospitals, corrections, juvenile justice, child welfare, special education – and figure out how to do a better job coordinating that care. Many of the evidence-based practices described in Observation #5 (for example, Wraparound Planning, Integrated Dual Disorder Treatment) derive much of their efficacy from this notion. Some states have even created integrated care management databases that routinely identify and support care coordination for people involved in multiple systems (for example, the State of Washington's PRISM system[80]). Colorado's efforts through HCPF to implement a Statewide Data Analytics Contractor in 2011 aim to develop a similar capacity to support the state's implementation of Regional Care Collaborative Organizations under its Accountable Care Collaborative Program, described further under Observation #5.

The first steps in this direction taken for people involved in Colorado's mental health and SUD treatment systems, however, was a joint effort between the BHTC and DBH in

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78    Personal communication, G. DelGrosso, July 17, 2011.

79    Gawande, A. The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? New Yorker, January 24, 2011. Retrieved at: http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande.

80    Washington State Department of Social and Health Services. January 30, 2011. Washington State Proposal to Integrate Care for Dual Eligibles. Retrieved at: http://www.familiesusa2.org/assets/pdfs/WA_Dual_Integration_Proposal.pdf.

2010, to begin to identify people using the most services across state agencies. DBH identified the top 267 people in terms of cost who had accessed five or more different types of state agencies (inclusive of mental health care in all cases). DBH has released preliminary results of this analysis for inclusion in this report, and more detailed analyses are underway and expected to be released during 2011.[81] Of these 267 people, just over half (51 percent) had Medicaid claims. Just the cost of their BHO in SFY 2008 and medical claims in the following year (SFY 2009) alone was over $30,000 per person, as shown in the following table.

| MEDICAID SERVICE COSTS OF MULTIPLE SYSTEM USERS | | | |
|---|---|---|---|
| **MEDICAID COST CATEGORY** | **TOTAL COSTS** | **NUMBER OF PEOPLE** | **AVERAGE COST PER PERSON** |
| Medicaid – Physical Health Services (SFY 2009) | $3,354,344 | 140 | $23,960 |
| Medicaid – BHO Contracted Services (SFY 2008) | $849,899 | 134 | $6,343 |
| **Total** | **$4,204,243** | **140** | **$30,030** |

These preliminary results indicate that these highest users tend to represent the following characteristics and risk factors:

- In terms of gender and race, the plurality are **white male adults**, with no dependent children;

- Many are **people with serious and persistent mental illness (SPMI)**, with multiyear system involvement;

- Many are **people with histories of suicide attempts** (40 percent have a history of being a danger to themselves and 10 percent have attempted suicide);

- Many have **histories of being victimized**;

- Many have histories of **multiple inpatient mental health and SUD treatment admissions**, as well as multiple outpatient services;

- A large majority **have histories of involvement with law enforcement**, court systems, and corrections, with 66 percent having past legal convictions and 63 percent histories of incarceration; the most common charges for these convictions are for non-violent illegal behavior, including 35 percent destroying property and 17 percent setting fires; however, many have more concerning behaviors, including sexual misconduct (21 percent) and physical injuries or threats to others (16 percent);

- Nearly half (46 percent) have **a current or past use of SUD services** (as reflected in their own or family member involvement in state-funded services;

- Nearly half **have learning disabilities** (48 percent);

- More than one-quarter (28 percent) **have co-occurring developmental disabilities**;

- One in 10 have **co-occurring physical impairments**, including 8.4 percent with traumatic brain injury and 1.8 percent with visual impairments; and

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81   Behavioral Health Transformation Council, Systems of Care Subcommittee (February 2011). Draft Summary of Findings for Behavioral Health High Utilizers Data.

- The most frequent diagnoses are 36 percent schizophrenia (or a related psychosis), 26.5 percent bipolar disorder, and 13.8 percent depression.

These findings underscore the central challenge of behavioral health care in the decade before us – finding new ways to identify and meet the complex and multiple needs of the people our many mental health, SUD and human services systems continue to fail to help.

Many of these needs have their roots in failed efforts to help children and their families. From January 2006 through August 2008, a partnership between state entities that fund behavioral health services and programs for children and youth studied coordination among Colorado's multiple child and family systems.[82] The Colorado LINKS for Mental Health Initiative survey of representatives of 19 state agencies responsible for some component of child, youth and family behavioral health services underscored the stark difficulties of serving children, youth and families across agencies: structural barriers (including differing policies, practices, mandates, and funding) and interpersonal barriers (including staff time and resources, turnover, and trust). The structural barriers go beyond specific policy or regulatory differences to the level of mission, vision and culture – at times, priorities across agencies can even directly conflict as individual health, family health, child safety, community safety, education, and a host of other more specific goals are pursued. Many are even wary of collaboration as simply an opportunity for work to be made complex or even "sloughed off" by other agencies. Some emphasized the challenge of multiple, competing collaboration efforts. While optimism persisted, the findings underscored the long-term, detailed work of integration.

These themes reflect growing frustration at the local, state and federal level to "reboot" the system and take on dramatic reforms (themes explored in more detail under Observation #4 below). The Colorado LINKS findings regarding successful efforts, however, point primarily to the need to develop specific solutions at the local level for individual children, youth and families. The experiences of the six grantees participating in ACMHC from 2005 to 2010 underscore that solutions for complex health care needs can be developed in a range of Colorado communities for a range of complex conditions. While agencies at the state and local level, and their varied policies, can hinder or support these local efforts, the opportunities to meet complex needs remain ultimately local.

## THE FUTURE OF SERVICES: INVESTING IN PREVENTION

The role of prevention in promoting health care broadly and behavioral health in particular has seen a surge in interest in the era of health care reform, both nationally[83] and within Colorado.

Central to many of these efforts was the watershed identification by a research team led by Vincent Felitti in 1998 that described the construct of Adverse Childhood Experiences (ACEs).[84] Research since then has shown that maltreatment of various kinds – physical and sexual abuse, psychological abuse and neglect – is associated with poor health and behavioral health outcomes.[85]

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82   Personal communication, J. Esquibel, July 7, 2011.

83   Miles, J., Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E. (2010). A Public Health Approach to Children's Mental Health: A Conceptual Framework. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Retrieved at: http://gucchdtacenter.georgetown.edu/publications/PublicHealthApproach.pdf?CFID=4544464&CFTOKEN=73266811.

84   Felitti, V.J. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14(4), 245-258.Gilbert, R. et al. (2009). Burden and consequences of child maltreatment in high-income countries. Lancet, 373, 68-81. Juhl, A. (2009, September). Prevention Services Division Improvement Plan Goal 3, Objective 2, Action Step D: Literature Review on Adverse Childhood Experiences. Colorado Department of Public Health and Environment, Epidemiology, Planning and Evaluation Branch, Prevention Services Division.

85   See http://www.theannainstitute.org/ACE%20Study/ACE-PUB.pdf for a September 2010 listing of major ACEs studies compiled by Dr. Felitti.

Studies from the literature and Colorado's own data show that several preventable risk factors lead to negative life trajectories, and poor long-term health and behavioral health outcomes for adolescents. At the same time, early childhood health promotion efforts can have a positive influence on the life course in adolescence and adulthood.[86] Colorado funds multiple prevention efforts related to behavioral health, primarily through CDPHE and DBH, which provide a broad array of community-based programs aimed at preventing risk factors and promoting processes that are associated with resilience. Key prevention services include:

- **DBH funds** an array of prevention services related to SUD, with just over $9 million of annual funding for primary prevention in SFY 2009 and SFY 2010 (nearly 16 percent of the amount spent on SUD treatment). Most of this comes from federal block-grant funding, and the July 2010 Substance Abuse Prevention and Treatment (SAPT) Block-grant report describes in detail the statewide infrastructure for coordinating planning and provision of SUD prevention supports that has shifted efforts increasingly toward targeted outcomes in recent years. Prevention efforts have been targeted through a competitive procurement process to prevent and reduce alcohol, tobacco and other drug use for people under age 18, change community norms regarding use of these substances, and address needs for specific population subgroups including young adults (ages 18 to 25), members of the armed forces and their families, sexual minorities, and older adults. There are also statewide priorities to fund capacity among current prevention providers focusing on prescription drug abuse, employee-assistance-program development for small businesses, parenting education, fetal alcohol spectrum disorder/prenatal substance abuse prevention, SUD among college students, and broader efforts to prevent tobacco, alcohol, and other drug use.[87]

86    Guyer, B. et al. (2009). Early childhood health promotion and its life health course consequences. Academic Pediatrics, 9, 142-149.

87    DBH. July 2010. Colorado Uniform Application FY2011: SAPT Block-Grant. Retrieved at: http://www. colorado.gov/cs/Satellite?c=Document_C&childpagename=CDHS-BehavioralHealth%2FDocument_C%2FCB ONAddLinkView&cid=1251583710216&pagename=CBONWrapper.

- **The Colorado Children's Trust Fund** has stimulated the development of initiatives, including the Nurturing Parenting Program, aimed at enhancing parenting skills and parent-child relationships in at-risk families. Results using the Adult-Adolescent Parenting Inventory have revealed encouraging results, including reduced evidence of traits associated with child maltreatment and reduced likelihood of abuse or neglect.[88] The Colorado Children's Trust Fund and CDPHE also more recently issued requests for applications to develop and implement creative, community-based proposals for using research- or experience-based parenting programs in the local community to promote healthier parenting practices.[89]

- **The Office of Suicide Prevention** provides a range of supports, including competitive community grants for the Gatekeeper Training project. This innovative approach involves training people in a variety of community settings – schools, human services agencies, voluntary organizations, and so on – in how to detect and intervene early to prevent suicide. The program also encourages attention to sub-groups of adolescents who are sometimes at heightened risk for suicide, including lesbian, gay, bisexual, transgender, and questioning youth.[90]

- **The Colorado State Child Fatality Prevention Review Team** is a statewide, multidisciplinary, multi-agency effort to prevent child deaths.[91] The team has been reviewing data on child deaths since 1989; prevention strategies and specific policy recommendations have been identified and promoted.

- **CDPHE's Colorado Adolescent Health Profile** documents the health status of Colorado youth and monitors trends over time. In 2009, 1,515 high school students in Colorado completed the 2009 Youth Risk Behavior Surveillance System (YRBSS) survey. Key YRBSS findings related to behavioral health include: reductions in binge drinking (from 30.6 percent to 25.1 percent), and increases in suicide attempts (from 1.0 percent to 3.1 percent). CDPHE uses these data to monitor

key public health goals, such as reducing the five-year average suicide death rate for children (which is within the goal of 5.0 per 100,000 for children ages 10 to 14 at 2.0 per 100,000 and far in excess of the goal of 5.0 per 100,000 for adolescents ages 15 to 19 at 11.1 per 100,000); reducing the proportion of adolescents "feeling sad or hopeless almost every day for two weeks or more that they stopped doing some activities over the past year" (rate of 25.4 percent, with a goal of 20 percent or less); reducing the proportion of high school age youth who had five or more drinks of alcohol in a row, within a couple of hours, on one or more of the past 30 days (rate of 25.1 percent with a goal of 25 percent or less); and reducing the proportion of high school age youth who used marijuana in the past 30 days (rate of 24.8 percent with a goal of 18 percent or less).

- As noted earlier, **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** interventions represent an established best-practice prevention approach in primary care settings for SUD risk and functional impairment. Just as a routine check of blood pressure can reveal health issues and guide recommendations to improve health outcomes, universal screening for substance use lets health care providers intervene sooner before risky substance use contributes to worse health outcomes. A federal SBIRT grant to the State of Colorado awarded in 2006 has demonstrated the efficacy of implementing SBIRT in a variety of health care settings including urban and rural hospitals, community clinics, FQHCs, and HIV care settings. As of June 2011, more than 110,000 people had received SBIRT services in 26 health care settings in Colorado, of which approximately 11 percent were found to have a level of substance use risk sufficient to receive an intervention. Outcome results demonstrated a substantial drop in overall use during the 30 days prior to a six-month follow-up as compared to the 30 days prior to intake: alcohol use fell by 47 percent and overall days of illicit substance use fell by 44 percent; binge drinking (consuming five or more drinks in a single sitting) fell by 50 percent; and cannabis and

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88   Recent Successes of the Colorado Children's Trust Fund ("CCTF successes" in MWord; appears to be from 2005-2006).

89   Colorado Children's Trust Fund and CDPHE February 2010 RFAs.

90   Office of Suicide Prevention (OSP) Community Grants Request for Applications (August 14, 2009 – June 30, 2012).

91   Colorado State Child Fatality Prevention Review Team. (November 2010). Colorado Child Fatality Prevention System Annual Report – 2010.

cocaine use fell by 43 percent and 88 percent, respectively. In addition to improved health outcomes, SBIRT has well documented potential to reduce health spending, including high-cost emergency room visits and hospital admissions and re-admissions. Through the five-year federal grant, there is now an existing infrastructure in Colorado for training health care professionals in fidelity implementation of SBIRT, as well as practice management and work flow guidance to streamline SBIRT services in various health care settings. In addition, screening and brief intervention for SUD is a billable preventative service under Colorado insurance plans and Colorado Medicaid and Medicare.[92]

## RECOMMENDATIONS TO PROMOTE INTEGRATION AND REDUCE CONTINUING FRAGMENTATION

It is clear that Colorado has better organized its behavioral health delivery systems in the last decade, particularly in the last four years. State agencies with a core mission to deliver mental health and SUD services (the OBH/DBH within CDHS, HCPF, and CDPHE) are working better together and coordinating with agencies that deliver mental health and SUD services as part of a different core mission (corrections, public safety, and youth corrections and child welfare within CDHS), as well as with other state agencies that play an important supportive role (labor/employment, local affairs, housing/community development, and vocational rehabilitation). Despite this progress, there is clearly still much work ahead. The complex process of integration – integration of mental health and SUD services, between mental health/SUD and physical health services, and between health and various supporting human services for those with the most complex needs – is critical to the success of health reform, as discussed in more detail in the observations that follow. It is also likely the work of years and decades, rather than months.

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92   Data on SBIRT provided via personal communication from J. Esquibel, CDPHE, July 7, 2011. For additional information on SBIRT and the research literature supporting it, see resources on the Colorado SBIRT website: http://www.improvinghealthcolorado.org/publicpolicy_research.php.

**AS COLORADO'S EFFORTS CONTINUE TO MOVE FORWARD, IT IS RECOMMENDED THAT THE FOLLOWING SPECIFIC ACTIONS BE PRIORITIZED BY POLICY MAKERS:**

1. **Integrate deliberately.** Policy makers should be mindful that meaningful progress in health and human services integration is always incremental, transformation is more cultural than structural, and reforms must prioritize broader system goals (such as the "Triple Aim" of health reform, discussed in more detail under Observation #4 below). State and local integration efforts need to focus more on the complex details of true integration rather than simply reorganization. Reorganization in the service of a more complex, thoughtful integration effort, however, can be a powerful tool.

2. **Rely on the Behavioral Health Transformation Council (BHTC)** as the lead resource in coordinating planning for publicly funded mental health and SUD services, and recognize that it needs resources to function well. Colorado has invested a tremendous amount of resources into the development of a single planning and policy development forum for behavioral health system improvement with executive, legislative, judicial, local government, and broader mental health and SUD stakeholder representation. The Hickenlooper administration has committed to work through this structure for its planning, and all health reform planning should coordinate with BHTC and its links to constituents across stakeholder groups statewide.

3. **Address behavioral health and local human services integration within Regional Care Collaborative Organizations (RCCOs) by:**

   • **Formally incorporating performance indicators for behavioral health care delivery within the RCCOs.** As discussed in more detail under Observation #5, the current RCCO efforts only involve mental health/SUD service delivery informally. Adding RCCO performance indicators for mental health/SUD outcomes and ensuring that broader integration strategies contain measurable outcomes to demonstrate improved access, cost and quality is critical. Focusing on a core set of performance indicators can ground system changes and measure progress with even a handful of key outcomes. Potential metrics include access to mental health/SUD care broadly, investment in specialty mental health/SUD services, and overall costs of care (mental health/SUD and other physical health) for those with the highest needs.

   • **Formally involving counties, to leverage their broader human services resources and reduce costs in jails and other adverse impacts of unmet behavioral health needs.** HCPF's Accountable Care Collaborative program is discussed in more detail as a national best practice under Observation #5 below. It is the primary focus of local health care reform planning and implementation for public sector funding in Colorado, and behavioral health should be formally incorporated in the program design at the earliest possible opportunity.

4. **Beyond Medicaid, look for opportunities to consolidate state-level delivery and financing** for behavioral services across agencies in order to align benefits and maximize access to federal funds, particularly for community-level corrections, juvenile justice, child welfare, and education. For example, the Colorado Commission for Criminal and Juvenile Justice's behavioral health task force recommended in 2010 that DBH purchasing models be adopted more broadly across human services purchasers of mental health and SUD services. Additionally, many juvenile justice and child welfare services in the community currently purchased primarily with state general funds are financed in other states as health care services to leverage federal Medicaid funding. Opportunities abound, and the Transformation Council can be a lead resource in identifying and addressing them.

# Observation #2
## Despite Gains and the Hope of Health Reform, Many People Still Cannot Access Needed Care

### Snapshot of Key Findings
### Regarding the Need for More Access to Care

### The Need for Behavioral Health Care in Colorado

▶ Updated national studies show that three in 10 Coloradans need treatment for mental health or SUD needs each year – more than 1.5 million people.

▶ More refined national and Colorado studies also show that needs vary across the population:

- ▼ Just over one in 10 (over 580,000) have a SUD of some kind (alcohol or drug, abuse or dependence).

- ▼ Just over one in 10 (between 550,000 and 700,000) have a mild mental health, SUD or co-occurring condition.

- ▼ About one in 11 (nearly 450,000) have a moderate mental health, SUD or co-occurring condition.

- ▼ About one in 12 (about 425,000) have a severe mental health, SUD or co-occurring condition.

- ▼ About one in 30 (over 170,000) are adults with a severe mental illness (SMI) that substantially impairs their functioning and ability to be self-sufficient. About 100,000 of these people also have co-occurring SUD. About 125,000 have low incomes (at or below 300 percent of the Federal Poverty Level).

- About 1 in 100 (60,000) are adults with severe SUD without SMI, an important, underserved group.

- More than one in 50 (90,000) are children and adolescents with SED that impairs their functioning and puts their ability to live at home at risk. Nearly two-thirds have low incomes. Many adolescents have SUD needs, including nearly two-thirds served by the Division of Youth Corrections.

▸ Nationally, access to care varies by level of need (and the estimate varies sometimes a lot by study):

- A substantial number of people with no diagnosable need get care (between 6.2 percent and 14.5 percent),

- Between one in 10 and one in five with mild needs receive care (11.3 percent to 23.0 percent),

- Between one in four and one in three with moderate needs receive care (26.3 percent to 37.2 percent), and

- Approximately two in five with severe needs receive care (37.1 percent to 40.5 percent).

▸ Looking at available Colorado data on the public system, about 61 percent of people with SMI/SED and 64.8 percent of people with severe SUD needs are served by public providers, much higher than in 2003.

## Rural and Frontier Areas

▸ Colorado is famous for its rural and frontier areas where many Coloradans choose to live. While levels of overall need are similar to urban areas, access to care outside the Front Range is much lower.

▸ Critical supports such as prescribers, acute care facilities (inpatient and detox), and intensive community supports are often 100 miles or more away. Often even primary care access is limited.

▸ Rural and frontier communities face additional challenges in 2011, given population losses, transient populations in recreational areas, undocumented residents in agricultural areas, and the disproportionate effects of the recent recession on job losses in small towns and rural areas.

▸ Payers and providers in rural areas have developed integrated care models and multi-agency partnerships that offer hope for addressing growing needs with limited supplies of providers.

## Other Indicators of Need

▸ A high and growing suicide rate.

- Nine hundred forty Coloradans took their own lives in 2009, ranking sixth among states, and more than the number of deaths attributable to homicide, motor vehicle accidents, flu, pneumonia, or diabetes.

- While the major impact is on the individuals and families involved, the financial impact is staggering: nearly $75 million in direct and hospital costs, and more than $1.33 billion in lost productivity.

▸ The growing needs of veterans and members of the armed forces.

- Approximately 2 million troops nationally have served in Afghanistan and Iraq since 2001.

- These veterans suffer rates of suicide two- to four-times greater than same age civilians, elevated rates of trauma-related disorders and depression, untreated traumatic brain injury, and disproportionate rates of unemployment, divorce, substance use, homelessness, and chronic (often acute) pain.

- Financial, delivery-system and attitudinal barriers to care dramatically impede mental health and SUD service delivery. Despite this, behavioral health supports for veterans are among the most innovative.

## Health Disparities

▸ Racial and ethnic minorities:

- Updated national data shows that persons of color receive far fewer mental health services, with African Americans overall only 50 percent as likely to receive care and Hispanic populations only 60 percent as likely.

- When they do, African Americans are 90 percent more likely and Hispanics 50 percent more likely to receive care in public human services settings, including child welfare, juvenile justice, and corrections.

- Colorado informants emphasize the continued concern that youth and adults of color (particularly African American and Latino) are disproportionately served in correctional settings.

PEOPLE WITH DEVELOPMENTAL DISABILITIES ARE AT HIGHER RISK FOR MENTAL HEALTH NEED AND VICTIMIZATION THAN THE GENERAL POPULATION, AND THEIR MENTAL HEALTH CARE CONTINUES TO BE PARTICULARLY FRAGMENTED.

## Snapshot of Key Findings
## Regarding the Need for More Access to Care – Continued

- ▼ Data on race and ethnicity are not reported on a relatively large proportion of Medicaid members (13.8 percent), substantially impeding the ability of the system to track progress on health disparities.

- ▼ Available Medicaid data suggest that two subgroups – Hispanic/Latino and Asian American – are underserved compared to their proportion of the Medicaid population.

▶ Sexual Minorities:

- ▼ People who are lesbian, gay, bisexual, or transgender (LGBT) also suffer health disparities, with clear empirical links between high rates of experienced discrimination and behavioral health needs.

- ▼ Suicide risk is two-to-three times higher, particularly earlier in life and in adolescence.

- ▼ Colorado stakeholders emphasized that the leading concern regarding LGBT behavioral health is access to services from organizations sensitive to LGBT concerns, developmental issues, and needs.

ADVANCING COLORADO'S MENTAL HEALTH CARE

▶ People with Disabilities:

  ▼ People with developmental disabilities are at higher risk for mental health need and victimization than the general population, and their mental health care continues to be particularly fragmented.

  ▼ Autism spectrum disorders (ASD) have become more widely recognized; Colorado's rate per 1,000/ population was 7.5, below the national average of 9.0, and in the middle of the national range.

  ▼ HCPF and CDHS co-manage a range of special Medicaid waivers to serve people with a range of DD. Colorado recently received a federal Money Follows the Person grant to expand access and better coordinate care. CDPHE coordinates care for children with special health care needs, including ASD.

  ▼ People with hearing, mobility, and vision disabilities are at greater risk for depression, and continue to experience a wide range of physical, linguistic, and cultural barriers to care.

  ▼ Within Colorado, the Colorado Cross-Disability Coalition is a leader in advocacy and outreach to support Colorado residents with co-occurring behavioral health and physical disabilities.

  ▼ Provider specialization is particularly important for people who are deaf and hard of hearing, and has been supported by standards through an initiative of the Colorado Commission for the Deaf and Hard of Hearing and the Mental Health Center of Denver, called the Daylight Project.

**Recommendations to Improve Access to Meet Unmet Needs**

1. Employ more refined indicators of need for planning and investment. Break down populations into key groups to better monitor progress in meeting priority needs. Recommended priorities include:

   ▼ The "few" who have high needs and high involvement with state systems inclusive of services across state systems: Adults with SMI, severe SUD, and severe co-occurring disorders, as well as children with SED and those involved with multiple state agencies, and

   ▼ The "many" who need better routine access to mental health/SUD care across all health care settings.

2. Focus more on challenges in rural areas that have fewer providers and lower funding, and that experience a disproportionate impact from the recession (especially job losses) and funding cuts.

3. Reduce health disparities in access/outcomes for racial, ethnic and linguistic minorities, sexual minorities, and people with disabilities. Given major gaps in data on race, ethnicity, and language in current data sets, an initial priority would ensure that data on each individual person's race, ethnicity, and spoken and written language is collected in health records and regularly updated.

BEST ESTIMATES ARE STILL THAT ONLY ONE IN THREE WITH A DIAGNOSABLE CONDITION RECEIVE TREATMENT. THESE MORE RECENT STUDIES, HOWEVER, SHOW THAT THE PROPORTION OF PEOPLE RECEIVING CARE VARIES BY SEVERITY.

# OVERVIEW

**The 2003 *Status Report* startled many readers in its claim that the best estimate available was that one in five Coloradans were in need of mental health services each year and that less than one-third received such care.**

Since then, more refined 12-month prevalence estimates have been developed that describe even higher levels of overall need (estimated at 29.1 percent to 30.5 percent, inclusive of substance use disorders),[93] but that differentiate between different levels of functional impairment associated with the disorder to allow more refined policy development, including (differences in estimates reflect in part differences in defining mild, moderate and serious):

- 11.5 percent with substance use disorders (SUD) of any kind,

- 10.8 percent to 13.8 percent (depending on the study) with conditions (mental health, SUD and co-occurring) termed mild,

- 7 percent to 13.5 percent (depending on the study) with moderate mental health/SUD/co-occurring, and

- 6.3 percent to 8.2 percent (depending on the study) with serious mental health/SUD/co-occurring.

93  Bilj, R., de Graaf, R., Hiripi, E., Kessler, R., Kohn, R., Offord, D., et al. (May/June 2003). The prevalence of treated and untreated mental disorders in five countries. Health Affairs, 22(3), 122-133.

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., Wang, P., Wells, K. B., and Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. New England Journal of Medicine, 352:2515-23.

So, while more people are in need than we had thought in 2003, we are now better able to prioritize and target efforts to address these needs. Best estimates are still that only one in three with a diagnosable condition receive treatment.[94] These more recent studies, however, show that the proportion of people receiving care varies by severity as follows:

- Of those with no diagnosable need, 6.2 percent to 14.5 percent nonetheless received treatment (42 percent in specialty care settings);

- 11.3 percent to 23 percent of those with mild conditions received treatment (46 percent in specialty care settings);

- 26.3 percent to 37.2 percent of those with moderate conditions received treatment (51 percent in specialty care settings); and

- 37.1 percent to 40.5 percent of those with serious needs receive treatment (63 percent in specialty care settings).

# WHO ARE THE PEOPLE IN NEED?

Using the stories presented at the outset of the report, we can get a better feel for the real-life situations represented by mental health and SUD diagnostic labels and their range from mild to severe need. Too often, what starts out mild and readily treatable does not get addressed until severity worsens. The experiences and underlying mental health and SUD diagnoses of the conditions affecting Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally show us how initial symptoms can evolve over time, given the course of diagnostic and treatment options considered and pursued.

## Adults with mild to moderate needs

### Barbara & Steve

Barbara has bipolar disorder, a mental health disorder that initially presented as depression. Given her children's ages and the apparent recent onset of her symptoms, there may be a post-partum component to

her condition. Despite the seriousness of her symptoms, they would fall into the moderate range of severity and, without additional functional impairment or poverty, Barbara's condition would not be considered among the severe disorders we would discuss in this report.

### Joan & Dave

Dave has an anxiety disorder (either generalized anxiety disorder or obsessive compulsive disorder – the details are not clear as to which) that he has "treated" on his own with alcohol off and on over the years. Chronic high anxiety levels can also result in depressive symptoms over time. Dave's otherwise mild condition, which includes co-occurring alcohol abuse, has worsened to moderate levels of severity and has posed a threat to his job over the last year.

## Adults with serious mental illness

### Bob

Bob has a severe mental health disorder – schizophrenia – along with a co-occurring SUD involving addiction to multiple substances, particularly alcohol. Bob also has hepatitis C, a severe disease of the liver, which can present with few symptoms for years before finally leading to more severe effects later in life.

### John

John has a related mental health disorder - schizoaffective disorder – that involves characteristics of schizophrenia-like hallucinations and delusions, as well as mood instability. John also abuses substances, though at a lower level than Bob, and has a serious health condition, type 2 diabetes.

**Co-occurring illness:** Both Bob and John would qualify as having a "serious mental illness," given their years of intensive service use, severe functional impairment, and homelessness. Their severe co-occurring health conditions are among those that typically lead to increased morbidity and mortality in adults with serious mental illness.

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94    Kessler, et al, 2005. Bilj et al estimated a treatment rate overall as low as one in 10, but the Kessler study is generally viewed as the current benchmark.

## Two youth and their families
## with moderate needs that become severe

### Gabriela & Rosa

Gabriela has a moderate underlying depression related to the death of her father. Depression and grief share many attributes, but in Gabriela's case, treatment has not been successful and her functional impairment has escalated to the point where she meets criteria for a SED. Gabriela was initially at risk for out-of-home placement and was ultimately placed there. She is also involved with multiple youth-serving systems: mental health, school, and child welfare.

### Assefa & Amira

Assefa has a similar underlying mental health need (depressive symptoms related to the loss of a parent) and functional impairment meeting criteria for SED and multi-agency services (mental health, school, juvenile justice). Although Assefa's presenting symptoms are in many ways less severe than Gabriela's, the situation leading to his arrest had a higher profile, and resulted in a rapid escalation of services.

**Role of culture:** Both Gabriela and Assefa are involved in situations where issues of acculturation and cultural practices (both within the family, and between the family and the broader society) complicate both the presentation of symptoms and the treatment choices most likely to help.

## Older adults with mild to moderate needs

### Nadine

Nadine has depressive symptoms related to grief over the loss of her husband. She may also have the initial stages of dementia (loss of memory), but the cognitive impact of depression is hard to differentiate from similar symptoms people associate with aging.

### Sally

Sally presented with symptoms similar to Nadine's, but her depression was correctly identified early on. Both Sally and Nadine have a level of depression that is mild to moderate if properly diagnosed, primarily reflecting the normal process of bereavement as people age. A correct diagnosis, however, can drive decisions that lead to very different – and improved - outcomes and costs.

# PEOPLE WITH MORE SEVERE NEEDS

The primary focus of public-sector planning for mental health and SUD needs focuses on those with severe needs. On first view, this makes sense, given the data reviewed under Observation #1 showing that most expenditures and public service risk across agencies is borne by a small number of people. As the examples above illustrated, however, severe needs quite often start out less severe and more readily treated, putting a premium on early identification and intervention.

Estimating trends in the number of people with severe mental health and SUD needs is fraught with challenges. For starters, all attempts to describe overall need are only estimates based on multiple and varied methods, such as rates of mental illness found in samples from various parts of the country, and demographic factors associated with certain geographical areas. The underlying statistics and demographics themselves are often estimated, and are usually not based on precise counts of all people in the population, so estimates of severe need are actually estimates synthesized from multiple underlying estimates. Second, the definitions of severity have evolved since the 2003 report. In the 2003 report, we provided conceptual definitions of serious mental illness and serious emotional disturbance, as follows:

**Serious Mental Illness (SMI)** – This term refers to adults and older adults whose diagnoses are seen as more severe, such as schizophrenia, severe bipolar disorder, or severe depression. A subgroup of these people is defined as having a Serious and Persistent Mental Illness (SPMI) that seriously impairs their ability to be self-sufficient, and has either persisted for more than a year or resulted in psychiatric hospitalization.

**Serious Emotional Disturbance (SED)** – In epidemiological studies, this term generally refers to children and youth ages newborn to 17 who have emotional or mental health problems so serious that their ability to function is significantly impaired, or their ability to stay in their natural homes may be in jeopardy.

While these conceptual definitions have not changed for the present report, the manner in which they are now operationally defined by leading epidemiologists has evolved. For example, in 2003, the construct of SMI was considered to be a broader and more inclusive category and the levels of functional impairment required for a disorder to be considered SMI were less stringent than they are currently.[95] Such changing operational definitions complicate comparisons across time periods. Additionally, estimates of need relevant to publicly funded care in Colorado are primarily concerned with people in need living at or below 300 percent of the Federal Poverty Level (300% FPL). As we will see, these rates can fluctuate considerably, even over the course of only a couple of years.

For these reasons (and perhaps others), the total number of people with severe needs in Colorado appears to have decreased slightly from 1999 (the year of the study used in the 2003 *Status Report*) to 2007 (the year of the most recent systematic study of severe need in Colorado), even though the Colorado population had increased by an estimated 12.6 percent during the same period.[96] It is unlikely that the number of people with SMI (as currently defined, at least) in Colorado decreased from 1999 to 2007. The WICHE estimates, however, which are based on contemporary understandings of psychiatric epidemiology, are the best estimates we have for 2007.

The effect of the economy can also be seen in the review of person-in-need (PIN) estimates below. In late 2007, the national economy, and the economies of most states including Colorado's, declined substantially. For this reason, it is not surprising that estimates of the number of Coloradans living at or below 300% FPL increased precipitously from 2007 to 2011. Although the economy

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95   See Dr. Chuck Holzer's website, which has an excellent discussion of these issues: http://66.140.7.153/estimation/estimation.htm. WICHE's 2009 report of Colorado persons in need of behavioral health services also has a brief overview of the problem of changing definitions of SMI.

96   WICHE Mental Health Program. (2002). Population in Need of Mental Health Services and Public Agencies' Service Use in Colorado. Boulder, Colo.: WICHE. Report was funded and directed by DBH.

may have only a minor effect on the incidence of SMI (for example, the 2005 Kessler study found no increase in prevalence of mental health and SUD needs from 1992 to 2003, despite the occurrence of the September 11 attacks and the 2003 recession), economic conditions do clearly have a dramatic effect on the number of people in need of publicly funded services.

The table to the right summarizes our analysis of the number of Coloradans in need of mental health and SUD services. We based our analysis primarily on the same source used by the State of Colorado (through DBH) and its primary epidemiological research firm, the WICHE Mental Health Program, the work of Chuck Holzer, Ph.D., retired professor of psychiatric epidemiology at the University of Texas Medical Branch, Galveston Texas. Dr. Holzer bases his research findings from the Collaborative Psychiatric Epidemiology Surveys of 2001-2003, which included the National Comorbidity Survey Replication (NCS-R), along with the National Survey of American Life (that focuses on African-American and Afro-Caribbean populations in the U.S.), and the National Latino and Asian American Study.

For this report, TriWest was able to obtain Dr. Holzer's epidemiological estimates for 2009. At the time we accessed the data, however, he had not yet applied his 2009 12-month prevalence estimates to the most recent data on the number of Coloradans living at or below 300% FPL). TriWest also obtained those data from the Colorado Health Institute, based on their analysis of 2009 data from the American Community Survey, and applied these updated estimates of the number of Coloradans living at/below 300% FPL to Holzer's epidemiological data.[97] This was necessary to have the best possible understanding of the demand for services that is being experienced by publicly funded systems in Colorado in 2009. Via personal communication with us in March 2011, Dr. Holzer indicated that our method was valid, at least until his updated estimates based on more recent census data are completed.

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97  Colorado Health Institute (CHI), analysis of the 2009 American Community Survey, personal communication, CHI, February 2, 2011. Dr. Holzer's estimates for adults with Serious Mental Illness and children/adolescents with Serious Emotional Disturbance can be found at http://66.140.7.153/estimation/state09_htm/w1states_2009.htm.

ADVANCING COLORADO'S MENTAL HEALTH CARE

## COLORADANS IN NEED OF MENTAL HEALTH SERVICES AND SUD TREATMENT IN 2009 (12-MONTH PREVALENCE FIGURES)[98]

| POPULATION | PEOPLE IN NEED (PIN) AT/BELOW 300% FPL | PEOPLE IN NEED (PIN) ABOVE 300% FPL | PEOPLE IN NEED ALL INCOME LEVELS COMBINED |
|---|---|---|---|
| Adults with SMI | 125,198 (2.5%) | 46,249 (0.9%) | 171,447 (3.4%) |
| Low Estimate: Co-occurring SMI/SUD[99] | 23,788 (0.5%) | N/A | N/A |
| High Estimate: Co-occurring SMI/SUD[100] | 75,119 (1.5%) | 27,749 (0.6%) | 102,868 (2.1%) |
| Adults with Non-SMI, but Severe, Mental Health Problems | 279,111 (5.5%) | 163,426 (3.2%) | 442,537 (8.7%) |
| Adults with Severe SUD | 100,272 (2.0%) | 62,766 (1.2%) | 163,038 (3.2%) |
| Children/Adolescents with SED | 56,078 (1.1%) | 32,936 (0.6%) | 89,014 (1.8%) |
| Children/Adolescents with SUD[101] | Data not available | Data not available | Data not available |
| | | | |
| **All SMI and SED** | **181,276 (3.6%)** | **79,185 (1.6%)** | **260,462 (5.2%)** |
| **All SMI, SED and Severe SUD** | **281,548 (5.5%)** | **141,952 (2.8%)** | **423,500 (8.3%)** |
| **All Behavioral Health Need** | **560,659 (11.0%)** | **305,377 (6.0%)** | **866,036 (17.1%)** |

There are some important methodological issues to consider in examining the estimates of people in need in the table above. First, the epidemiological data for children and adolescents are not as complete as the data for adults. The NCS-R included only adolescents 15 years and up. Several efforts to conduct comparable epidemiological studies with children have failed to come to fruition during the past two decades.[102]

Second, there are no available epidemiological studies, on the scale of the CPES, available on SUDs in children and adolescents. While there are various studies on the use of alcohol and drugs among adolescents, neither we nor the various informants we talked with we were aware of any epidemiological studies of SUDs among adolescents.

The lack of data in that area likely leads to a slight under-estimation of the number of Coloradans, overall, in need of behavioral health services, and a significant under-estimation of the number of adolescents in need of SUD treatment. As was seen in the discussion under Observation #1 on SUD needs for youth served by the Colorado Division of Youth Corrections (DYC), there is an extremely high percentage of youth in that system (63.5 percent) in need of SUD services related to their reason for involvement in DYC.

Third, the estimates of co-occurring disorders among people with SMI currently used by DBH are likely low in our view. Dr. Holzer explained that the NCS-R interview contained two parts and not all those surveyed responded

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98    Most of the data in this table was drawn from Dr. Holzer's synthesis of the Collaborative Psychiatric Epidemiology Surveys (2001-2003), and were retrieved online at: http://66.140.7.153/estimation/state09_htm/w1states_2009.htm. Holzer's rates were applied to the 2009 population estimate used in this report of 5,074,567, because the most updated 300% FPL data available are based on the 5,074,567 population estimate for 2009.

99    The low estimate for adults with COD living at/below 300% FPL was based on DBH's finding that 19 percent of the people with SMI served in SFY 2010 had a COD. This data only applies to people served by DBH, so it was not used to estimate need for those living above 300% FPL are not provided.

100   This is based on the 60 percent overlap that our team believes to be most credible, based on the national work and consulting experience of Dr. Ken Minkoff and Dr. Chris Cline.

101   Epidemiological data on SUD needs for adolescents is not available.

102   Studies that have been completed, however, do indicate high prevalence rates for children and adolescents, including for very young babies and toddlers. See the recent special issue of the American Psychologist on Infant Mental Health (February/March 2011), including Osofsky and Lieberman (2010). A call for integrating a mental health perspective into systems of care for abused and neglected infants and young children. American Psychologist, 66(2), 120-128.

to the part containing questions on SUD. Combined with the fact that schizophrenia was not included in the NCS-R, this may explain, in part, why Dr. Holzer's estimates for the number of people in Colorado with both SMI and SUD is rather low. Buckley and colleagues found in a recent, comprehensive review of comorbidities in schizophrenia that 47 percent of affected people have a lifetime prevalence of SUD, which they indicate is a "conservative" estimate.[103] Leading researchers in this area, such as Ken Minkoff, M.D., recommend estimates of 60 percent.

Fourth, the CPES did not include schizophrenia and other psychotic disorders. According to Dr. Holzer, CPES researchers chose not to include those diagnostic categories for two main reasons. First, past epidemiological surveys yielded very low percentages of people who reported symptoms associated with those disorders, perhaps due to a reluctance to report symptoms. The other reason is that because comorbidity in the population of people with schizophrenia and related disorders is so high[104] – both with other mental illnesses and with SUDs – the vast majority of people with these disorders will be included in the estimates of the population in need. Nevertheless, the exclusion of these disorders likely leads to slightly lower estimates of the number of people with SMI than actually exist in the population.

Finally, the NCS-R estimated that just over 30 percent of adults in the U.S. had a mental health disorder or SUD.[105] That number is considerably higher than the 17.2 percent estimated from Dr. Holzer's application of the unique demographics in Colorado to the data from the NCS-R and other CPES studies. In personal communication with us, Dr. Holzer explained that his estimates use impairment level cut-offs for determining that a person is "in need" that are more strict than were used for the published studies in 2005. Dr. Holzer uses more strict impairment cut-offs because his data routinely are used by states in estimating the number of people who will, in fact, be in need of treatment. Certainly, Dr. Holzer's use of impairment criteria is crucial for his estimates of SMI. Note that his overall percentage of 17.2 percent falls in between the combined moderate and severe figures from the two primary national epidemiological studies we cited (19.8 percent for Kessler et al and 15.2 percent for Bilj et al).

We also compared 1999 and 2009 estimates of the number of people with SMI/SED living in four Colorado regions (see the chart to the right). These estimates must be treated with caution, because we applied Holzer's statewide estimates of SMI in adults (6.63 percent) and SED for children/adolescents (8.08 percent) to each region. This relatively blunt estimation may bias estimates of geographical areas that, based on the use of demographic and other variables, may have rates of SMI/SED that deviate significantly from the statewide average. The reader should recall that, overall, 2009 estimates of persons in need will necessarily be biased downward, relative to 1999, because of the narrower

103  Buckley, P.F. et al. (2009). Psychiatric comorbidities and schizophrenia. Schizophrenia Bulletin, 35(2), 383-402.

104  Buckley, P.F. et al. (2009). Psychiatric comorbidities and schizophrenia. Schizophrenia Bulletin, 35(2), 383-402.

105  Kessler, R.C. et al. (2005). Prevalence and treatment of mental disorders, 1990-2003. New England Journal of Medicine, 352, 2515-2523.

definition of SMI used. The data seem to indicate, however, that the bulk of the increase in the number of people with severe needs and living at/below 300% FPL was accounted for in the Denver metropolitan area.

**ESTIMATED NUMBER OF PEOPLE WITH SED/SMI LIVING AT OR BELOW 300% FPL BY REGION, SFY 1999 AND SFY 2009[106]**
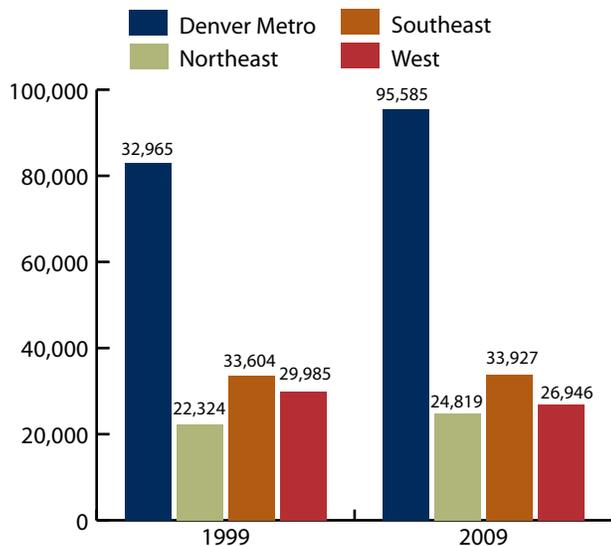


Trends in the number of people enrolled in Colorado's Medicaid BHOs are consistent with the recent increases in the estimated number of people with severe needs, who are living at/below 300% FPL. As can be seen in the chart below, Medicaid growth from SFY 2002 to SFY 2010 easily outpaced statewide population growth: while the Colorado population grew only 10.9 percent over the course of the decade, Medicaid growth increased by just over 72 percent during that same time period. The increase in the number of full-time equivalent Medicaid BHO members in just the last two full fiscal years was nearly 25 percent, dwarfing the rate of statewide population growth.

**MEDICAID ENROLLMENT VS. COLORADO STATEWIDE POPULATION, SFY 2002 AND SFY 2008 TO SFY 2010[107]**



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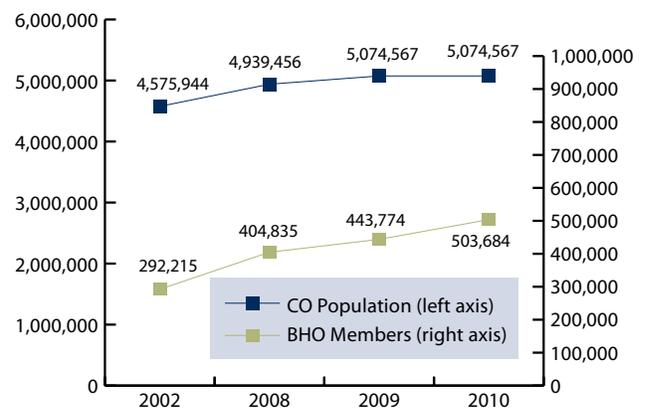
106  1999 and 2007 data are from WICHE's 2002 and 2009 Colorado's Population in Need studies (the 2009 study was funded and directed by the Colorado Division of Behavioral Health). 2009 data are from Holzer's estimates, with the most recent 2009 300% FPL calculations from the Colorado Health Institute analysis of the 2009 American Community Survey, personal communication, CHI, February 2, 2011, applied to Dr. Holzer's statewide estimates for adults (6.63 percent) and children/adolescents (8.08 percent).

107  SFY 2002 data are from TriWest (2003), p. 24. SFY 2008 to SFY 2010 Medicaid enrollment data are from Health Services Advisory Group, (2010), 2009-2010 External Quality Review Technical Report for Colorado Medicaid. Colorado population data are from the U.S. Census Bureau.

# NEEDS OF RURAL AND FRONTIER POPULATIONS

One of Colorado's most distinctive characteristics is the large number of residents living in rural and frontier areas. While overall prevalence rates of mental illness in rural communities are similar to those in urban communities,[108] rates for suicide, depression and some SUDs have been found to be higher,[109] and service use patterns differ substantially. Various factors appear to reduce service use in rural and frontier areas: accessibility (getting there and paying), availability (someone there when you are), and acceptability (choice, quality, knowledge).[110] As a result, rural and frontier residents tend to be served in primary care and other social service settings.[111] Gamm and colleagues[112] summarized key issues related to primary care providers available to provide services in rural areas, including:

108  Hartley, D., Bird, D., & Dempsey, P. (1999). Rural mental health and substance abuse. In T. C. Ricketts (Ed.), Rural Health in the United States. (pp.159-178). NY: Oxford University Press.

109  Eberhardt, M. S., Ingram, D. D., Makuc, D. M. (2002). Urban & rural health chartbook. Health, U.S., 2002. Hyattsville, Md.: National Center for Health Statistics.

CASA Study White Paper. (2000). No place to hide: Substance abuse in mid-size cities and rural America. Unpublished manuscript. Retrieved, July 13, 2003, from the National Center on Addiction and Substance Abuse at Columbia University website: http://www.casacolumbia.org/publications1456/publications_show. htm?doc_id=23734

110  Larson, M. L., Beeson, P. G., & Mohatt, D. F. (1993). Taking rural into account: A report of the National Public Hearing on Rural Mental Health. St. Cloud, MN: National Association for Rural Mental Health and the Federal Center for Mental Health Services.

Mohatt, D. F. (2000). Access to mental health services in frontier areas. Journal of the Washington Academy of Sciences, 86, 35-48.

Mohatt, D. F. (2003). Rural mental health: Challenges and opportunities caring for the country. Presentation to the President's New Freedom Commission on Mental Health, Washington, DC.

111  U.S. Surgeon General. (1999). Mental health: A report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

112  Gamm, L., Tai-Seale, M., & Stone, S. (2002). White paper: Meeting the mental health needs of people living in rural areas. College Station, TX: Department of Health Policy and Management, School of Rural Public Health, Texas A&M University System Health Science Center.

- Insufficient clinical skills among rural providers and underdetection of disorders,

- Lack of specialized backup,

- Insufficient training in mental health in medical school or residency,

- Limited time for continuing education to better manage difficult cases,

- Heavy caseloads, shorter patient visits, and

- Not enough time for psychotherapy or counseling.

In 2009 as part of Colorado's federal Transformation Transfer Initiative grant activities, TriWest Group led a cross-state stakeholder input process that carried out more than 70 forums, which involved 561 people receiving services, family members, providers, and other stakeholders.[113] The process included forums for rural and frontier areas through a network of video conference sites in Craig, Durango, Lamar, Sterling, and Trinidad, plus additional telephone conferences, involving a total of 128 rural and frontier stakeholders. These stakeholders endorsed a broad range of concerns, but the most often endorsed was a lack of resources and providers in rural and frontier areas.

The shortage of providers in rural and frontier areas is arguably the single largest challenge facing Colorado's rural communities. The federal government designates and tracks Health Professional Shortage Areas (HPSAs) by county and other geographical areas, as well as by various population groups. Following is a geomap of Mental Health Professional Shortage Areas (MHPSAs) in Colorado. As can be seen, MHPSA counties cover the balance of the state, with only a central corridor of 16 counties out of a total of 64 (25 percent of all counties) not designated as MHPSAs.[114] The green-shaded counties in the geomap that follow are the MHPSA counties. A legend is also included that indicates the type of facility, center or population highlighted in the federal analysis (by no means a complete listing of health facilities), represented by the colored circles located throughout the geomap. As documented with far more data in the discussion under Observation #6 of this report, even counties with larger cities such as Mesa and Weld include vast areas with few providers. Additionally, some counties that are not designated with MHPSAs include rural areas where travel to providers is challenging (for example, Clear Creek, Gilpin, Huerfano, Larimer, Las Animas, and Park counties).

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113 TriWest Group and Advocates for Human Potential. (February 2010). The 2009 Colorado Behavioral Health Transformation Transfer Initiative: Final Grant Report. Retrieved at: http://www.colorado.gov/cs/ Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blo bheadervalue1=inline%3B+filename%3D%22Behavioral+Health+Transfer+Initiative%3A+Final+Grant+Report.pdf%22&blobheadervalue2=application% 2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251694157818&ssbinary=true.

114 Health Resources and Services Administration website, December 2010: http://bhpr.hrsa.gov/shortage.

**MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS (MHPSAS) IN COLORADO AND KEY FACILITIES**
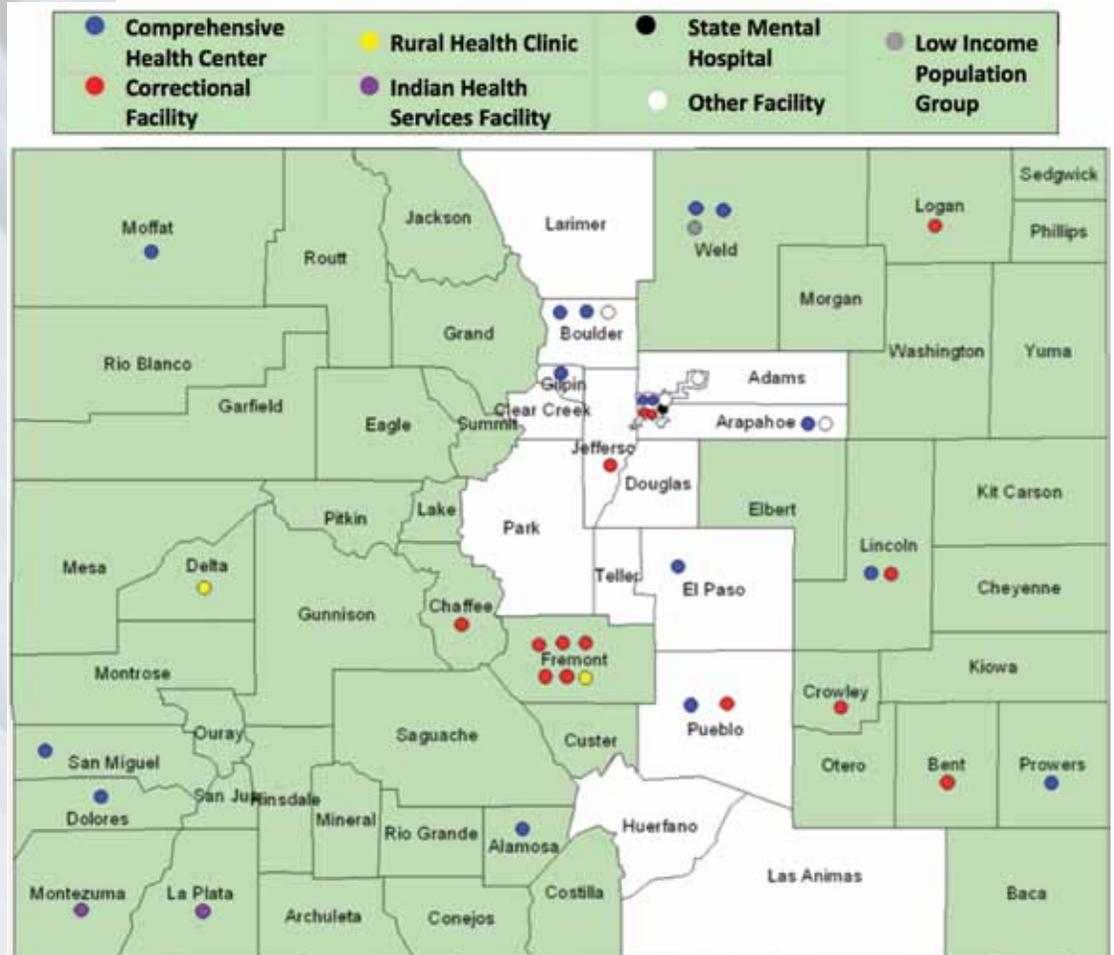


This widespread lack of providers in rural and frontier areas of Colorado (including addictions specialists, as well as mental health professionals) is explored in more detail below under Observation #6 on the availability of mental health and SUD providers in Colorado. Some stakeholders reported early indications that workforce challenges in rural and frontier areas are worsening as providers increasingly compete for primary care physicians and behavioral health specialists to prepare for health care reform. Rural stakeholders also reported that they have been able to form partnerships with training programs to ensure a flow of professionals into their communities, some of whom stay on after their training ends, but all of whom fill an important need during their stay. As with most areas of the state, rural providers note that few behavioral health professionals come to them trained in approaches that prepare them to function in integrated primary care settings.

Primary care is a particularly important resource in rural areas of the state. Colorado rural and frontier counties rely on 51 rural health centers distributed across 14 of Colorado's 23 frontier counties, 16 of 24 rural counties, and underserved areas of two partially urban counties.[115] While these clinics provide only basic primary care resources, often they are the only health care resources available, and must provide behavioral supports. A large proportion of services are provided to people with Medicare, given Colorado's growing rural older adult population.[116] Stakeholders also noted that county public health departments provide additional critical supports and are often key catalysts in knitting together regional health delivery approaches that include mental health and SUD services.

But lack of individual health professionals is only part of the story. Lack of access to specialized services and facilities is also challenging. Psychiatry and other prescriber access is a chronic concern voiced by multiple informants. Another key informant we talked with explained the challenges of accessing even a basic service such as inpatient psychiatric care and SUD detoxification in her multi-county rural catchment area, where many people must drive more than 100 miles for such care. Community providers there are exploring innovative partnerships with medical and nursing facilities to develop alternatives. Informants also noted that many intensive evidence-based practices (for example, Multisystemic Therapy for youth and Integrated Dual Disorders Treatment for adults with co-occurring mental health/SUD needs) are harder to maintain in rural areas, given provider shortages, restrictive funding requirements that complicate their delivery, and fluctuating numbers of people in need. Rural providers noted that foundation funding for start-up, state rule waivers by DBH, and thoughtful adaptations of evidence-based approaches have helped increase this capacity, despite challenges.

Specialized clinical resources for minority populations are also stretched, particularly as many rural communities experience increases in Latino and Spanish-speaking residents and even greater resource gaps to serve them. As one key informant noted, while urban areas struggle to have enough Spanish-speaking therapists, many rural areas struggle to have any. And rural diversity includes many other subgroups, too. For example, one key informant noted an increase in East African/Somali immigrants in one rural area, a disproportionate number of whom experienced trauma prior to emigrating. Telehealth through entities such as the Colorado Telehealth Network has offered many rural communities the ability to augment such limited resources with linkages to better-resourced urban areas.

Resources to pay for care are also more limited. A 2006 performance audit of Medicaid BHO rates by the Colorado State Auditor found chronically and substantially lower Medicaid spending in rural areas such as northeast Colorado.[117] While steps have been taken since then to move toward equalization of Medicaid rates, stakeholders reported that inequities continue. Resources are also limited more broadly, as stakeholders reported to us that many working people with private coverage are underinsured, and many who have no insurance at all are not eligible for public funding. Access to Medicare reimbursement is also impeded, as this generally requires licensed staff that is far less available in rural and small town areas.

Resource challenges are a particular concern for undocumented residents of rural and frontier areas. While undocumented individuals reside across Colorado, proportions of the population in rural and frontier areas can be higher, and providers in these areas do not have sufficient economies of scale to absorb this unfunded care.

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115  Colorado Rural Health Center. Clinics as of October 2010. Retrieved at: http://www.coruralhealth.org/programs/rhc/coloradorhcs.htm.

116  Colorado Rural Health Center. RHC/FQHC Comparison. Retrieved at: http://www.coruralhealth.org/programs/rhc/documents/RHC-FQHC.pdf.

117  Colorado State Auditor. (November 2006). Medicaid Mental Health Rates, Department of Health Care Policy and Financing, Performance Audit. Retrieved at: http://www.leg.state.co.us/OSA/coauditor1.nsf/All/8E6CDA5BBC1EDC8B87257241006DCA83/$FILE/1754%20Medicaid%20MH%20 Rates%20rel%20Dec%202006.pdf.

Other noted concerns included the unique challenges faced in mountain communities, with a transient population (varying over the recreational seasons), and the dichotomy of high land prices and relatively low wages for working and lower income populations residing in these communities. These economic challenges also pose difficulties for the behavioral health workforce in resort communities such as Aspen, Vail, Breckenridge, and Steamboat, where cost of living is high, and it can be challenging for provider staff to afford a home or other expenses.

Based on interviews conducted for this report, a range of additional concerns was noted, including the challenges of serving undocumented residents, the disproportionate impact of reductions in funding that are felt more acutely in less densely populated areas of the state without economies of scale, and disproportionate effects of the current recession on job losses in small towns and rural areas. Also noted was the dramatic loss of population in rural areas, with stakeholders in many rural counties reporting losses of over 15 percent of their population in the last decade.

The challenges of rural areas also have countervailing advantages. Rocky Mountain Health Plans is a recognized leader in integrated care in the state, and has robust partnerships with community mental health providers, integrated care settings such as the Marillac Clinic (and many others across Western Colorado), and hospitals. The BHO for Western Colorado (Colorado Health Partnerships) is currently working with Rocky Mountain Health Plans to identify top-using individuals across physical health and behavioral health settings, similar to efforts by Colorado Access documented earlier under Observation #1, to address the cost trends explored in more detail below under Observation #4. On the behavioral health side, Colorado West Regional Mental Health has worked to build medical home capacity in its clinics, with 13 outpatient sites in 10 counties certified under Colorado Medicaid rules as of early 2011, and expanded access more broadly through an innovative same-day access model for routine care that cut wait times dramatically. More broadly, the Colorado Behavioral Healthcare Council's integration tracking project identifies dozens of integration initiatives in rural and frontier areas.

ADVANCING COLORADO'S MENTAL HEALTH CARE

# HEALTH DISPARITIES

## Racial and Ethnic Minorities

The 2003 *Status Report* provided substantial detail on the mental health needs of racial and ethnic minorities, and much of that information remains relevant. For this report, we have attempted to summarize and update that information, with a particular focus on emerging best practices to respond to the substantial health disparities affecting these groups. These needs and best practices are more important than ever to Colorado's behavioral health systems given the tremendous growth in Colorado's overall population among people of color over the last decade, as documented in the 2010 census. Census data show that, while Colorado's White population grew 9.9 percent since 2000 (3,520,793 in 2010), growth in the Asian American/Pacific Islander population was 45.4 percent (141,225 in 2010), growth in the Hispanic population was 41.2 percent (1,038,687 in 2010), growth in the African American population was 19.1 percent (188,778 in 2010), growth in the American Indian/Alaska Native population was 7.8 percent (31,244 in 2010), and growth in the multi-racial population was 38.7 percent (100,847 in 2010).[118]

Various terms are used in different studies to refer to these groups. For this report, we follow the usage and definitions below, except where a specific study we cite employs a different term, where we maintain the use of the study's terminology where it differs from our term usage (e.g., Black versus African American). We use the terms as defined below:

- **Hispanic Americans** – This term is inclusive of people with European (Spanish) ancestry and the four main Hispanic and Latino groupings (Mexican, Puerto Rican, Cuban, Central American). Federal Substance Abuse and Mental Health Services Administration

(SAMHSA) guidelines also mention that this group may have ancestral ties to Asia or Africa. In Colorado, many Hispanic Americans have ties to Mexico, but the population overall is much more diverse.

- **African Americans** – This term is inclusive of all people of African and Caribbean descent.

- **Asian Americans and Pacific Islanders** – This term is inclusive of Asian Americans, including Asian Indian, Cambodian, Chinese, Hmong, Korean, Laotian, Japanese, Philippino, Vietnamese, and others. It also includes the following Pacific Islander cultures: Native Hawaiian, Guamanian/Chamorro, Samoan, and other Pacific Islander cultures.

- American Indians and Alaska Natives – This term is inclusive of all continental U.S. and Alaskan indigenous people.

National data on the need for and delivery of mental health and SUD services demonstrate many trends in prevalence of disorders and service delivery related to culture. Trends related to race and ethnicity were well summarized in the 2001 supplement to the 1999 Surgeon General's Report on mental health services entitled Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General[119] documenting "the existence of striking disparities for [racial and ethnic] minorities in mental health services and the underlying knowledge base" (p. 3). The report built upon and amplified the observation from the preface to the original 1999 Surgeon General's Report on Mental Health that "Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services" (U.S. Surgeon General, 1999, p. vi).[120] The supplemental report documents less access to mental health services, lower likelihood of receiving care, and greater likelihood that any care received is poorer in quality. Specific barriers include a lack of knowledge and

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118  U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Tables PL1, PL2, PL3, and PL4, and 2010 Census Redistricting Data (Public Law 94-171) Summary File, Tables P1, P2, P3, and P4. Retrieved at: http://2010.census.gov/news/xls/cb11cn39_co_2010redistr.xls.

119  U.S. Department of Health and Human Services. (2001). Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the surgeon general. Rockville, Md.: Author.

120  U.S. Surgeon General. (1999). Mental health: A report of the surgeon general. Rockville, Md.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health

awareness of cultural issues, bias, and inability to speak client languages on the part of mental health providers, and an understandable level of fear and mistrust of treatment on the part of people in need of care. Disparities also relate to historical and current experiences of racism and discrimination, which have impacts not only on the treatment process, but also on mental health, economic status, and political influence. For new immigrants and refugees, trauma is often a factor complicating both trust in helping institutions and accurate diagnosis when underappreciated. When persons of color do receive care, they are much more likely to do so in non-medical human services settings. More specific findings include the following:

• Compared to White populations, national studies find that persons of color receive far fewer mental health services, with African Americans overall only 50 percent as likely to receive care and Hispanic populations only 60 percent as likely. Further complicating this disparity, African Americans are 90 percent more likely and Hispanics 50 percent more likely to receive mental health care in government human services settings, including child welfare, juvenile justice, and corrections.[121] The review of Colorado trends in service delivery under Observation #1 did in fact find higher rates of involvement of African American people in Colorado's public mental health system, compared to their proportion of the population, but rates for Hispanic Americans were lower.

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121 Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., Wang, P., Wells, K. B., and Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. New England Journal of Medicine, 352:2515-23.

- There is evidence that, across the lifetime, African American and Hispanic populations overall suffer from somewhat lower rates of anxiety, mood and (for African Americans only) SUD than White populations, but these findings likely reflect some level of underreporting and also still represent levels of need that exceed available treatment resources.[122] That being said, a link between the experience of racism, bias, and discrimination, and increased risk for mental disorders, has been noted across studies for many years.[123] The magnitude of the association between the combination of major and day-to-day discrimination and poorer mental health was comparable to more commonly studied stressful life events such as the death of a loved one, divorce, or loss of a job. Major findings focused primarily on differences between African American and White groups, but other studies have made similar links between perceived discrimination and risk for depression among Asian Americans and Hispanic Americans. Other factors related to increased risk for mental disorders that disproportionately affect many members of minority racial and ethnic groups include poverty, living in neighborhoods with higher levels of violence and crime, and lower education levels. Mental disorders are highly prevalent across all populations, regardless of race or ethnicity, but cultural and social factors contribute to the causation of mental illness in complex interactions that vary by disorder.

Colorado informants emphasize the continued concern that youth of color (particularly African American and Latino youth) and adults of color continue to be disproportionately served in correctional settings, arguing that many of these individuals failed to receive adequate services earlier in life, including mental health and SUD services. The following table presents data on Medicaid service trends for people served in the public mental health system. Compared to both their representation in the Medicaid population and the overall Colorado population, Latino and White populations are underserved relative to their proportion of the population. This table fails, however, to take into account differential levels of need related to poverty and other factors. It should not be interpreted to suggest that African Americans and American Indians receive too much mental health care. Trends across the youth corrections and criminal justice systems and poverty rates suggest that service adequacy is insufficient, which may also be a function of the cultural relevance of the services and the cultural and linguistic competency of the service providers (discussed in more detail under Observation #5).

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122  Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merkangas, K. R., and Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. Archives of General Psychiatry, 62:593-602.

123  USDHHS. (2001). Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the surgeon general. Rockville, Md.: Author.

The following table looks at the number of people served in several different ways. For example, looking at the table, 5,499 African American Medicaid members were served by BHOs in 2010. They represented 7.8 percent of all people served for whom race/ethnicity was reported, whereas African Americans represent 3.8 percent of the overall Colorado population and 9.2 percent of all BHO Medicaid members. Looked at another way, 14.6 percent of African American Medicaid members received mental health services.

## PEOPLE SERVED IN THE MENTAL HEALTH SYSTEM BY ETHNICITY IN SFY 2010[124]

| RACIAL / ETHNIC GROUP | NUMBER SERVED | PERCENT OF ALL SERVED[125] | PERCENT OF COLORADO POPULATION[126] | PROPORTION OF BHO MEDICAID MEMBERS | PENETRATION RATE[127] |
|---|---|---|---|---|---|
| African American | 5,499 | 7.8% | 3.8% | 9.2% | 14.6% |
| American Indian/ Alaskan Native | 1,181 | 1.7% | 0.6% | 1.4% | 16.1% |
| Asian American | 703 | 1.0% | 2.8% | 2.2% | 6.7% |
| Native Hawaiian/ Pacific Islander | 178 | 0.3% | 2.8% | 0.8% | 15.2% |
| Hispanic or Latino | 19,088 | 27.0% | 20.7% | 45.5% | 9.3% |
| White | 39,557 | 56.0% | 70.0% | 35.1% | 18.4% |
| More Than One Race/Other | 4,443 | 6.3% | 2.0% | 5.8% | 15.6% |
| Not Available | 15,192 | -- | -- | -- | 13.8% |
| **Total** | **85,841** | **100%** | **100%** | **100%** | **13.7%** |

### LOOKING ACROSS THESE DATA, SEVERAL POINTS STAND OUT:

• Data on race and ethnicity are not reported on a relatively large proportion of Medicaid members (13.8 percent). This is concerning, as it impedes the ability of the system to accurately track health disparities across groups.

• Available data suggest that two subgroups – Hispanic/Latino and Asian American – are underserved compared to their proportion of the Medicaid population.

• All other subgroups receive services at rates greater than their proportion of the Medicaid population.

These trends differ in one major way from those reported in the 2003 *Status Report*: Latino/Hispanic service trends no longer match the proportion of Latino/Hispanic people in either the broader Colorado population or the Medicaid population. This suggests that service delivery has not kept up with the tremendous growth in the last decade of Colorado's Latino/Hispanic residents.

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124 Overall data are from personal communication with Bruck Makonnen, DBH, January, 2011 (NASMHPD/ CMHS data tables); Medicaid data are from personal communication with Jerry Ware, Colorado Department of Health Care Policy and Financing, January 5, 2011.

125 Medicaid served is 67,989. Total number of members is 503,684. A large number (127,988 of the 503,684 FTE members) had an "unknown" race. Unknown race was excluded from this analysis so totals would add up to 100 percent. Hispanic/Latino was reported as "Spanish American."

126 Colorado State Demography Office – 2010 Estimate, based on 2010 U.S. Census. Percentages of the Colorado population for Asian American and Native Hawaiian/Pacific Islander populations were combined because those categories were collapsed in the data reported on the Colorado State Demography Office website.

127 Penetration rate refers to the proportion of Medicaid members overall or in a subgroup that received care.

# Sexual Minorities

Sexual minorities continue to be an important and growing subgroup within Colorado's population. We use the term sexual minorities in this report to refer primarily to people who are lesbian, gay, bisexual, or transgender (LGBT). Current usage often expands the definition to include an even broader range of people (for example, questioning, intersex, and 2-spirit),[128] but we use the term LGBT in this report to reflect the usage of Colorado informants. Colorado stakeholders emphasized that the leading concern regarding the behavioral health needs for the LGBT community is the ability to access services from organizations and agencies that are sensitive to LGBT concerns, developmental issues, and needs. Informants also emphasized that the LGBT community in Colorado encompasses all other aspects of diversity noted above – racial and ethnic diversity, varying needs across the lifespan (as adolescents, adults and older adults), additional barriers in rural and frontier areas of Colorado, comorbid health concerns (including, but in no way limited to AIDS-related health needs), poverty and too often a lack of insurance coverage. Informants emphasized the importance of cultural competency, as discussed in more detail under Observation #5 below. The Center, in Denver, offers resources of advocacy and support for Colorado's LGBT communities,[129] including an online directory and certification process for identifying "LGBT-friendly" providers. The Center provides support to providers seeking to become LGBT-friendly, including suggested questions for obtaining information regarding gender and sexual orientation.

Serving members of Colorado's LGBT communities requires knowledge of the history of behavioral health services for sexual minorities and special needs among members of the LGBT community. Trends for sexual minorities include a long history of psychiatry viewing non-heterosexual identity as pathological, a trend that did not formally end until the mid-1990s.[130] Today, differential levels of mental health need for LGBT people are viewed in the literature as a function of the various stressors associated with minority status (particularly discrimination), rather than a function of simply having a LGBT identity. Lesbian, gay, and bisexual people have been found to experience higher rates of discrimination, victimization, and violence by others than the general population, including particular stress during adolescence.[131] Studies of suicide risk factors, including attempts, clearly document elevated risk – two to three times higher than the general population – for lesbian, gay, and bisexual people, particularly earlier in life and specifically during adolescence. The information that is available suggests that risks are higher for stress-related needs across the group of transgender people, including SUD. Other specific trends include:

- Many studies have theorized that higher rates of mental health and SUD need among lesbian, gay, and bisexual people are related to the experience of discrimination, largely based on the fact that the types of disorders showing higher rates were those known to be affected by stress and negative life events.[132] These studies found a clear empirical link between higher rates of experienced discrimination and behavioral health needs among lesbian, gay, and bisexual men and women. The primary conclusion across nationally representative studies is that lesbian, gay, and bisexual people seem to be at elevated risk for mental health disorders influenced by

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128 Gamache, P. and Lazear, K. J. (Summer 2009). Asset-based approaches for lesbian, gay, bisexual, transgender, questioning, intersex and 2-spirit (LGBTQI2-S): Youth and families in systems of care. Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida: Retrieved at: http://rtckids.fmhi.usf.edu/rtcpubs/FamExp/lgbt-mono.pdf.

129 For additional information, see: http://www.glbtcolorado.org/. For information on screening questions recommended by the Gay and Lesbian Medical Association, see: http://www.glbtcolorado.org/ForHealthProfessionals_ScreeningQuestions.aspx.

130 Harris, H. L., and Licata, F. (2000). From fragmentation to integration: Affirming the identities of culturally diverse, mentally ill lesbians and gay men. Journal of Gay and Lesbian Social Services, 11, 93-103.

131 Mays, V. M., and Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. American Journal of Public Health, 91, 1869-1876.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? American Psychologist, 56, 931-947.

132 Paul, J. P., Catania, J., Pollack, L., Moskowitz, J., Canchola, J., Mills, T., Binson, D., and Stall, R. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. American Journal of Public Health, 92, 1338-1345.

Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., and Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. American Journal of Public Health, 91, 933-939.

GAY AND BISEXUAL MEN WERE MORE THAN TWICE AS LIKELY AS HETEROSEXUAL MEN TO MEET CRITERIA FOR ANXIETY, MOOD, AND SUDs. DIFFERENCES BETWEEN LESBIAN AND BISEXUAL WOMEN VERSUS HETEROSEXUAL WOMEN WERE LESS STRONG, BUT THE SAME PATTERN OF HIGHER PREVALENCE WAS OBSERVED.

social stigma – including depression, other mood disorders, post-traumatic stress disorder, other anxiety disorders – as well as for SUD.[133] Colorado informants particularly emphasized unmet needs in the area of SUD. The pattern of findings across multiple studies seems clear. Gay and bisexual men were more than twice as likely as heterosexual men to meet criteria for anxiety, mood, and SUDs. Differences between lesbian and bisexual women versus heterosexual women were less strong, but the same pattern of higher prevalence was observed. The HIV/AIDS epidemic has also been a major source of grief, loss, and stress within gay, lesbian, and bisexual communities since it was first identified in 1981.

- Studies of suicide risk factors, including attempts, clearly document elevated risk for lesbian, gay, and bisexual people, particularly earlier in life and specifically during adolescence.[134] Eight large-scale surveys conducted between 1998 and 2001 reported that prevalence of suicide attempts ranged from two to three times higher for lesbian, gay, and bisexual people, with higher rates generally being associated with samples that included adolescents (75 percent of suicide attempts happen before age 25).

- Transgender people have come into focus as a specific population of interest in studies of mental health and SUD needs and services in the last decade. Most of the psychiatric literature had previously focused primarily on the needs of transsexuals (people seeking to change their sexual orientation), generally viewing their "gender dysphoria" as pathological. But since the late 1990s, with the first publications on transgender youth and their social needs appearing in the professional literature, the needs of transgender people have begun to be viewed more broadly. The information that is available suggests that risks are higher for stress-related needs across the group of transgender people, including SUD.[135] Literature also shows that transgender people are routinely denied care at higher levels than others.[136] The World Professional Association for Transgender Health publishes guidelines for health care professionals serving transgender people.[137]

133 Cochran, S. D., Sullivan, J. G., and Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. Journal of Consulting and Clinical Psychology, 71, 53-61. Plus Mays and Cochran (2001), Cochran (2001), Gilman, et al. (2001), all previously cited.

134 USDHSS. (2001). National strategy for suicide prevention: Goals and objectives for action. Rockville, Md.: Author. Plus Cochran (2001).

135 Gamache, P. and Lazear, K. J. (Summer 2009). Previously cited.

136 Grant, J.M., Mottet, L.A., Tanis, J. October 2010. National Transgender Discrimination Survey report on health and health care. National Center for Transgender Equality and The National Gay and Lesbian Task Force. Retrieved at: http://www.thetaskforce.org/downloads/reports/reports/ntds_report_on_health.pdf.

137 http://www.wpath.org/documents2/socv6.pdf.

• The literature seems to clearly establish that lesbian, gay, and bisexual adults access mental health treatment in higher numbers than do heterosexual people. Adjusting for demographic differences and current insurance status, Cochran and her colleagues[138] found gay, lesbian, and bisexual men and women were more likely to seek help for mental health needs than their heterosexual counterparts, a finding that had been suggested in the literature for some time. It is not clear that these findings apply to youth. Rates of service use among adolescents is complicated by lower rates of insurance and service use overall, and gay, lesbian, and bisexual youth seem particularly vulnerable to bias and stigma exhibited by health professionals.[139] There is also evidence of particular disparities in access to care for transgender individuals.[140] Colorado informants underscored a particular lack of access to SUD services for the LGBT community.

## People with Disabilities

As in the 2003 report, we differentiate between two groups of people with disabilities. One major group includes people with developmental disabilities; the second group includes people with various physical disabilities, including hearing, mobility, and vision disabilities. The primary findings of the 2003 report are still applicable, but we summarize some key trends here.

**People with Developmental Disabilities.** As in the 2003 report, we use the term developmental disabilities to refer to a range of conditions that limit people's intellectual and overall functioning. Furthermore, while people with mental retardation typically constitute the largest group of those with developmental disabilities and have been the main focus of much of the services, research, and advocacy in this area, most people with developmental disabilities also have other disabilities. Autism spectrum disorders (ASD) have become much more widely recognized since 2003. Colorado is one of 11 states participating in the Centers for Disease Control and Prevention's national surveillance project to track prevalence of ASD, and, in 2006, the rate per 1,000/population was 7.5, below the national average of 9.0 and just below the middle of the national range of 4.2 to 12.1.[141] In response to these needs, in 2009 Colorado passed SB 09-244 establishing required benefits to help children with ASD access evidence-based practices such as Applied Behavioral Analysis.[142]

Although most people with developmental disabilities do not have a mental illness, people with developmental disabilities tend to have more mental health needs than the general population. The 2003 report found the generally accepted prevalence rate of co-occurring developmental disability and mental health needs to be 30-35 percent across settings, populations, and age groups. A prevalence rate of 30-40 percent has been found in adults, and 40-60 percent in children.[143] Prevalence rates have been found to decrease with age, with a 20 percent estimate for people ages 65 and older.[144] Paradoxically, while developmental disabilities have been found to increase the risk of mental illness, they have also been found to decrease access to mental health services.[145]

138 Cochran, et al. (2003). Previously cited.

139 Ryan, C., and Futterman, D. (1998). Lesbian and gay youth. Care and counseling. New York: Columbia University Press.

140 Gamache, P. and Lazear, K. J. (Summer 2009). Previously cited.

141 Rice, C. (December 18, 2009). Prevalence of Autism Spectrum Disorders: Autism and Developmental Disabilities Monitoring Network, U.S., 2006. 58 (SS10); 1-20. Retrieved at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5810a1.htm#tab2.

142 See http://autismcolorado.org/index.php/autism-in-colorado/current-legislation for additional information on these benefits.

143 Cited in Dosen, A., & Day, K. (2001). Epidemiology, etiology, and presentation of mental illness and behavior disorders in persons with mental retardation. In A. Dosen & K. Day (Eds.), Treating mental illness and behavior disorders in children and adults with mental retardation (pp. 3-224). Washington, DC: American Psychiatric Press, Inc.

144 Dosen, A., & Day, K. (2001). Previously cited.

145 Reiss, S. (2001). People with dual diagnosis. America's powerless population. In A.J. Tymchuk, K.C. Lakin, & R. Luckasson (Eds.), The forgotten generation. The status and challenges of adults with mild cognitive limitations (pp. 275-298). Baltimore, Md.: Paul H. Brookes Publishing Co., Inc.

Inadequate access to appropriate mental health services and providers, especially in the community, has been well documented through research[146] and by key informants.

- There are multiple barriers to access and appropriateness of mental health services for this population. Mental retardation and related behavioral problems, in particular, may "diagnostically overshadow" other mental disorders, resulting in the need for mental health services going unrecognized.[147] Furthermore, even when mental disorders are recognized, there is a tendency to specify them as "secondary" diagnoses, typically resulting in funding for services for only the "primary" diagnosis of mental retardation.[148]

- There is also a lack of providers who are trained to work with the unique needs of this population, leading to recruiting difficulties.[149]

- There are also system barriers. Administrative agencies for mental health and developmental disability services in Colorado and most other states are organizationally separated, including their funding streams and service systems,[150] leading to a lack of coordination across providers in the multiple systems.

In Colorado, the CDHS Division for Developmental Disabilities (DDD) coordinates a wide range of services and supports for children and adults, and the Department of Health Care Policy and Financing co-manages with CDHS several Medicaid Home and Community Based Services (HCBS) waivers to fund specific services. Access to HCBS services, however, is subject to wait lists. The sheer number of discrete waivers funding

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146 Einfeld, S. L., & Tonge, B. J. (1996). Population prevalence of psychopathology in children and adolescents with intellectual disability, II: Epidemiological findings. Journal of Intellectual Disability Research, 40, 99-109.

Check indent Fletcher, R. J., & Poindexter, A. R. (1996). Current trends in mental health care for persons with mental retardation. Journal of Rehabilitation, 62, 23-26.

Reiss, S. (2001). Previously cited.

147 Reiss, S. (2001). Previously cited.

White, M. J., Nichols, C. N., Cook, R. S., Spengler, P. M., Walker, B. S., & Look, K. K. (1995). Diagnostic overshadowing and mental retardation: A meta-analysis. American Journal of Retardation, 100, 293-298.

148 Reiss, S. (1994b). Psychopathology in mental retardation. In N. Bouras (Eds.), Mental health and mental retardation (pp. 67-78). Cambridge, UK: Cambridge University Press.

149 Reiss, s. (2001). Previously cited.

Szymanski, L., Madow, L., Mallory, G., Menolascino, F., Pace, L., Eidelman, S. (1991). Report of the task force on psychiatric services to adult mentally retarded and developmentally disabled persons. Washington, DC: American Psychiatric Association.

150 National Association of State Mental Health Program Directors. (August 2000). State mental health agency organization and structure: 1999. State profile highlights. (No. 6). Retrieved July 21, 2003, from the NASMHPD Research Institute website: http://www.nri-inc.org.

care (seven as of May 2009) also fragments service delivery and system oversight.[151] As part of its broader health care reform efforts, Colorado was awarded an initial $2 million of an overall $22 million award through 2016 to implement a Money Follows the Person grant to expand access and better coordinate care among these waivers. For children, the CDPHE Children with Special Health Care Needs Unit coordinates a network of resources for children with a wide range of developmental and other needs, including ASD.

**People with physical disabilities.** People with co-occurring physical disabilities and behavioral health needs face many unique needs and barriers to appropriate mental health services. Within Colorado, the Colorado Cross-Disability Coalition has been a leader in advocacy and outreach to address the needs of Colorado residents with co-occurring behavioral health and physical disabilities. Our examination of these issues focused primarily on the following three categories of people: people who are blind or visually disabled, people who are deaf or hard of hearing, and people with mobility impairments. Like the general population, people with blindness, deafness, or impairments in mobility may experience a range of mental health and SUD needs. Most of the research on prevalence of mental illness among people with physical disabilities has focused on depression. While it is clear that not all people with physical disabilities also experience depression, and most lead happy and productive lives,

research has shown that there is a higher incidence of depression among people with physical disabilities than in the general population.[152] This finding extends across disabilities, encompassing vision, hearing, and mobility. While people with visual disabilities certainly experience barriers to care such as written materials and cultural issues, the added need for alternative means of verbal expression and physical access for people with hearing and mobility disabilities may heighten awareness of the needs of these groups.

- **Specific needs of people with mobility impairments.** Mobility impairments can stem from a wide range of causes, including congenital conditions, degenerative physical diseases such as multiple sclerosis or muscular dystrophy, and traumatic injury, such as injury to the spinal cord. Issues for people with degenerative disease-based mobility impairments such as multiple sclerosis or muscular dystrophy are often quite different. For people who experience both depression and disease-based loss of mobility, there is evidence of a bi-directional impact, with depression affecting the disability and the disability affecting the depression.[153] Suicide rates and suicide attempts have been found to be higher among people with spinal cord injuries.[154]

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151 Community Based Long Term Care Section, Colorado Department of Health Care Policy and Financing. (May, 2009). Home and Community Based Services (HCBS) Medicaid Waivers.

152 Boekamp, J. R., Overholser, J. C., & Schubert, D. S. (1996). Depression following a spinal cord injury. International Journal of Psychiatry in Medicine, 26, 329-349.

Hample, H. (2002). Depression: The doctors are in. Inside MS. A special reprint.

Jensen, P. S., Koretz, D., Locke, B. Z., Schneider, S., Radke-Yarrow, M., Richters, J. E., & Rumsey, J. M. (1993). Child and adolescent psychopathology research: Problems and prospects for the 1990s. Journal of Abnormal Child Psychology, 21,551-580.

Kishi, Y., Robinson, R. G., & Kosier, J. T. (2001). Suicidal ideation among patients with acute life-threatening physical illness: Patients with stroke, traumatic brain injury, myocardial infarction, and spinal cord injury. Psychosomatics, 42, 382-390.

National Multiple Sclerosis Society. (2003). Depression and multiple sclerosis. Denver, Colo.: Author

Ravesloot, C., Seekins, T., & Walsh, J. (1997). A structural analysis of secondary conditions experienced by people with physical disabilities. Rehabilitation Psychology, 42, 3-16.

Reinherz, H., Stewart-Berghauer, G., Pakiz, B., Frost, A., Moeykens, B., & Holmes, W. (1989). The relationship of early risk and current mediators to depressive symptomatology in adolescence. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 942-947.

Richards, J. S., Kewman, D. G., & Pierce, C. A. (2000). Spinal cord injury. In R. G. Frank & T. R. Elliott (Eds.), Handbook of rehabilitation psychology, (pp. 11-27). Washington, DC: American Psychological Association.

153 Jensen, et al. (1993). Previously cited.

154 Judd, F. K., & Brown, D. J. (1992). Suicide following acute traumatic spinal cord injury. Paraplegia. 30, 173-177.

Kishi et al. (2001). Previously cited.

- People who are **deaf or hard of hearing** are quite heterogeneous, and have been increasingly recognized as cultural and linguistic minority groups. While the two groups are typically defined together, their behavioral health needs and strategies to address them can differ. The literature suggests that people who are deaf or hard of hearing and have behavioral health needs are often misdiagnosed or underdiagnosed, as a result of the lack of specialized providers or interpreters with mental health knowledge who have the skills to appropriately communicate and understand how various mental disorders may manifest themselves in this population.[155] While psychiatric disorders in earlier studies were found to be at least twice as common in children who are deaf or hard of hearing as they are in the general population, these prevalence rates appear to be decreasing as a function of improvements in educational practices and parenting skills. Addressing impediments to social support and stressors seems to have in part reduced differences in behavioral health needs between this group and the general population.

Provider specialization is particularly important for serving people who are deaf and hard of hearing, and has been supported through the development of standards under a joint initiative through the Colorado Commission for the Deaf and Hard of Hearing and the Mental Health Center of Denver called the Daylight Project.[156] The learning collaborative for the project involves six additional mental health and SUD provider agencies and has developed standards for mental health and SUD services to people who are deaf or hard of hearing. The needs are multi-faceted. For example, a provider serving deaf and hard of hearing people has to understand and accommodate a broad range of linguistic needs with sign fluency (American Sign Language and other sign systems), as well as understand the specific cultural needs within subpopulations (such as the unique needs of people who have acquired deafness versus people who are born deaf, or deaf children who attend schools with hearing children, as opposed to those who attend schools for the deaf). Similarly, providers also need to be aware of how psychological assessment tools and best-practice interventions may have to be modified for people who are deaf or hard of hearing. Finally, if specialist providers are not available for direct services, it is essential for non-specialist providers to at least have access to regular specialized consultation. Even those providers who are more accessible may still convey an attitude of inaccessibility by what they do or say. This can relate to a range of factors, including a lack of understanding about disability cultures (including terminology), about how the person culturally identifies with their disability and the disability community, or about how a disability may or may not relate to behavioral health needs. For example, many providers make eye contact with the interpreter who is speaking verbally rather than with their deaf client, who is signing. Similarly, differences within disability groups need to be understood and acknowledged, such as how a person who is congenitally deaf may culturally identify with the deaf community in a different way than a person who became deaf during their lifetime. This observation applies to other disability groups, as well (for example, people who are blind).

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155  Hindley, P., and Kitson, N. (Eds.). (2000). Mental health and deafness. London: Whurr Publishers Ltd.

156  See http://www.coloradodeafcommision.com/pdf/Advocacy/Daylight%20Project%20Update%20April%20 2011.pdf for additional information on the Daylight Project and draft standards.

# OTHER INDICATORS OF NEED

## Colorado's High and Growing Suicide Rate

The Colorado Trust's 2009 report, *Preventing Suicide in Colorado*, highlights the fact that Coloradans are at increased risk for suicide, ranking sixth highest among states.[157] The CDPHE Office of Suicide Prevention (OSP) reported that Colorado's suicide rate of 18.4 per 100,000 people in the 2009 population was the highest recorded since 1988, and that the number of people who died by suicide that year (940) accounted for the highest single-year total in the state's recorded history.[158] From a public health perspective, suicide is significant.

- For every person who dies by suicide, there are four times as many who are hospitalized after a suicide attempt: an estimated 12,800 suicide attempts annually in Colorado result in approximately 3,200 hospitalizations.[159]

- For every person who dies from suicide, there are approximately six to eight additional people left behind who are acutely affected. That means that in 2009 approximately 5,600 to 7,500 grieving individuals were acutely affected by the 940 suicides that year.[160]

- In 2009, the number of people who died by suicide (940) was more than the number who died by homicide (190), motor vehicle accidents (553), influenza and pneumonia combined (655), and diabetes (778).[161] Looking at 2007 data, the Colorado Trust observed that the number is higher than the number that die annually from breast cancer.[162]

- Suicide has a financial impact, as well. A suicide death costs an estimated $3,738 in direct costs (autopsies, investigations, health care expense, etc.) and more than $1.4 million per suicide in indirect costs associated with productive years of life lost.[163] A hospitalization for a suicide attempt costs an average of just over $10,000

in direct costs and another $12,000 in indirect costs.

- Those figures are from 2005, and certainly underestimate costs in 2011, as hospitalization costs, for example, have increased significantly since then. Taken together, however, based on 2009 trends, suicide costs Colorado a staggering $3.5 million in direct costs of the 940 deaths, $70.4 million in the direct and indirect costs of approximately 3,200 annual hospitalizations, and over $1.33 billion in the lost productivity of the people who die.

The Colorado Suicide Prevention and Intervention Plan was issued in November 1998, after Governor Roy Romer's administration identified suicide as a major public health problem in Colorado. In 2000 the Office of Suicide Prevention was established as a new state agency, working under the lead of the Suicide Prevention Coalition of Colorado. The OSP has fostered the development of a comprehensive suicide prevention effort, which includes community education, prevention, and treatment programs. Additional sources of support have been instrumental. For example, as of 2009, The Colorado Trust had invested $4.1 million in suicide prevention activities. In addition, federal grants have aided Colorado's effort to carefully track suicide rates and have led to the development of prevention and intervention programs. Why the suicide rate has increased recently, despite prevention efforts, is not totally clear. The OSP has noted, however, that studies show a relationship between economic stress and suicide rates, and the high suicide rate in 2009 may be due in part to the economic downturn and high unemployment rate in Colorado that year. While broader epidemiological studies have not demonstrated changes in overall rates of mental health and SUD need due to economic changes, those broad studies are, in our judgment, not sufficiently sensitive to more specific trends such as this. Some possible reasons for Colorado's chronic high level of suicide deaths and risk have also emerged. Very recent studies suggest that people

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157  The Colorado Trust. (2009). Preventing suicide in Colorado: Progress achieved and goals for the future. Denver, Colo.: The Colorado Trust.

158  Colorado Office of Suicide Prevention (OSP). (November, 2010). Suicide Prevention in Colorado 2009-2010. CDPHE, p. 1.

159  The Colorado Trust. (2009).

160  OSP. (November 2010).

161  OSP. (November 2010).

162  The Colorado Trust (2009), p. 3.

163  Suicide Prevention Resource Center. Colorado Suicide Prevention Fact Sheet.

living at high altitude have a greater risk of suicide, and that may also provide a partial explanation for Colorado's high suicide rate, compared to other states.[164] It has also long been known that states with less population density (a higher proportion of rural areas) and states with greater access to firearms have higher suicide rates, as well.[165]

It is important that suicide is better understood and that Colorado continues to learn from efforts to prevent suicide and suicide attempts. This is true particularly for older adults, who have the highest rate of suicide among all age groups—people 85 and over have a rate of 46.9 deaths per 100,000 population—and for people ages 10 to 34, for whom suicide is the second leading cause of death.[166]

Despite an increase in the suicide rate for 2009, the OSP reports that, otherwise, the suicide rate in Colorado has remained flat in recent years. Multi-year trends through 2007 show that the suicide rate had dropped 6.5 percent since 1998.[167] The OSP has implemented several suicide-prevention programs since its founding that may be helping to keep the suicide rate lower than it would have been without them. One of these programs is the suicide crisis Lifeline, which has offered phone-based assistance since 2000 to people who are feeling suicidal. Use of this resource has increased markedly, with the number of calls doubling since 2006, an increase likely related at least in part to efforts to de-stigmatize help-seeking and promote use of the resource.

Another important OSP effort initiated in 2009 is Project Safety Net, which involves training adults in more than 20 participating counties who work with at-risk youth involved in the juvenile justice and child welfare systems, as well as Colorado's broader population of LGBT youth, who are at much higher risk than other youth (as discussed in more detail later in this section). In the first year of implementation, nearly 500 people were trained as "gatekeepers" with special skills to work with high-risk youth and intervene when suicidality is recognized. All studies to date, however, emphasize the need to integrate promising efforts like Lifeline and Project Safety Net into a broader, more coordinated public health strategy to address these very serious needs.

## The Needs of Veterans and Members of the Armed Forces

Over the past decade, the needs of America's growing number of veterans and active-duty members of the armed forces, as well as their families, have grown dramatically and become better understood. Recent studies focused on the approximately 2 million troops who have served since 2001 in Operation Enduring Freedom (OEF – Afghanistan theater), Operation Iraqi Freedom (OIF – Iraq theater through September 2010), and

164  Brooks, M. (2011, January). High-altitude living an independent suicide risk factor. Medscape. Retrieved April 14, 2011 from http://www.medscape.com/viewarticle/735956

165  Miller, M., Lippman, S.J., Azrael, D., Hemenway, D. (2007). Household firearm ownership and rates of suicide across the 50 United States. The Journal of Trauma, 62, 1029-1035.

166  Colorado Office of Suicide Prevention (November 2010). Suicide Prevention in Colorado 2009-2010. Colorado Department of Public Health and Environment, p. 1.

167  Colorado Trust (2009), Introduction.

ADVANCING COLORADO'S MENTAL HEALTH CARE

Operation New Dawn (OND – Iraq theater since September 2010) have underscored these needs,[168] and they include:

- Related to the previous subsection, a high suicide rate among OEF/OIF/OND veterans is a growing concern. Suicide rates for OEF/OIF/OND veterans is many times the national average,[169] and rates for OEF/OIF/OND veterans between the ages of 20 and 24 in particular are estimated to be between two and four times higher than the rate for civilians the same age (a rate of suicide that could eventually exceed the combat death toll for these conflicts).[170] Of the 30,000 suicide-related deaths each year, 20 percent are currently estimated to be among veterans.[171]

- Compared to past wars, advances in medical technology and body armor have reduced the rate of death for troops in these conflicts, yet many more "invisible wounds of war" have emerged as a result: mental health conditions, SUDs, and cognitive impairments resulting from deployment experiences. It has been estimated that of these 1.64 million service members serving through 2008, approximately 300,000 individuals currently suffer from Post-Traumatic Stress Disorder (PTSD), or major depression, and that 320,000 individuals experienced a probable traumatic brain injury (TBI) during deployment.[172] The Rand Corporation's landmark study in 2008 also found that approximately one-third of those previously deployed had at least one of these three conditions (PTSD,

major depression or TBI), and about 5 percent reported symptoms of all three. Further, a telephone study of 1,965 individuals previously deployed in OEF/OIF, sampled from 24 geographic areas, found substantial rates of mental health problems in the past 30 days, with 14 percent screening positive for PTSD and 14 percent for major depression. A similar number (19 percent) reported a probable TBI during deployment. Major depression is often not considered a combat-related injury, yet analyses suggested that it is highly associated with combat exposure, and should be included in the spectrum of post-deployment mental health consequences.

- Elevated rates of unemployment, divorce, substance use, and homelessness[173] are estimated to cost $5 to $7 billion a year in direct and indirect effects.[174]

- Many of the hundreds of thousands of troops returning from the wars in Iraq and Afghanistan suffer from acute pain and face the possibility of a lifetime of chronic pain, which is related to a variety of co-occurring behavioral health needs.[175]

Gaps in access to and quality of mental health services were widely noted in these reports.[176] Insufficient workforce capacity and lack of sufficient training in evidence-based practices for PTSD and TBI in particular are common issues,[177] as are limitations in ongoing quality improvement efforts and infrastructure within the Department of Defense

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168  Armed Forces Health Surveillance Center. Causes of Medical Evacuations from Operations Iraqi Freedom (OIF), New Dawn (OND) and Enduring Freedom (OEF), Active and Reserve Components, U.S. Armed Forces, October 2001-September 2010Medical Surveillance Monthly Report (MSMR). March 2011; 18(02):2.

 Institute of Medicine (IOM). 2010. Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, DC: The National Academies Press.

169  D. Holmes, personal communication, March 30, 2011.

170  Yonkman, M. and Bridgeland, J. (2009). All Volunteer Force: From Military to Civilian Service. Civic Enterprises.

171  Comments by VA Secretary E. Shinskei in November 2010 cited in Prevail Health Solutions and Give an Hour. (Spring, 2011). The Vets Prevail Program: Providing a safety net for our returning Service Members. Retrieved at: http://www.vetsprevail.org/resources/Vets%20Prevail%20and%20Give%20an%20 Hour%20Partnership.pdf.

172  Tanielian, T. and Jaycox, L. (editors). (2008). Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery. Rand Center for Military Health Policy Research, Rand Corporation, Santa Monica, CA. Retrieved from: http://www.rand.org/pdfrd/.

173  Tanielian, T. and Jaycox, L. (2008).

174  2010 Vets Prevail Fact Sheet. Personal communication, R. Gengler, April 14, 2011.

175  See http://www.exitwoundsforveterans.org/ for these statistics and additional information.

176  Departments of Defense and Veterans Affairs published clinical-practice guidelines for the treatment of PTSD in 2004 and found that only 10 percent (n = 14) of 137 DoD mental health professionals surveyed (mostly psychologists and social workers) use any of the four recommended psychotherapeutic modalities (cognitive therapy, eye-movement desensitization and reprocessing, exposure therapy, and stress inoculation). Of these 14 clinicians, only four reported that DoD funded their training. (Cited in Tanielian, T., and Jaycox, L., 2008.)

177  Rand Center for Military Health Policy Research. (2009). Fact Sheet: Improving Mental Health Care for Returning Veterans

(DoD), Veterans Administration (VA), and community-based systems.[178] Often, National Guard members on active duty for short periods of time are not eligible for any military health benefits.[179] It was estimated in 2009 that the costs of providing a single year of needed mental health care for OEF/OIF veterans would require an additional $4 billion, essentially doubling the entire mental health budget for the VA that year. Backlogs of over 700,000 cases seeking to access VA services have been noted, as has the general reluctance among veterans and service members to seek mental health and SUD treatment. This includes a general mistrust of DoD and VA programs, related to broader concerns about stigma. Nearly two-thirds of active duty service members surveyed strongly agreed that they would "be seen as weak" (65 percent) and be treated differently by their unit leadership (63 percent) if they received mental health care.[180]

Colorado is home to multiple military bases and many veterans, active duty service members, National Guard and Reserve members, and their families. The Citizen Soldier project tracks numbers of returning veterans from OIF/OEF/OND and has identified more than 7,750 veterans in Colorado, most living in the El Paso County area due to the many military facilities in that area. National data suggests that there are more that 32,000 OIF/OEF/OND veterans in Colorado.[181]

| NUMBER OF COLORADANS DEPLOYED TO OIF/OEF SINCE 9/11/2001 BY MILITARY BRANCH AND GEOGRAPHICAL AREA[182] | | | | |
|---|---|---|---|---|
| MILITARY BRANCH | EL PASO COUNTY | DENVER METRO | REST OF STATE | STATEWIDE |
| Air Force Reserve | 727 | 280 | 125 | 1,132 |
| Air National Guard | 121 | 833 | 282 | 1,236 |
| Army National Guard | 490 | 1,154 | 769 | 2,413 |
| Army Reserve | 673 | 1,166 | 578 | 2,417 |
| Marine Corps Reserve | 52 | 262 | 147 | 461 |
| Navy Reserve | 20 | 55 | 17 | 92 |
| Total | 2,083 | 3,750 | 1,918 | 7,751 |

178  Tanielian, T. and Jaycox, L. (2008).

179  Personal communication, C. Smith, July 15, 2011.

180  Prevail Health Solutions and Give an Hour. (Spring, 2011). The Vets Prevail Program: Providing a safety net for our returning Service Members. Retrieved at: http://www.vetsprevail.org/resources/Vets%20Prevail%20 and%20Give%20an%20Hour%20Partnership.pdf.

181  Estimated by applying Colorado's overall proportion of the 2010 population to the 2 million estimate of total numbers having served in OEF/OIF/OND.

182  Data from the Citizen Soldier Support Program, received through personal communication with Mimi McFaul, Psy.D., Associate Director of the WICHE Mental Health Program, May 2, 2011. Note: there was only one Coast Guard Reserve member in the state.

Colorado providers have responded directly to these needs. For example, the Colorado Behavioral Healthcare Council initiated the **Civilians for Veterans Fund** in partnership with six CMHCs operating in rural areas and multiple partners (including private funders) to provide free care to returning veterans of OEF/OIF/OND.[183] In response to these needs, multiple initiatives have been undertaken that use technology and peer-based strategies to fill gaps in service, improve access to care, and increase natural supports for veterans, warriors, and their families. These include:

- **Warrior Gateway**, a web portal and search platform that provides returning veterans access to information about local community resources, and helps fill gaps in access to a variety of needed services, including mental health care and SUD services.[184]

- Online communities for veterans (**Vets Prevail** – see www.vetsprevail.com) and active duty armed forces (**Warriors Prevail** – see www.warriorsprevail.com), which provide an anonymous, easily accessible entry into support and care that uses peer outreach by specially trained veterans to overcome stigma and provide 24-hour-a-day, seven-day-a-week access to online peer support using chat technology; social network links (for example, see www.facebook.com/VetsPrevail); online access to a National Science Foundation-backed teaching program to enhance coping skills and symptom recognition; and links to a network of more than 5,000 mental health professionals through Give an Hour, providing free mental health services for those who need face-to-face treatment. The project is a best practice among peer interventions nationally, and incorporates evidence-based approaches such as cognitive behavioral therapy (CBT); and is participating in an independent clinical trial that has shown significant reductions in symptoms of PTSD and depression, winning a 2010 National Science Foundation award for innovative research in behavioral health. Their promotional materials estimate more than $16,000 in short term cost avoidance for every veteran that participates, and the program is currently being modified for application to other populations.

- **Give an Hour** (www.givenanhour.org) is a nonprofit organization founded in September 2005 with the mission to develop national networks of volunteers capable of responding to both acute and chronic mental health conditions. As of Spring 2011, Give an Hour had developed a network of more than 5,000 mental health professionals willing to donate at least an hour of their time each week to provide free mental health services to military service members and veterans.[185] Give an Hour provides an online search function to find resources for individuals, couples and families, and children and adolescents, offering treatment for anxiety, depression, SUD, post-traumatic stress disorder, traumatic brain injuries, sexual health and intimacy concerns, supports for LGBT people, and loss and grieving. A search for individual services we conducted in May 2011 on the Give an Hour website within 50 miles of Boulder, Colo., found more than 100 in-person and telephone resources. A search for a Grand Junction, Colo., address found no in-person resources and eight telephonic resources, a finding likely related to Colorado's underlying provider gaps in more rural areas.

- To mobilize and organize community resources, the **Community Blueprint Initiative** has brought together a coalition of leading nonprofit organizations serving veterans and their families to develop an online tool to help local community leaders assess and improve support available in their community. The Blueprint focuses on organizing local resources, providing information to community leaders on the challenges faced by returning veterans, service members, and their families, and offering advice on best practice approaches. Behavioral health is one of eight key areas addressed.[186]

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183 See http://www.cbhc.org/cvf/resources-for-veterans-and-families/ for additional information.

184 D. Holmes, personal communication, March 30, 2011. See http://www.warriorgateway.org/ for additional information.

185 The Vets Prevail Program: Providing a safety net for our returning Service Members. Retrieved at: http://www.vetsprevail.org/resources/Vets%20 Prevail%20and%20Give%20an%20Hour%20Partnership.pdf.

186 Draft Community Blueprint Fact Sheet. (April, 2011). Provided via personal communication with B. Van Dahlen, May 5, 2011.

- **Services for PTSD and Depression.** Despite gaps in access to and quality of care, a number of successful initiatives exist. The DoD Center of Excellence for Psychological Health and Traumatic Brain Injury (TBI) promotes improved care, and provides training based on emerging clinical practice guidelines. VA Centers have been training their counselors in evidence-based therapies for PTSD. The VA's national depression collaborative care program is noted as a successful program in treating persistent depression. Other successful programs include the Bureau of Primary Health Care's effort to integrate mental health professionals into primary care settings for low-income people diagnosed with depression; a primary care program in Maine that prescribes antidepressant medication to people identified as being depressed, and provides telephone follow-up by case managers; the MacArthur Initiative on Depression and Primary Care, which developed the Re-Engineering Systems for Primary Care Treatment of Depression Project (RESPECT), a systematic QI program for depression in primary care; and the RESPECT-Mil program, an example of a multifaceted model in a military setting, based on the RESPECT program, designed to decrease stigma and improve access to care by providing behavioral health care within the primary care setting.[187]

- **Services for TBI.** Centers of care for moderate to severe TBI include Polytrauma System of Care within the VA and the Defense Veterans Brain Injury Center. Other programs and services include: Center for the Intrepid, Wounded Warriors Program (Army), Marine for Life Injured Support (Marine Corps.), Safe Harbor (Navy), Palace HART (Helping Airmen Recover Together) (Air Force), Military Severely Injured Center, and Community Based Health Care Organizations (CBHCOs). Community-based facilities focusing on treatment, rehabilitation, and long-term support for patients with TBI and their families include Scripps Rehabilitation Center and Lakeview.[188] Models of care that show particular promise for treating TBI include integrated team-

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187  Tanielian, T. and Jaycox, L. (2008).

188  Tanielian, T. and Jaycox, L. (2008).

based care; providing "Recovery Coordinators" to work with existing case managers ("Recovery Coordinators" manage different aspects of care, including engaging family members, arranging for support programs, and serving as advocates for service members across systems of care); and the chronic illness care model. Integrated teams are in use at some military medical facilities, including the Center for the Intrepid at Brooke Army Medical Center in San Antonio and Fort Carson's "One Stop Shop."

• **Services for Chronic Pain and Other Needs.** "Exit Wounds," a written resource and website developed by a wounded Iraq war veteran in collaboration with the American Pain Foundation, offers a variety of resources to veterans, including those that address psychological issues and physical health and rehabilitation.[189] It was also noted that improving a person's civic health through volunteerism could support improved physical and mental health and also help reduce the stigma of mental health issues service members may experience.[190]

## HOW IS COLORADO DOING?

The table that follows summarizes information on public mental health and SUD services provided to Coloradans with severe needs. While the populations in the table overlap to some degree and also include some people without severe needs (for example, CMHCs in Colorado serve many people with private insurance, and BHOs serve Medicaid members more broadly than simply those with moderate to severe disorders), it seems that Colorado is serving a greater proportion of people with severe mental health/SUD disorders and incomes under 300% FPL than were served in 2003,[191] and a number much higher than the national benchmark of 40.5 percent.[192] These increases could very well be part of a national trend, given that the Kessler study showed consistent increases in service availability from 1992 to 2003, trends which may very well have continued nationally. Data clearly show, however, that service availability has improved from a broad perspective, although the disparities noted above for many particular groups in need persist.

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189  http://www.exitwoundsforveterans.org/.

190  Yonkman, M. and Bridgeland, J. (2009).

191  In the table on the next page, we show that 26.1 percent of public sector need is being met, but that analysis includes more than just those with the most severe needs; it also includes those with non-SMI but severe mental health problems. If we only include those with SMI/SED living at or below 300% FPL (n=181,276) in the analysis, then Colorado is serving approximately 60.7 percent of those people with SMI/SED (110,000/181,276) and 64.8 percent of those with severe SUD needs (65,000/100,272), for a combined average of 62.5 percent (175,000/281,548). This is higher than the 61 percent of SMI/SED served cited in the 2003 *Status Report* (p. 61) given that that estimate included people served in primary care settings and the 60.7 percent does not.

192  Kessler, et al, 2005.

## PUBLIC MENTAL HEALTH AND SUD SERVICES PROVIDED TO COLORADANS WITH SEVERE NEEDS

| | 2009 SEVERE NEED UNDER 300% FPL | PERSONS SERVED 2010 | PROPORTION OF PUBLIC SECTOR NEED | COMPARED TO 2003 NATIONAL BENCHMARK |
|---|---|---|---|---|
| **Mental Health**[193] | **181,276** | **110,000** | **60.7%** | **40.5%** |
| All SMI/SED Need Served by Medicaid-funded BHOs | 181,276 | 67,989 | 37.5% | |
| All SMI/SED Need Served by DBH-funded CMHCs[194] | 181,276 | 32,355 | 17.8% | |
| All SMI/SED Need Served by CMHIs (State Hospitals) | 181,276 | 2,425 | 1.3% | |
| All SMI/SED Need Served by Division of Criminal Justice Mental Health Programs | 181,276 | 172 | 0.1% | |
| All Adult SMI Need Served by Metro Denver County Jails | 125,198 | 5,630 | 4.5% | |
| All C/A SED Need Served by DYC Commitment – Parole-Mental Health[195] | 56,078 | 514 | 0.9% | |
| All C/A SED Need Served by Child Welfare Mental Health | 56,078 | 4,602 | 8.2% | |
| **Substance Use Disorder (SUD)[196]** | **100,272** | **65,000** | **64.8%** | **40.5%** |
| Adults with SUD Served by DBH SUD Programs | 100,272 | 50,844 | 50.7% | |
| Adults with SUD Served by Medicaid SUD Treatment Benefit | 100,272 | 4,398 | 4.4% | |
| Adults with SUD served by DOC Alcohol and Drug Programs | 100,272 | 7,678 | 7.7% | |
| Adults with SUD served by Division of Probation Offender Treatment and Services (some mental health, mostly SUD) | 100,272 | Unavailable | N/A | |
| Adults with SUD served by Division of Probation SB 03-318 (drug courts) | 100,272 | 2,000 | 2.0% | |
| Division of Criminal Justice SUD Programs | 100,272 | 533 | 0.5% | |
| All C/A SED Need Served by DYC Commitment – Parole-SUD[197] | 56,078 | 77 | 0.1% | |
| All C/A SED Need Served by Child Welfare SUD[198] | 56,078 | 4,667 | 8.3% | |

193 Excludes people receiving services in the Metro County jails, since the extent of services received is unclear.

194 The number of people with SMI/SED served in 2010 cited here (32,355) represents those who were served through non-Medicaid sources only, and who were never served through Medicaid in 2010.

195 Number served (mental health and SUD) are from non-residential served in TriWest's (2010) Continuum of Care Report, re-analyzed by TriWest Group in February, 2011. This analysis of continuum of care youth receiving mental health and SUD services does include some people who were in residential, who were being prepared for parole through continuum of care services. Some of the services generically classified as mental health services may also have targeted SUDs.

196 Does not include the 30,000 people evaluated through the Division of Probation Alcohol and Drug Driving Safety Program.

197 For this need comparison, we are using estimates of the number of children/youth with Serious Emotional Disturbance as the public-sector comparison points, because epidemiology on SUDs for children / youth are not available.

198 As with DYC, for the need comparison, we are using estimates of the number of children/youth with Serious Emotional Disturbance as the public-sector and overall need comparison points, because epidemiology on SUDs for children/youth are not available.

# RECOMMENDATIONS FOR INCREASING ACCESS TO CARE

While more people in 2011 are accessing mental health and SUD care in Colorado than ever before, there are still too many people failing to receive care of any type and many more receiving care in criminal justice and other settings long after symptoms arise, at higher overall cost and with lower possible outcomes. As Colorado's efforts continue to move forward, the following specific actions should be prioritized by policy makers:

1. **Employ more refined indicators of need** for planning and investment. Rather than looking at overall numbers served, break down populations into key subgroups, to better monitor progress in meeting priority needs. Recommended priorities, building on current groups tracked by DBH and the BHTC, include:

   • The **"few"** who have high needs and high involvement with state systems inclusive of services across state systems: Adults with SMI, severe SUD, and severe co-occurring disorders, as well as children with SED and those involved with multiple state agencies, particularly criminal justice, juvenile justice, and child welfare, and

   • The **"many"** who need better routine access to mental health/SUD services across all health care settings.

2. **Focus more on challenges in rural areas.** Rural areas have fewer providers and lower funding, and they also experience a disproportionate impact from the recession (especially job losses) and from funding cuts, in the absence of the economies of scale found in more populated areas that can more readily absorb them.

3. **Reduce health disparities** in access/outcomes for racial, ethnic and linguistic minorities, sexual minorities, and people with disabilities. Given major gaps in data on race, ethnicity, and language in current data sets, an initial priority would focus on Cultural and Linguistically Appropriate Services in Health Care (CLAS) standard #10 (described in detail under Observation #5) and ensure that data on each individual person's race, ethnicity, and spoken and written language is collected in health records, integrated into the organization's management information systems, and regularly updated.

# Observation #3
## Funding for Mental Health Services is Still Low, Funding for Substance Use Disorder Services and Prevention is Even Lower, but the Situation is Somewhat Better Than Before

## Snapshot of Key Findings
## Regarding Funding for MH, SUD and Prevention Services

### Overall Funding Trends

▸ Even though the recession of 2008 was much worse than the recession of 2001, the Ritter Administration maintained Colorado's investment in mental health and SUD services. Nevertheless, Colorado's national ranking for public sector mental health spending fell one place to 32nd in 2007; data on SUD spending shows rates one-third the national average.

▸ Since the 2007 release of the HJR-1050 Task Force recommendations on funding integration, stakeholder funding priorities have shifted to value financing reform as highly as funding increases.

### Long-Term National Mental Health/SUD Service Funding Trends

▸ From 1986 to 2005, spending grew more slowly for SUD (4.8 percent) and mental health (6.9 percent) than for all health spending (7.9 percent).

▸ In 2005, spending on SUD treatment was 1.2 percent of all health spending; mental health spending was 6.1 percent.

▸ For mental health treatment, spending on psychiatrists ($11.4 billion) was more than double the spending on nonpsychiatric physicians ($4.9 billion); however, the rate of spending for nonpsychiatric physicians approached that of other professionals, such as psychologists and social workers ($5.8 billion).

▸ For SUD treatment, the practitioner proportions were reversed. Most is spent on other professionals ($1.8 billion), followed by nonpsychiatric physicians ($0.9 billion) and psychiatrists ($0.5 billion).

▸ While mental health centers provide a substantial proportion of facility-based SUD outpatient care (nearly $2.0 billion out of $11.6 billion), substance abuse centers provide essentially none of the $14.3 billion spent on facility-based mental health outpatient care.

▸ Medicaid remains the largest payer, growing from 17 percent in 1986, to 27 percent in 2002, to 28 percent in 2005. Unlike overall health spending, public spending has always been the primary payer.

▸ For mental health treatment, rates of increase in private insurance spending from 1986 to 2005 are comparable, though somewhat lower, than rates of increase in Medicaid spending. While public sector spending on SUD treatment tripled from 1986 to 2005, private insurance spending fell dramatically below 1986 levels and had only returned to comparable levels by 1995.

▸ Medicare spending has increased dramatically (over four times since 1986 for mental health, and more than double since then for SUD). Medicare plays an important role in shaping health policy, and particularly affects delivery of services to older adults.

## Colorado Public Sector Financing Trends

▸ Spending on mental health treatment in Colorado rose substantially from SFY 2002 to SFY 2009, resulting in increases in spending from multiple perspectives:

   ▾ Per capita based on the overall Colorado population ($62 to $84),

   ▾ Per estimated person in need ($1,665 to $2,256), and

   ▾ Per person living at/below 300% FPL ($129 to $158).

   ▾ These increases were driven by dramatic increases for Medicaid (up 82 percent) and state-funded community mental health (54 percent).

   ▾ Most of that growth occurred prior to the recession in 2008, and growth since SFY 2009 has been limited to Medicaid.

▸ Spending on SUD treatment in Colorado has risen substantially, with per capita funding reaching a high point of $9.44 per capita in SFY 2009, falling back somewhat following cuts in SFY 2010.

▸ Acute care hospital spending increased at nearly five times the rate as state hospital expenditures (a 55 percent increase versus just under 11 percent, respectively) from 2002/3 to present.

▸ More than $53 million was spent on prevention of SUD by DBH in SFY 2010.

## Total Known Behavioral Health Spending

Although data are not available for all behavioral health spending in Colorado, they are available for a wide array of public agencies and inpatient care. Available data for the most recent available year show:

▸ Of the $887 million in known expenditures spent on behavioral health in 2010, just over 53 percent was spent through the formal public behavioral health system.

▸ Nearly half (47 percent or nearly $413 million) was spent in other systems.

▸ More than $93 million was spent on behavioral health needs in the criminal justice system. This represents more than one-tenth of total known behavioral health expenditures. It is also more than one-fifth higher than the amount spent through the formal public behavioral health system.

▸ Expenditures for the vast majority of privately paid care are unknown (only private acute inpatient expenditures were identified for this report).

## Spending Recommendations

▸ While it is understood that state revenue is still recovering in 2011 from the effects of the 2008 recession, it is strongly recommended that, as revenue recovers and funds allow, Colorado public sector payers invest more in mental health service delivery and substantially more in SUD treatment and prevention services.

## OVERVIEW

**In the 2003 *Status Report*, mental health funding in Colorado was the most frequently mentioned concern among key informants. That finding was also true in the key informant interviews we conducted in late 2010 and early 2011 for this report.**

The tone of the current input, however, was very different. In 2003, most informants referred to the funding situation as a "crisis" (or used a related term such as "disaster," "catastrophic," "devastating," or "debacle"). This time, the discussion was more sober, and the focus of discussion more solution-oriented, centering on concepts like "bending the cost curve," "finance reform," "payment methodologies," "accountable care," "integrated funding," and, of course, "inadequate funding."

At first glance, this change seems counter-intuitive given that the recession of 2008 was much worse than the recession of 2001 that preceded the 2003 *Status Report*. The difference was how state government approached mental health and SUD service delivery after each recession. The 2003 report was written as Colorado was emerging from the 2001 recession, and facing large budget cuts, many directly to mental health and SUD treatment funding. This report was written at a similar point in time, following a much worse recession and major cuts to public services, but this time, key informants uniformly noted how the Ritter Administration had prioritized health and behavioral health services for multiple reasons, including their key role in protecting against greater costs in the criminal and juvenile justice systems. It seems that decision-makers are both more inured to the reality of tough budget choices, and more willing to prioritize the role of behavioral health funding as a key lever, to deliver effective health care and reduce the use of more restrictive public services. This concept is explored more fully under Observation #4.

In addition to the priorities of the Ritter Administration, the evolution in public policy surrounding behavioral health funding described at the beginning of this report, driven initially by the House Joint Resolution 07-1050 (HJR-1050) Task Force, was also apparent in the key informant interviews. During the 2009 statewide forums (more than 70 total) conducted under Colorado's federal Transformation Transfer Initiative grant activities, the 561 stakeholders representing people served, family members, providers, and others, showed a marked degree of consensus in endorsing two major financing concepts: spending more on behavioral health services tied for second most important state-level change, but financing reform ranked first.[199] The findings in this report reflect that same consensus.

## HOW FUNDING CHANGES AFFECT PEOPLE

Much of the burden of low funding for mental health and SUD services falls on the people living daily with such needs, as well as their families. We again turn to our stories of Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally to see how payment structures impact delivery of their care.

### Adults with private insurance

#### Barbara & Steve

Barbara's primary care provider that initially treated her mood disorder did not use a mental health diagnosis because the provider has learned that many insurance carriers "carve-out" coverage for mental health needs; Barbara's specific complaints included sleep problems and other medical needs that were sufficient for billing at that time. Because of recent laws in Colorado and nationally requiring that mental health disorders be covered at a level comparable to the broader health

benefit, Barbara's treatment would have been covered if she could have found an outpatient therapist. Practitioners in her network have very long wait lists, however, or are not taking new clients, and there are much higher co-pays for using providers outside of the network. This network meets minimum regulatory requirements for participation, but the insurer has not addressed network adequacy recently. Finally, while parity has improved mental health benefits, it also only applies if the employer chooses to offer mental health coverage. Given recent enhanced requirements for benefits overall, including parity, Steve's company is considering dropping their mental health coverage next year.

#### Joan & Dave

As a teacher, Dave's medical coverage is top-notch: co-pays are minimal and the network is broad. Even more importantly in this case, Dave's primary care medical practice has negotiated a "medical home" payment premium to cover coordination activities not covered under fee-for-service billing. The practice also received SBIRT technical assistance two years ago, and since then it has used those billing codes for screening and brief intervention for SUD. The insurer has approved these services for the practice, given their medical home designation. The practice also has a registry to track medical conditions requiring greater coordination, including behavioral health disorders.

199 TriWest Group and Advocates for Human Potential. (February 2010). The 2009 Colorado Behavioral Health Transformation Transfer Initiative: Final Grant Report. Retrieved at: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Behavioral+Health+Transfer+Initiative%3A+Final+Grant+Report.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251694157818&ssbinary=true.

## Adults with serious mental illness

### Bob

Bob's chances of getting treatment for his schizophrenia and co-occurring alcohol dependence are better now than they would have been five years ago, given the priority his community mental health center has placed on reducing homelessness (as part of a broader city-wide effort). His current services are funded under a federal demonstration grant that will run out in two years, however, and the center is still working on its sustainability planning to continue funding post-award. Of even greater concern is Bob's physical health care. He has no coverage, and his current integrated treatment team through the mental health center only addresses coordination with physical health providers at a minimal level. Bob keeps telling his therapist that he intends to get a physical "soon," but this has not been a top priority for Bob.

### John

John's treatment provider offers multiple "integration" initiatives. Most started as federal or private grant-funded efforts that have since been sustained with ongoing local, state and federal funds, including contracts with the local county to serve adults who are homeless or incarcerated. The IDDT team was established several years ago, and currently relies on a mix of local, state and Medicaid funds. While funding is in doubt every year because of ongoing fiscal challenges, through a strong outcome tracking capacity, the provider consistently demonstrates to local funders its ability to successfully reduce costs and improve outcomes. Another critical component to integration efforts is this provider's partnership with the local FQHC, which places a primary care practitioner on-site at the behavioral health clinic each week. Using local homeless outreach funding, the FQHC is able to reduce productivity expectations for the primary care practitioner involved with the partnership – the complex health needs of the adults they see simply take longer to treat than a typical 20-minute visit.

## Two youth and their families

### Gabriela & Rosa

Gabriela's family does not have health coverage, but even if they did, private insurance rarely covers residential and intensive in-home treatment. She is still residing at the Therapeutic Residential Child Care Facility (TRCCF), a service that her local child welfare agency pays for with state and federal child welfare funds. Her most recent multiagency treatment planning meeting recommended in-home services again, for which she is now eligible, given her extended TRCCF stay. Fortunately, recent changes in child welfare and youth corrections funding allow in-home service capacity to be maintained for residential step-downs, despite ongoing budget cuts. Combined with her prior stay at the runaway shelter, Gabriela has lived away from home for more than six months, and is likely to face another 30-to-60-day wait for the step-down. Everyone is very worried about Gabriela's transition back home and to her new school; Gabriela is uncertain if she wants to go back to school when she gets out, and is thinking she may just try to get a GED.

### Assefa & Amira

Assefa's family is also uninsured, though like Gabriela, the primary services Assefa has received are rarely reimbursed by private insurance. Assefa was fortunate, however, to reside in a county that paid for fidelity-based Wraparound Planning for youth in the juvenile justice system. Wraparound is expensive and, while less expensive than residential placements, requires a commitment across agencies for funding and ongoing support. The 1451 interagency planning process established five years ago in his county created a critical interagency planning, coordination, and data sharing infrastructure that led to joint funding of Wraparound Planning for youth diverted from residential placements. Assefa only qualified because of the severity of his

charges, given that a weapon was involved. Every day, many other youth in Assefa's county with similar levels of need go without such supports, because of a lack of such high level juvenile justice involvement.

## Older adults with Medicare and Medicaid

### Nadine

Nadine continues to deteriorate in her functioning at the nursing home, which is paid for by Medicaid now that her personal resources have been exhausted. Staff at the nursing home have not referred her to the nursing home outreach worker from the local community mental health center, since Nadine is not acting out in a way that disrupts other residents, and since her caregivers perceive that her depression is just part of the natural aging process. Nadine will continue to receive medication from her primary care physician, who oversees her care at the nursing home.

### Sally

Nadine's friend, Sally, continues to do well at home. She is no longer in treatment, as her depression has remitted. Sally continues to see her primary care physician regularly, and Medicare pays for those visits. Medicare also covered her sessions with the licensed therapist from the mental health center. On a couple of occasions, however, her weekly depression support group was led by a non-licensed therapist from the mental health center, because the regular licensed therapist was on medical leave. Sally had to pay out of pocket for those sessions, since Medicare does not cover non-licensed therapists.

# LONG-TERM NATIONAL MENTAL HEALTH/SUD SERVICE FUNDING TRENDS

The 2003 report reviewed behavioral health financing trends from 1987 to 1997. National funding trends available now and those published in a 20-year review in February 2011 examine mental health and SUD treatment funding from 1986 to 2005.[200] In 2005, approximately $113 billion was spent on mental health treatment and $22 billion on SUD treatment. In addition to spending rates on mental health treatment being five times those of SUD treatment, the study made several striking observations:

- Spending across the 20 years grew more slowly for SUD (4.8 percent) and mental health (6.9 percent) than for all health spending (7.9 percent). The pattern remained the same for the three most recent study years (2002 to 2005).

- Given its slower growth, the proportion of health care spending on SUD treatment fell from 2.1 percent of all health spending in 1986 to 1.2 percent in 2005; mental health treatment spending fell from 7.2 percent of all health spending in 1986 to 6.1 percent in 2005. As a proportion of Gross Domestic Product (GDP), SUD treatment spending fell from 0.21 percent to 0.18 percent, whereas mental health treatment spending increased slightly from 0.71 percent to 0.89 percent over that same period.

Exhibit 2

Annual Expenditure Growth Rates, All Health, Mental Health And Substance Abuse, And Gross Domestic Product (GDP), 1986–2005



SOURCE Substance Abuse and Mental Health Services Administration, Center for Mental Health Services and Center for Substance Abuse Treatment. NOTE MHSA is mental health and substance abuse.

The table on the next page presents trends in spending on different types of services. Several observations can be made:

- For mental health treatment, spending on retail prescription drugs increased more than 12-fold, total outpatient spending increased nearly five times, and total inpatient spending did not even double. Spending on insurance administration increased more than five times. The total for all mental health providers reflects the move from inpatient treatment to outpatient since the 1980s. In 1986, the ratio of inpatient to outpatient was approximately 1.75 to 1. By 2005 this ratio had reversed with outpatient spending about 1.75 times the spending level for inpatient.

200  Mark, T.L., Levit, K.R., Vandivort-Warren, R., Buck, J.A., and Coffey, R.M. (February, 2011). Changes in US spending on mental health and substance abuse treatment, 1986 – 2005, and implications for policy. Health Affairs, 30, no. 2:284-292. Retrieved at: http://content.healthaffairs.org/content/30/2/284.full.htmlat.

- For SUD treatment, spending on retail prescription drugs increased more than 23 times, total outpatient spending increased just over five times, and total inpatient spending fell by one-third. Spending on insurance administration nearly tripled. The shift from inpatient to outpatient treatment seen in mental health is also seen with SUD expenditures.

- Retail prescription spending for mental health treatment is more than 212 times higher than retail prescription drug spending on SUD treatment.

The table also presented information on specific providers that is pertinent to the question of behavioral health and primary care integration.

- For mental health treatment, spending on psychiatrists ($11.4 billion) is more than double the spending on nonpsychiatric physicians ($4.9 billion); however, the rate of spending for nonpsychiatric physicians approaches that of other professionals, such as psychologists and social workers ($5.8 billion).

- For SUD treatment, the practitioner proportions are reversed. Most is spent on other professionals ($1.8 billion), followed by nonpsychiatric physicians ($0.9 billion) and psychiatrists ($0.5 billion).

- While mental health centers provide a substantial proportion of facility-based SUD outpatient care (nearly $2.0 billion out of $11.6 billion), substance abuse centers provide essentially none of the $14.3 billion spent on facility-based mental health outpatient care.

| SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT SPENDING Millions of Nominal Dollars, By Provider and Service, Selected Years 1986-2005 | | | | | |
|---|---|---|---|---|---|
| TYPE OF PROVIDER & SITE OF SERVICE | 1986 | 1992 | 1998 | 2002 | 2005 |
| MENTAL HEALTH TREATMENT SPENDING | $31,764 | $50,476 | $66,839 | $93,637 | $112,787 |
| General hospitals | 5,345 | 8,626 | 11,400 | 14,268 | 16,750 |
| General hospital, specialty units | 3,026 | 6,185 | 8,657 | 10,187 | 11,540 |
| General hospital, nonspecialty units | 2,320 | 2,441 | 2,743 | 4,081 | 5,210 |
| Specialty hospitals | 8,251 | 11,733 | 10,032 | 11,966 | 13,416 |
| All physicians | 3,814 | 6,787 | 9,947 | 12,776 | 16,266 |
| Psychiatrists | 2,755 | 4,543 | 6,746 | 8,734 | 11,403 |
| Nonpsychiatric physicians | 1,058 | 2,244 | 3,201 | 4,042 | 4,864 |
| Other professionals | 1,519 | 3,255 | 4,207 | 5,071 | 5,812 |
| Freestanding nursing homes | 4,903 | 5,759 | 4,812 | 5,957 | 6,855 |
| Freestanding home health | 112 | 304 | 667 | 740 | 1,070 |
| Retail prescription drugs | 2,362 | 4,245 | 10,683 | 23,242 | 29,974 |
| All other personal and public health | 3,916 | 7,290 | 11,384 | 13,027 | 14,259 |
| Specialty mental health centers | 3,916 | 7,290 | 11,384 | 13,027 | 14,259 |
| Specialty substance abuse centers | - | - | - | - | - |
| Insurance administration | 1,542 | 2,477 | 3,707 | 6,590 | 8,384 |
| Total, all mental health service providers | 27,860 | 43,754 | 52,450 | 63,805 | 74,429 |
| Total inpatient | 13,314 | 18,290 | 17,817 | 20,436 | 21,653 |
| Total outpatient | 7,559 | 15,282 | 23,294 | 29,668 | 37,195 |
| Total residential | 6,988 | 10,183 | 11,339 | 13,700 | 15,581 |
| SUBSTANCE ABUSE TREATMENT SPENDING | $9,147 | $13,162 | $14,414 | $19,134 | $22,175 |
| General hospitals | 3,254 | 3,674 | 2,986 | 3,841 | 4,343 |
| General hospital, specialty units | 2,505 | 2,817 | 2,228 | 2,785 | 2,842 |
| General hospital, nonspecialty units | 748 | 857 | 758 | 1,057 | 1,502 |
| Specialty hospitals | 1,409 | 1,337 | 1,488 | 1,123 | 1,214 |
| All physicians | 1,091 | 1,186 | 1,074 | 1,312 | 1,391 |
| Psychiatrists | 237 | 626 | 340 | 370 | 482 |
| Nonpsychiatric physicians | 854 | 560 | 734 | 942 | 909 |
| Other professionals | 651 | 1,285 | 1,183 | 1,438 | 1,760 |
| Freestanding nursing homes | 114 | 153 | 233 | 265 | 273 |
| Freestanding home health | 2 | 5 | 13 | 3 | 4 |
| Retail prescription drugs | 6 | 10 | 17 | 32 | 141 |
| All other personal and public health | 2,113 | 4,963 | 6,715 | 9,905 | 11,572 |
| Specialty mental health centers | 325 | 516 | 1,418 | 1,723 | 1,951 |
| Specialty substance abuse centers | 1,788 | 4,447 | 5,297 | 8,182 | 9,621 |
| Insurance administration | 507 | 550 | 706 | 1,216 | 1,477 |
| Total, all substance abuse service providers | $8,634 | $12,602 | $13,692 | $17,886 | $20,557 |
| Total inpatient | 5,103 | 5,010 | 2,902 | 3,247 | 3,662 |
| Total outpatient | 2,073 | 4,917 | 7,166 | 9,586 | 10,703 |
| Total residential | 1,457 | 2,676 | 3,623 | 5,053 | 6,191 |

The study also examined major payers:

| MENTAL HEALTH TREATMENT SPENDING - MAJOR PAYERS | | | | | |
|---|---|---|---|---|---|
| **TYPE OF PAYER** | **1986** | **1992** | **1998** | **2002** | **2005** |
| **Mental health treatment spending** | **$31,764** | **$50,476** | **$66,839** | **$93,637** | **$112,787** |
| **Private, total** | 13,471 | 19,227 | 25,865 | 38,051 | 47,108 |
| Out-of-pocket | 5,569 | 6,706 | 8,515 | 11,857 | 13,802 |
| Private insurance | 6,308 | 10,327 | 15,273 | 23,836 | 30,417 |
| Other private | 1,594 | 2,194 | 2,077 | 2,358 | 2,890 |
| **Public, total** | 18,293 | 31,249 | 40,974 | 55,586 | 65,678 |
| Medicare | 2,099 | 4,095 | 6,232 | 7,353 | 8,630 |
| Medicaid | 5,503 | 10,938 | 15,711 | 25,381 | 31,115 |
| Other federal | 1,993 | 2,519 | 3,369 | 4,582 | 5,673 |
| Other state and local | 8,698 | 13,697 | 15,662 | 18,270 | 20,261 |
| **All federal** | **$7,172** | **$13,562** | **$18,821** | **$26,860** | **$32,078** |
| **All state** | **$11,122** | **$17,687** | **$22,153** | **$28,725** | **$33,601** |

- For mental health treatment (see the figure above), Medicaid remains the largest payer (just as it was in the 2003 report), growing from 17 percent in 1986 to 27 percent in 2002 to 28 percent in 2005. This growth was offset by reductions in non-Medicaid state and local government spending, which fell from 27 percent in 1986 to 20 percent in 2002 to 18 percent in 2005. The next largest payer was private insurance at 27 percent. Note that, unlike overall health spending, public spending has always been the primary payer. The major change has been the dramatic growth in Medicaid spending and the shift from state to federal funding.

| SUBSTANCE ABUSE TREATMENT SPENDING - MAJOR PAYERS | | | | | |
|---|---|---|---|---|---|
| **TYPE OF PAYER** | **1986** | **1992** | **1998** | **2002** | **2005** |
| **Substance abuse treatment spending** | **$9,147** | **$13,162** | **$14,414** | **$19,134** | **$22,175** |
| **Private, total** | **3,642** | **3,680** | **3,274** | **4,046** | **4,615** |
| Out-of-pocket | 943 | 1,227 | 1,023 | 1,266 | 1,407 |
| Private insurance | 2,444 | 1,931 | 1,768 | 2,239 | 2,613 |
| Other private | 255 | 522 | 483 | 542 | 595 |
| **Public, total** | **5,504** | **9,483** | **11,140** | **15,088** | **17,560** |
| Medicare | 737 | 860 | 940 | 1,211 | 1,487 |
| Medicaid | 1,052 | 2,100 | 2,810 | 3,845 | 4,624 |
| Other federal | 912 | 2,732 | 2,209 | 3,149 | 3,497 |
| Other state and local | 2,803 | 3,790 | 5,181 | 6,883 | 7,952 |
| **All federal** | **$2,236** | **$4,939** | **$4,805** | **$6,611** | **$7,626** |
| **All state** | **$3,268** | **$4,543** | **$6,335** | **$8,477** | **$9,934** |

- For SUD treatment (see the figure above), state and local funding are the largest payer at 36 percent, followed by Medicaid (21 percent), and other federal spending (16 percent). Total private spending is dwarfed. In the words of the study authors: "...substance abuse treatment is much more dependent on public financing than all health and mental health services."

The study concludes with an important observation about the nature of funding for both mental health and SUD treatment, noting that, while Medicaid is a major funder for mental health treatment, people with the most severe disorders often tend to be adults without dependent children. In Colorado (and many other states), currently, the only way to obtain Medicaid coverage as an adult without dependent children is to be certified as having a disability. When substance dependence was removed in 1996 as a qualifying disability for Medicaid coverage, many people with addictions lost coverage, and Medicaid coverage became much less attainable for most people with SUD needs. The study estimates that 4.9 million people with "serious psychological distress" and 5.5 million people with SUD are without any form of coverage, thus heightening the potential positive impact of the federal Patient Protection and Affordable Care Act. This is discussed in more detail under Observation #4.

Trends since 2005 are less clear. Examination of broader health care spending found that costs grew at a "historically low rate" in 2009 due to the effects of the recession.[201] Spending on Medicaid grew 22 percent that year, however – its highest rate of growth since 1991 – and the overall proportion of the economy spent on health grew from 16.6 percent in 2008 to 17.6 percent in 2009.

Data are not available on private sector mental health and SUD treatment spending trends in Colorado. Since we will see in the next section that Colorado public trends seem to have closely mirrored the broader national spending trends (slower rates of growth since 2008, large increases in Medicaid spending for mental health treatment, relatively higher spending on SUD treatment through state and federal block-grant funds), however, it seems reasonable to assume that private behavioral health spending trends in Colorado also follow similar patterns to national trends. This would imply that:

- For mental health treatment, rates of increase in private insurance spending from 1986 to 2005 are comparable, though somewhat lower, than rates of increase in Medicaid spending, increasing nearly five-fold, whereas Medicaid grew just over five-fold. Out-of-pocket spending increased by less, but still more than doubled.

- While public sector spending on SUD treatment tripled from 1986 to 2005, private insurance spending fell dramatically below 1986 levels and had only returned to comparable levels by 1995. Out-of-pocket spending had increased by half.

It is also of interest to note trends in Medicare spending. While comprising a relatively smaller portion of overall funding than Medicaid and the private sector, Medicare spending has increased dramatically (more than four times since 1986 for mental health and more than double since then for SUD). Furthermore, Medicare plays an important role in shaping health policy, and particularly affects delivery of services to older adults.

Key informants we spoke with – knowledgeable about older adult mental health and SUD needs – emphasized the limitations on Medicare reimbursement to only the more traditional categories of licensed practitioners (physicians, psychologists, and licensed social workers), so the limited availability of such practitioners overall, and the specific lack of older adult specialists among them (see the discussion under Observation #6 for more detail, including data showing that there are only 12 geriatric psychiatrists in Colorado, all of whom practice in the Denver and Colorado Springs areas), severely hampers access to care. This limitation is compounded by the increasing unwillingness of many providers to accept Medicare reimbursement, resulting in what Colorado key informants described as a "massive gap" for older adults with behavioral health needs. These same factors also limit access to primary care prescribers that might otherwise be able to fill some of the gaps created by limited access to specialist providers with geriatric expertise. Furthermore, even when providers are available, Medicare only pays for traditional inpatient and outpatient treatment, and does not pay for case management interventions, which limits reimbursement for care to only services that can be provided in those settings.

201  Martin, A., Lassman, D., Whittle, L., Catlin, A., and the National Health Expenditure Accounts Team. (May 2011). Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades. Health Affairs, 30, no.1 (2011):11-22.

# COLORADO PUBLIC SECTOR FINANCING TRENDS

**Historical trends.** The 2003 *Status Report* found that Colorado ranked 31st among states in 2001 for its level of public mental health spending per capita ($64.24 per person), 21 percent below the U.S. average of $81.16 per person.[202] The most recent year of comparison since then for public mental health spending was 2007, and Colorado slipped somewhat comparatively, ranking 32nd among states at $74.28 per capita, 25 percent below the U.S. average of $99.54.[203] Trends for SUD treatment spending were not as readily available, but a 2010 report by DBH noted that in 2000, spending per Colorado resident was only $7.50, compared to $27 per U.S. resident nationally.

**Current Colorado Mental Health Treatment Expenditures.** Looking more specifically at state level expenditures, spending on mental health treatment in Colorado rose substantially from SFY 2002 to SFY 2009, resulting in increases in spending from multiple perspectives:

• Per capita based on the overall Colorado population ($62 to $84),

• Per estimated person in need ($1,665 to $2,256), and

• Per person living at/below 300% FPL ($129 to $158).[204]

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202  Lutterman, T., Hollen, V., & Shaw, R. (2003). Funding sources and expenditures of state mental health agencies: Fiscal Year 2001. Alexandria, Va.: NASMHPD Research Institute.

203  Lutterman, T.C., Phelan, B.E., Berhane, A., Shaw, R., Rana, V. (January, 2010). Funding and characteristics of SMHAs: 2007. NASMHPD Research Institute. Retrieved at: http://store.samhsa.gov/shin/content// SMA09-4424/SMA09-4424.pdf

204  Source for SFY 2002 financial data was the 2003 Status of Mental Health Care in Colorado report. SFY 2009 financial data is from Colorado General Assembly, Joint Budget Committee (December 10, 2010). FY 2011-12 Staff Budget Briefing. Department of Health Care Policy and Financing and Department of Human Services (Mental Health and Alcohol and Drug Abuse Services). A Joint Budget Committee (JBC) Working Document. Prepared by Kevin Neimond, JBC Staff.

The following analyses reveal the primary factors underlying these trends. The first analysis focuses on overall funding levels, which have increased dramatically for Medicaid (up 82 percent), markedly for state-funded community mental health (54 percent), and slightly for CMHIs (9.8 percent). Note that most of that growth occurred prior to the recession in 2008, and growth since SFY 2009 has been limited to Medicaid. Spending trends on Medicaid antipsychotic pharmaceuticals were only reported separately through SFY 2009, and they increased from $19,533,930 in SFY 2002 to $42,666,675 in SFY 2009, an increase of 218 percent.

The following chart examines the same trends on a per capita basis, where the growth rates are adjusted for Colorado's substantial growth in population since 2002. Viewed through this lens, spending per person from SFY 2002 to SFY 2012 increased for Medicaid (57 percent) and community mental health (33 percent), but fell for CMHIs (-5.6 percent). Even the increase in the Medicaid expenditures was driven primarily by growth in the increased spending per Medicaid member.[206] Per capita spending on Medicaid antipsychotic pharmaceuticals was only reported separately through SFY 2009, and it increased from $4.33 per capita in SFY 2002 to $8.64 per capita in SFY 2009, an increase of just under 200 percent. The increase across these four expenditures (39 percent), however, is well below the overall rate of health expenditure increase since 2002 (approximately 46 percent), reflecting the broader national trends discussed above in which mental health spending rose more slowly than overall health spending.[207]

**MEDICAID, COLORADO MENTAL HEALTH INSTITUTE (CMHI) AND COMMUNITY MENTAL HEALTH FUNDING[205]**



**PER CAPITA MEDICAID, CMHI AND COMMUNITY MENTAL HEALTH FUNDING[208]**
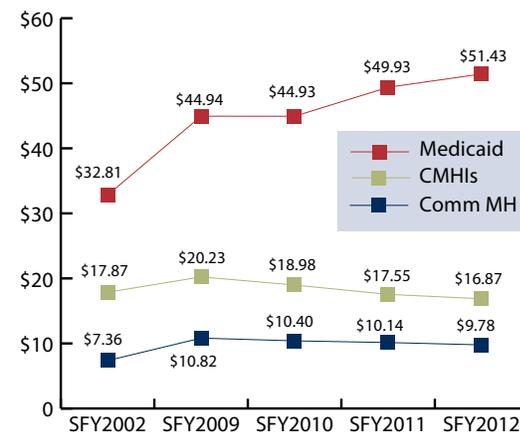
205 Colorado General Assembly, Joint Budget Committee (December 10, 2010). FY 2011-12 Staff Budget Briefing. Department of Health Care Policy and Financing and Department of Human Services (Mental Health and Alcohol and Drug Abuse Services). A JBC Working Document – Subject to Change. Prepared by Kevin Neimond, JBC Staff. Note that Medicaid figures exclude Medicaid Antipsychotic Pharmaceuticals, which doubled in expenditures from SFY 2002 to SFY 2009. Community Mental Health Funding is Non-Medicaid Community Mental Health Funding.

206 Altarum Institute. (June, 2011). Colorado Behavioral Health Organizations Bend the Cost Curve While Increasing Access to Care for Medicaid Beneficiaries. Personal communication, G. Delgrosso, July 11, 2011.

207 Martin, A., et al. (May 2011).

208 Colorado General Assembly, Joint Budget Committee (December 10, 2010). FY 2011-12 Staff Budget Briefing.

**Current Colorado SUD Treatment Expenditures**. Spending on SUD treatment in Colorado has risen substantially in recent years. DBH reports increases in SUD treatment and detoxification funding from SFY 2006 to SFY 2010. Per capita funding reached a high point of $9.44 per person in the overall population in SFY 2009, falling back somewhat following cuts in SFY 2010.

**COLORADO PER CAPITA DBH SUD AND MEDICAID SUD TREATMENT FUNDING SFY 2006 TO SFY 2010**[209]
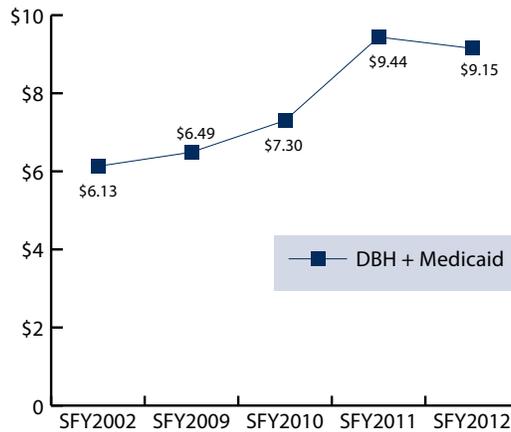


**SUD TREATMENT AND DETOXIFICATION FUNDING TRENDS**[210]



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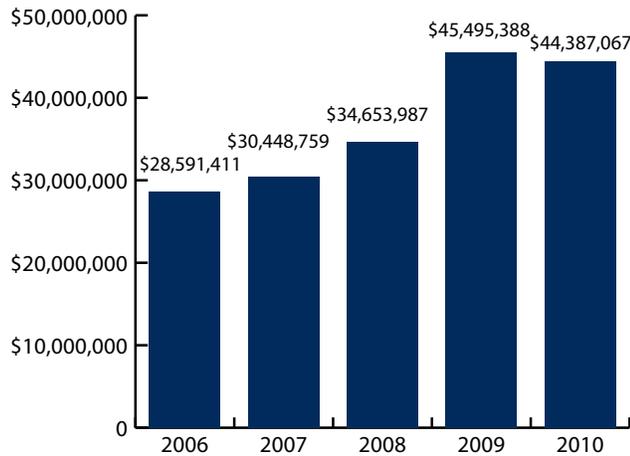
209 DBH funding data are from: Colorado Division of Behavioral Health (2009, 2010). Cost-Effectiveness of SUD Programs in Colorado. Chart was reproduced from a chart on p. 9 of the 2010 report. Medicaid Substance Abuse Treatment Benefit data are from Marceil Case, personal communication, November 24, 2010; chart appears in tab, "Quarterly trend," in the spreadsheet, "1303_BLINDED OSA Printouts_Q4 FY0910."

210 Colorado Division of Behavioral Health (2009, 2010). Cost-Effectiveness of SUD Programs in Colorado. Chart was reproduced from a chart on p. 9 of the 2010 report.

While still representing a relatively small level of expenditure, the addition of the Medicaid SUD treatment benefit in SFY 2008 helped contribute to increases overall and per capita, as follows.

## MEDICAID SUD TREATMENT BENEFIT[211]
### SUBSTANCE ABUSE QUARTERLY SPENDING



The graph that follows shows total charges for all acute inpatient care payers in CY 2009.

## CHANGE IN ACUTE CARE HOSPITAL CHARGES (CY 2003 VS. CY 2009) AND CMHI FUNDING (SFY 2002 VS. SFY 2011)[212]
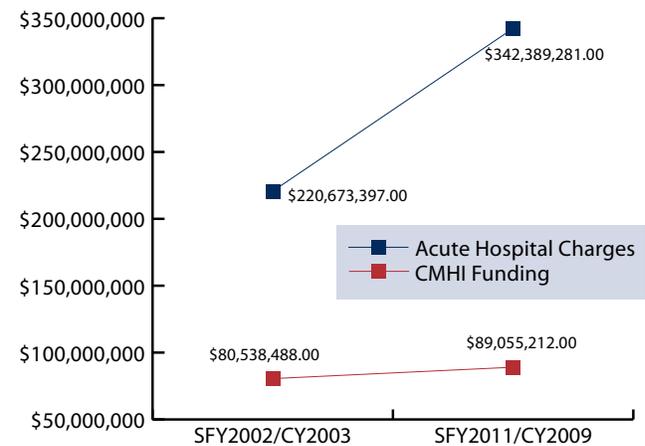


Although Medicaid is the leading payer nationally and in Colorado for behavioral health, it is not the major payer for acute inpatient care, per the chart on the next page. Private insurance pays more than three times as much as Medicaid, and Medicare and self-pay each pay more than double the amount paid by Medicaid. Note that TriCare expenditures for active-duty armed-forces members are also quite substantial.

## ACUTE INPATIENT SPENDING

As noted previously, data are not available on overall private mental health and SUD treatment spending trends in Colorado. Data on total expenditures for acute psychiatric care (inclusive of both private and public funds) are available, however, and are summarized in the following graph. As can be seen, acute care hospital spending increased at nearly five times the rate as state hospital (CMHI) expenditures (a 55 percent increase versus just under 11 percent, respectively) from CY 2003 to CY 2009 (CMHI trends were from SFY 2002 to SFY 2011).

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211 From Marceil Case, personal communication, November 24, 2010; chart appears in tab, "Quarterly trend," in the spreadsheet, "1303_BLINDED OSA Printouts_Q4 FY0910."

212 Note total is slightly different than the previous chart, because of a minor amount of missing data on payer source for a small number of inpatients.

## PAYERS FOR BEHAVIORAL HEALTH SERVICES IN ACUTE CARE HOSPITALS, 2009

| PAYER | TOTAL CHARGES | % OF TOTAL |
|---|---|---|
| Private Insurance | $113,607,758 | 33% |
| Medicare | $77,722,766 | 23% |
| Self Pay | $71,330,067 | 21% |
| Medicaid | $34,463,604 | 10% |
| Colorado Medically Indigent | $21,631,779 | 6% |
| TriCare | $15,197,069 | 4% |
| Other Government | $4,198,516 | 1% |
| All Others | $4,128,634 | 1% |
| **Total** | **$342,280,193** | **100%** |

The following graph shows the rate of increase in the top five acute care funders from CY 2003 to CY 2009.

## CHARGES FOR CARE IN ACUTE CARE HOSPITALS BY PAYOR (2003 VS. 2009)[213]
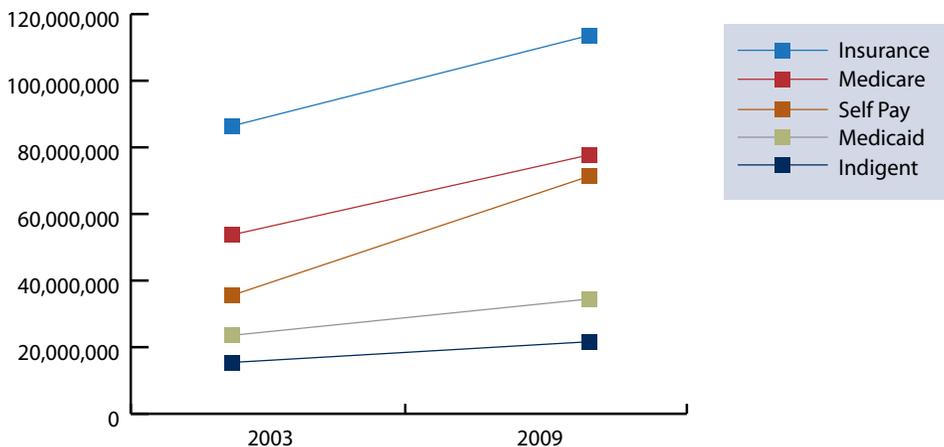


While private insurance payments increased more than 31 percent, rates of increase in the four other major payers were much higher: Medicare increased 45 percent, Medicaid increased 46 percent, self-pay increased over 100 percent, and Indigent care increased 40 percent.

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213 Data obtained from Colorado Hospital Association, through personal communication with Bob Finn, March 24, 2011.

ADVANCING COLORADO'S MENTAL HEALTH CARE

## Total Known Spending on Behavioral Health

Although data are not available for all behavioral health spending in Colorado, they are available for a wide array of public agencies and inpatient care. Available data on expenditures for the most recent available year are summarized in the following table, highlighting the following key points of comparison:

- Of the $887 million in known expenditures spent on behavioral health in 2010, just over 53 percent was spent through the formal public behavioral health system;

- Nearly half (47 percent or nearly $413 million) was spent in other systems;

- Over $93 million was spent on behavioral health needs in the criminal justice system;

  - This is more than one-tenth of total known expenditures and more than one-fifth as much as is spent through the formal public behavioral health system;

  - More than one-third of this amount was spent incarcerating people with severe behavioral health needs in the seven metro Denver area county jails;

- Expenditures for the vast majority of privately paid care are unknown (only private acute inpatient expenditures were identified for this report).

| CARE SETTING | PEOPLE SERVED 2002 | PEOPLE SERVED 2010 | KNOWN EXPENDITURES 2002 | KNOWN EXPENDITURES 2010 |
|---|---|---|---|---|
| **Public Behavioral Health System** | | | **$281,133,701** | **$471,318,302** |
| Mental Health | | | | |
| DBH (Non-Medicaid) Community Mental Health[214] | 40,031 | 46,816 | $33,189,118 | $52,325,625 |
| Medicaid Capitated and Fee for Service Mental Health[215] | 47,049 | 67,989 | $147,872,165 | $225,955,715 |
| Medicaid Antipsychotic Pharmaceuticals | Unavailable | Unavailable | $19,533,930 | $42,666,675 |
| Mental Health Institutes (State Hospitals)[216] | 3,484 | 2,425 | $80,538,488 | $95,438,279 |
| Substance Use Disorders | | | | |
| DBH SUD Treatment and Prevention[217] | Unavailable | 50,844 | Unavailable | $53,302,080 |
| Medicaid SUD Treatment Benefit | Not applicable | 4,398 | Not applicable | $1,629,928 |

214 Colorado General Assembly, Joint Budget Committee (December 10, 2010). FY 2011-12 Staff Budget Briefing. Department of Health Care Policy and Financing and Department of Human Services (Mental Health and Alcohol and Drug Abuse Services). A JBC Working Document – Subject to Change. Prepared by Kevin Neimond, JBC Staff. Note that the 46,816 figure of people served in 2010 includes all people who were served through non-Medicaid sources at some point in the year.

215 Colorado General Assembly, Joint Budget Committee (December 10, 2010). FY 2011-12 Staff Budget Briefing.

216 Personal communication with David Poulin, DBH, January 31, 2011. Total includes those consumers served in Forensics, and in Child/Adolescent, Adult, and Geriatric Civil beds. Note that some persons could have been served in more than the inpatient category during the fiscal year, so could be counted in more than one category.

217 Includes people discharged from treatment in programs overseen by the DBH. Includes SUD treatment and detoxification. Does not include Driving Under the Influence (DUI) services. Expenditures include $8,915,013 in prevention services for 2010. "People Served" figure for 2010 does not include people served through prevention services.

| CARE SETTING | PEOPLE SERVED 2002 | PEOPLE SERVED 2010 | KNOWN EXPENDITURES 2002 | KNOWN EXPENDITURES 2010 |
|---|---|---|---|---|
| **Other Systems** | | | **$197,660,408** | **$415,929,632** |
| **Veterans Administration** | Unavailable | Unavailable | Unavailable | Unavailable |
| Other Hospitals (non-CMHI) [218] | | | | |
|    Mental Health[219] | 15,416 | 12,048 | $137,229,311 | $182,005,384 |
|    SUD | 7,721 | 6,546 | $70,613,179 | $135,170,364 |
|    Organic / Developmental Disability | 967 | 840 | $13,366,179 | $25,213,533 |
| Criminal Justice System/Dept. of Corrections | | | | |
|    Mental Health Programs[220] | Unavailable | Unavailable | Unavailable | $21,850,737 |
|    Alcohol and Drug Programs[221] | Unavailable | 7,678 | Unavailable | $8,187,389 |
| Division of Probation Services [222] | | | | |
|    Offender Treatment and Services Fund (SUD, some Mental Health) | Unavailable | Unavailable | Unavailable | $10,932,013 |
|    SB 03-318 (drug courts) | Unavailable | 2,000 | Unavailable | $2,120,000 |
|    Alcohol and Drug Driving Safety | Unavailable | 30,000[223] | Unavailable | $5,000,000 |

218 Data from Personal Communication with Bob Finn, Colorado Hospital Association, March 2011. Data is for 2003 and 2009. Note that people served data is actually the number of episodes, and includes duplicated counts.

219 This amount includes $34,463,604 spent by Medicaid in Acute Care Hospitals. Since this was also counted above, it is excluded from the "Other Systems" Sub-Total in order to not be double-counted in the overall estimate.

220 Colorado General Assembly Joint Budget Committee (Dec. 20, 2010). Department of Corrections FY 2011-12 Staff Budget Briefing. (p. 119)

221 Colorado General Assembly Joint Budget Committee (Dec. 20, 2010). Department of Corrections FY 2011-12 Staff Budget Briefing. (p. 119)

222 Colorado Commission on Criminal and Juvenile Justice (2010, December) White Paper, pp. 69 ff.

223 Does not provide treatment, only evaluation.

| CARE SETTING | PEOPLE SERVED 2002 | PEOPLE SERVED 2010 | KNOWN EXPENDITURES 2002 | KNOWN EXPENDITURES 2010 |
|---|---|---|---|---|
| Division of Criminal Justice | | | | |
| Mental Health Programs[224] | Unavailable | 172 | Unavailable | $2,953,410 |
| SUD Programs[225] | Unavailable | 533 | Unavailable | $4,396,341 |
| County Jails[226] | Unavailable | Unavailable | Unavailable | $35,100,021 |
| Probation — Mental Health[227] | Unavailable | Unavailable | Unavailable | $565,000 |
| Probation — SUD | Unavailable | Unavailable | Unavailable | $2,000,000 |
| Juvenile Justice System | | | | |
| Division of Youth Corrections[228] | Unavailable | Unavailable | Unavailable | $3,993,704 |
| Detention and SB 94 | Unavailable | Unavailable | Unavailable | Unavailable |
| Commitment — Parole-Mental Health[229] | Unavailable | 514 | Unavailable | Unavailable |
| Commitment — Parole-SUD[230] | Unavailable | 77 | Unavailable | Unavailable |
| Child Welfare — Core Services | | | | |
| Mental Health | Unavailable | 4,602 | Unavailable | $4,888,933 |
| SUD | Unavailable | 4,667 | Unavailable | $2,916,407 |
| **Total Known Expenditures (Public and Private)** | | | **$478,794,109** | **$887,247,934** |

224 Colorado Commission on Criminal and Juvenile Justice (December 2010). White paper from the Treatment Funding Working Group. Division of Criminal Justice, Department of Public Safety. Includes 160 Mental Health Beds ($2,713,4100) and 12 slots available through the John Eachon Re-entry Program ($240,000).

225 Includes 208 served through Intensive SUD Residential Treatment ($1,039,334) and 200 served through Modified Therapeutic Community ($2,851,380). In personal communication on December 16, 2010 with Jeanne M. Smith, these amounts/number served were reported to be $379,247/237 and $606,969/272.

226 From personal communication with Regina Huerter, January 12, 2011. Only includes mental health funding, not SUD funding. This amount is the estimated cost of incarcerating people with DSM Axis I mental disorders in Denver Metro Area County jails and county correctional facilities in 2009.

227 Personal communication with Susan Colling, February 3, 2011.

228 DYC data is from Division of Youth Corrections Management Reference Manual, Fiscal Year 2009-2010. Only includes Continuum of Care project treatment expenditures – TriWest (2010). Total DYC funding cannot be computed.

229 Number served (mental health and SUD) are from non-residential served in TriWest's (2010) Continuum of Care Report, re-analyzed by TriWest in February 2011. This analysis of continuum of care youth receiving mental health and SUD services does include some people who were in residential being prepared for parole through continuum of care services. Some of the services generically classified as mental health services may also have targeted SUD issues.

230 These data also comes from TriWest's (2010) Continuum of Care Report, re-analyzed by TriWest in February, 2011. The same caveats apply.

## The Possible Future of Behavioral Health Funding Under Health Reform

A related finding from the analysis of overall behavioral health funding is that most of Colorado's current behavioral health funding comes from state and local sources. At first this claim seems counter-intuitive, as Medicaid is the single largest funding source (accounting for more than $270.2 million annually in 2010, but just over 30 percent of total known funding). That, however, leaves at least $267.9 million in 2010 (another 30 percent) that flows from the following state and local sources (we use the term "at least" because this only counts known spending – much is unknown, including the amount spent by non-metro Denver counties on services in jails):

• As noted in the previous section, in the most recent years data were available, more than $93 million was spent on behavioral health needs in the criminal justice system, including $35 million to incarcerate people with severe disorders in the seven Denver metro area county jail systems (and this number does not count similar jail costs in Colorado's remaining 60 counties, as data for these were not available);

• Nearly 96 percent ($141.5 million out of $147.8 million in SFY 2010) of DSHS (DBH and CMHI) spending on mental health treatment involves state funding (for community mental health and CMHI services); most of the just over $6 million in federal funding is a mental health block-grant;

• Conversely, under half (45 percent or $19.4 million in SFY 2010) of DBH spending on SUD treatment involves state or local funds (the rest comes from the federal SUD treatment and prevention block-grant);[231]

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231  Colorado Division of Behavioral Health (2009, 2010). Cost-Effectiveness of SUD Programs in Colorado.

- Similarly, just under one-sixth (15.7 percent) of DBH spending on SUD prevention services involves state funding (84.3 percent comes from federal funds, primarily the federal SUD treatment and prevention block-grant), and 100 percent of SUD recovery services come from federal funding through the Access to Recovery Grant (CSAT-SAMHSA),[232] and

- Other child-serving systems (juvenile justice and child welfare) spend a combined $11.8 million.

Medicaid remains a primary focus, however, given that so much of state and federal health reform efforts center on its future. The figure that follows shows the role of Medicaid among other funders as it will evolve under the future provisions of the 2009 Colorado Health Care

Affordability Act (CHCAA) and the 2010 federal Patient Protection and Accountable Care Act (PPACA). The top of the graphic shows the two phases of planned expansion primarily focused on adults in poverty without dependent children (APWDC): up to 100 percent of the Federal Poverty Level (FPL) in January 2012 under CHCAA, and up to 133% FPL in January 2014 under PPACA. Also in January 2014, people with incomes between 133% FPL and 450% FPL will qualify for federal subsidies to purchase private insurance in Colorado's health insurance exchange.

| STATE/LOCAL INSTITUTIONAL CARE | STATE-FUNDED MEDICAL CARE | MEDICAID (AND CHP+) | INSURANCE EXCHANGES | PRIVATE INSURANCE | MEDICARE |
|---|---|---|---|---|---|
| **Planned Health Reform** | | | | | |
| | | **1/2012**: Adults in poverty without dependent children (APWDC) up to 100% FPL<br>**1/2014**: Non-disabled people up to 133% FPL | **1/2014**: Subsidies for people from 133% FPL to 450% FPL | Other changes under PPACA | Other changes under PPACA |
| **Current** | | | | | |
| Jails<br>Prisons<br>Juvenile Detention Centers<br>State Psychiatric Hospitals<br>- Forensic<br>- Adults | Community Mental Health<br>- APWDC<br>SUD Services<br>- APWDC | People who are disabled up to 250% FPL and children and pregnant women up to 100% FPL<br>State Psychiatric Hospitals<br>- Children<br>- Older adults<br>Developmental disabilities<br>- State-run regional centers<br>- 2 HCBS waivers for 7,019 adults<br>- 5 HCBS waivers for 2,257 children with special health care needs<br>Medicaid eligibles needing nursing facility care<br>- Nursing facilities<br>- 2 HCBS waivers for 22,864 disabled adults<br>- HCBS waiver for people with HIV/AIDS (110 people)<br>- HCBS waiver for people with TBI (400 people)<br>Money Follows Person (100 people) | Unavailable | Individual market<br>Employee people and their dependents | Older adults<br>People who are disabled with work history |

232 Personal communication, C. Smith, July 15, 2011.

**SEVERE SUD DISORDERS DO NOT QUALIFY PEOPLE AS DISABLED UNDER FEDERAL LAW. THE PROCESS FOR BEING RECOGNIZED AS DISABLED IS EXTREMELY COMPLEX, AND OFTEN REQUIRES MULTIPLE APPLICATIONS – A TASK THAT CAN BE DIFFICULT FOR A PERSON ALSO COPING WITH A DISABLING MENTAL HEALTH CONDITION.**

One primary implication of this is that many people who currently have their mental health and SUD care paid for with state and local (and some federal block-grant) funds through DBH will be eligible for Medicaid. A key question facing Colorado policy makers in 2011 is the design of the Medicaid benefit package that these adults without dependent children will receive starting in January 2012.

One common misconception among many outside the public mental health and SUD health care systems is that people without Medicaid are not disabled (given that Medicaid currently covers people with disabilities, including those based on mental health diagnoses). This is not true, for several reasons. One (discussed earlier in this section of the report) is that severe SUD disorders do not qualify people as disabled under federal law. Another is that the process for being recognized as disabled is extremely complex, and often requires multiple applications – a task that can be difficult for a person also coping with a disabling mental health condition.

To try to gauge the extent to which people who are currently uninsured have severe mental health needs, the Colorado Behavioral Healthcare Council asked its member CMHCs in 2010 to count the number of uninsured people they served who were under 100% FPL. They found that over half of the uninsured people they currently serve (53 percent or just over 12,000 in SFY 2010) – people who for the most part have serious mental illnesses – would qualify for the 2012 Medicaid benefit. Many more would be expected to gain coverage in 2014 under PPACA. See the table to the right for additional detail.

## ADULTS IN FY 2010 WHO HAD NO THIRD-PARTY PAYOR, WHO ARE PROJECTED TO BECOME ELIGIBLE FOR MEDICAID UNDER THE ADULTS NO DEPENDENT CHILDREN CATEGORY, STATEWIDE AND BY REGION

| REGION | # SERVED SFY 2010 | NUMBER ELIGIBLE | PERCENT ELIGIBLE |
|---|---|---|---|
| Colorado Total | 22,851 | 12,018 | 53% |
| Access Behavioral Care Region (MHCD, Asian, Servicios de La Raza) | 1,831 | 908 | 50% |
| BHI Region (Adams, Arapahoe, Aurora) | 7,045 | 3,537 | 50% |
| Colorado Health Network Region (Pikes Peak, San Luis, Southeast, Spanish Peaks, West Central, Colorado West, Midwestern, SW, AspenPointe, Axis) | 9,963 | 5,279 | 53% |
| Foothills Behavioral Health Region (Jefferson, Boulder) | 1,850 | 1,279 | 69% |
| Northeast Behavioral Health Region (Centennial, Larimer, North Range BH) | 2,162 | 1,015 | 47% |

The initial expansion in January 2012 represents a potential 17.7 percent increase in the number of Medicaid members served in the public behavioral health system overall and a 30 percent increase in the number of Medicaid members served in CMHCs and clinics. See the following chart.

### MEDICAID ENROLLMENT AND ENROLLEES SERVED, SFY 2002 AND SFY 2010 WITH AND WITHOUT EXPECTED NEW ELIGIBLES
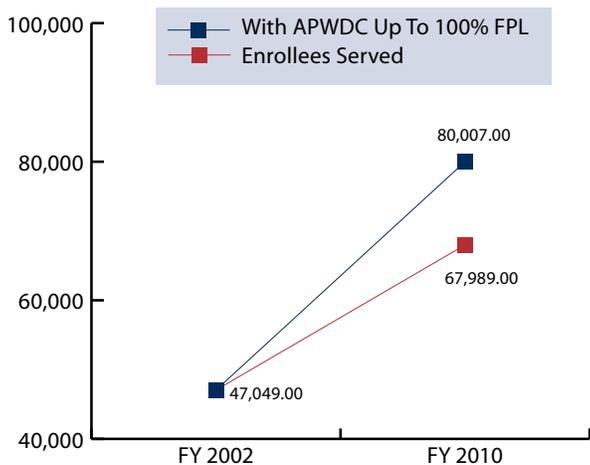


### POSSIBLE FUTURE QUESTION #1: WHAT WILL THE COLORADO-LED MEDICAID EXPANSION BENEFIT COVER?

Based on this analysis, the content of the new Medicaid benefit will directly affect the ability of BHOs to fund the care of these individuals, as well as others not currently served due to waitlists at CMHCs for the uninsured and other barriers to care. Many stakeholders we spoke with strongly advocated for ensuring that this benefit matches the current benefit design of the BHOs so that providers would be in a position to adequately serve these new enrollees.

One concern would be that such a rich benefit (a benefit much broader than essentially all private health insurance benefits) would increase costs too much. Yet stakeholders also emphasized the cost-effectiveness of BHO care in two areas: (1) BHOs have substantially reduced use of acute psychiatric inpatient care over the last decade, and (2) BHOs have expanded care to many people without the most severe diagnoses (that is, adults with SMI and children with SED) to serve the broader Medicaid population (for example, Temporary Assistance for Needy Families recipients).

The data are clear that BHO rates have remained relatively stable while covered populations have expanded and numbers served grown considerably.

## POSSIBLE FUTURE QUESTION #2: WHAT WILL BE THE SHAPE OF FEDERAL MEDICAID REFORM?

The discussion above highlighted the potential expansion of Medicaid benefits under PPACA. The 2010 elections and legislation introduced in the House of Representatives has raised two questions, however, about the shape of federal Medicaid reform: (1) will the PPACA expansion in 2014 move forward, and (2) will Medicaid be redesigned as a block-grant. A recent Kaiser Family Foundation (KFF) report underscored the implications of these questions for Colorado, given that Colorado is one of the states likely to benefit the most through the PPACA Medicaid expansion.[233] The first figure below shows the 44 percent reduction nationally in Medicaid spending projected by the House budget proposal.

### FEDERAL MEDICAID SPENDING IN 2021 UNDER CURRENT LAW AND THE HOUSE BUDGET PLAN

**44% Reduction in Spending**

| Spending Under Current Law, Including ACA | Spending Under the House Budget Plan |
|---|---|
| $554 Billion | Cut due to Block-Grant $137 Billion |
| | Cut due to ACA Repeal: $106 Billion |
| | $310.30 Billion |

Chart y-axis: $600, $500, $400, $300, $200, $100, 0

House Budget Plan bar segments (top to bottom): $137 Billion, $106 Billion, $310.30 Billion
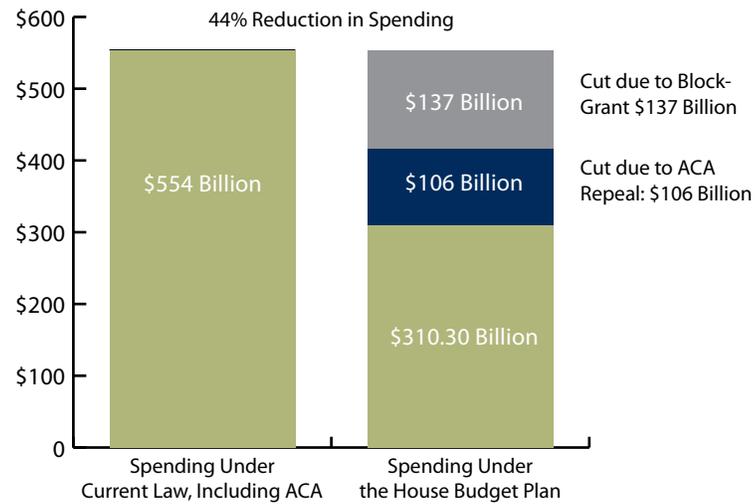
233 Holahan, J., Buettgens, M., Chen, V., Carroll, C., and Lawton, E. (May, 2011) House Republican budget plan: State-by-state impact of changes in Medicaid financing. Kaiser Family Foundation. Retrieved at: http://www.kff.org/medicaid/upload/8185.pdf.

The average reduction from 2012 through 2021 would be 33.9 percent nationally. The next figure, however, shows that the percentage reduction expected for Colorado would be much higher at 41.4 percent (tying for the fourth biggest percent reduction).

While less federal Medicaid revenue would be available under the House budget proposal based on the KFF analysis, Colorado and other states would instead receive additional flexibility under the plan to rework their Medicaid programs to respond to state-level priorities.

**PERCENTAGE OF REDUCTION IN FEDERAL SPENDING UNDER HOUSE BUDGET PLAN COMPARED TO CURRENT ALW BASELINE WITH ACA, 2012-2021**

| State | Percentage |
|---|---|
| Wyoming | 44.4% |
| Florida | 43.7% |
| Alaska | 41.6% |
| Colorado | 41.4% |
| Georgia | 41.4% |
| Oregon | 41.1% |
| Nevada | 40.9% |
| Delaware | 40.2% |
| West Virginia | 39.5% |
| Louisiana | 39.5% |
| North Carolina | 39.3% |
| Texas | 38.4% |
| Maryland | 37.9% |
| South Carolina | 37.6% |
| North Dakota | 37.2% |
| Arkansas | 37.0% |
| Virginia | 36.3% |
| Tennessee | 35.8% |
| Utah | 35.8% |
| Hawaii | 34.8% |
| New Mexico | 34.8% |
| Arizona | 34.6% |
| Idaho | 33.9% |
| US TOTAL | 33.9% |

## RECOMMENDATIONS REGARDING SPENDING ON MENTAL HEALTH AND SUD SERVICES

Unlike the severe cuts to mental health and SUD services earlier in the decade following the 2002-03 recession, the Hickenlooper and Ritter Administrations both prioritized behavioral health funding, and largely maintained spending levels in the face of the most severe recession in a generation. While Colorado spends more today than ever before on mental health and SUD services in the public sector, the state has still lost ground nationally in terms of per capita spending on behavioral health. In the following section of the report – Observation #4 on health care cost trends – we examine more closely the trade-offs in spending on behavioral health and broader health care, documenting how increased investment in behavioral health services is necessary to bend the overall health cost curve. SUD treatment and prevention services are particularly underfunded, especially when viewed against amounts that continue to be spent on services within the criminal justice system on the effects of SUD.

While it is understood that state revenue is still recovering in 2011 from the effects of the 2008 recession, it is strongly recommended that as revenue recovers and funds allow, Colorado public sector payers invest more in mental health service delivery, and substantially more in SUD treatment and prevention services. The following two sections of the report – Observations #4 and #5 – describe priorities for that enhanced investment.

# Observation #4

## Health Care Costs Continue to Increase, and Bending the Cost Curve Depends on Better Integration of Health, Behavioral Health, and Human Services

**Snapshot of Key Findings Regarding Health Care Costs and Ways to Bend the Curve through Better Integration of Health, Behavioral Health, and Human Services**

### National Trends Driving the Need for Integration

▸ The key organizing construct of health care reform is the "Triple Aim," a three-fold simultaneous goal to:

  ▾ Improve the health of the population,

  ▾ Enhance the patient experience of care (including quality, access, and reliability), and

  ▾ Reduce, or at least control, the per capita cost of care.

▸ There are two stark facts known about health care in the U.S.:

  1. The U.S. spends more per capita on health care than any other nation, and

  2. The U.S. suffers more preventable deaths per 100,000 population than any developed country.

▸ Chronic health conditions among U.S. children, including SED and other behavioral health conditions, are on the rise, increasing from 12.8 percent in 1994 to 26.2 percent in 2006. In Colorado, just under 18 percent of children in 2008 under the age of 14 had special health care needs.

- U.S. adults with SMI are dying, on average, at age 53, of largely preventable causes. This average life expectancy is comparable to that of sub-Saharan Africa.

  - Rates of respiratory disease are five times higher,

  - Rates of diabetes, cardiovascular disease, and infectious diseases are 3.4 times higher,

  - Rates of lung cancer are three times higher, and

  - Rates of stroke among people under age 50 are two times higher.

- Mental disorders were one of six key drivers of increases in overall Medicare spending from 1987 to 2006, accounting for more than one-third of the rise in Medicare spending in that time period.

- A recent study of the California Medi-Cal system found that, in 2007, individuals with SMI account for 10 percent of the fee-for-service population, but payments for their total health care costs (not just behavioral health) represented 37 percent of payments. This was driven by health care costs, including spending on diabetes (2.8 times higher), heart and cerebrovascular disease (3 times higher), chronic respiratory disease (2.6 times higher), inpatient days (3.4 times higher), and ER visits (3.5 times higher).

## The Impact in Colorado

- Research conducted by Colorado Access has replicated the national findings discussed above for Colorado Medicaid populations, with overall health spending 124 percent higher overall per person for those with any mental health diagnosis as for those without, with 73 percent of this difference driven by increased physical health and prescription costs.

- Involvement with other human services systems exacerbates these differences. DBH identified the top 267 people in terms of cost who had accessed five or more different types of state agencies (inclusive of mental health care in all cases). Just over half (51 percent) had Medicaid claims, and simply the cost of their behavioral health and medical claims was over $30,000 per person, nearly 10 times the cost of typical Medicaid medical costs.

## Recommendations to Leverage Behavioral Health Care to Bend the Cost Curve

1. In the short term (2012 and 2013), **continue to emphasize integration of local and regional service delivery systems *without losing* past gains** made through discrete delivery systems such as BHOs and SUD Managed Service Organizations (MSOs). BHOs and MSOs should be integrated as partners into the evolving regional delivery system, building on their achievements, rather than starting anew.

2. In the longer term (targeting 2014), Medicaid mental health and SUD benefits should be integrated and expanded within the broader health system, taking the following steps:

   - **Work systematically toward funding stream integration** for mental health and SUD services within the evolving accountable care structure of the Medicaid program, with a target of 2014, but do not rush into integrated funding, and take steps to help local delivery system structures get ready.

   - In the mean time, **take incremental steps now to align financial risk, resources, incentives and accounting** for all health care funding with the Triple Aim. At the very least, behavioral health and broader health systems should work together to monitor mental health and SUD expenditures. In addition, joint efforts to "hot spot" and work to improve services for people with significant behavioral health needs, poor overall health outcomes, and overuse of emergency and inpatient care settings could both reduce costs and increase outcomes in the short term, and inform longer term planning.

   - Post-integration, **maintain discrete accounting and performance incentives for behavioral health funding** separate from physical health, to ensure that behavioral health needs are adequately funded and performance aligned with broader outcomes. Accounting and performance monitoring should include discrete tracking for mental health, SUD and prevention services, since each subcomponent of behavioral health care delivery requires accountability over time.

# OVERVIEW

**The 2003 *Status Report* clearly documented the costs of untreated mental health conditions in terms of both workplace productivity and broader health costs.**

Since then, the impact of untreated mental health and SUD on the workplace has continued to be well documented, with a seminal 2004 study estimating losses related to depression alone at $44 billion to $66 billion annually (in 2011 dollars, that amount would be $52 billion to $78 billion annually).[234] Most of the recent in-depth analysis of behavioral health costs, however, has focused on their relationship to health care reform. A key organizing construct of health care reform is the "Triple Aim," a simple and very challenging three-fold simultaneous goal to:[235]

- Improve the health of the population,

- Enhance the patient experience of care (including quality, access, and reliability), and

- Reduce, or at least control, the per capita cost of care.

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234 Lerner, D., Adler, D.A., Chang, H., Lapitsky, L., Hood, M.Y., Perissinotto, C., Reed, J., McLaughlin, T.J., Berndt, E.R., and Rogers, W.H. (2004). Unemployment, job retention and productivity loss among employees with depression. Psychiatric Services, 55:1371-1378. Retrieved at:

http://psychservices.psychiatryonline.org/cgi/reprint/55/12/1371. The 2011 estimate was computed by multiplying the cumulative rate of inflation from January 2004 through January 2011 (18.91 percent) by the estimated range and adding that amount to the estimates, rounding to the nearest billion dollars.

235 Berwick, D.M., Nolan, T.W., and Whittington, J. (May/June, 2008). The Triple Aim: Care, health, and cost. Health Affairs. 27(3):759-769. Retrieved at: http://content.healthaffairs.org/content/27/3/759.full.pdf+html.

ADVANCING COLORADO'S MENTAL HEALTH CARE

# HOW HEALTH CARE EXPENDITURE TRENDS AFFECT PEOPLE

The findings in this observation document how the U.S. overall – and Colorado in particular – invests health care spending in the wrong place. We spend too much on care too late to optimize costs and outcomes, and we have separated the "head" (behavioral health care) from the rest of the "body" (other physical health care). The impact of our misdirected spending trends on people in Colorado can be illustrated by revisiting the stories of Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally.

## Adults with private insurance

### Barbara & Steve

Given the age of her children, it is likely that Barbara's mood instability may have been related to post-partum effects following the delivery of one or both of her children. Had her children's well baby care and her own post-partum primary care included a financial incentive to attend more to Barbara's behavioral health needs, her expensive inpatient stay and the incalculable distress experienced by her entire family could well have been prevented.

### Joan & Dave

As noted previously, Dave's primary care practice is – like many other Colorado practices – at the leading edge of integrated care delivery. The practice was successful in documenting the trade-offs in cost between more up-front behavioral health care delivery and reduced specialty care and inpatient spending. They were also proactive in adopting SBIRT practices to deliver SUD prevention and early intervention. This paid off for Dave and his family, as well as their insurer. All of this change, however, was driven by the provider. It would be better if the private and public payers more broadly, as well as training programs for new primary care and specialist practitioners, provided stronger support for the development of such integrated practices.

## Adults with serious mental illness

### Bob

We already observed how Bob tends to get better access to care when homeless. The "system" seems designed to primarily deliver care when his needs become critical. In addition, like many people, Bob is not very motivated to seek care unless he "really needs it." While this is a major factor in his continued homelessness, it is also very likely that it will lead to premature death and high, unnecessary health expenditures, given Bob's untreated hepatitis C.

### John

Like his friend, Bob, John also does not place as high a priority on his health care as he does on other parts of his life. However, unlike Bob, John does not have to do anything other than show up at his regular IDDT team appointment to receive physical health care from the integrated FQHC provider. This has allowed John to identify and begin to take steps to manage his type 2 diabetes. John and his treatment team are hopeful that John can get his weight under better control, learn to manage his insulin levels through diet and medication, and avoid the adverse health outcomes and high expenditures that many people with type 2 diabetes suffer.

## Two youth and their families

### Gabriela & Rosa

Gabriela had to become involved with the child welfare system before she could access the intensive services she needed. Her entire story was in many ways one of lost opportunities – a lack of attention by primary care providers to her emotional well-being following the death of her father (an event that can reliably predict an increased need for behavioral health treatment), a lack of awareness of the emotional issues that drove her increasing difficulties at school, a lack of funding for intensive services in the community that would have served her better than long-term residential care (by more directly helping her family improve its functioning and better maintaining her social supports at home and school), and a lack of linkages between her residential

care and school that put her at increased risk of dropping out of school, and losing the economic and social advantages of having a high school diploma. To Rosa, sometimes it seemed like the entire system was designed to ignore Gabriela's needs rather than address them. And Rosa herself has suffered both the ongoing loss of her daughter's presence during her placement at the residential facility and the stigma of having her child "taken away" from her. This has truly been a blow to her entire family, on top of the loss of her husband.

## Assefa & Amira

There were also missed opportunities for Assefa. Like Gabriela, the loss of a father should have been a risk factor recognized by both primary care and school staff. While Assefa's legal difficulties were not prevented, the work of the Wraparound team to re-knit Assefa and Amira into their family and community has allowed for care to be delivered closer to home, for social supports to be strengthened rather than strained, and for sustainable changes to be worked out and implemented by the family and the important people in their lives. Expensive residential services were avoided, and natural supports were leveraged to help Assefa and his entire family improve their functioning. Outpatient treatment opportunities that were missed earlier are now being pursued, and Assefa is on a positive path, despite the losses and challenges suffered by his family.

## Older adults with Medicare and Medicaid

## Nadine

In large part because of a misdiagnosis of dementia instead of depression, Nadine has expended all of her life savings and is now entirely dependent on the Medicaid system for her ongoing nursing home costs. She has lost her independence, is increasingly alienated from her family, and, because of her many and compounding losses, is now more fully in the grip of a dementia misdiagnosis than otherwise would have been the case. Sadly, Nadine is likely to experience a poorer quality of life, endure unnecessarily high long-term care costs, and suffer a premature death as a result.

## Sally

Unlike her good friend Nadine, Sally will enjoy many more years at home and, unless other health conditions arise, many more years of life. Additionally, she has maintained her family ties and financial independence, and she has expanded her social supports through the people she met through the depression support group. Well-targeted and efficient health services have helped Sally maintain and improve her life situation.

# NATIONAL TRENDS FOR HEALTH EXPENDITURES

One of the leading translators of the Triple Aim to behavioral health is Dale Jarvis, CPA, of Jarvis Associates, LLC. In his many national presentations over the past two years on the opportunities and challenges of health care reform, he frames the matter as a tension between two concepts:

- The U.S. spends more per capita on health care than any other nation,[236] and

- The U.S. suffers more preventable deaths per 100,000 population than any developed country.[237]

The two charts that follow provide a graphic comparison of these pernicious trends.

**PER CAPITA TOTAL CURRENT HEALTH CARE EXPENDITURES,
U.S. AND SELECTED COUNTRIES, 2008**

| Country | Expenditure |
|---|---|
| Austria | $3,758 |
| Belgium | $3,677 |
| Canada | $3,865 |
| Finland | $2,858 |
| France | $3,595 |
| Germany | $3,610 |
| Iceland | $3,359 |
| Ireland | $3,632 |
| Italy | $2,750 |
| Luxembourg | $3,843 |
| Netherland | $3,728 |
| New Zealand | $2,685 |
| Norway | $4,713 |
| Spain | $2,804 |
| Sweden | $3,295 |
| Switzerland | $4,469 |
| United Kingdom | $2,966 |
| United States | $7,164 |
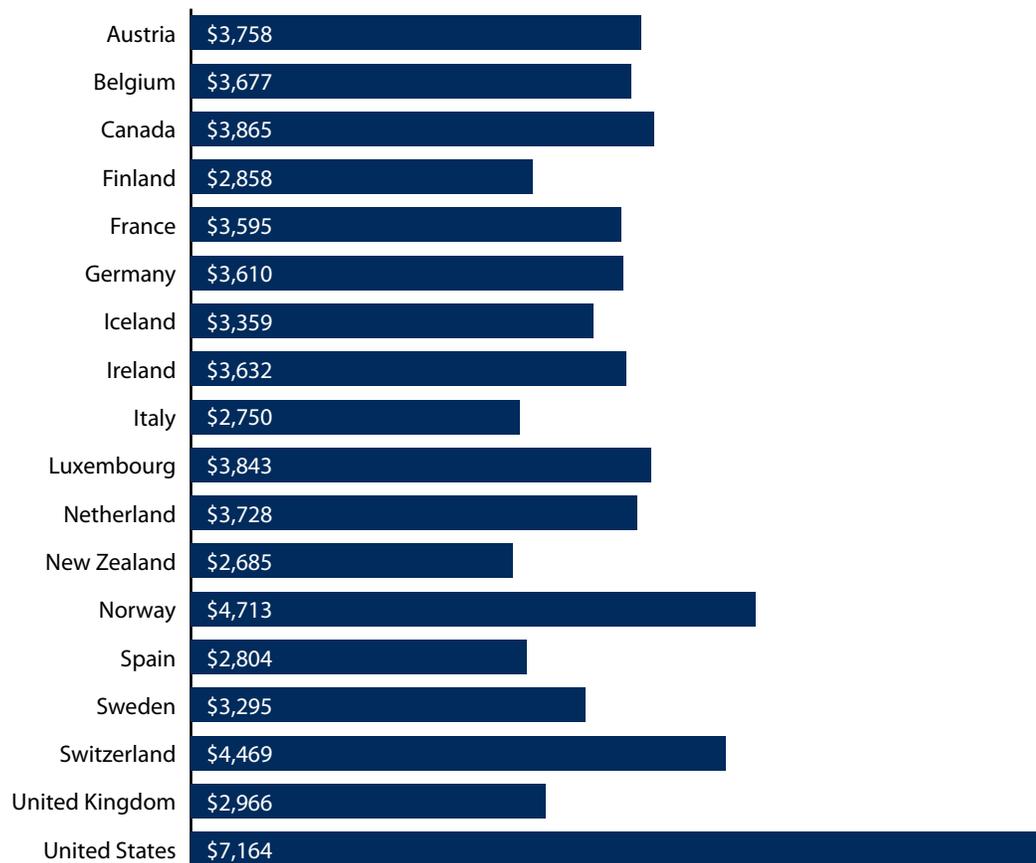
236 Kaiser Family Foundation. (January 2011). Chart developed from Organisation for Economic Co-operation and Development. OECD Health Data 2010, from the Source OECD Internet subscription database updated October 2010. Copyright OECD 2010, http://www.oecd.org/health/healthdata. Data accessed on 01/06/11. Chart retrieved at: http://facts.kff.org/chart.aspx?ch=359.

237 Nolte, E. and McKee, C.M. (January, 2008). Measuring the health of nations: Updating and earlier analysis. Health Affairs, 27(1):58-71.

**MORTALITY AMENABLE TO HEALTH CARE, 2002-03:
DEATHS PER 100,000 POPULATION**
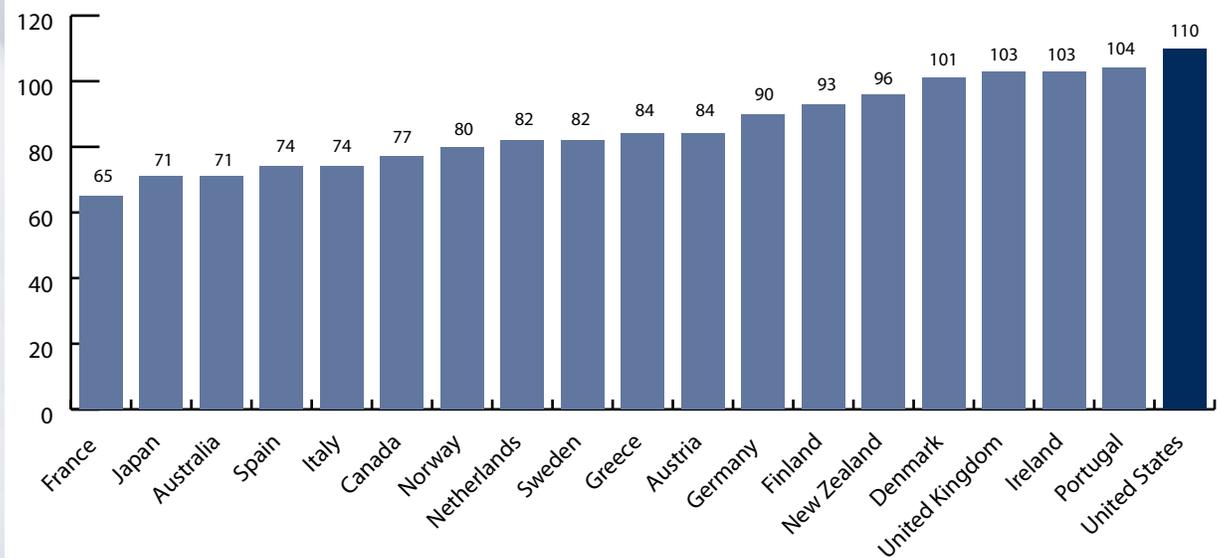


Furthermore, these trends particularly affect people with mental health and SUD needs:

- Chronic health conditions among U.S. children, including SED and other behavioral health conditions, are on the rise, increasing dramatically from 12.8 percent of all children in 1994 to 26.2 percent in 2006.[238] Underlying factors are not fully understood and could range from increased access to health and diagnostic care, to social risk factors including adverse childhood experiences (ACEs), to over-diagnosis.[239] In Colorado, HCPF estimates that just under 18 percent of children in 2008 under the age of 14 had special health care needs, totaling over 162,000 children.[240]

- U.S. adults with SMI are dying, on average, at age 53, of largely preventable causes. This average life expectancy is comparable to that of sub-Saharan Africa and the poorest nations in the world (red shaded regions in the map on the page to the right).[241]

238 Van Cleave, J., Gortmaker, S. L., and Perrin, J. M. (2010). Dynamics of Obesity and Chronic Health Conditions Among Children and Youth. JAMA. 2010;303(7):623-630. Retrieved at: http://jama.ama-assn.org/content/303/7/623.full.pdf+html.

239 Halfon, N. and Newacheck, P.W. (2010). Editorial: Evolving Notions of Childhood Chronic Illness. JAMA. 2010;303(7):665-666. Retrieved at: http://jama.ama-assn.org/content/303/7/665.full.

240 HCPF data summarized by G. Robinson. Personal communication, March 9, 2011.

241 Parks, J., Svendsen, D., Singer, P., and Foti, M.E. (Mauer, B., editor). (October 2006). Morbidity and mortality in people with serious mental illness (SMI). NASMHPD. Retrieved at: Service Use in Colorado. Boulder, Colo.: WICHE. Report was funded and directed by DBH. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf.

**MORTALITY AMENABLE TO HEALTH CARE, 2002-03:**



NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*
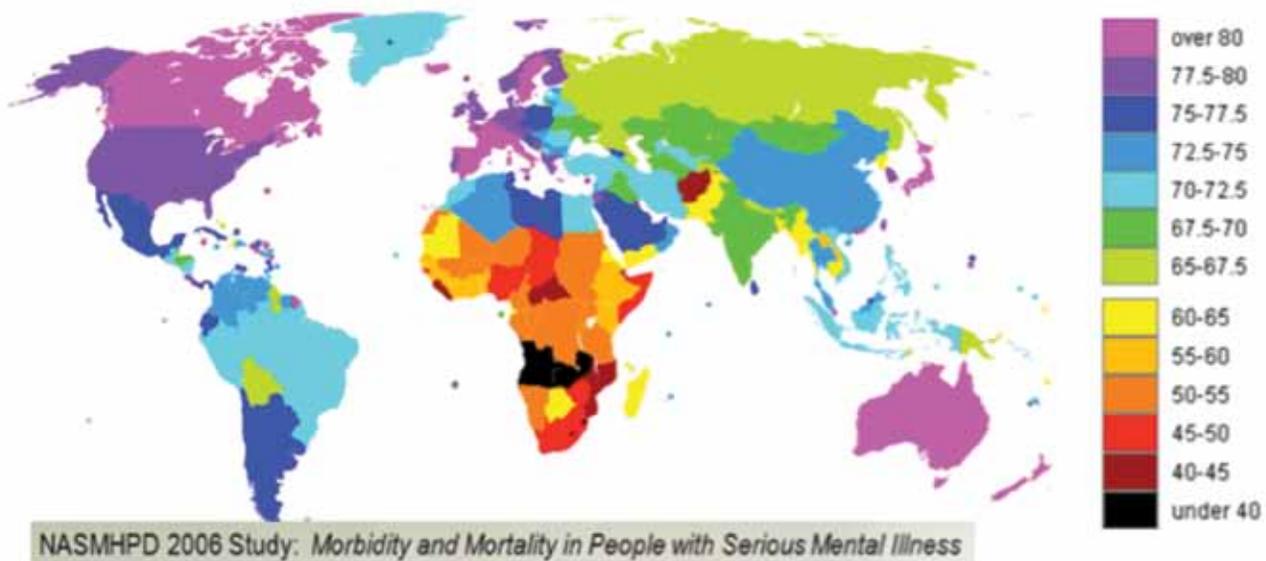
Focusing on adults with SMI, the factors underlying this trend, as described in the NASMHPD study, are largely preventable conditions:

• Rates of respiratory disease are five times higher,

• Rates of diabetes, cardiovascular disease, and infectious diseases are 3.4 times higher,

• Rates of lung cancer are three times higher, and

• Rates of stroke among people under age 50 are two times higher.

Mauer and Jarvis have clearly documented the cost implications of these tragic early deaths: [242]

• Mental disorders were one of six key drivers of increases in overall Medicare spending from 1987 to 2006. Along with diabetes, arthritis, hyperlipidemia, kidney disease, and hypertension, they accounted for more than a third of the rise in Medicare spending.[243]

• The Faces of Medicaid III documents that 49 percent of Medicaid beneficiaries with disabilities have a psychiatric condition (52 percent of dual eligibles) and psychiatric illness is represented in three of the top five most prevalent disease dyads among the highest-cost 5 percent of beneficiaries with disabilities. See the figure on the next page (an excerpt of the top 10 conditions from the Faces of Medicaid report).[244] Mauer and Jarvis (June, 2010) estimate very conservatively that as many as 25 percent of these high cost beneficiaries also have a comorbid SUD condition.[245]

242  Mauer, B., and Jarvis, D. (June 30, 2010). The business case for bidirectional integrated care: Mental health and substance use services in primary care settings and primary care services in specialty mental health and substance use settings. California Institute for Mental Health. Retrieved at: http://www.cimh.org/LinkClick.aspx?fileticket=FBCYbhoBeg8%3d&tabid=489. Page 16.

243  Thorpe, K.E., Ogden, L.L., Galactionova, K. (April, 2010). Chronic conditions account for rise in Medicare spending from 1987 to 2006. Health Affairs. Vol. 29 No. 4.

244  Kronick, R.G., Bella, M., and Gilmer, T.P. (October 2009). The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions. Center for Health Care Strategies, Inc. Retrieved at: http://www.chcs.org/usr_doc/Faces_of_Medicaid_III.pdf.

245  Mauer, B., and Jarvis, D. (June 30, 2010). The business case for bidirectional integrated care: Mental health and substance use services in primary care settings and primary care services in specialty mental health and substance use settings.

## FREQUENCY OF DIAGNOSTIC DYADS BY COST AMONG MEDICAID-ONLY BENEFICIARIES WITH DISABILITIES, 2002, CDPS + RX DATA

| DIAGNOSIS 1 | DIAGNOSIS 2 | FREQUENCY AMONG ALL BENEFICIARIES | FREQUENCY AMONG MOST EXPENSIVE 5% |
|---|---|---|---|
| Psychiatric | Cardiovascular | 24.5% | 40.4% |
| Psychiatric | Central Nervous System | 18.9% | 39.8% |
| Cardiovascular | Pulmonary | 12.5% | 34.3% |
| Cardiovascular | Central Nervous System | 13.1% | 32.9% |
| Psychiatric | Pulmonary | 11.2% | 28.6% |
| Cardiovascular | Gastrointestinal | 10.2% | 27.8% |
| Central Nervous System | Pulmonary | 7.0% | 26.2% |
| Cardiovascular | Renal | 7.1% | 24.6% |
| Pulmonary | Gastrointestinal | 5.9% | 24.2% |
| Psychiatric | Gastrointestinal | 9.5% | 24.0% |

A recent study conducted by JEN Associates for the California Medi-Cal system found that in 2007 individuals with SMI accounted for 10 percent of the fee-for-service population, but payments for their total health care costs (not just behavioral health) represented 37 percent of payments. Of the almost 250,000 enrollees with SMI in the sample, a subset of almost 10,000 individuals received approximately $500 million worth of care ($50,000 each).[246] See the figure that follows.

## CALIFORNIA FEE FOR SERVICE MEDI-CAL ANALYSIS - 2007

| | MEDI-CAL FFS TOTAL | MEDI-CAL FFS SMI | METRIC |
|---|---|---|---|
| Medi-Cal FFS Enrollees | 1,580,440 | 166,786 | 11% SMI % of Total |
| Medi-Cal FFS Costs | $6,186,331,620 | $2,395,938,298 | 39% SMI % of Total |
| Medi-Cal FFS Cost/Enrollee | $3,914 | $14,365 | 3.7 SMI/Non-Ratio |
| | | | |
| Diabetes | 4% | 11% | 2.8 SMI/Total-Ratio |
| Ischemic Heart Disease | 2% | 6% | 3.0 |
| Cerebrovascular Disease | 1% | 3% | 3.0 |
| Chronic Respiratory Disease | 5% | 13% | 2.6 |
| Arthritis | 2% | 7% | 3.5 |
| Health Failure | 1% | 3% | 3.0 |
| | | | |
| Inpatient Episodes/1,000 | 100 | 293 | 2.9 SMI/Total-Ratio |
| ER Visits/1,000 | 337 | 1,167 | 3.5 |
| Inpatient Acute Days/1,000 | 609 | 2,094 | 3.4 |
| Primary Care Visits/1,000 | 128 | 492 | 3.8 |
| Specialist Visits/1,000 | 1,211 | 6,058 | 5.0 |

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246  JEN Associates. February 2010. Beneficiary risk management: Prioritizing high risk SMI patients for case management/coordination. Presentation at the California 1115 Waiver Behavioral Health Technical Work Group, Cambridge, Mass. Cited in Mauer and Jarvis (June 2010). The figure from the Mauer and Jarvis report is reprinted here with permission from D. Jarvis.

- A 2007 federal report found that nearly one in four adult hospital stays in U.S. community hospitals in 2004 involved mental health or SUD disorders. Three-quarters of these admissions were for a non-mental health/SUD disorder with a secondary mental health/SUD diagnosis. Out of approximately 33 percent of all uninsured stays, 29 percent of Medicaid stays and 26 percent of Medicare stays were related to mental health/SUD disorders, compared to about 16 percent of privately insured stays.[247]

- A review of 1999 claims data for adult Medicaid beneficiaries in six states (Arkansas, Colorado, Georgia, Indiana, New Jersey, and Washington) found that people with diagnosed SUD had significantly higher expenditures overall, and that half of the additional care and expenditure was for treatment of comorbid physical health conditions. The six states "paid $104 million more for medical care and $105.5 million more for behavioral health care delivered to individuals with SUD diagnoses than for care given to persons with other behavioral health disorders but no SUD diagnosis."[248]

- A study by the State of Washington of Medicaid medical expenses prior to and following specialty SUD treatment compared Medicaid expenses for this group to the untreated population. Average monthly medical costs for persons receiving SUD treatment were $414 per month higher than costs for those not receiving treatment. In the Medicaid population, 66 percent of frequent users (those with 31 or more visits in a year) of emergency departments had SUD diagnoses.[249]

The bottom line is that, whatever happens in the future with health care reform, "bending the cost curve" for overall health care will require effective strategies for addressing comorbid behavioral health costs within a better integrated delivery system. Three emerging models of integrated care delivery with the potential to help accomplish this are discussed further under Observation #5: medical/health homes, accountable care organizations, and approaches to integrate behavioral health and primary care.

The effects of chronic health conditions on children are just as compelling. As noted above, rates of chronic health conditions are on the rise, affecting 26.6 percent of all children in 2006. Even more troubling are the disparities among which children are most affected: male, children of color (Hispanic and African American). The long-term effects of these conditions have many tragic consequences, and one of the most unfortunate is the later risk of involvement of these children in the child welfare and juvenile justice systems. For example, in the juvenile justice arena, two-thirds of the youth in secure juvenile facilities are youth of color, yet they comprise one-third of the nation's youth.[250]

247 Owens, P., Myers, M., Elixhauser, A., and colleagues. (2007). Care of adults with mental health and substance abuse disorders in U.S. community hospitals. Agency for Healthcare Research and Quality: Rockville, Md. Retrieved at: http://www.ahrq.gov/data/hcup/factbk10/factbk10.pdf.

248 Clark, R.E., Samnaliev, M., and McGovern, M. (January 2009). Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. Psychiatric Services, Vol. 60 No. 1: 35-42. Retrieved at: http://ps.psychiatryonline.org/cgi/reprint/60/1/35.

249 Krupski, A. (May, 2006). Expanding alcohol/drug treatment: An investment in health care cost containment and public safety. Washington State Division of Alcohol and Substance Abuse. Presentation to the Select Committee on Mental Health and Substance Abuse. Cited in Mauer and Jarvis (June 2010). Cited with permission of D. Jarvis.

250 Armour, J. and Hammond, S. (January, 2009). Minority youth in the juvenile justice system: Disproportionate minority contact. National Conference of State Legislatures. Retrieved at: http://www.ncsl.org/print/cj/minoritiesinjj.pdf.

# THE IMPACT IN COLORADO

Key informants we spoke with emphasized the impact of untreated behavioral health conditions on both health care costs and broader human services, particularly rates of incarceration in the criminal and juvenile justice systems.

Research conducted by Colorado Access has replicated the national findings discussed above for Colorado Medicaid populations involved in both the BHO and HMO benefits (see below).[251]
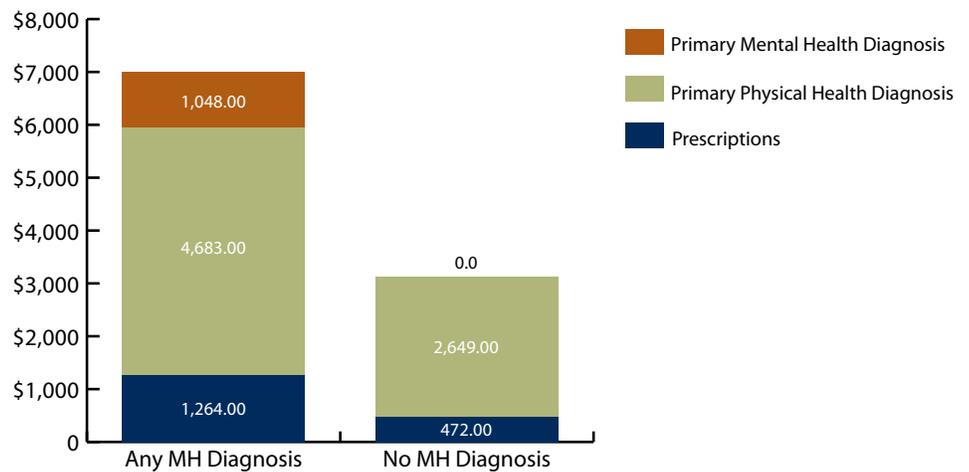


Note that people with behavioral health needs had 124 percent higher overall per person average health costs than those without, and 73 percent of this difference was driven by increased physical health and prescription costs.

Involvement with other human services systems exacerbates these differences. Recall the data on people served by Medicaid with multi-system involvement, described previously under Observation #1. DBH identified the top 267 people in terms of cost who had accessed five or more different types of state agencies (inclusive of mental health care in all cases).[252] Of these 267 people, just over half (51 percent) had Medicaid claims. Simply the cost of their BHO in SFY 2008 and medical claims in the following year (SFY 2009) alone were over $30,000 per person, as shown in the following graphic. This is nearly a ten-fold difference in cost for people with multi-system involvement (most of whom live in the Denver area), versus typical Medicaid medical costs reported for Colorado Access (which serves largely a Denver metro area population).

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251 Thomas, M. (2006). Improving Managed Care for Persons with Behavioral Health Disabilities. Medicaid Health Plans of America Best Practices Forum. This chart was reproduced, based on a chart received through personal communication with Dr. Marshall Thomas, February 5, 2011.

252 BHTC, Continuity of Care Work Group (February 2011). Draft Summary of Findings for Behavioral Health High Utilizers Data.

ADVANCING COLORADO'S MENTAL HEALTH CARE

| MEDICAID SERVICE COSTS OF MULTIPLE SYSTEM USERS | | | |
|---|---|---|---|
| MEDICAID COST CATEGORY | TOTAL COSTS | NUMBER OF PEOPLE | AVERAGE COST PER PERSON |
| Medicaid – Physical Health Services (SFY 2009) | $3,354,344 | 140 | $23,960 |
| Medicaid – BHO Contracted Services (SFY 2008) | $849,899 | 134 | $6,343 |
| Total | $4,204,243 | 140 | $30,030 |

The dilemma is clear and compelling – our health system is failing many of our most vulnerable citizens. Fortunately, the emerging and evidence-based practices discussed in the next Observation point the direction forward.

## RECOMMENDATIONS TO LEVERAGE BEHAVIORAL HEALTH CARE TO BEND THE COST CURVE

Both the national and Colorado data demonstrate clearly that controlling overall health spending depends on effective behavioral health services within integrated health care delivery systems. Costs cannot be controlled without more and earlier investment in behavioral health care, and integration is necessary in order to both account for cost-offset trends and create financial incentives to achieve the Triple Aim. The following specific steps are recommended to advance this effort:

1. In the short term (2012 and 2013), **continue to emphasize integration of local and regional service delivery systems** through efforts such as the Medicaid Accountable Care Collaborative (described in more detail under Observation #5) without losing past gains made through discrete delivery systems such as BHOs and SUD MSOs. The BHOs and MSOs should be integrated as partners into the evolving regional delivery system, building on their achievements, rather than starting anew.

2. In the longer term (targeting 2014), Medicaid mental health and SUD benefits should be integrated and expanded within the broader health system, taking the following steps:

- **Work systematically toward funding stream integration** for mental health and SUD services within the evolving accountable care structure of the Medicaid program, with a target of 2014, but do not rush into integrated funding and take steps to help ensure that local delivery system structures are ready.

- In the mean time, **take incremental steps now to align financial risk, resources, incentives and accounting** for all health care funding with the Triple Aim. As an interim step toward integrated funding streams and unified accountability, at the very least behavioral health and broader health systems should work together to monitor mental health and SUD expenditures. In addition, joint efforts to "hot spot" and work to improve services for people with significant behavioral health needs, poor overall health outcomes, and overuse of emergency and inpatient care settings could both reduce costs and improve outcomes in the short term and inform longer term integration planning.

- Post-integration, **maintain discrete accounting and performance incentives for behavioral health funding** separate from physical health, to ensure that behavioral health needs are adequately funded, and performance aligned with broader outcomes of the Triple Aim. As noted previously, the historical experience of "integrated funding" has too often been that behavioral health funding (mental health, SUD, and prevention) becomes invisible within the broader array and suffers neglect and erosion. Given the importance of behavioral health to all overall health outcomes and cost-containment, accountability should be maintained. Furthermore, accounting and performance monitoring should include discrete tracking for mental health, SUD and prevention services, since each subcomponent of behavioral health care delivery requires accountability over time.

# Observation #5
## More Than Ever is Known About What Works, and What Works is Somewhat More Available

### Snapshot of Key Findings
### Regarding What Works and Its Availability

### Overview

The approaches outlined in the 2003 *Status Report* are still among the most valid available. So for 2011, the report focuses on:

▸ Analysis of the change in availability of evidence-based approaches in since 2003, and

▸ An overview of two additional sets of research-based practices not covered in the 2003 report:

  ▾ Integrated behavioral health and primary care, and

  ▾ Practices to reduce health disparities.

### Progress in Promoting Evidence-Based Practices (EBPs) in Colorado

▸ Successful EBP promotion begins with an understanding of their real-world limitations.

▸ One major limitation is that the literature prioritizes randomized clinical trials that address **efficacy** in controlled research settings, whereas practitioners require research evidence on **effectiveness** in typical practice settings. Research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking.

▶ Major concerns center on culture, with wide consensus that too little research has been carried out to document the differential efficacy of EBPs. There are strategies to adapt EBPs cross-culturally.

▶ Efforts to promote a wide range of EBPs have begun to be subjected to systematic study, and typically involve a multi-state process of development involving a complex interplay of organizational capacities, technical expertise, and quality improvement over time.

▶ In Colorado, implementation of Therapeutic Foster Care, Multisystemic Therapy, and Functional Family Therapy is tracked. Only 5 percent of all children served received any of the three EBPs in SFY 2009, falling to 3 percent in SFY 2010.

▶ For adults, Supported Housing, Supported Employment, and Assertive Community Treatment are tracked. In SFY 2010, 10.5 percent of adults served received any of the three. Family Psychoeducation, Integrated Treatment for Co-occurring Mental Health/SUD, Illness Self-Management, and Medication Management were also tracked, with 18 percent receiving any of the four in SFY 2010.

▶ The Colorado Department of Public Safety (CDPS) and the Colorado Commission on Criminal and Juvenile Justice (CCCJJ) together secured a $2.1 million, two-year Justice Assistance Grant in October 2009 used to fund EBP training in Motivational Interviewing, cognitive behavioral approaches, and Mental Health First Aid in five demonstration sites.

▶ In 2009, the Colorado Division of Youth Corrections won a $1.8 million federal Justice Assistance Grant to fund nine county-level Collaborative Management Programs to use the Colorado Juvenile Risk Assessment, an actuarially derived criminogenic risk-assessment process, as well as a second EBP such as multi-systemic therapy (MST) and cognitive behavior therapy.

▶ Colorado has expanded problem-solving courts, doubling the number statewide in the past four years to a total of 64 mental health, SUD, and veterans courts, emphasizing diversion and treatment alternatives.

## Best Practices in Behavioral Health and Primary Care Integration

▶ The Colorado Behavioral Healthcare Council initiated a Integrated Care Mapping Project to disseminate information on nearly 100 programs across the state offering integrated behavioral health/primary care.

▶ A primary emphasis is on **Person-Centered Medical Homes (PCMH)** to promote higher quality, better coordinated health care that addresses problematic health-related behaviors and chronic conditions.

  ▼ CDPHE's Colorado Medical Home Initiative has been working since 2001 to increase the number of Medical Homes for children eligible for Medicaid and CHP+ in Colorado.

  ▼ In 2007, these actions were strengthened by the Colorado General Assembly's passage of SB 07-130, and the formation of the Colorado Children's Healthcare Access Program (CCHAP), a foundation-funded nonprofit promoting access to medical homes for children across Colorado.

  ▼ HealthTeamWorks is coordinating a multi-payer, multi-state PCMH pilot involving 16 family medicine and internal medicine practices in Colorado working with private and public payers.

  ▼ The National Committee on Quality Assurance released new PCMH standards in March 2011, with enhanced requirements for mental health and SUD screening and treatment coordination.

  ▼ Many lessons have been learned, many involving staffing levels. In 2007, Group Health added more staff (primarily physician extenders) and shifted to 30-minute primary care visits. Within one year, they had reduced burnout, increased quality scores and recouped the entire cost of the expansion.

▸ **Collaborative care** is a model of integrating mental health (but also SUD in some applications) and primary care services in primary care settings, to: (1) treat the individual where he or she is most comfortable, (2) build on the established relationship of trust between a doctor and person served, (3) better coordinate mental health and medical care, and (4) reduce the stigma associated with receiving mental health services.

- ▾ The DIAMOND model is a recent adaptation that has been disseminated in many places across Colorado that includes reimbursement methods.

- ▾ Primary challenges center on the primary care and behavioral health consultant work force. Collaborative care requires a different set of skills, knowledge and attitudes than traditional roles.

▸ **Regional Care Collaboratives** are a model that states are pursuing to integrate specialty health plans into the broader health system ("reconnecting the head to the body").

- ▾ The **Colorado Regional Integrative Care Collaborative** has early evidence of lower costs, less use of hospital and emergency room care, and increased use of outpatient services.

- ▾ In December 2010, the Colorado Department of Health Care Policy and Financing (HCPF) awarded contracts to seven **Regional Care Collaborative Organizations** (RCCOs) to implement its **Accountable Care Collaborative** (ACC) Program. The ACC is a hybrid model blending characteristics of a regional Accountable Care Organization (ACO) within a network, rather than a single organization. Start-up for the RCCO contracts began in February 2011. While not required, all RCCOs have partnered with their local BHOs, and most with their local SUD MSOs. The program tests multiple models across the seven current RCCOs, grouped by one stakeholder into three sets: 1) health plan-driven models by Colorado Access (three regions) and Rocky Mountain Health Plans (one region), 2) provider-driven models by the Colorado Community Health Alliance (one region) and Community Care of Central Colorado (one region), and 3) a safety net provider model of FQHCs and CMHCs in one region through Integrated Community Health Partners.

- ▾ **Health Information Exchanges**. Critical to the success of the RCCOs will be the health information exchange (HIE) infrastructure being developed under the leadership of a nonprofit organization, the Colorado Regional Health Information Organization (CORHIO).

- ▾ **Health Care Neighborhoods** take accountable care to a broader level by adding human services partners to the health service framework for people in restrictive human services settings such as adult corrections, juvenile justice, or child welfare, or who have complex needs like homelessness.

**Practices to Address Health Disparities**

▶ **Cultural competence standards**. The most well-known national standards to address health disparities are the National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards). They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence.

▶ **Cultural brokers** are advocates between groups of differing cultural backgrounds. For health care settings, these individuals help span the boundaries between the culture of health care delivery and the cultures of the people served. National guidelines focus on the development of programs within health care organizations to expand availability of cultural brokers for specific communities served.

**Recommendations to Improve Access to Empirically Based Care**

1. Continue to expand access to evidence-based care across the board (while remaining mindful of the limitations of current evidence), and

2. Put a priority on expanded access to **person-centered health/medical homes** that integrate behavioral health and primary care using strategies for specific subgroups of people:

   ▼ For the "many," health/medical homes should be in all primary care settings, and

   ▼ For the "few," health/medical homes should either be in the settings where people receive most health services (for example, community mental health centers for adults with SMI), or through specific evidence-based models such as IDDT and Wraparound that can serve as temporary (one-to-two year) health homes to knit human services and natural supports together, to improve health outcomes, avoid or minimize use of restrictive service settings, and facilitate longer term health care delivery in more natural settings.

# OVERVIEW

**The 2003 *Status Report* emphasized the importance of "empirically based" approaches to providing care.**

Since the approaches outlined in that report are still among the most valid available, for the 2011 update, we are focusing on two emphases: (1) an analysis of the change in availability of evidence-based and other research-based approaches in Colorado since 2003, and (2) an overview of two additional sets of research-based practices not covered in the 2003 report – one set focused on integrated behavioral health/primary care, and a second set focused on health disparities.

# HOW EMPIRICALLY BASED PRACTICES AFFECT PEOPLE

The findings in this observation document an array of practices that work, as well as limitations in our current knowledge base. The potential value of medical practices with established efficacy can also be illustrated by the stories of Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally.

## Adults with private insurance

### Barbara & Steve

Screening tools and practice standards are available for post-partum depression. As noted above, earlier detection would have been very helpful for their family.

### Joan & Dave

As described more in this observation and throughout this report, Dave had access to an array of best practices: the coordination of a medical home, SBIRT screening, and Motivational Interviewing to help him leverage his treatment and personal behavior in support of his work goals.

## Adults with serious mental illness

### Bob

It seems likely that Bob's homelessness outreach services incorporate case management practices that are effective. Unfortunately, he did not seem to have access to best practice homelessness interventions like permanent, supported housing. As noted previously, he was also missing the benefits of integrated primary care at his specialty behavioral health setting.

### John

John had access to an array of best practices. Integrated Dual Disorder Treatment (IDDT) is itself comprised of over a dozen proven practices for mental health and SUD treatment, including Motivational Interviewing and stage-based change. John also had access to integrated primary care at his specialty behavioral health setting.

## Two youth and their families

### Gabriela & Rosa

Gabriela came close to receiving a best practice – Multisystemic Treatment, an intensive, in-home treatment that provides the intensity of residential care in a community setting with proven outcomes. Gabriela and Rosa also failed to receive care in line with the cultural and linguistic CLAS Standards.

## Assefa & Amira

Assefa and his family had the benefit of Wraparound service coordination, an evidence-based model for coordinating multiple agency supports, and supporting youth and their families to build natural supports in their home and community to address intensive service needs.

## Older adults with Medicare and Medicaid

### Nadine

Nadine did not receive any best practices. One that would have been particularly helpful for her would have been integrated, standardized assessment protocols for cognitive decline in older adults that would have helped differentiate the effects of depression from dementia.

### Sally

Sally received multiple best practices – "gatekeeper" supports from staff at the senior center, who identified her depression risk and helped link her to services, accurate assessment of her depression within a primary care setting with integrated behavioral health capacity, and access to appropriate grief supports.

# STATUS OF BEHAVIORAL HEALTH EVIDENCE-BASED PRACTICES IN COLORADO

## What Does "Evidence-Based" Mean?

There are hundreds of evidence-based practices (EBPs) available for mental health and SUD treatment. In 2011, the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP).[253] The NREPP includes mental health and SUD treatment approaches ranging from prevention through treatment. While the NREPP is, in its own description, "not exhaustive," it is the most complete source on EBPs of which we are aware. Unlike standards in use in 2003 that differentiated between "evidence-based" and "promising" practices, the NREPP refers to all practices in the registry as "evidence-based," using the following definition: "Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation." The NREPP then rates each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention. Thus, many approaches formerly termed "promising" are now included in the NREPP, albeit with lower scores in some domains.

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253  The NREPP's searchable database can be found at: http://www.nrepp.samhsa.gov/.

THERE IS WIDE
CONSENSUS IN THE
LITERATURE THAT TOO
LITTLE RESEARCH HAS
BEEN CARRIED OUT
TO DOCUMENT THE
DIFFERENTIAL EFFICACY
OF EVIDENCE-BASED
PRACTICES ACROSS
CULTURE.

Successful EBP promotion begins with an understanding of the real world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. The reasons for stakeholder concerns are well documented and significant.[254] One major issue is that the literature prioritizes randomized clinical trials (RCTs) that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This "efficacy-effectiveness gap" was clearly defined in the 1999 U.S. Surgeon General's report on mental health services in America,[255] and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships.[256] Related uncertainties about implementing EBPs in children's mental health include a lack of clarity about the interactions of development, and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between children and their environments over time, and is inextricably linked to natural contexts such as families, schools, and communities, the efficacy research literature is largely silent on these relationships.[257] Because of this, practitioners must in many cases extrapolate from the existing research evidence.

254 Waddell, C. & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. Evidence-Based Mental Health, 8, 60-62.

255 U.S. Surgeon General. (1999). Mental health: A report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

256 Hoagwood, K., Burns, B.J., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52, 1179–89.

257 Hoagwood K., Burns B.J., Kiser L., et al. (2001).

These inherent limitations in the research base often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting much-vaunted EBPs is applicable to their communities and the situations they encounter on a daily basis. In addition, when practices are promoted based on the efficacy research, many people receiving services are understandably concerned that having policy makers specify particular approaches might limit the service choices available to them. Similarly, many providers remain reluctant to implement EBPs due to the costs and risks involved in training and infrastructure-building, processes that require commitments over years rather than months.

Perhaps the primary concern involves culture. There is wide consensus in the literature that too little research has been carried out to document the differential efficacy of EBPs across culture.[258] There are also emerging strategies to help adapt EBPs when they are applied cross-culturally.[259] This issue was the subject of a 2007 training sponsored by the foundations funding ACMHC. The training emphasized that, while it makes sense for communities to implement programs such as EBPs that have been shown to work in other settings, two overarching concepts must be kept in mind:

• Given the absence of conclusive studies on the effect of an EBP across racial and cultural groups, we should neither assume that an EBP is culturally competent nor assume that it is not.

• When implementing an EBP in a local community, an assessment of the cultural competence of local services should be included in understanding the overall competence of the implementation.

Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation efforts to determine whether they are effective for the local populations being served.

Partly in response to the growing recognition that efficacy research provides an insufficient base on which to build policy decisions regarding public mental health benefits, and partly to support the successful implementation of EBPs, increasing attention is turning to the need for system and organizational infrastructures that will support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions. The infrastructures need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes (i.e. a data and learning-centered construct implicit in an array of broader constructs, including "learning organizations," "continuous quality improvement," and others).

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258  U.S. Surgeon General. (2001). Mental health: Culture, race, and ethnicity – A supplement to mental health. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

259  Stewart, D. (February 8, 2007). Adapting evidence based practices to culture and community. Presented at the 2nd Annual Advancing Colorado's Mental Health Care Conference, Denver, Colo.

Some researchers[260] use the term "evidence-based culture" to describe the constellation of policy, procedural, and funding mechanisms that, in concert with a favorable culture and climate, support successful practice.[261] An evidence-based culture includes the following:

- Involves all levels of the system – state and regional administrators, provider program managers, clinical supervisors, clinicians, people served, and their family members – in the implementation process;

- Begins with a thorough understanding of the current treatment system, the interventions that are utilized, the need for coordination with other human services systems (for example, child welfare, juvenile justice, criminal justice, primary care) and the outcomes being achieved;

- Includes a systematic approach to reviewing available evidence and recommending changes in intervention strategies as appropriate;

- Supports a reimbursement rate commensurate with the level of work required to implement new interventions (including any impact on clinic-based productivity expectations) so that all allowable provider costs are covered;

- Provides reimbursement for the training and clinical supervision, as well as the administrative overhead required by health plans and providers, that are essential to implementation of evidence-based practices;

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260  Dixon, G.D. (2003). Evidence-based practices. Part III. Moving science into service: Steps to implementing evidence-based practices. Tallahassee, Fla.: Southern Coast Beacon (a publication of the Southern Coast ATTC). Available online at http://www.scattc.org/pdf_upload/Beacon003.pdf .

Barwick, M.A., Boydell, K.M., Stasiulis, E., Ferguson, H.B., Blase, K, & Fixsen, D. (2005). Knowledge transfer and implementation of evidence-based practices in children's mental health. Toronto, Ontario: Children's Mental Health Ontario.

261  Rivard, J., Bruns, E., Hoagwood, K., Hodges, K., & Marsenich, L. (2006). Different Strategies for Promoting and Institutionalizing an Evidenced-Based Culture. In C. Newman, C. Liberton, K. Kutash, & R. M. Friedman (Eds.), The 19th Annual Research Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

- Creates and maintains data collection and reporting mechanisms that will document EBP results;

- Develops and supports policies that facilitate adoption and implementation of EBPs;

- Supports bi-directional communication between researchers and clinicians;

- Promotes an appropriate balance between fidelity and adaptation; and,

- Uses outcome data to drive systems change.

In keeping with this line of thought, members of the National EBP Consortium [262] expressed much concern that the increasingly common approach taken by many states of mandating the use of specific EBPs does not necessarily lead to improved outcomes, and does little to help agencies, provider organizations, and communities understand how best to select and implement effective interventions. To make the most of the movement toward EBP at the federal, state, and local levels, discussions are increasingly turning towards a systematic process through which decisions are made at the community level, so that communities are supported to select, implement, and sustain effective practices. Such a process ideally is inclusive, strategic, and driven by the needs, strengths, and local cultures of people served, their families, and their communities. The efforts of New York[263] and Hawaii[264] to implement EBPs statewide offer best practice examples of states working towards an evidence-based culture.

Building on this research, efforts to promote a wide range of EBPs have begun to be subjected to systematic study in the past decade, and Fixsen and his colleagues summarized the lessons learned through that research in their seminal 2005 work.[265] Their detailed review describes a multi-year, six stage process involving (1) exploration and adoption, (2) program installation, (3) initial implementation, (4) full operation, (5) innovation, and (6) sustainability. The process of moving from one stage to the next involves a complex interplay of organizational capacities, technical expertise, and quality improvement over time. Fixsen and his colleagues describe three levels of influence that together determine successful implementation: (1) core implementation components, including specific training, coaching and performance measurement related to the practice being implemented; (2) organizational components, including staff selection practices, program evaluation capacity, administrative capacity, and ability to carry out systems interventions; and (3) external influence factors at the social, economic and political level. The summary provides a wealth of insight into the complex technical, organizational, and broader system factors influencing best practice implementation, but the core implication for systemic efforts to address health disparities is this: change is multi-determined and dependent on sustained organizational commitment and broader organizational capacity over time.

This is the context in which Colorado payers for and providers of mental health and SUD treatment are struggling to improve their practices. Next, we see the very real progress they have made.

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262  Rivard, J. et al. (2006).

263  Carpinello, S. et al. (2002). New York State's Campaign to Implement Evidence-Based Practices for People with Serious Mental Disorders. Psychiatric Services, (53) 2.

264  Daleiden, E.L. & Chorpita, B.F. (2005). From data to wisdom: Quality improvement strategies supporting large-scale implementation of evidence based services. In B.J. Burns & K.E. Hoagwood (Eds.), (2005). Evidence-Based Practice, Part II: Effecting Change, Child and Adolescent Psychiatric Clinics of North America, 14, 329-349.

265  Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, Fla.: University of South Florida. Downloaded at: http://www.fpg.unc.edu/~nirn/resources/publications/Monograph/pdf/Monograph_full.pdf.

## CURRENT EVIDENCE-BASED PRACTICE AVAILABILITY IN COLORADO

For their participation in a joint project of the federal Center for Mental Health Services (CMHS) within SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD), the Colorado DBH reports on the number of children, adolescents, and adults who receive certain prioritized EBPs. These data are summarized in the following tables. The first table focuses on children and adolescents. Overall, the percentage of children and youth receiving EBPs remains small, and availability seems to have shrunk in the most recent year from SFY 2009 highs.

### NUMBER OF CHILDREN AND ADOLESCENTS WITH SED WHO RECEIVED CORE EVIDENCE-BASED PRACTICES THROUGH PUBLICLY FUNDED PROGRAMS, SFY 2009 AND SFY 2010[266]

| AGE RANGE | THERAPEUTIC FOSTER CARE | | MULTISYSTEMIC THERAPY (MST) | | FUNCTIONAL FAMILY THERAPY | | ANY OF THE 3 EBPS | | TOTAL (UNDUPLICATED) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | SFY09 | SFY10 | SFY09 | SFY10 | SFY09 | SFY10 | SFY09 | SFY10 | SFY09 | SFY10 |
| 0-12 Years | 0 | 0 | 42 | 22 | 148 | 112 | 190 (1.8%) | 134 (1.2%) | 10,368 | 10,821 |
| 13-17 Years | 0 | 0 | 211 | 153 | 627 | 378 | 838 (8.8%) | 531 (5.3%) | 9,502 | 9,956 |
| All Ages Total | 0 | 0 | 253 | 175 | 775 | 490 | 1,028 (5.2%) | 665 (3.2%) | 19,870 | 20,777 |

As the following table shows, higher proportions of adults with SMI are receiving EBPs.

### ADULTS WITH SMI RECEIVING CORE EBPS THROUGH PUBLICLY FUNDED PROGRAMS, SFY 2010[267]

| AGE RANGE | SUPPORTED HOUSING | SUPPORTED EMPLOYMENT | ASSERTIVE COMMUNITY TREATMENT | ANY OF THE 3 CORE EBPS | TOTAL SERVED (UNDUPLICATED) |
|---|---|---|---|---|---|
| 18-20 Years | 14 | 22 | 123 | 159 (5.7%) | 2,809 |
| 21-64 Years | 1,384 | 721 | 2,277 | 4,382 (10.9%) | 40,079 |
| 65+ Years | 38 | 12 | 138 | 188 (8.2%) | 2,290 |
| ALL AGES TOTAL | 1,436 | 755 | 2,538 | 4,729 (10.5%) | 45,178 |

266 SFY 2009 and SFY 2010 data is from personal communication with Bruck Makonnen, Colorado Division of Behavioral Health, January 19, 2011.

267 SFY 2009 and SFY 2010 data is from personal communication with Bruck Makonnen, Colorado Division of Behavioral Health, January 19, 2011. "Received any of the 3 EBPs" could include duplicated clients, so numbers may be somewhat inflated.

ADVANCING COLORADO'S MENTAL HEALTH CARE

In addition, more than 8,000 other adults with SMI received the following EBPs:

| ADULTS WITH SMI RECEIVING OTHER EBPS THROUGH PUBLICLY FUNDED PROGRAMS, SFY 2010[268] | | | | | |
|---|---|---|---|---|---|
| AGE RANGE | FAMILY PSYCHO-EDUCATION | INTEGRATED TREATMENT FOR COD | ILLNESS SELF-MANAGEMENT | MEDICATION MANAGEMENT | TOTAL (UNDUPLICATED) |
| 18-20 Years | 7 | 99 | 74 | 212 | 2,809 |
| 21-64 Years | 78 | 2,974 | 1,407 | 3,079 | 40,079 |
| 65+ Years | 3 | 68 | 48 | 153 | 2,290 |
| ALL AGES TOTAL | 88 (0.2%) | 3,141 (7.0%) | 1,529 (3.4%) | 3,444 (7.6%) | 8,202 (18.2%) of 45,178 |

In addition to these mental health and co-occurring mental health/SUD treatment practices, Colorado has many providers using EBPs for SUD services. We are not aware of any definitive accounting for these services, but the following examples were identified through the key informant interviews just for the correctional system:

- The Colorado Department of Public Safety (CDPS) and the Colorado Commission on Criminal and Juvenile Justice (CCCJJ) together secured a $2.1 million two-year Justice Assistance Grant in October 2009, with the goal to reduce recidivism among adult offenders, and enhance public safety through EBPs. Called the Evidence-Based Practice Implementation for Capacity (EPIC) project, the following agencies came together in this multi-agency collaboration: the CDPS Division of Criminal Justice, Office of Community Corrections; the Department of Corrections, Division of Adult Parole, Youthful Offender System (Parole), and Institutions; the Judicial Department, Division of Probation Services; and the Department of Human Services, DBH. The grant funds EBP training in Motivational Interviewing, cognitive behavioral approaches, and Mental Health First Aid through a "change agent" approach in five demonstration sites.

- In 2009, the Colorado Division of Youth Corrections won a $1.8 million federal Justice Assistance Grant for the Colorado Juvenile Justice Capacity Building project (administered by the Colorado Office of Adult and Juvenile Justice Assistance). Funding supports nine county-level Collaborative Management Programs[269] across Colorado in their efforts to enhance implementation of evidence-based practices with youth involved in the juvenile justice system. Goals include increasing EBP and intervention use within local juvenile justice systems, and reducing use of secure and restrictive services for youth under community supervision. All nine programs are using the Colorado Juvenile Risk Assessment, an actuarially derived criminogenic risk assessment process, as well as a second EBP such as multi-systemic therapy (MST) and cognitive behavior therapy.

- Colorado expanded access to problem-solving courts, doubling the number of such courts statewide in the past four years, to a total of 64 mental health, SUD, and veterans courts that emphasize diversion and treatment alternatives to incarceration for adults.[270]

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268  SFY 2009 and SFY 2010 data is from personal communication with Bruck Makonnen, Colorado Division of Behavioral Health, January 19, 2011.

269  The nine Collaborative Management Programs are Alamosa/Conejos, Chaffee, Denver, Douglas, Fremont/Custer, Garfield, Grand, Larimer and Mesa Counties.

270  Colorado Problem-Solving Courts as of March 11, 2011. State Court Administrator's Office, through the Division of Planning and Analysis.

Taken in aggregate, Colorado has taken significant steps toward increasing access to EBPs. While some ground was lost in mental health treatment systems from SFY 2009 to SFY 2010, progress is still being made across multiple fronts. Furthermore, the engagement of system partners such as the adult criminal justice system and DYC reflects a qualitative shift in the broader culture of state health and human services to prioritize evidence-based practices.

The rest of this section highlights two sets of research-based practices not covered in the 2003 *Status Report*: integrated behavioral health and primary care, and health disparities.

## Best Practices in Behavioral Health and Primary Care Integration

The findings under Observation #4 underscored the critical linkage between mental health and SUD treatment needs and the challenge of bending the broader health care cost curve. Toward that end, Colorado is a leader in grassroots efforts to build capacity for integrated behavioral health and primary care. Two of the six ACMHC grant communities focused their efforts on expanding access to integrated behavioral health and primary care, and they are two leaders among dozens of sites across the state advancing various models of this approach. The Colorado Behavioral Healthcare Council initiated its Integrated Care Mapping Project to disseminate information on nearly 100 programs across the state that offer some level of integrated behavioral health/primary care.[271]



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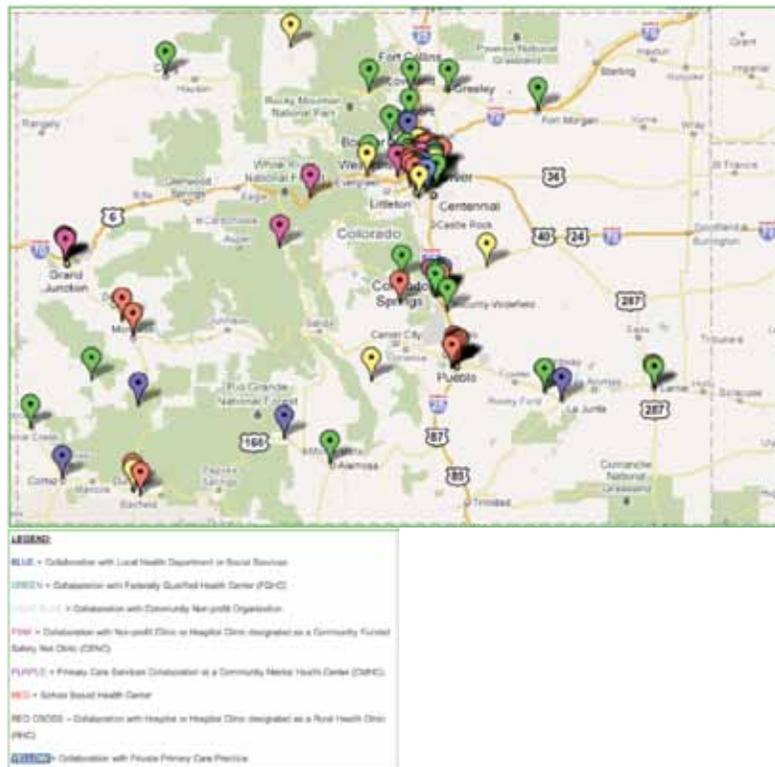
271  See http://www.cbhc.org/integration/map/ for additional information.

In this section, we profile four levels of best practices that can support integrated care: medical homes, collaborative care models for integrated behavioral health/primary care (for example, IMPACT, DIAMOND), regional care collaboratives, and health care neighborhoods.

## PERSON-CENTERED MEDICAL HOMES/HEALTHCARE HOMES

A revolution is occurring in primary care and family medicine focused on Person-Centered Medical Homes (PCMH), to promote higher quality, better coordinated health care that more effectively addresses problematic health-related behaviors and chronic health conditions.[272] A PCMH involves an "ongoing relationship with a personal physician; team approaches to care; a whole-person orientation; mechanisms to support care integration, quality, safety and access; and payment for added value."[273] That report goes on to describe a National Demonstration Project (NDP) of the implementation of this model in primary care/family medicine, which found that the transformation of independent practices into PCMHs is "feasible," but also is extremely time- and resource-intensive, requiring a high level of commitment and motivation.

Colorado has made a major investment in the development of PCMHs. As noted earlier in this report, CDPHE's Colorado Medical Home Initiative has been working since 2001 to increase the number of Medical Homes for children eligible for Medicaid and CHP+ in Colorado. In 2007, these actions were strengthened by the Colorado General Assembly's passage of SB 07-130, and the formation of the Colorado Children's Healthcare Access Program (CCHAP), a foundation-funded nonprofit with a mission to reduce barriers and promote access to medical homes for children across Colorado. Key informants were mixed in their assessments of the success of this initiative,

noting that the broad effort obscures questions about the substance and effectiveness of the actual practice. Colorado clearly is a leader, however, in promoting and developing this approach, and the work has been recognized nationally as a model.[274] Initial data from HCPF show meaningful gains, with more children in Colorado receiving care in medical homes (59.3 percent) than the national average (57.5 percent),[275] and with 47 percent of CCHAP children having a well-child visit within the six-month observation period compared with 35 percent of non-CCHAP children.[276]

Steven Poole, M.D., of the University of Colorado School of Medicine's Department of Pediatrics and Section Head for Community Pediatrics, has been a leader in promoting the model for children in Colorado, and Larry Green, M.D., of the University of Colorado School of Medicine's Family Medicine Department, has been a leader in Colorado and nationally in the development of training and research to support medical homes. Dr. Green is currently leading the Advancing Care Together project funded by The Colorado Health Foundation, to develop working models of primary care and behavioral health integration within medical homes. Another Colorado leader in the promotion of medical homes is HealthTeamWorks, which is coordinating a multi-payer, multi-state PCMH pilot involving 16 family medicine and internal medicine practices in Colorado working with private and public payers, with an evaluation funded by The Colorado Trust and the Commonwealth Fund. Their efforts to promote behavioral health integration in medical homes are initially targeting depression, and they have incorporated widespread use of the behavioral best practice of Motivational Interviewing. As has been the case nationally, translating these concepts into practice has been met with both success and challenges, and efforts to address behavioral health integration have lagged behind broader development of the model. Development

272  Future of Family Medicine Project Leadership Committee (2004). The future of family medicine: A collaborative project of the family medicine community. Annals of Family Medicine, 2(Suppl 1), s3-s32.

273  Crabtree, B.F. et al. (2010). Summary of the National Demonstration Project and recommendations for the patient-centered medical home. Annals of Family Medicine, 8(Suppl 1): s80-s90; quote is from p. s80.

274  Silow-Carroll, S. and Hagelow, G. September, 2010. Systems of care coordination for children: Lessons learned across state models. The Commonwealth Fund. Retrieved at: http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Sep/Systems-of-Care-Coordination-for-Children.aspx.

275  Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health. Data Resource Center for Child and Adolescent Health website. Retrieved at: http://nschdata.org/StateProfiles/CustomProfile07.aspx?rid=5&geo=Colorado&geo2=Nationwide.

276  HCPF data summarized by G. Robinson. Personal communication, March 9, 2011.

in this area is fast-paced, with accrediting agencies such as the National Committee on Quality Assurance releasing new PCMH standards and guidelines in March 2011, that included enhanced requirements for mental health and SUD screening and treatment coordination.[277]

Across the nation and Colorado, mental health and SUD providers have adopted the PCMH model (renaming it the Person-Centered Healthcare Home), and adapted it to the specific needs of people with mental health and SUD needs.[278] Similarly, experts promoting behavioral health/primary care integration from a primary care perspective also utilize the PCMH/PCHH model in identifying an array of integration alternatives.[279] Establishing PCHHs for people with behavioral health problems is demanding, and involves implementing multiple new systems and practices, including the co-location of providers, integrated electronic health records (EHRs) and a clinical registry for tracking services, and various self-management and wellness interventions. An initial review of the first wave of PCHH efforts in Colorado found many to be promising and cost-effective. Here too, however, several different program and policy issues need to be addressed, including how to use incentives to motivate participation of people receiving services in PCHHs. Colorado efforts have also found that carve-out funding arrangements in both private and public sector settings complicate behavioral health integration efforts within PCMHs.[280]

277  See http://www.ncqa.org/tabid/631/default.aspx for additional information.

278  Mauer, B. (December 2010). Vision for a system of integrated mental health/substance use/primary care treatment services in person-centered medical homes. Washington State Department of Social and Health Services, Behavioral Health and Primary Care Integration Collaborative.

Mauer, B., and Jarvis, D. (June 30, 2010). The business case for bidirectional integrated care: Mental health and substance use services in primary care settings and primary care services in specialty mental health and substance use settings. California Institute for Mental Health. Retrieved at: http://www.cimh.org/LinkClick.aspx?fileticket=FBCYbhoBeg8%3d&tabid=489.

279  Collins, C. et al. (2010). Evolving models of behavioral health integration in primary care. Milbank Memorial Fund.

280  Colorado Regional Integrative Care Collaborative: Interim Experience and Lessons Learned. Unpublished draft manuscript received through personal communication with Marshall Thomas, M.D. of Colorado Access, February 5, 2011.

Findings from the National Demonstration Project (NDP) of PCMHs were encouraging, though still mixed. In their examination of outcomes from the NDP, Jaén and colleagues found no improvement in patient-rated outcomes and quality of care measures. Improvement was seen, however, in scores on a standard measure of quality of care and on scores of chronic disease care. More complete adoption of PCMH model components was associated with improved access, better prevention scores, and chronic disease care scores; and adoption of additional PCMH model components was positively associated with patient-rated outcomes for access, but not with outcomes for health status, patient empowerment, and elements related to patient experience with the practice and provider.[281]

As PCMHs have evolved, even over the course of the NDP implementation, the relative emphasis has shifted from the technological aspects of implementation (EHRs, clinical registries) to the care coordination and relational aspects, including the importance of a "personal relationship over time" with the practitioner.[282] Toward that end, Group Health's experience with the model is instructive.[283] From 2002 to 2006, Group Health implemented the mechanisms of a PCMH in their Factoria, Wash., clinic, including email access to physicians, online medical records, and same day/next day appointments. They found dissatisfying initial outcomes, including provider burnout and declines in standard quality scores. In 2007, they added more staff (primarily physician extenders), and shifted to 30-minute primary care visits. Within one year, they had reduced burnout, increased quality scores and recouped the entire cost of the extended primary care visits. Savings 21 months into the project are $10.30 per patient, per month.

To fully implement PCMH/PCHH models, both technological and other types of shifts are crucial. In a qualitative study of the experiences of practices participating in the NDP, Nutting et al. (2010) discovered six key themes, which are summarized in the table below:

| IMPORTANT IMPLEMENTATION FINDINGS FROM THE NATIONAL DEMONSTRATION PROJECT |
| --- |
| Practices' "adaptive reserve" (ability to make and sustain change) is critical to managing change |
| Developmental pathways to success vary by practice |
| Motivation of key practice members is critical |
| The larger system can help or hinder (payment systems and other incentives, for example) |
| Transformation is more than a series of changes, and requires shifts in roles and mental models |
| Practices benefit from multiple facilitator roles: consultant, coach, negotiator, connector, and facilitator |

Finally, the implementation of any new model requires start-up costs, as well as ongoing, additional expenditures, if payment/reimbursement systems do not adjust to the new model. The Group Health example cited above was only able to save money because Group Health is one of the few truly integrated health systems in the country and can account for savings in inpatient and emergency room care at their facilities attributable to increased primary care costs. Most primary care systems would not be able to even account for, much less reinvest, such savings. One study among practice-based research networks found that practices spent an average monthly amount of $58 per patient participating in a new health promotion intervention (the range was large: $1 to $354 per patient, per month).[284] Costs for the Group Health model cited above were approximately $16 per month, per patient in the primary care practice, plus an additional $37 per month, per patient for additional specialty referrals for health conditions that were previously missed.

281 Jaén, C.R., Ferrer, R.L., Miller W.L.., et al. (2010). Patient outcomes at 26 months in the patient-centered medical home National Demonstration Project. *Annals of Family Medicine*, 8(Suppl 1), s57-s67.

282 Crabtree et al. (2010), p. s81

283 Reid, R.J., Coleman, K., Johnson, E.A., Fishman, P.A., Hsu, C., Soman, M.P., Trescott, C.E., Erikson, M., and Larson, E.B. The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers. Health Affairs. 29, no. 5: 835-843.

284 Krist, A.H., Cifuentes, M., Dodoo, M.S., & Green, L.A. (2010). Measuring primary care expenses. *J. of the American Board of Family Medicine*, 23(3), 376-383.

The idea of how PCMHs save money while improving costs is the notion of "preventable health costs." Dale Jarvis often talks about the U.S. having a "sick care system" instead of a "health care system," because our payment mechanisms are set up to pay for (and reward) only illness.[285] The following diagram captures the flow.[286] Funding is accessed when preventable conditions arise, and even more funding is provided if the condition results in an acute hospital episode, where additional funds can also be accessed through high-cost successful procedures, as well as through readmissions or treating complications and infections.
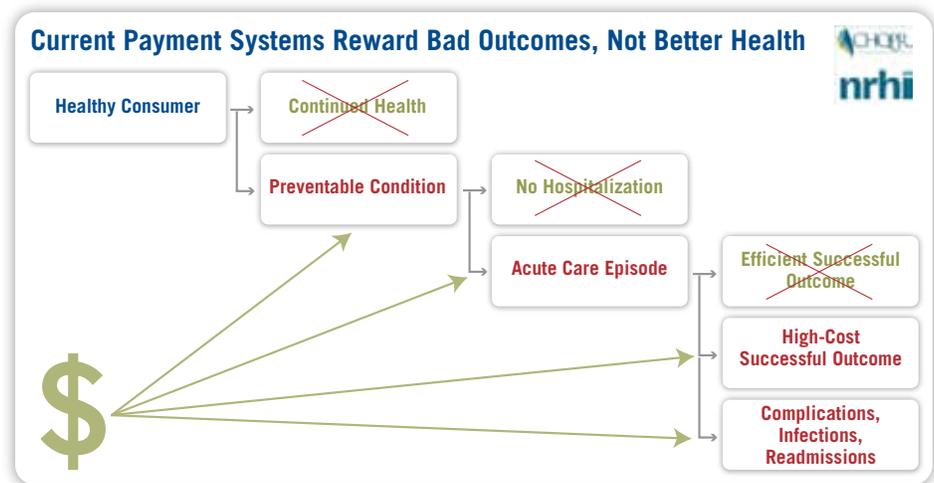


Given this, experts on PCMH/PCHH implementation have emphasized the importance of payment systems. The greater value added by PCMHs/PCHHs necessitates a more attractive reimbursement rate for practitioners. And, if new practices that are central to the success of the new model are not included in the benefit package, practitioners will discontinue them. One study found that, when grant-funded support for an intensive behavioral health counseling intervention (for weight loss and smoking cessation) ran out, referrals from primary care practitioners dropped by 97 percent.[287]

285  Keller, A., and Jarvis, D. (May 1, 2011). Designing the Healthcare Neighborhood: Where is Mr. Rogers When We Need Him Most? 41st National Council Mental Health and Addictions Conference, San Diego, May 2-4, 2011.

286  Miller, H. (September 2009). How to create accountable care organizations. Center for Healthcare Quality and Payment Reform. Retrieved from: http:/chqpr.org/downloads/howtocreateaccountablecareorganizations. pdf.

287  Krist, A.H., et al. (2010). Patient costs as a barrier to intensive health behavior counseling. American Journal of Preventive Medicine, 38(3), 344-348.

## COLLABORATIVE CARE: MENTAL HEALTH /SUD TREATMENT IN PRIMARY CARE SETTINGS

Two of the ACMHC pilots discussed in the introduction of this report, in Mesa County through the Marillac Clinic, and in Summit County through Colorado West, implemented versions of the collaborative care model of behavioral health/primary care integration in their projects. They are leaders among the nearly 100 sites across Colorado implementing some level of integrated behavioral health/ primary care treatment.

Collaborative care is a model of integrating mental health (but also SUD in some applications) and primary care services in primary care settings, to: (1) treat the individual where he or she is most comfortable, (2) build on the established relationship of trust between a doctor and person served, (3) better coordinate mental health and medical care, and (4) reduce the stigma associated with receiving mental health services.[288] Two key principles form the basis of collaborative care models:

1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate people served, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and

2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of collaborative care models include screening, patient education and self-management support; stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity); and linkages with other community services such as senior centers, day programs or Meals on Wheels.[289] Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,[290] depression in adults,[291] and depression in older adults.[292] For example, a study of IMPACT (Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression) – a multi-state collaborative care program with study sites in five states – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care.[293] The DIAMOND model is a recent adaptation initiated in Minnesota that has been disseminated in many places across Colorado.[294] One key feature of the DIAMOND derivation is that it includes specific reimbursement methods.

288 Unutzer, J., Katon, W. Hogg Foundation Integrated Care Initiative (2006). Training presentation retrieved at: http://www.hogg.utexas.edu/programs_ihc_program.html.

289 Unutzer, J., Katon, W., Sullivan, M., and Miranda, J. (1999). Treating Depressed Older Adults in Primary Care: Narrowing the Gap between Efficacy and Effectiveness. The Milbank Quarterly, 77, 2.

290 Katon, W.J., Roy-Byrne, P., Russo, J. and Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. Archives of General Psychiatry, 59, 1098-1104.

291 Katon, W., Von Korff, M., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. Archives of General Psychiatry, 56, 1109-1115.

292 Unutzer, J., Katon, W., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. Journal of the American Medical Association, 288, 2836-2845.

See also President's New Freedom Commission on Mental Health Final Report at 66.

293 Katon, W.J., Schoembaum, M., Fan, M., Callahan, C.M., Williams, J., Hunkeler, E., Harpole, L., Zhou, A.X., Langston, C., & Unützer, J. (2005). Cost-effectiveness of improving primary care treatment of late-life depression. Arch Gen Psychiatry. 2005;62:1313-1320. Downloaded at http://archpsyc.ama-assn.org/cgi/reprint/62/12/1313.pdf.

294 Institute for Clinical System Improvement. (2008). The DIAMOND Initiative. Retrieved at: http://www.hogg.utexas.edu/uploads/documents/rls15_resrc_natl1_oftedahl.pdf.

More broadly, the national literature emphasizes a multiplicity of approaches that are (1) tailored to the need level of the person served (embedding behavioral health in primary care settings for lower-need individuals and primary care resources in community behavioral health settings for persons with more persistent and complex disorders),[295] and (2) grounded in an evidence-based shift away from traditional office-based models. Common features of most collaborative care primary care integration models include: co-location; use of validated screening tools for both behavioral health and physical health risks, integrated information technology support (including patient registries to track/monitor appointments, preventive care, chronic care interventions, and patient preferences); shared electronic health records (EHR); and routine outcomes tracking with emphasis on brief, widely used protocols. There is also a need to address challenges, such as billing protocols that may not allow for same-day primary care provider and behavioral health visits, implementation of the Screening, Brief Intervention and Referral to Treatment (SBIRT) codes, the need to pay for case management and the cost of coordination, and movement away from a fee-for-service funding arrangement.

The biggest challenges, however, center on the primary care physician and behavioral health consultant (BHC) work force. Collaborative care requires a different set of skills, knowledge and attitudes. The program must recruit primary care physicians who are comfortable with behavioral health issues, and leadership must buy into and promote the model through support, assertive promotion and supervision. The role of the primary care physician is much different, emphasizing collaboration between the primary care physician and BHC to develop and implement the treatment plan. Similarly, the role of the BHC is quite different from a traditional clinical role, as the BHC works together

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295  See: Mauer, B.J. (April 2009). Behavioral health/primary care integration and the person-centered healthcare home. Washington, DC: National Council for Community Behavioral Healthcare. Retrieved at: http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20 Healthcare%20Home.pdf.

Mauer, B.J. (March 2010). Substance use disorders and the person-centered healthcare home. Washington, DC: National Council for Community Behavioral Healthcare. Retrieved at: http://www.thenationalcouncil.org/ galleries/business-practice%20files/Substance%20Use%20Condition%20Report.pdf.

with a case manager or peer support specialist to provide education to increase awareness of behavioral health functioning, support self-management and promote active engagement in treatment for the person served. For individuals not responding to the BHC and primary care physician, the team would contact the psychiatrist for consultation or refer to an external specialist.

The role of the BHC in the collaborative care model is also quite different from a traditional clinical role. The BHC can be supported by a peer support specialist instead of a case manager as a variation of the model. The BHC and peer specialist can work together to provide education to increase awareness and support self-management, so that the persons served are actively engaged in their treatment. The BHC provides medication support, brief counseling, treatment response monitoring, and relapse prevention planning. The psychiatrist acts as consultant to the team for individuals who are not responding to the BHC and primary care physician.

There is a heavy focus on clinical integration via care coordination, team meetings, "warm handoffs," and informal coordination "in the hallway." This alternate approach to delivering services involves:

- Short, targeted behavioral health consultations versus the standard 50-minute hour,

- Longer primary care sessions to conduct adequate screening,

- Joint sessions when appropriate,

- A view that sessions are "interruptible," as key members are either brought in to respond to emerging issues, or are consulted on other cases, and

- Group delivery of medication management and other services that both enhances efficiency and promotes mutual support among persons served.

## REGIONAL CARE COLLABORATIVES

As states and counties around the nation struggle to integrate mental health and SUD services with their broader health care systems, those that have implemented behavioral health carve-outs in their Medicaid plans face a common dilemma: how to integrate specialty health plans into the broader health system (sometimes referred to as "reconnecting the head to the body") without losing the capacity of the carve-out plans that have generally demonstrated success in reducing mental health/SUD costs, and improving access and quality, particularly for people with severe needs.

While it is too early for these efforts to have accumulated evidence for their effectiveness, there are preliminary signs that regional partnerships to increase collaboration across carved-out behavioral health plans (like Colorado's BHOs for mental health) and physical health plans are meeting with success. In this section, we explore some initial evidence from efforts by Colorado Access, which manages both the BHO for Denver and a Medicaid HMO, and how these lessons can apply to Colorado's broader efforts to develop regional accountable care collaboratives for Medicaid.

**The Colorado Regional Integrative Care Collaborative (CRICC)**. This effort is part of the national-level Rethinking Care Program, which is focused on reducing costs and improving care among the highest-need, highest-cost Medicaid beneficiaries. The CRICC involves the following:

- High-need patients are served through primary care medical homes within federally qualified health centers (FQHCs),

- Care management funding for FQHCs supports coordination between behavioral health and primary care providers,

- Case management from the mental health BHO, Colorado Access, using the EBP Motivational Interviewing to promote self-management,

- CMHC management of behavioral health needs that require specialty intervention, and

- Co-management efforts center on five chronic health conditions: diabetes, hypertension, chronic obstructive pulmonary disease (COPD), osteoarthritis, and asthma.

Initial data from CRICC provided to us by Marshall Thomas, M.D., at Colorado Access suggest that the program has led to lower costs, less use of hospital and emergency room care, and increased use of outpatient services.[296] Initial 15-month findings suggest that when high-need clients are served through primary care medical homes within FQHCs, cost of care "was favorably impacted by as much as 14 percent compared to comparable Medicaid client cohorts treated in the private sector." Key components of this finding included the following:

• **Hospital admissions declined for enrolled members:**
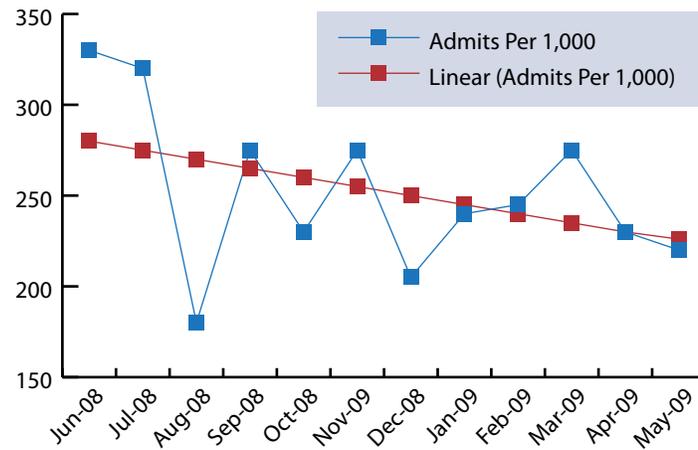


• **Emergency room visits declined for enrolled members:**



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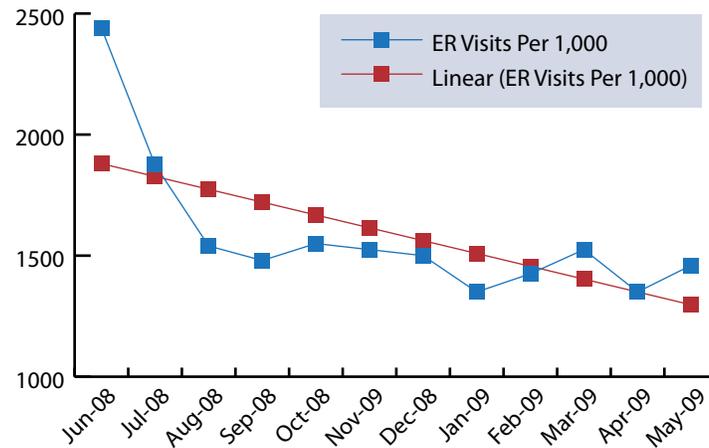
296 Colorado Regional Integrative Care Collaborative: Interim Experience and Lessons Learned. (January 17, 2011). Received through personal communication with Dr. Marshall Thomas, Feb. 5, 2011. Colorado is one of the first two regional sites involving regional integrative care collaboratives.

ADVANCING COLORADO'S MENTAL HEALTH CARE

- People assigned to a medical home at a community health center (CHC) incurred approximately a 12 percent lower total cost of care over the first 12-month period and a 15 percent lower cost of care ($562.95 per member, per month [PMPM]) compared with the cost of care in a non-integrated setting ($659.72 PMPM):
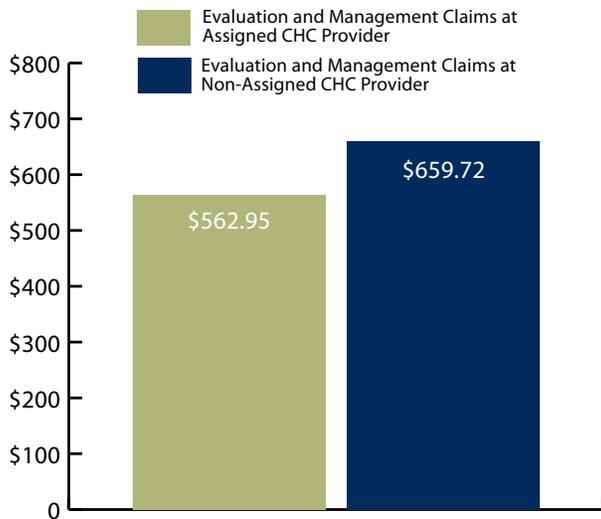


The project encountered multiple challenges in achieving these results. The initiative targeted people with very high needs, so enrolling people in the PCMH was often challenging, especially for those who were homeless or very mobile and did not have telephones. Approximately 50 percent of enrollees could not be reached or elected out of the program in the pilot study. Of the remaining participants, about one-third chose to maintain primary care relationships within a private practice or another non-assigned point of care, one-third ended up in a PCMH within their assigned FQHC, and one-third only used their pharmacy benefits and did not incur other medical claims.

**Regional Care Collaborative Organizations (RCCOs).** In December 2010, the HCPF awarded contracts to seven Regional Care Collaborative Organizations (RCCOs) to implement its Accountable Care Collaborative (ACC) Program. RCCOs are accountable for controlling costs and improving the health of Medicaid members in their region, with an emphasis on improving care for Medicaid recipients still in the fee-for-service system. The ACC is a hybrid model blending characteristics of a regional Accountable Care Organization (ACO). As such, the ACC is predicated on collaboration between partners, as opposed to an ACO, which owns and controls all components of its delivery system.

ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a defined group of patients who are cared for by ACO clinicians. Medicare-approved ACOs need to serve at least 5,000 patients, have sufficient primary care capacity, include inpatient capacity, and be able to report on cost, quality and patient experience. ACOs are integrated delivery systems with capacity to manage financial risk.



**Accountable Care Organization Care Delivery**

While the RCCOs are not ACOs (they are voluntary collaboratives of independent organizations, rather than integrated delivery systems within a single organization), the regional span of the ACC fits within the ACO framework. A 2009 overview of ACOs describes four different levels of ACO organization. The fourth and most comprehensive level brings together health care providers and the broader human services delivery system to address the needs of those with the most complex conditions, including people who are homeless, people in the criminal justice system, and others, as depicted in the figure that follows.[297]

## Different Forms of Accountable Care Organizations

| | Health Care Providers Included | Examples of Cost Reduction Opportunities |
|---|---|---|
| **Level 4 ACO** | Public Health / Safety-Net Clinics | Coordinated Health and Social Services Support |
| **Level 3 ACO** | Hospitals / Other Specialists | Improved Management of Complex Patients |
| **Level 2 ACO** | Major Specialists (Cardiology, Orthopedics, Etc.) | Improved Outcomes and Efficiency for Major Specialties |
| **Level 1 ACO** | Primary Care Practices | Reduction in Preventable ER / Appropriate Use of Testing/Referral / Prevention and Early Diagnosis |

The two central goals of the ACC program are to improve health outcomes through a coordinated, person-centered, proactive system and to control costs by reducing "avoidable, duplicative, variable and inappropriate use of health care resources."[298] To reach these goals, HCPF set four program objectives:

1. Expand access to comprehensive primary care,

2. Provide medical homes to coordinate and integrate access to other services,

3. Promote member and provider satisfaction and engagement, and

4. Use statewide data and analytics functionality to support data sharing, as well as monitoring and measurement of health care costs and outcomes.

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297  Miller, H. (September 2009). Previously cited. Page 82.

298  RCCO RFP.

Key to the success of the RCCOs is the role of the Statewide Data and Analytics Contractor (SDAC) that is charged with developing and operating the infrastructure for "statewide data and analytic functionality" noted in Objective #4 above. The responsibility for primary care, specialty care, inpatient care, and behavioral health will still be spread across a few HMOs (only 15 percent of Medicaid recipients belong to an HMO such as Colorado Access or Rocky Mountain Health Plans), numerous fee-for-service primary, specialty and inpatient providers and the BHOs; therefore, the only infrastructure pulling together information and cost data across participants will be the SDAC. That is a large responsibility, and the intention of making its data access "real time" is a high bar to set.

Start-up for the RCCO contracts began in February 2011. While the RCCO model did not integrate mental health funding through the Medicaid BHOs, all of the successful RCCO partnerships included BHO partners, and most also included as partners Management Service Organizations (MSOs) responsible for managing DBH's state-funded SUD treatment networks. In our view, and the view of many of the stakeholders we interviewed, the RCCO framework provides a positive approach to building a bridge toward increased integration predicated on collaboration. While other states have focused more on developing integrated funding streams to contract with free-standing ACOs, Colorado has recognized that ACOs currently are primarily creatures of the private sector. No ACOs of which we are aware have demonstrated competency in managing behavioral health care for impoverished people with complex behavioral health conditions served by the public sector. The ACC program allows for different parts of the state to try out different models for accountable care, in recognition of both Colorado's diversity and the lack of industry consensus as to which approaches are best. One stakeholder described three models across the seven current RCCOs: 1) health plan driven models by Colorado Access (three regions) and Rocky Mountain Health Plans (one region), 2) provider-driven models by the Colorado Community Health Alliance (one region) and Community Care of Central Colorado (one region), and 3) a safety net

provider model of FQHCs and CMHCs in one region through Integrated Community Health Partners. While some may dispute this generalization (Colorado Access, for example, is a partnership between safety net providers), it is clear that multiple models are being attempted. While there are still many uncertainties as to the success of the endeavor, the model clearly puts an emphasis on locally driven solutions and assessment of multiple approaches.

This is not to say that there is not a strong rationale for moving quickly beyond regional collaboration to administratively integrate health plans through a more formal ACO approach.

Reasons to do so range from administrative efficiency to better aligning financial incentives from primary care through specialty care, through emergency room and inpatient care. Furthermore, as observed in the 2003 Status Report, the national experience in the private sector has been that when health plans "integrate" their behavioral health carve-outs, they still maintain specialized behavioral health units (just as Colorado Access has done with its Access Behavioral Care BHO plan).

Despite these advantages, there are reasons to wait that are just as compelling. As noted above, behavioral health carve-outs have accomplished much: increased access, decreased use of hospitals, and increased quality. Rapid integration risks losing the gains of the carve-outs accomplished by the BHOs, and many stakeholders emphasized the proven experience and success of the BHOs in managing at least the psychiatric component of chronic health care conditions over time. Also, too often the history of "integrated" funding has been invisible funding. Despite its disproportionate potential impact on overall spending, behavioral health spending is such a small part of overall health funding that it historically received little management attention. But the most serious concern we have identified through our stakeholder interviews and work in other states has been the risk that putting too much attention too soon on reorganizing payers will take away from efforts to reorganize the actual delivery of services within regions. This is not to say that reasons for concern

about the RCCO implementation do not exist: for example, the regions seem to rely primarily on balancing numbers of Medicaid members across political subdivisions rather than on how people seek out health care (for example, three of the seven RCCOs are in the Denver metro region – see below), and much of the success of the model is riding on the ability of the SDAC to deliver on "real time" data access. Other limitations noted by stakeholders include the lack of risk bearing by the RCCOs and questions about the adequacy of the rates, given the need to coordinate care and promote medical homes across fee-for-service providers without the leverage of managed care arrangements. But the focus on collaboration and offering both incentives and opportunities for regional partnerships to evolve over time is encouraging.



Regions 2 & 3: Colorado Access

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Region 1: Rocky Mountain Health Plans

Region 7: Community Care of Central Colorado

Region 4: Integrated Community Health Partners

▲ Region 5: Colorado Access (Denver County)
● Region 6: Colorado Community Health Alliance
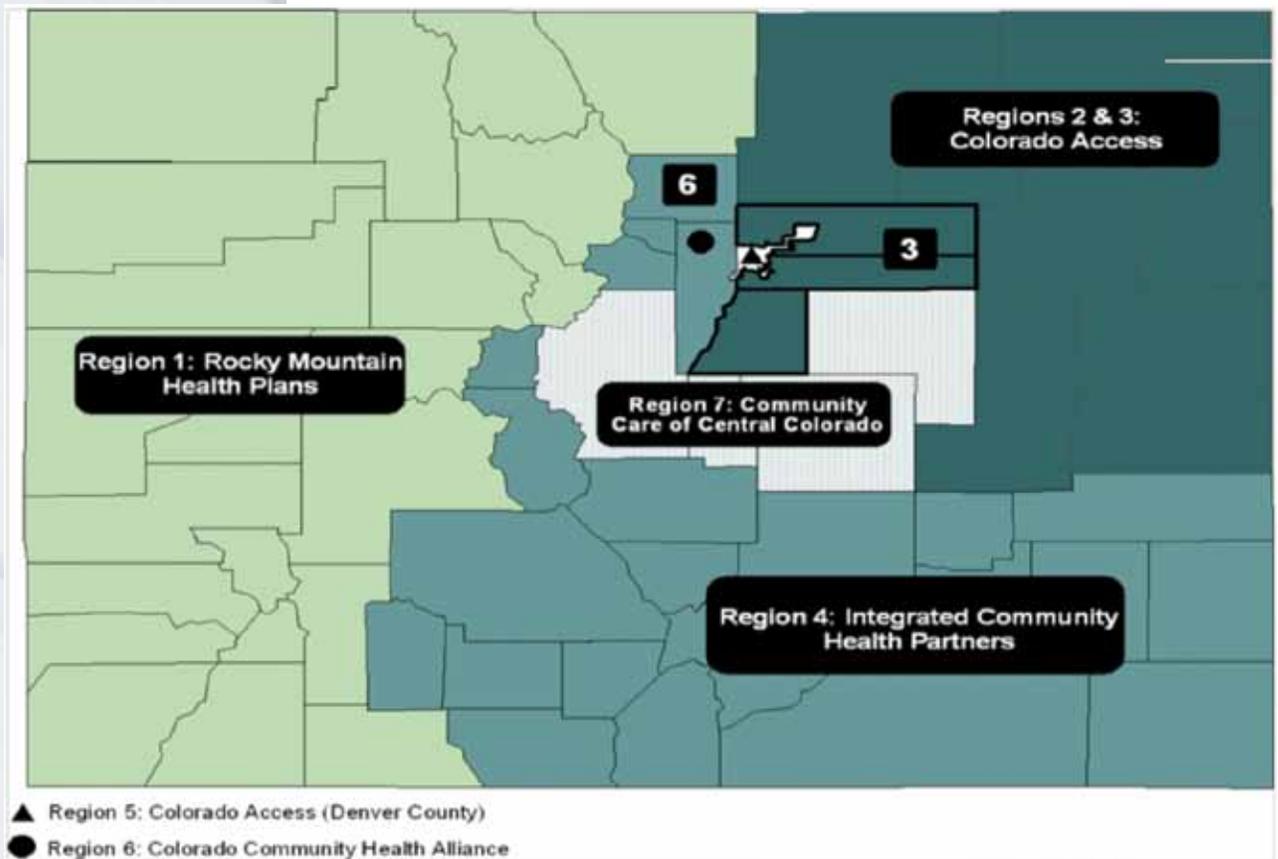
**Health Information Exchanges.** Critical to the success of the RCCOs and the SDAC will be the health information exchange (HIE) infrastructure being developed under the leadership of a nonprofit organization, the Colorado Regional Health Information Organization (CORHIO). HIEs are secure information networks that allow participating providers the ability to share health records, with appropriate protections for the privacy of behavioral health information, including the enhanced federal safeguards for SUD treatment (42 CFR Part 2). While HIEs offer great promise, groups representing people who receive mental health and SUD services across the nation have voiced concern that this information, if not properly protected, could be used in a harmful way. In Colorado, the mental health peer-run consumer advocacy group WE CAN! (which receives administrative support from Mental Health America of Colorado), has taken a lead in representing these concerns, and partnering with CORHIO to both ensure consumer protections and provide public education on the safeguards that are being put in place. Recognizing the tremendous harm that results from uncoordinated care in the lives of many people with chronic behavioral health needs, described in detail above under Observation #4, WE CAN! has tried to balance its advocacy between both consumer protection and health care quality improvement through information shared with safeguards.

Given the complexities involved, CORHIO is supporting HIE development on a community by community basis, initially working in six communities – Boulder, Colorado Springs, Northern Colorado, Pueblo, the San Luis Valley and Summit County – and with two statewide systems (The Children's Hospital and the 13-hospital Centura Health system). CORHIO is also coordinating its efforts with the Quality Health Network, a HIE that has been operating since 2005 in Mesa County and that is expanding to many communities on the Western Slope. CORHIO and Quality Health Network are working to ensure interoperability between the two networks so that providers and consumers across the state receive the same benefits and services provided by robust HIE.

Before beginning the HIE visioning and planning process in each community, COHRIO ensures that all health care stakeholders are brought to the table – long term care, primary care, mental health/SUD providers, other specialists, hospitals, public health, safety net providers, and advocates – to form a Community Advisory Committee to act as a community-level decision-making body to define goals and guide implementation. Across communities, CORHIO is building a common platform to enhance interoperability and cross-community data sharing. HIE infrastructure is widely seen as a fundamental tool to improve the value of health care services, deliver payment system and delivery system reforms, and support development of integrated systems such as ACOs.

CORHIO provides the interoperable technology platform needed to support the concept of virtual integration so providers can work together without necessarily belonging to the same organization or broader integrated delivery network. CORHIO conducted a review of best practices for HIE in other states, taking into account Colorado's competitive delivery system and insurance markets, as well as its geographic and cultural diversity. CORHIO's current focus is on sharing information for treatment purposes among providers, with an emphasis on discrete data transfers with appropriate consent. Information sharing can occur through exchange between Electronic Health Records (EHRs) or through a web-based inbox/workflow tool provided by CORHIO. As would be expected, incorporation of behavioral health data is more difficult and technically challenging because of the need for specific consents. As a result, at the current time, behavioral health providers are mainly acting as data and information receivers within the system, as sending behavioral health information will require more robust privacy practices and policies that are more complicated to implement. Several Colorado behavioral health providers have already signed commitments to join the HIE, including five community mental health centers.

Multiple informants we spoke with talked about the changes in 2011 to Colorado's sun-setting Mental Health Practice Act (MHPA) to better align Colorado's rules governing non-physician mental health practitioners with HIPAA. Before the 2011 changes to the MHPA, mental health practitioners were required to obtain consent every time they shared patient information, even with other consulting health care providers. A practical example of this is that a psychiatrist (who is not subject to MHPA as a physician) could share information with referring providers, but a non-physician licensed mental health provider could not. The MHPA changes implemented through Senate Bill 11-187 and signed into law by Governor Hickenlooper instead establishes HIPAA as the governing policy for the health care activities of these practitioners when it applies.

The time line for CORHIO implementation statewide is as follows:

- 2011 – Clinical messaging between providers in the initial communities is in progress, as it tends to show the most immediate value and is technically simpler.

- By late 2011/early 2012, CORHIO will provide an EHR query option in the six currently implementing communities, allowing both direct querying of EHRs and a web portal for document uploads for providers that do not have their own EHR.

- Expansion into the remaining communities and with statewide partners will depend on community readiness and interest. In urban areas, competition between health systems may complicate efforts to build community wide capacity.

- CORHIO also plans to work closely with the Medicaid SDAC, with an eventual intent to integrate the two efforts so that RCCO providers can receive more current and clinically relevant information on the people they are accountable for treating.

**Reimbursement Redesign.** Another critical component of Colorado's health care reform efforts is redesigning reimbursement systems. As was noted above, current payment structures that reimburse units of care contribute to the maintenance of our nation's "sick care" system. To transcend this and shift payment toward outcomes, improved health status, and reduced costs, the Center for Improving Value in Health Care (CIVHC) has taken the lead in Colorado in convening experts and stakeholders to develop new reimbursement approaches under its Payment Reform Initiative. This work is closely aligned with CIVHC's efforts to develop an All Payer Claims Database (APCD) to foster better understanding of health cost trends in Colorado,[299] and there is a private-public partnership driven Payment Reform Advisory Group helping guide the broader stakeholder engagement and decision-making process.

The Payment Reform process began in January 2011 with a broad focus to establish an overall consensus. The emphasis of initial consensus seems to be better management of chronic health conditions through performance incentives for primary care, specialty, and tertiary/hospital levels of the system. Behavioral health payment is included under this rubric, but not called out specifically in this process. In a related initiative, The Colorado Health Foundation is partnering with the Collaborative Family Healthcare Association in the second half of 2011 to focus on current funding barriers and best practices to promote integrated behavioral health and primary care. CIVHC's Payment Reform initiative is central to consensus building in Colorado to transition to performance-based payment approaches essential to accountable care. It is important that behavioral health stakeholders be involved as decisions are made in the coming year.

## Health Care Neighborhoods

The Neighborhood Union Center in Fulton County, Ga., illustrates just where health care reform could take us if our vision is broad enough.[300] At the center, local residents have access to the following:

- Primary care (focused on both wellness and sickness),

- Obstetric and gynecology services,

- Behavioral health services,

- Oral health services,

- Travel immunization services,

- Communicable disease intervention,

- WIC services and nutrition education,

- A day center for parents receiving services,

- Employment assistance,

- Disability and vocational rehabilitation services,

- Foreclosure prevention services and housing assistance,

- A reading room and information center that offers English as a Second Language (ESL) classes, and

- A farmer's market, community garden, and walking trail.

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299  To view CIVHC's February 2011 Final Report to the Governor and Legislature on the APCD, see http://www.civhc.org/getattachment/CIVHC-Initiatives/Data-and-Transparency/All-Payer-Claims-Database-Activities/APCD-FINAL-REPORT---E-Edition.pdf.aspx.

300  D. Jarvis. Dale Jarvis and Associates, LLC. Dale uses this example as a central theme in his many presentations on integrated care across the country. He has given permission for anyone to use the material he has developed (and specifically did so for this report), given his interest in maximizing access to emerging ideas on health care reform. For more information on the Fulton County program, see: http://www.fultoncountyga.gov/locations-bh/neighborhood-union-health-center-bh. The material for this section was developed by D. Jarvis and A. Keller for the following presentation: Keller, A., and Jarvis, D. (May 1, 2011). Designing the Healthcare Neighborhood: Where is Mr. Rogers When We Need Him Most? 41st National Council Mental Health and Addictions Conference, San Diego, May 2-4, 2011. It can be downloaded on line at: http://www.djconsult.net/resources-1/2011-national-council-conference-materials.

The idea at the heart of the Fulton County Neighborhood Union Center is the health care neighborhood. Increasingly, this concept is being recognized within medical circles. The American Academy of Physicians recently released a policy paper focused on the interface between PCMH and specialty practices.[301] The policy paper focuses on the concept of the "Medical Home Neighbor," and defines a range of characteristics that specialty partners will need to develop to work effectively with PCMHs. These include:

• Determining the type(s) of clinical relationships that the PCMH and specialist are willing to enter into: pre-consultation exchange (sometimes called "curbside consults"), formal consultation, co-management, or transfer to specialty care;

• Formalizing the structure of these relationships through care coordination agreements with financial and non-financial incentives to encourage specialist participation; and

• Working to be recognized as a neighbor by demonstrating competency around:

  - Communication, coordination, and integration,

  - Timely consultations and referrals,

  - Timely, effective exchange of clinical data,

  - Effective participation in co-management situations,

  - Patient-centered care, enhanced care access, and high levels of care quality and safety, and

  - Supporting the PCMH practice's work.

The health care neighborhood embodied by the Fulton County Neighborhood Union Center takes this to the next level by adding human services partners to the health service framework. There are four key parts to the health care neighborhood concept:

301  American College of Physicians. (2010). The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia: American College of Physicians; Policy Paper. Retrieved at: http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf.

1. **Effective PCMHs integrated with behavioral health**.
   Barbara Mauer first described the four-quadrant model as a framework for primary care and behavioral health integration in 2006.[302] The model describes two dimensions that define four categories of people in need who require different models of integrated behavioral health/primary care intervention: Quadrant 1 - people with low behavioral health and low primary care needs, Quadrant 2 - people with high behavioral health and low primary care needs, Quadrant 3 - people with low behavioral health and high primary care needs, and Quadrant 4 - people with high behavioral health and high primary care needs. The health care neighborhood has access to PCMHs for people in all four quadrants. This is the first piece of the puzzle (see figure below):

**Different Forms of Accountable Care Organizations**



| Quadrant 2 | Quadrant 4 |
|---|---|
| People with high behavioral health and low primary care needs. | People with high behavioral health and high primary care needs. |

**Health Care Delivery System**
Access to PCMHs for people in all four quadrants.

| Quadrant 1 | Quadrant 3 |
|---|---|
| People with low behavioral health and low primary care needs. | People with low behavioral health and high primary care needs. |

2. **Community-based prevention.** Also essential is community-based prevention across the entire system – primary, secondary, and tertiary efforts – all coordinated by a guiding set of health priorities. This adds a second piece to the puzzle (see figure that follows):

**Different Forms of Accountable Care Organizations**



| Quadrant 2 | Quadrant 4 |
|---|---|
| People with high behavioral health and low primary care needs. | People with high behavioral health and high primary care needs. |

**Health Care Delivery System**
Access to PCMHs for people in all four quadrants.

| Quadrant 1 | Quadrant 3 |
|---|---|
| People with low behavioral health and low primary care needs. | People with low behavioral health and high primary care needs. |

**Community-Based Prevention Led by Public Health**

3. **Human services transformation.** The community and the health care neighborhood partners must have a commitment to transforming their human services – jails, homeless shelters, child welfare, juvenile justice, education, employment supports, and basic needs supports – within a person-centered framework that emphasizes movement from institutional to natural supports. This third piece of the puzzle is depicted in the following graphic:



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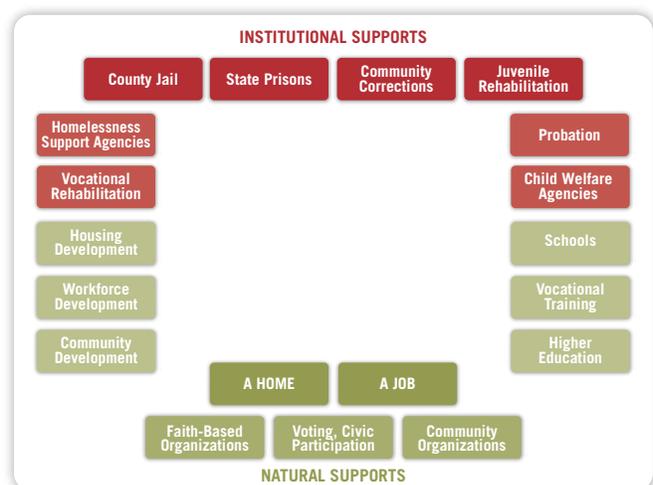
302  Mauer, B. (February, 2006). Behavioral health / primary care integration: The four quadrant model and evidence-based practices. National Council for Community Behavioral Healthcare. Retrieved at: http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf.

**4. Coordinating EBPs.** The fourth component of the health care neighborhood involves EBPs that focus on coordination of multiple supports for people with complex behavioral health needs. Examples of these EBPs were described in the 2003 *Status Report*, and they include Wraparound, Integrated Dual Disorder Treatment (IDDT), and the Program for Assertive Community Treatment (PACT). As an example, Wraparound is an intensive care coordination approach centered on a team-based planning and implementation process geared to develop the problem-solving skills, coping skills and self-efficacy of the children and youth involved in multiple human services systems (juvenile justice, child welfare, special education, mental health, and/or SUD) and their families. The goal is to integrate the child or youth into the community by building the family's social support network. Wraparound targets the top 1- 5 percent of youth in need, and is very intensive. The major outcomes of Wraparound Planning include: fewer restrictive placements, improved school and broader functioning, reduced justice system recidivism and detention use, and reduced mental health symptoms.[303] These EBPs become the fourth and final piece of the health care neighborhood puzzle (see below):

**Coordinating EBPs
(Wraparound, PACT, etc.)**
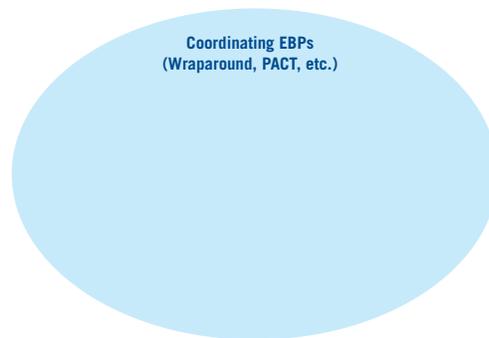
The diagram on the following page puts all the pieces of the health care neighborhood puzzle together, joining human services and health care providers within a single coordinated system. Because health care delivery is fundamentally local, the health care neighborhood conceptualizes county and multi-county delivery systems with a new level of collaboration, risk-sharing, and joint effort to translate the promise of health reform into a reality. Without such arrangements, better integrated delivery systems that center only on health services may simply be better positioned to shift the costs for the most vulnerable onto locally funded county services. With a full partnership between county human services and integrated health plans, not only can the incentives to shift costs be minimized, but human services and health care partners alike will be positioned to share in the realization of cost savings through better integrated care, savings that can, it is hoped, fill gaps in service, address disparities in access to health care, and promote opportunities for prevention that would otherwise continue to go unmet. Hearkening back to the $30 million spent in the seven metro Denver counties on jail services for persons with behavioral health needs, it is clear that both finances and needed outcomes argue for such an approach as depicted to the right.

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303  See http://nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-(evidence-base).pdf for additional information.
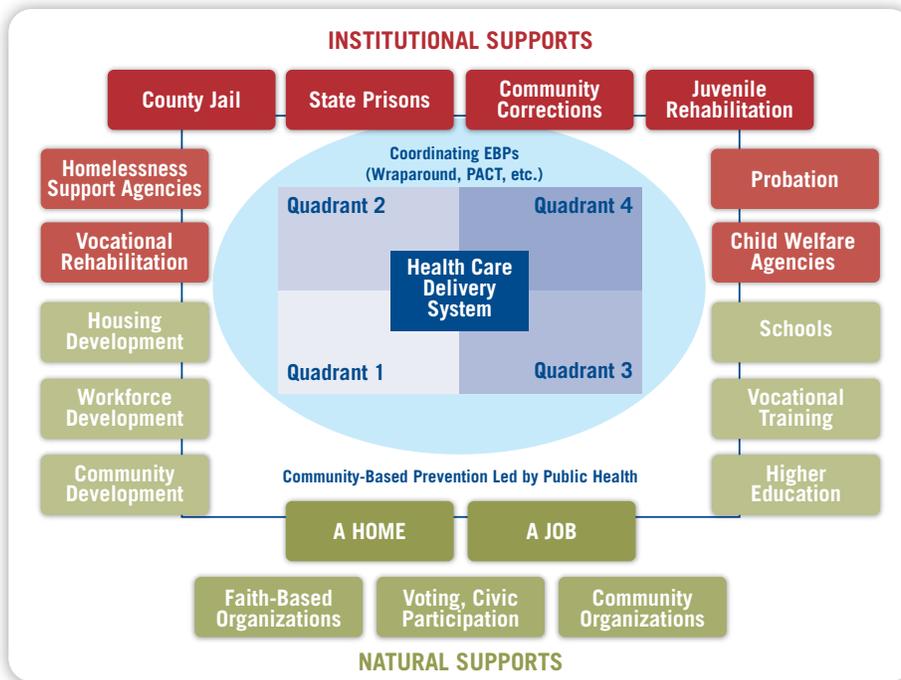
The model is strongly related to the chronic care model depicted below. To bring communities together to build health care neighborhoods, the following system-level processes are essential:

- Communitywide needs assessment by a group that represents all the major payers of health and human services within the region (including counties);

- Systemwide processes for performance measurement and improvement;

- Multi-payer "virtual" budget development where partners share data on costs and expenditures and track financial performance over time – while financial decision-making is still retained by individual partners for their own services, transparency is promoted, and decisions on reinvestment and spending are collaboratively made;

- Multi-payer payment, contracting, and performance measurement models are developed to reduce the need for providers to respond to multiple, often-redundant, and sometimes contradictory, payment methods; and

- Development of regionwide HIEs is supported.

## Practices to Address Health Disparities

The reality of health disparities across cultural groups was described under Observation #3. In this section we present two practices for addressing health disparities: system-level cultural competence standards based on national models, and a specific approach for engaging members of underserved groups in care. While neither of these approaches is an EBP, they are practices that have growing support.

### CULTURAL COMPETENCE STANDARDS

The most well-known national standards related to health disparities focus on services for members of ethnic minority groups, but they are applicable to any underserved cultural group. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)[304] were adopted in 2001 by the U.S. Department of Health and Human Services (USDHHS) Office of Minority Health (OMH) with the goals of "equitable and effective treatment in a culturally and linguistically appropriate manner" and "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers" in order "to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available,[305] but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American/Pacific Islander, Hispanic/Latino, and American Indian/Alaska Native groups is also available.[306]

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304  U.S. Department of Health and Human Services (USDHHS), Office of Minority Health. (March 2001). National Standards for Cultural and Linguistically Appropriate Services in Health Care. Washington, DC: Author.

305  The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf.

306  USDHHS, Substance Abuse and Mental Health Services Administration. (2001). Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Rockville, Md.: Author.

For health care services overall, the CLAS standards set the current benchmark against which the performance of health care organizations that receive federal funds is assessed. CLAS standards are intended for wider use by a range of stakeholders, including individual providers, accrediting and credentialing agencies, policy makers, purchasers, and advocates. The CLAS definition of cultural and linguistic competence is based on the 1989 work of Cross, Bazron, Dennis, and Isaacs and is specified as follows in the CLAS document:

*Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Pages 4-5)*

The National Standards on CLAS delineate 14 standards for health care institutions to address, as follows:

- **Culturally competent care.** Guidelines addressing culturally competent care, which state that health care organizations should:

  1. Ensure that persons served receive, from all staff members, effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

  2. Implement strategies to recruit, retain and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of the service area.

  3. Ensure that staff at all levels, and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.

- **Language.** Mandates for all recipients of federal funds, which address language access and state that health care organizations must:

  4. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each person served with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.

  5. Provide to persons served in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

  6. Assure the competence of language assistance provided to limited English proficient persons served by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the person served).

  7. Make available easily understood consumer-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

- **Organizational infrastructure.** Guidelines addressing organizational support for cultural competence, which state that health care organizations should:

  8. Develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

  9. Conduct initial and ongoing organizational self-assessments of CLAS related measures within internal audits, performance improvement programs, consumer satisfaction assessments and outcome-based evaluations.

  10. Ensure that data on the individual person's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.

  11. Maintain a current demographic, cultural and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing CLAS-related activities.

13. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross cultural conflicts or complaints by persons served.

- **Public reporting.** A final recommendation regarding organizational support for cultural competence, which states that health care organizations:

14. Are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Regarding data and performance improvement, in 2004 the National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Association of State Mental Health Program Directors (NASMHPD) issued a report describing best practice strategies for promoting cultural competency.[307] The guidelines in that report focus on the importance of ongoing data collection and related quality improvement activities in the promotion of cultural competence. The report describes steps to institutionalize a comprehensive infrastructure at the system level in support of improved cultural competence and reduced health disparities over time, centering on leadership, self-assessment, performance standards, measurement of performance related to those standards and quality improvement practices to improve performance.

## Cultural Brokers

To address the widely documented lack of diversity in the health care workforce, standards have also been developed regarding the strategy of employing cultural brokers. The potential utility of cultural brokers in mental health settings has been described,[308] and the National Center for Cultural Competence (NCCC) at the Georgetown University School of Medicine has developed a guide to promote the development of cultural broker programs.[309] The NCCC guidelines take a broad view of culture, including factors related to sexual orientation, age, disabilities, socioeconomic status, religion, political beliefs, and education. The guide defines a cultural broker broadly as an advocate between groups of differing cultural backgrounds. It defines the role more specifically for health care settings as a particular intervention to engage a range of individuals with diverse backgrounds, to help span the boundaries between the culture of health care delivery

307  NTAC and NASMHPD. (September 2004). Cultural competency: Measurement as a strategy for moving knowledge into practice in state mental health systems. Alexandria, VA: NASMHPD. Retrieved from http://www.nasmhpd.org/general_files/publications/cult%20comp.pdf.

308  Singh, N.N., McKay, J.D., and Singh, A.N. (1999). The need for cultural brokers in mental health services. Journal of Child and Family Studies, Vol. 8, No. 1, 1-10.

309  National Center for Cultural Competence, Georgetown University Medical Center (2004). Bridging the cultural divide in health care settings: The essential role of the cultural broker programs. Washington, DC: Author. Downloaded at: http://nccc.georgetown.edu/documents/Cultural_Broker_Guide_English.pdf.

and the cultures of the people served. These individuals range in their roles within the health care delivery system from people served to providers to system leaders. Singh and his colleagues describe the broker as acculturated in the mainstream health care delivery culture and one or more minority cultures. The NCCC guidelines note that, while cultural brokers generally achieve acculturation in a particular minority culture through their own experience as a member of that culture, membership is neither a sufficient nor a necessary requirement. The guidelines instead center on the person's

*. . . history and experience with cultural groups for which they serve as a broker including the trust and respect of the community; knowledge of values, beliefs, and health practices of cultural groups; an understanding of traditional and indigenous wellness and healing networks within diverse communities; and experience navigating health care delivery and supportive systems within communities. (Page 5)*

The NCCC guidelines focus on the development of programs within health care organizations to expand the availability of cultural brokers for the specific communities served by those organizations. It should be noted that, while membership in a specific cultural group is not necessary to serve as a cultural broker, a high level of acculturation is necessary. For a person to bridge two cultures, a level of acculturation in both cultures is needed. A cultural broker does not have knowledge of how to work with "all cultures" or even "all members of a specific culture," as such a standard is simply not attainable. They instead have sufficient knowledge and skill to be viewed as credible by a sufficient number of the members of the specific communities being served to function as a bridge.

# RECOMMENDATIONS TO IMPROVE ACCESS TO EMPIRICALLY BASED CARE

Colorado is making steady progress in the promotion of empirically based care, including the expansion of integrated care and person-centered health/medical homes. Future efforts need to:

1. **Continue to expand access to evidence-based care** across the board (while remaining mindful of the limitations of current evidence), and

2. Put a priority on **expanded access to person-centered health/medical homes** that integrate behavioral health and primary care using strategies for specific subgroups of people:

   • **For the "many,"** health/medical homes should be in all primary care settings, and

   • **For the "few,"** health/medical homes should either be in the settings where people receive most health services (for example, community mental health centers for adults with SMI), or through specific evidence-based models such as IDDT and Wraparound that can serve as temporary (one-to-two year) health homes, to knit human services and natural supports together, to improve health outcomes, avoid or minimize use of restrictive service settings, and facilitate longer term health care delivery in more natural settings.

WHILE THERE IS
GEOGRAPHICAL
DISPARITY ACROSS
NEARLY ALL BEHAVIORAL
HEALTH PRACTITIONER
GROUPS, THE DISPARITY
IS MOST PRONOUNCED
FOR THE PROFESSIONS
THAT REQUIRE THE
MOST TRAINING.

# Observation #6
## There Are Still Too Few Providers – and the Need is Growing

**Snapshot of Key Findings
Regarding Provider Scarcity in Light of Growing Needs**

### Overall Trends

▶ Colorado continues to have a relatively good supply of mental health practitioners and certified addictions counselors, but has critical shortages of particular subgroups of providers:

  ▼ Psychiatrist and other prescribers,

  ▼ Any providers trained in empirically based approaches, and

  ▼ Those specializing in the care of children, older adults, people living in rural areas, minority cultures, and people who speak languages other than English.

▶ There are also too few mental health and SUD providers of the types needed who are willing to serve priority populations given current reimbursement levels.

▶ As a result, the types of systematic approaches to integrating mental health and SUD treatment with primary care resources discussed under the previous section are essential to leveraging available providers to meet growing demands expected under health reform.

## Specific Trends

▸ The number of Colorado's mental health and SUD practitioners has increased since 2003 from 10,564 to 14,217; the increase of nearly 35 percent has more than kept pace with overall population increases of about 10 percent.

▸ Changes in the number of psychiatrists and psychologists relative to the Colorado population have been modest, however, even slightly decreasing for psychiatrists per capita by 4 percent.

▸ There has been dramatic increase in the number of licensed masters-level practitioners and licensed/certified addictions counselors of 29 percent to 32 percent by category.

▸ The role of certified peer support specialists and family advocates was emphasized by multiple stakeholders, and there was general consensus that current needs outstrip the available supply.

▸ For SUD prevention providers, there is a movement in Colorado to develop a certification process for SUD prevention professionals. In addition, DBH in the Spring of 2011 established International Certification and Reciprocity Consortium (ICRC) certification for prevention specialists.

▸ While there is geographical disparity across nearly all behavioral health practitioner groups, the disparity is most pronounced for the professions that require the most training. As level of training increases (number of years of graduate-level training), behavioral health providers are found disproportionately in the Denver and Colorado Springs areas.

▸ Psychiatrists across all sub-specialties are predominantly located in the Denver metro area and El Paso County. Six hundred nineteen of the 753 practicing psychiatrists (82 percent) were located in Denver and El Paso Counties alone. An even higher percentage of child psychiatrists (86 percent) were located in those two urban counties, and essentially all psychiatrists specializing in SUD treatment (95 percent) and in geriatrics (100 percent) were in the Denver and Colorado Springs areas.

## Recommendations for the Behavioral Health Workforce

1. Focus workforce development on mental health/SUD and primary care integration skill development and care delivery models, to leverage resources optimally to address provider shortages that cannot be resolved in the short to medium term (and may likely never be resolved).

2. Target workforce expansion efforts in two areas:

   ▾ Access in communities beyond the Denver metro and Colorado Springs areas, and

   ▾ Access in specialized areas of need: trained prescribers (particularly for SUD and child populations), geriatric and child specialists, and culturally and linguistically competent specialists.

THERE IS ALSO A NEED FOR SYSTEM-LEVEL PLANNING IN COLORADO FOR THE RANGE OF SUBGROUPS IN NEED. ONE EXAMPLE HIGHLIGHTED BY KEY INFORMANTS WAS PLANNING FOR OLDER ADULTS.

## OVERVIEW

**The 2003 *Status Report* found that Colorado enjoyed a relatively good supply of mental health practitioners and certified addictions counselors overall, but had critical shortages of particular subgroups of providers: psychiatrist and other prescribers, any providers trained in empirically based approaches, and those specializing in the care of children, older adults, people living in rural areas, minority cultures, and people who speak languages other than English.**

While the numbers have changed and even improved somewhat overall, these critical gaps still remain – and are all the more concerning given the expected increases in access to care and needed providers with health care reform. Stakeholders we spoke with emphasized continued lack of specialists for young children (under age 5), children overall, adolescents, youth in transition from adolescence to adulthood, older adults, people living in Colorado anywhere other than the highly populated Front Range communities surrounding Denver and Colorado Springs, and specialists for all ethnic, racial, linguistic and cultural minorities. These are ongoing needs and require a long-term commitment to improving access and addressing disparities, as discussed in the previous section.

One point is particularly clear across all of the findings of this section: there are too few mental health and SUD providers of the types needed and willing to serve priority populations, given current reimbursement levels and the distribution of providers across the state. Furthermore, the gaps are so severe that they cannot hope to be fully addressed in the near or even medium term. As a result, the types of systematic approaches to integrating mental health and SUD treatment with primary care resources discussed under the previous section (Observation #5) are essential to meeting the demand. Numerous stakeholders we interviewed emphasized that these integration strategies were the only hope of meeting the needs before us – both current needs and those anticipated under health care reform.

There is also a need for system-level planning in Colorado for the range of subgroups in need. One example highlighted by key informants was planning for older adults. Medicare funding limitations discussed under Observation #3, and the lack of specialists noted above and further detailed later in this section, create major systemic barriers to care. Furthermore, organizational expertise varies considerably across community providers. While there are some nationally recognized models (for example, Jefferson County's Senior Reach program), capacity and quality varies widely in the view of Colorado experts. Diagnosis and treatment of mental health and SUD conditions is more complex among older adults, with a greater need to factor in cognitive impairments and the effects of comorbid medical needs (for example, psychotic symptoms induced by a urinary tract infection). There is also a need to coordinate supports across multiple human services agencies, given needs related to housing, transportation, social support, basic living, and other needs that can emerge as people age.

Yet, while the challenges are great, there are also the promising practices around medical homes and accountable care within the Medicare system that offer paths to improve practice. Furthermore, integrated care models such as IMPACT and DIAMOND, as well as improvements in screening and identification of geriatric behavioral and cognitive impairments,[310] offer approaches to leverage limited geriatric behavioral health resources within primary care settings. Linkages among electronic health records can support enhanced coordination across care settings. Various groups in Colorado are working to support planning for coordinated development of integrated systems incorporating these approaches, including Silverprint Colorado, the Adult and Older Adult Subcommittee of the state's Mental Health Planning and Advisory Council, local area offices, and the Colorado Behavioral Healthcare Council. Key informants, however, noted a need for these various efforts to be coordinated and integrated with broader health care reform planning, to ensure that the behavioral health needs of older adults are incorporated.

The complexities are clear and efforts to address them are underway, but stakeholders have reported a need to raise planning efforts to a higher level. This same observation could be made across all of the multiple areas of specialized need noted above, including young children, children overall, adolescents, youth in transition, people living in rural/frontier areas, and multiple ethnic, racial, linguistic and cultural minority groups. The analysis of mental health and SUD specialist provider availability described in the following section is only a part of this overall planning need, but it shows how these critical resources are currently distributed across Colorado.

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310 Sara Qualls, Ph.D., Director of the Gerontology Center in the Department of Psychology at the University of Colorado at Colorado Springs, is working with others to develop the Cognitive and Psychological Screen (CaPS), which "is a self-administered computerized screening tool that captures both the most common cognitive problems of later adulthood and frequent co-occurring conditions, in a time and cost efficient way that is practical in primary care and other non-medical professional settings." Tools such as this will be an important resource to integrated practices as they develop.

**CHANGES IN THE NUMBER OF PSYCHIATRISTS AND PSYCHOLOGISTS RELATIVE TO THE COLORADO POPULATION HAVE BEEN MODEST, EVEN SLIGHTLY DECREASING FOR PSYCHIATRISTS.**

# HOW PROVIDER AVAILABILITY AFFECTS PEOPLE

The findings in this observation document specific provider shortages and problematic deployment of available resources. The stories of Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally help illustrate these concerns.

## Adults in an urban setting

### Barbara & Steve

Barbara and Steve live in metro Denver, the area in the state with the highest number of behavioral health providers. The problem they encountered was that mental health providers were not readily accessible because of (1) a lack of integration with primary care, and (2) the network limitations of their insurer.

### Joan & Dave

Joan and Dave live in the same part of the state, but integration of SUD specialist resources helped ensure access. In addition, their insurance provider has a broader network and more flexible benefits, both of which tend to attract more providers.

## Adults with complex needs in an urban setting

### Bob

Bob lives in metro Denver and is also able to readily access providers when he qualifies for mental health and SUD benefits. The challenge to his care came from a lack of integration and coordination across providers.

### John

John also lives in metro Denver, but his providers are deployed in integrated settings, and are both more readily accessible and more efficiently coordinated.

ADVANCING COLORADO'S MENTAL HEALTH CARE

## Two youth and their families with cultural needs in an urban setting

### *Gabriela & Rosa*

Gabriela and her family also live in an urban area. The challenges in care that they faced were a lack of culturally and linguistically competent providers, as well as a lack of providers specializing in adolescent issues and disruptive behavior conditions, particularly for young women.

### *Assefa & Amira*

Assefa and his family also live in an urban area where there is a lack of culturally and linguistically competent providers. Access to a Wraparound Planning specialist and providers trained in that model, however, allowed Assefa and his family to identify and access local natural supports through their mosque and community.

## Older adults in a rural setting

### *Nadine*

Since there are very few geriatric behavioral health specialists in the state, and even fewer outside the Denver/Colorado Springs metro areas, it's not surprising that Nadine was misdiagnosed. Even so, she then received a great deal of care – just the wrong kind of care.

### *Sally*

Sally lives in an area with just as few geriatric specialists, but the combined work of staff from the senior center and an integrated primary care and behavioral health clinic led to the right diagnosis and treatment for her.

# PROVIDER AVAILABILITY AND DISTRIBUTION

For this report, we examined the following groups of providers, focusing on data from a December 2010 report by the WICHE Mental Health Program, supplemented by additional analyses prepared by the Colorado Health Institute: psychiatrists, licensed psychologists (doctoral level), licensed clinical social workers (LCSW), licensed marriage and family therapists (LMFT), licensed professional counselors (LPC), licensed/certified addictions counselors (LAC/CAC), and unlicensed therapists (a group Colorado tracks, but which has essentially neither governing standards nor minimum credential qualifications). We do not include unlicensed therapists in our analyses in this section.

The data this time also focus on provider distribution. We did not conduct a provider survey to uncover dynamics related to specialization in treatment of different racial, ethnic, or cultural groups, or specialization with regard to language. Our interviews with key informants, however, confirmed that such provider specialties continue to be sorely lacking.

As noted above, the number of Colorado's mental health and SUD practitioners has increased since 2003 from 10,564 to 14,217. This impressive increase of nearly 35 percent has more than kept pace with the increase of approximately 10 percent in the Colorado population during that time. If we look more closely at the data, however, the picture is not quite as encouraging as it first seems. As the chart below reveals, changes in the number of psychiatrists and psychologists relative to the Colorado population have been modest, even slightly decreasing for psychiatrists. But on the positive side, there has been a dramatic increase in the number of licensed masters-level practitioners and LAC/CACs.
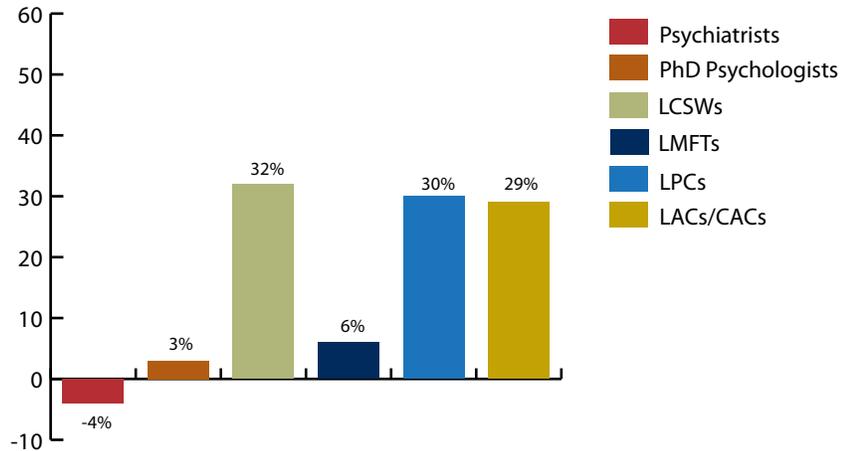
Also of concern, as the chart that follows shows, is the fact that growth in the overall
number of available providers from 2003 to 2010 has been outpaced by the growth in
Medicaid enrollees, such that there are fewer providers available, per Medicaid BHO
enrollee, in 2010 than there were in 2003. This is an important fact to keep in mind,
given the planned increased in Medicaid enrollees envisioned under health care reform (as
described under Observation #4). It is also concerning given this stakeholder input during
the 2009 process that developed the BHTC, and repeated by those we interviewed for
this update: many providers, particularly in rural areas, will not treat Medicaid enrollees
because of concerns about low reimbursement.

**CHANGES IN THE NUMBER OF COLORADO BEHAVIORAL HEALTH PROVIDERS, 2003 TO 2010[312]**



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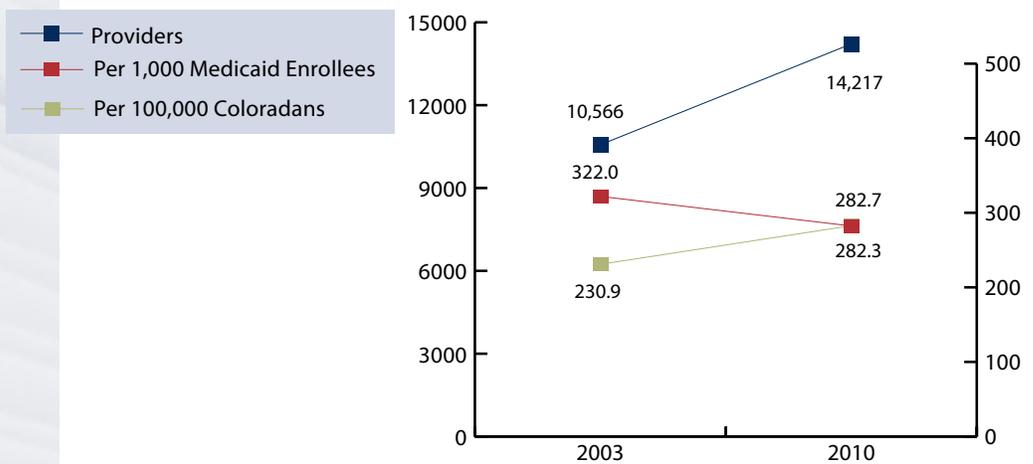
311  2003 data is from TriWest Group (2003), p. 41. 2010 data is from Western Interstate Commission for
    Higher Education (WICHE) Mental Health Program. (December, 2010). The Behavioral Healthcare Workforce
    In Colorado: A Status Report. WICHE: Boulder, Colo., p. 17. Retrieved from: http://www.wiche.edu/info/
    publications/bhWorkforceColorado2010.pdf. WICHE's report was funded by The Colorado Health Foundation.
    2010 Colorado population figures are based on U.S. Census Bureau – figure is based on actual 2010 Census.

312  TriWest Group (2003), p. 41; 2010 data is from WICHE (2010), p. 17. 2010 Colorado population figures
    are based on U.S. Census Bureau – figure is based on actual 2010 Census. County data were not yet
    available at the time of our analysis.

Another question of concern is whether providers are well prepared to serve persons with severe needs. Our stakeholder interviews indicated that there is great concern about the extent to which practitioners coming out of graduate programs understand the needs of people typically served in publicly funded programs, and have the tools and the expertise to meet their needs. Nationally and in Colorado, most programs still do not train practitioners with the most severe behavioral health needs in mind. There were examples of some changes in that situation, such as training tracks through Swedish Hospital in Denver and St. Mary's Family Medicine in Grand Junction, to train psychologists and primary care providers to provide collaborative care in integrated behavioral health/primary care settings. In addition, nearly all of the stakeholders we spoke with who were knowledgeable about SUD practitioners voiced concerns about the lack of quality and training in the CAC curriculum, particularly for lower level CACs (levels 1 and 2). The table below gives a breakdown of the specific dynamics discussed above, by provider type.

| LICENSED COLORADO BEHAVIORAL HEALTH PROVIDERS, 2003 AND 2010[313] | | | | | |
|---|---|---|---|---|---|
| TYPES OF PROVIDERS | 2003 | 2010 | PERCENT CHANGE: PROVIDERS | PERCENT CHANGE: CO POPULATION | PERCENT CHANGE: MEDICAID |
| CO Statewide Population | 4,575,944 | 5,029,196 | | +10.9% | |
| Medicaid FTE Members | 328,157 | 503,684 | | | +53.5% |
| Psychiatrists[314] | 713 | 753 | +5.6% | | -31.2% |
| Per 100,000 Population | 15.6 | 15.0 | | -4.0% | |
| Licensed Psychologists | 1,812 | 2,056 | +13.5% | | -26.1% |
| Per 100,000 Population | 39.6 | 40.9 | | +3.2% | |
| Licensed Clinical Social Workers | 2,656 | 3,849 | +44.9% | | -5.6% |
| Per 100,000 Population | 58.0 | 76.5 | | +32.0% | |
| LMFTs | 476 | 554 | +16.4% | | -24.2% |
| Per 100,000 Population | 10.4 | 11.0 | | +5.90% | |
| LPCs | 2,704 | 3,868 | +43.0% | | -6.8% |
| Per 100,000 Population | 59.1 | 76.9 | | +30.1% | |
| LACs / CACs | 2,205 | 3,137 | +42.3% | | -7.3% |
| Per 100,000 Population | 48.2 | 62.4 | | +29.4% | |
| Total | 10,566 | 14,217 | +34.6% | | |
| Per 100,000 Population | 230.9 | 282.7 | | +22.4% | |
| Per 10,000 Medicaid Enrollees | 32.2 | 28.2 | | | -12.4% |

313  TriWest Group (2003), p. 41; **2010 data is from WICHE (2010), p. 15. Note that some of the statewide totals in the calculations on p. 15 of the WICHE report are not accurate. Statewide totals reported here are based on calculations we conducted on the county-level data, and that were confirmed by CHI in separate calculations. 2010 Colorado population figures are based on U.S. Census Bureau – figure is based on actual 2010 Census.

314  2003 Psychiatrist data are from the American Medical Association, and 2010 data are from Medical Quest.

Key informants also offered the following observations about the broader mental health/SUD workforce:

• **Peer support specialists and family advocates.** The role of certified peer support specialists and family advocates (particularly for parents and caregivers of children with SUD) was emphasized by multiple stakeholders. The compelling evidence base supporting use and expansion of both of these sets of providers is explored further under Observation #7, but multiple Colorado key informants that addressed this issue pointed out that there has not been enough attention to the level of need for these supports or the number of peer support specialists available to meet the need. There was general consensus that current needs outstrip the available supply. A 2009 review by WE CAN! identified five full-time and 35 part-time peer specialists in the mental health system of the six metropolitan Denver area counties. The VA system also provided a substantial amount of peer support in the Denver area in 2009 through three additional full-time employees, one part-time employee, and six volunteers. There is great opportunity to expand these resources. Through the ACMHC project, Colorado Springs's Mental Health America chapter developed a peer navigator program using the nationally recognized Georgia Peer Support model that employs more than 30 part-time peer specialists. Also, while a certification process for mental health peer support that allows for Medicaid reimbursement is currently in place, WE CAN! is working with HCPF to standardize it and a comparable process (and funding stream) is entirely lacking (within Medicaid) for SUD peer support. Also, there is no formal certification process for family advocates, nor is there a clear Medicaid funding stream. This is an issue nationally, as Medicaid has focused on peer-to-peer support among people receiving care, but not on their caregivers.[315]

• **Prevention workforce.** For SUD prevention providers, there is a movement in Colorado to develop a certification process for SUD prevention professionals. In addition, DBH in the Spring of 2011 established International Certification and Reciprocity Consortium (ICRC) certification for prevention specialists. There is less attention currently on the mental health prevention workforce, most likely because there is not a dedicated funding stream for mental health prevention (as there is for SUD prevention through DBH).

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315 TriWest Group and the SHB2654 Work Group. (2008). Report to the legislature on Substitute House Bill (SHB) 2654: Strategies for developing consumer and family run services. The State of Washington, Department of Social and Human Services, Health and Recovery Services Administration, Mental Health Division. Retrieved online September 23, 2010 at: http://www.dshs.wa.gov/pdf/hrsa/mh/consumerdirectedmentalhealthcare.pdf.

ADVANCING COLORADO'S MENTAL HEALTH CARE

- **Workforce development.** While there are numerous efforts to build the broader health care workforce, there was concern among some that there are not similar programs through the federal government or other sources to build needed capacity for the mental health/SUD provider workforce. This is particularly critical, as will be seen below, outside of the Front Range. Stakeholders estimated that the mental health/SUD workforce is less than half of what is needed to respond to the demands of health care reform.

- **Other prescribers.** While solid data are available on psychiatrists, data on other prescribers, particularly advance practice registered nurses (APRNs), are lacking, as are data on nursing resources for psychiatry. Nurses play a critical role in community mental health treatment, and APRNs are an important resource to extend prescriber availability in urban as well as rural areas. More data on nursing resources would be useful to planners.

Another concern raised in the 2003 *Status Report* was the extent to which providers are adequately distributed geographically. The chart to the right shows that the metro Denver and Southeast regions, which include the Denver and Colorado Springs urban centers, have higher concentrations of providers. If we look specifically, however, at the provider group that is often the most difficult to obtain access to – psychiatrists – we see that the disparity between regions is most pronounced.

**NUMBER OF TOTAL PRACTICING PROVIDERS AND PSYCHIATRISTS AVAILABLE IN 2010 PER 100,000 POPULATION, WITHIN FOUR COLORADO REGIONS**[316]
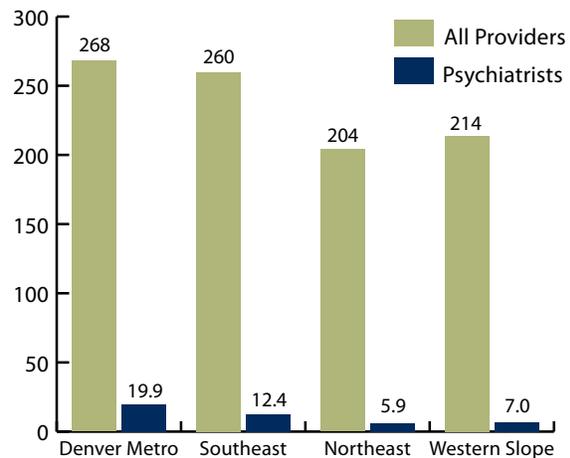


In general, the more training required for a particular group of behavioral health practitioners, the more disparity in availability there is between the urban and rural areas of Colorado. The table below of practicing behavioral health providers in Colorado shows that, while there is geographical disparity across nearly all behavioral health practitioner groups, the disparity is most pronounced for the professions that require the most training. As level of training increases (number of years of graduate-level training), behavioral health providers are found disproportionately in the Denver and Colorado Springs areas.

316  From WICHE (2010), Appendix A, pp. 47-48; psychiatrists data modified based on Colorado Health Institute analysis of Medical Quest master data set, January 2011. Please see Appendix Four for a listing of the Colorado counties included in each of the four regions.

| PRACTICING BEHAVIORAL HEALTH PROVIDERS IN COLORADO – 2010[317] | | | | | |
|---|---|---|---|---|---|
| TYPES OF PROVIDERS | DENVER METRO | SOUTHEAST | NORTHEAST | WESTERN SLOPE | TOTAL |
| WICHE 2009 Population Estimate[318] | 2,813,748 | 865,122 | 631,117 | 714,761 | 5,024,748 |
| Psychiatrists | 559 | 107 | 37 | 50 | 753 |
| Per 100,000 Population | 19.9 | 12.4 | 5.9 | 7.0 | 15.0 |
| Licensed Psychologists | 1,088 | 243 | 165 | 123 | 1,619 |
| Per 100,000 Population | 38.7 | 28.1 | 26.1 | 17.2 | 32.2 |
| Licensed Clinical Social Workers | 1,152 | 333 | 143 | 197 | 1,825 |
| Per 100,000 Population | 40.9 | 38.5 | 22.7 | 27.6 | 36.3 |
| Mental Health Counselors | 2,857 | 1,043 | 530 | 710 | 5,140 |
| Per 100,000 Population | 101.5 | 120.6 | 84.0 | 99.3 | 102.3 |
| Certified and Licensed Addictions Counselors | 1,889 | 525 | 415 | 446 | 3,275 |
| Per 100,000 Population | 67.1 | 60.7 | 65.8 | 62.4 | 65.2 |
| Total - Providers | 7,545 | 2,251 | 1,290 | 1,526 | 12,612 |
| Total - Per 100,000 Population | 268.1 | 260.2 | 204.4 | 213.5 | 251.0 |

The table to the right underscores the general findings above by more closely examining the data on the geographical distribution of practicing psychiatrists. Psychiatrists across all sub-specialties are predominantly located in the Denver metro and Southeast areas (which includes El Paso County). In fact, 619 of the 753 practicing psychiatrists (82 percent) were located in Denver and El Paso Counties alone. An even higher percentage of child psychiatrists (86 percent) was located in those two urban counties, and essentially all psychiatrists specializing in SUD treatment (95 percent) and in geriatrics (100 percent)

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317  From WICHE (2010), Appendix A, pp. 47-48; psychiatrists data based on Colorado Health Institute analysis of Medical Quest master data set, January 2011. Please note that the "Totals" for each provider type and for all providers do not match the totals used for 2010 above, in the 2003 versus 2010 comparisons. There are two reasons for this. First, the data used in the 2003 versus 2010 comparison was from the state's database on licensed providers (the same database that was used in the 2003 report). An exception is with the Psychiatrists category, for which we used one data source for 2010 - the number of practicing psychiatrists reported by Medical Quest. In the four-region analysis presented in this table, except in the case of Certified and Licensed Addictions Counselors, the data were drawn from Medical Quest, which only includes practicing providers, and which undercounts the number of Social Workers working in behavioral health (John Pike of Medical Quest, personal communication, August 16, 2011). (The data for CACs and LACs were drawn from DORA.) Second, while the DORA data report is based on licensure status, the Medical Quest data allow providers to define their own category. For example, a Licensed Clinical Social Worker might identify as a "Mental Health Counselor" in response to the Medical Quest survey and would be categorized as such by Medical Quest, whereas, in DORA, the person would be categorized as an LCSW.

318  From WICHE (2010).

were in the Denver and Colorado Springs areas.[319] Given the complexity of medical and prescribing challenges for people with SUD (stakeholders noted under Observation #1 the reluctances even of many psychiatrists to prescribe addiction medications) and older adults (their more frequent medical comorbidities complicate prescription efficacy and safety for many non-specialists), the ability of non-specialist psychiatrists and the broader range of primary care prescribers to take up the slack is limited.

| PRACTICING PSYCHIATRISTS AND SELECTED PSYCHIATRY SPECIALTIES ACROSS FOUR COLORADO REGIONS[320] | | | | | |
|---|---|---|---|---|---|
| SUB-SPECIALTIES | DENVER METRO | SOUTHEAST | NORTHEAST | WESTERN SLOPE | TOTAL |
| 2009 Population | 2,813,748 | 865,122 | 631,117 | 714,761 | 5,024,748 |
| All Psychiatrists | 559 | 107 | 37 | 50 | 753 |
| Per 100,000 Population | 19.7 | 12.0 | 5.9 | 6.9 | 14.8 |
| Child and Adolescent | 91 | 14 | 5 | 7 | 117 |
| Per 100,000 Population | 3.2 | 1.6 | 0.8 | 1.0 | 2.3 |
| Addiction Medicine | 19 | 2 | 0 | 1 | 22 |
| Per 100,000 Population | 0.7 | 0.2 | 0.0 | 0.1 | 0.4 |
| Geriatric Psychiatry | 9 | 3 | 0 | 0 | 12 |
| Per 100,000 Population | 0.3 | 0.3 | 0.0 | 0.0 | 0.2 |

Several geomaps showing the distribution of providers across Colorado were produced in late 2010 by the Colorado Health Institute and the WICHE Mental Health Program.[321] These maps provide compelling pictorial representations of the geographical distributions of behavioral health providers in Colorado. The geomap for psychiatrists is presented on the next page, and additional maps for the other major provider groupings can be found in Appendix Five of this report.

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319  General Note on WICHE methodology: Data on mental health providers in the geomaps and tables below were obtained from the Medical Quest master data set, which sometimes, but not always, uses the data from DORA. (Addictions Counselors data were drawn directly from DORA.) WICHE (2010) Data on psychiatrists used in the geomap below were provided to WICHE on 10/19/2010 by Medical Quest. Addresses were geocoded using the Centrus system, "which may result in slightly different counts than the method DORA uses to classify addresses…" (p. 48).

320  From WICHE (2010), Appendix A, and personal communication with Colorado Health Institute, January 6, 2011.

321  WICHE Mental Health Program. (December, 2010). The Behavioral Healthcare Workforce In Colorado: A Status Report. WICHE: Boulder, CO. Retrieved from http://www.wiche.edu/info/publications/bhWorkforceColorado2010.pdf.

Practicing psychiatrists (2010) and population per square mile (2009), Colorado

**Providers**
- ○ Practicing psychiatrist

**Population per square mile**
- <= 3.0
- 3.1 - 6
- 6.1 - 25
- 25.1 - 250
- 250.1 - 2,500
- >= 2,501

**Data source information**

Data on practicing psychiatrists provided on 10/19/2010 by Peregrine Management Corporation.

http://www.peregrine.us

Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.

Metro Denver
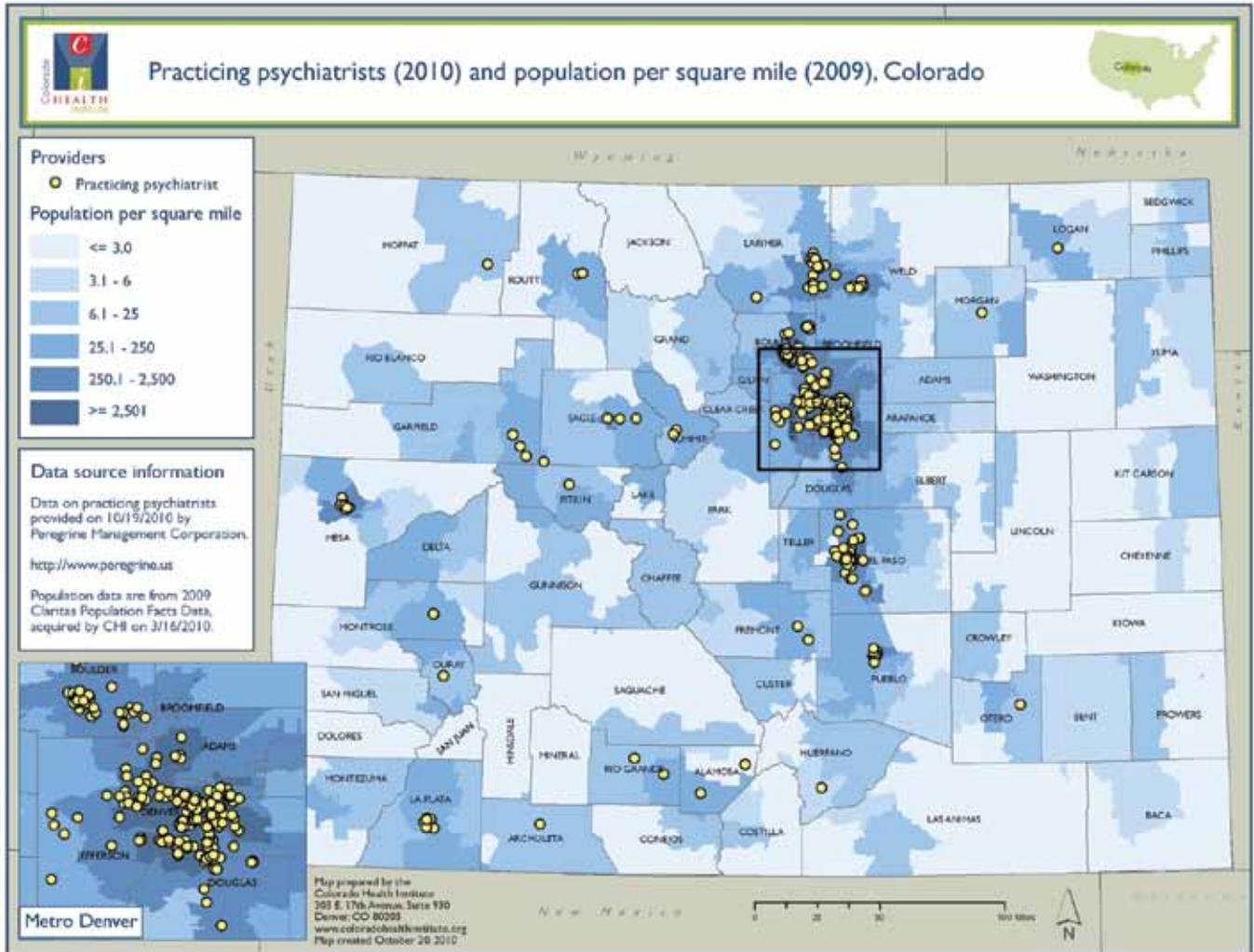
# RECOMMENDATIONS FOR THE BEHAVIORAL HEALTH WORKFORCE

While Colorado's mental health and SUD workforce continues to develop, and additional progress in targeted areas is needed (specifically, trained prescribers, geriatric and child specialists, providers outside the metro Denver and metro Colorado Springs areas), this report does not simply endorse efforts to expand the mental health and SUD service delivery workforce, because it may not be feasible (or even desirable) for the workforce to expand indefinitely. Instead, two priority recommendations are offered to address very real provider shortages in the face of growing needs:

1. Focus workforce development on mental health/SUD and primary care integration skill development and care delivery models to leverage resources optimally to address provider shortages that cannot be resolved in the short to medium term (and may not be resolved even in the longer term).

2. Target workforce expansion efforts in two areas:

   • Access in communities beyond the metro Denver and Colorado Springs areas, and

   • Access in specialized areas of need: trained prescribers (particularly for SUD and child populations), geriatric and child specialists, and culturally and linguistically competent specialists.

# Observation #7
## Prioritization of Resilience and Recovery is Still Needed

**Snapshot of Key Findings
Regarding the Need to Prioritize Resilience and Recovery**

### Recovery and Resilience

▸ Recovery is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

▸ Resilience refers to an individual's capacity for adapting to change and stressful events in healthy and flexible ways.

### The History of Peer Support Nationally and in Colorado

▸ The consumer and family advocacy movement dates back to at least 1845.

  ▾ The evidence base for peer support for both mental health and SUD needs is substantial and growing.

  ▾ Colorado has two leading organizations representing the voices of people with mental health needs: WE CAN! (which receives administrative support from the advocacy organization Mental Health America of Colorado) and the Colorado Cross-Disability Coalition (CCDC). Colorado also has a strong peer voice for people with SUD needs through Advocates for Recovery and Peer Assistance Services.

- The National Alliance on Mental Illness (NAMI) had its beginnings in the early 1970s. NAMI Colorado supports 16 affiliates across the state, and is the leading voice for family members of people with severe mental health needs. Founded in 1990, NAMI Colorado has more than 200,000 members.

- The development of family peer-to-peer support for parents and caregivers of children and youth with SED took a critical step in 1989 when the Federation of Families for Children's Mental Health (the Federation) was incorporated. The Federation's Colorado Chapter has taken a lead in advocacy for children with SED and their families.

- The development of youth involvement in mental health systems of care formally dates back to 2000. In Colorado, the Mental Health Planning and Advisory Committee's Youth and Young Adult Transitions Committee has taken a lead in advocacy for youth and young adults with mental health needs. CDPHE supports the Colorado Youth Development Team to promote positive youth supports across the state.

## Promotion of Peer Providers

- Peer-run organizations are entities that emphasize self-help as their operational approach and that are owned, administratively controlled, and operated by people who receive and/or need mental health or SUD treatment services, or their families.

- Expansion of peer-run organizations will require:

  - Dedication of specific resources to fund **technical assistance to develop peer-run organizations across the state** at multiple levels of development, including dedicated funding for start-up of new organizations and the enhancement of existing organizations to expand;

  - Development of **regulatory requirements to certify peer-run organizations** to allow those organizations ready to seek expanded state and Medicaid funding to do so; and

  - **Ongoing funding and evaluation** of peer-run supports to document their benefits, costs, and potential cost-savings to the broader system.

## Recommendations to Support Recovery and Resilience

1. **Increasing access to peer support**, employing skills of people with real life experience, and

2. **Expanding the role and development of peer-run organizations** to help individuals, groups and communities take more responsibility for solutions in their lives, modeling this on successful efforts, such as grass-roots support networks for returning veterans and their families, as well as the many programs across Colorado promoting peer-support in mental health and SUD systems through the Medicaid BHO program, CMHCs, and programs such as Access to Recovery.

## OVERVIEW

The 2003 *Status Report* emphasized the role of recovery for adults and resilience for children. The definitions offered in 2003 are just as relevant and meaningful in 2011:

"…a person … can recover even though the illness is not 'cured'…(Recovery) is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."[322] Resilience refers to an individual's capacity for adapting to change and stressful events in healthy and flexible ways.[323]

Resilience has been identified in research studies as a characteristic of youth who, when exposed to multiple risk factors, show successful responses to challenge and use this learning to achieve successful outcomes.[324]

322  Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychological Rehabilitation Journal, 16, 11-24.

323  Catalano, R., Berglund, R.L., Ryan, J., Lonczak, H., & Hawkins, J.D. (1998). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. Seattle, WA: Social Development Research Group, University of Washington School of Social Work.

324  Hawkins, J.D., Catalano, R.F. & Associates. (1992). Communities That Care: Action for drug abuse prevention. San Francisco: Jossey-Bass.

Masten, A.S., Best, K. M. & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. Development and Psychopathology, 2, 425-444.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. British Journal of Psychiatry, 147, 598-611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. American Journal of Orthopsychiatry, 57(3), 316-331,

Werner, E. E. (1995). Resilience in development. Current Directions in Psychological Science, 4(3), 81-85.

For 2011, we focus on the challenges and opportunities encountered, as a movement that originally started out as advocacy has grown to become one of the most important sources of support in today's systems of care for people with mental health and SUDs.

# THE RECOVERY AND RESILIENCE OF COLORADO PEOPLE

There are a myriad of ways in which people pursue recovery and increase resilience in response to mental health and substance use disorders. The stories of Barbara & Steve, Joan & Dave, Bob, John, Gabriela & Rosa, Assefa & Amira, Nadine, and Sally illustrate several.

## Adults with mild to moderate needs

### Barbara & Steve

As a mother of young children, Barbara's resilience in the face of her bipolar disorder symptoms could be increased through social support. Steve has clearly been a support to her, and there may be more that he could do, including learning more about bipolar disorder and its effects on families, and pursuing lifestyle changes as a family that would promote Barbara's recovery, manage Steve's stress, and help maintain stability in the home. Other people in their lives may also be able to help with child care, even if just for a weekend respite, for the two of them to get away.

### Joan & Dave

By involving Joan in Dave's treatment to focus on changes at home, the behaviorist at the primary care clinic is directly involving Dave's primary source of social support: his spouse. Tapping into the resilience of families – and treating family members as sources of support rather than stress – is still an underused option in treatment. For ongoing support with his alcoholism, Dave may very well benefit from a self-help group. Self-help groups are also available for the family members of people with substance use or mental health needs.

## Adults with complex needs

### Bob

There are an array of peer and self-help supports that Bob could benefit from, especially in the Denver metro area. There are multiple self-help groups, consumer and family-run organizations, and providers employing people recovering from serious mental illness, to provide peer support. Given Bob's SUD needs, he could potentially access supports under Colorado's Access to Recovery (ATR) program, a five-year, $13 million federal grant to provide recovery-focused supports for people without insurance. In addition to treatment, ATR offers peer and wellness supports. Another important resource available to Bob would be WE CAN!, the consumer-run support arm of Mental Health America of Colorado. WE CAN! offers training in Wellness Recovery Action Planning, a proven approach to helping people with long-term mental health needs take charge of their own recovery. In addition, Bob might benefit from a dual diagnosis (mental health/SUD) support group like Double Trouble.

## John

John could access the same array of recovery supports as Bob, though since he has Medicaid, he would not be eligible for ATR supports. However, Medicaid would pay for peer support from a certified peer specialist within John's Medicaid BHO network, offering John support and coaching from someone who has moved forward in his own recovery. In addition, John's IDDT team puts an explicit emphasis on linking people they serve with self-help groups for mental health and SUD needs. Recently, the team also helped John reconnect with one of his two adult children, from whom he has been estranged since they were children. Initially, neither child wanted to see John, but he began to send them each a small check each month with a note explaining that he wanted to start paying them back for the child support he failed to provide after he and their mother divorced. Six months later, he had lunch with one and they now talk on the phone every week. The other child has not made contact, but has begun to attend a local chapter of the National Alliance on Mental Illness (NAMI), to learn more about the effects of mental illness.

## Two youth and their families with severe needs

## Gabriela & Rosa

Unfortunately, while Gabriela and her family were primarily offered formal services, no effort was made to tap into their natural supports. By taking Gabriela out of her home for so long, her ties to family, school and friends were actually weakened rather than strengthened; returning home will be more difficult for her as a result. In fact, the breakdown in her social ties directly contributed to her plan to drop out of school. Also, an exploration of faith-based and cultural practices important to Gabriela and her family did not occur. Specifically, addressing differences in acculturation processes for Gabriela – who is distancing herself from her background – and her mother would have helped identify ways to increase support within the family, and perhaps more broadly among their support system.

## Assefa & Amira

The Wraparound team that came together to support Assefa and his family changed the trajectory of their functioning primarily by identifying and accessing local natural supports through their mosque and community. Respite has played a critical role in releasing stress and allowing family members to settle charged feelings, and then reconnect. Members of their faith community have provided direct support, and Assefa's martial arts class has provided an activity that builds skills and positive developmental supports. The team also linked them with interpreter supports and additional school-based health care resources to help them better use their health services. Through this process, Amira has become more aware of the mental health needs of immigrant families, and the need for communities to provide better supports. Recently, she contacted her local chapter of the Federation of Families for Children's Mental Health to find out about volunteer opportunities.

## Older adults with mild to moderate needs

## Nadine

Unfortunately, the process of care has systematically dismantled Nadine's resilience and supports, as she has lost her home, spent all of her remaining financial resources, left her community, and now rarely sees family. These losses have accelerated her cognitive declines, and the recent move from the assisted-living facility to the hospital and then to the nursing home has led to an even higher level of confusion and disorientation. Now Nadine is experiencing hallucinations and delusional behavior, where she reports that she is trapped underground and being chased by rats. While Nadine has made a few new connections with some kind and caring staff at the nursing home, she is less close with staff on other shifts, and her delusional behavior makes some staff uncomfortable and more hesitant to engage her.

## Sally

Sally's social supports were assembled in response to her depression, with a very different set of outcomes than Nadine. Sally's supports at the senior center helped identify her depression, and encourage her to seek care. In addition to her medical treatment, the primary factor in her recovery from depression was her weekly depression support group. These additional supports helped reverse her depression and improve her cognitive functioning, allowing her to remain at home, pay for her own living costs, and stay connected with the friends and family she has always known.

# PEER SUPPORT AND CONSUMER/ FAMILY-OPERATED SERVICES

## A Brief History of the Peer Support Movement[325]

According to a definitive history of the movement, "the mental health consumer movement began when people who had been psychiatrically hospitalized and/or their families protested against the inhuman treatment received."[326] The report cites examples of some of the earliest efforts of the mental health consumer movement, including The Alleged Lunatic's Friend Society, established in England in 1845; the Anti-Insane Asylum Society, founded by Elizabeth Packard in the U.S. shortly after the Civil War; Elizabeth Stone's work around the same time in Massachusetts; and Clifford Beers' writings and involvement in founding the National Committee for Mental Hygiene in the early 1900s. Around this same time, the roots of the peer movement for SUD began with the early work of the Oxford Group, out of which grew the formation of Alcoholics Anonymous by Bill W. in the early 1930s.[327] In the late 1940s, a self-help group, called We Are Not Alone (WANA), was formed by patients in Rockland State Hospital, New York. After discharge from the hospital, this group continued to meet, attracted volunteers

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325 Much of the content for this section was adapted from a previous TriWest publication for the State of Washington on consumer and family-run services. See TriWest Group and the SHB2654 Work Group. (2008). Report to the legislature on substitute house bill (SHB) 2654: Strategies for developing consumer and family run services. The State of Washington, Department of Social and Human Services, Health and Recovery Services Administration, Mental Health Division. Retrieved online September 23, 2010 at: http://www.dshs.wa.gov/pdf/hrsa/mh/consumerdirectedmentalhealthcare.pdf. TriWest is particularly thankful to Laura Van Tosh and Tamara Johnson for their respective authorship of the consumer and youth peer support histories.

326 Van Tosh, L., Ralph, R. and Campbell, J. (1999). The rise of consumerism. A Contribution to the Surgeon General's Report on Mental Health.

327 For additional information, see: http://www.aa.org/aatimeline/.

and eventually evolved into Fountain House, the founder of the clubhouse movement. The mental health consumer movement began its modern form in the early 1970s, as described by Van Tosh, Ralph and Campbell quoting earlier work by Frese and Davis:

> "… individuals in different parts of the country who had been hospitalized for mental illness began to realize that former patients, like members of other marginalized groups, had been legally denied basic rights. They saw that they, too, were regularly described by insulting and devaluating language, and that society discriminated against people who were stigmatized as the mentally ill. Sensing the possibility for change, former mental patients began to gather periodically, to plan strategies to regain their rights and renounce the imposed role of powerless victims (pp. 243-244)" (Pages 1-2).

Building on this civil rights focus, many early groups, such as the Alliance for the Liberation of Mental Patients, The Insane Liberation Front, and Project Release, took an antagonistic stance against psychiatry and the established mental health system, which involuntarily committed individuals to psychiatric hospitalization. This tension between collaborating with professionals and forming separate alternatives has been the legacy of peer support and "remains a creative tension."[328] The evidence base for peer support for both mental health and SUD needs is substantial and growing.[329]

Colorado has two leading organizations representing the voices of people with mental health needs: WE CAN! (which receives administrative support from the advocacy organization Mental Health America of Colorado),[330] and the Colorado Cross-Disability Coalition (CCDC).[331] Both organizations play important roles in advocating for the rights and needs of people with behavioral health needs. Representatives of both organizations serve on multiple committees across state government, and have also added more direct service delivery to their roles in recent years. WE CAN! is now a chapter of the National Association of Peer Specialists and is in the process of becoming an independent 501 (c)(3) organization. WE CAN! is also working with state agencies to support the development of more standardized training and certification processes for peer specialists providing publicly funded peer support. CCDC has focused its efforts of late on enhancing access to new benefits available under Colorado-specific health care reforms using the SOAR model,[332] including benefit expansion and reforms such as Money Follows the Person. Both organizations are also emphasizing training in advocacy for peers to serve on state-level boards and committees. Colorado also has a strong peer voice for people with SUD needs through Advocates for Recovery[333] and Peer Assistance Services.[334] Both organizations serve on multiple state agency committees, representing the interests of people with SUD needs, and also promote direct delivery of peer support.

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328  Center for Mental Health Services (November 2007). Consumer Operated Services (COSP) Evidence-Based Practices KIT – Field Review Draft: The Evidence. Unpublished manuscript. Rockville, Md.: Substance Abuse and Mental Health Services Administration.

329  See the following studies: Lucksted, A., McNulty, K., Brayboy, L., and Forbes, C. (2009). Initial evaluation of the Peer-to-Peer program. Psychiatric Services, 60:2, 251-254. Campbell, J. (2009). Federal multi-site study finds consumer-operated service programs are evidence-based practices. St. Louis, Mo.: Missouri Institute of Mental Health. Chinman, M., Hamilton, A., Butler, B., Knight, E., Murray, S., and Young, A. (2008). Mental health consumer providers: A guide for clinical staff. Rand Corporation. Retrieved at: http://www.rand.org/pubs/technical_reports/2008/RAND_TR584.pdf. Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B., Horvath, A.T., Kaskutas, L.A., Kirk, T., Kivlahan, D., Laudet, A., McCrady, B.S., McLellan, A.T., Morgenstern, J., Townsend, M., and Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. Journal of Substance Abuse Treatment, 26, 151-158. Retrieved at: http://www.chce.research.va.gov/docs/pdfs/pi_publications/humphreys/2004_humphreys_etl_self_help_organizations.pdf.

330  For additional information, see: http://www.mhacolorado.org/page/wecan/.

331  For additional information, see: http://www.ccdconline.org/.

332  SSI/SSDI Outreach, Access and Recovery. For additional information, see: http://www.prainc.com/soar/.

333  For additional information, see: http://www.advocatesforrecovery.org/.

334  For additional information, see: http://www.peerassistanceservices.org/index.php.

The National Alliance on Mental Illness (NAMI) had its beginnings in the early 1970s, as concerned family members around the country, responding to increased family burden and fragmented or unavailable professional support (and influenced by the self-help movement), began reaching out to each other. A group from San Diego, California calling themselves Parents of Adult Schizophrenics began meeting around their kitchen tables to offer each other support during this era when "parents were thought to be the cause of their children's mental illness."[335] In 1974, a group of concerned parents of adult children with mental illness founded the support group Oasis Fellowship in Lansing, Michigan, with additional independent family support groups forming over the next few years throughout that state.[336] In September 1979, approximately 250 family members from seven states – California, Florida, Maryland, Missouri, New York, Wisconsin and Washington – met in Madison, Wisconsin and founded the National Alliance for the Mentally Ill (now called the National Alliance on Mental Illness).[337] NAMI Colorado[338] supports 16 affiliates across the state and is the leading voice for family members of people with severe mental health needs. Founded in 1990, NAMI Colorado has more than 200,000 members, and provides both advocacy and a range of peer supports for families and individuals in need. NAMI Colorado represents families on multiple committees across state government.

The development of family peer-to-peer support for parents and caregivers of children and youth with SED is closely linked to both the broader family empowerment movement[339] and the growth of consumer provided services.[340] In 1989, the Federation of Families for Children's Mental Health (the Federation) was incorporated, opening a national office in 1992. Since then the Federation has served as an organizing voice for family empowerment, and has fostered the growth and acceptance of family peer-to-peer support through training and advocacy. The Federation's Colorado Chapter has taken a lead in advocacy for children with SED and their families, serving on multiple state agency committees.[341]

335  NAMI San Diego. (2007). NAMI San Diego's history. Retrieved October 3, 2008, from the NAMI San Diego website: http://www.namisandiego.org/history.php.

336  Huebel, H. (2006). An updated history of NAMI Michigan. Retrieved October 3, 2008 from the NAMI Michigan website: http://mi.nami.org/HISTORYHH2.htm.

337  E. Owen, personal communication, October 2008.

338  For additional information, see: http://www.namicolorado.org/.

339  Huff, B., (1998). Federation celebrates 10 year anniversary. Claiming Children, Spring 1998.

340  Solomon, P., & Draine, J. (2001). The state of knowledge of the effectiveness of consumer provided services. Psychiatric Rehabilitation Journal, 25(1), 20-27.

341  For additional information, see: http://www.coloradofederation.org/.

The development of youth involvement in mental health systems of care closely follows the growth and acceptance of family peer-to-peer support, and the broader family empowerment movement, as well as the growth of consumer provided services.[342] The youth movement is following a path similar to that of the family movement. Youth involvement in policymaking has steadily risen, helped by organizations such as the Federation of Families for Children's Mental Health, the Children's Defense Fund, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS).[343] There were two important milestones in the emergence of youth as full partners in mental health systems of care. The first was the Surgeon General's Conference on Child Mental Health in September 2000, the first such conference where young people were invited to "sit at the table" with families and professionals to discuss the Surgeon General's focus on children's mental health. While the intent of the meeting organizers and adult participants was to include youth, participating youth did not feel meaningfully included, and unanimously decided not to attend the conference on the second day, due to what they identified as a lack of respect. Instead the youth worked together to develop a "manifesto" to make adults aware of their needs, and to ask for respect and dignity in the way they were treated.[344] Among the requests were to:

• Not use acronyms without explanations that youth would understand,

• Not use acronyms, labels and diagnoses to describe youth in meetings (e.g., a "SED kid"),

• Fund and support youth organizations at the same level as family organizations, and

• Make room for youth to participate when they are asked to sit at policy tables.

The second milestone followed the next year at the System of Care Community Meeting in Puerto Rico. At this conference, youth were invited to facilitate a discussion on the needs of youth in mental health systems of care across the nation. Building on the manifesto developed the previous year, participating youth developed a list of recommendations for their communities and national policymakers. These two events and the recommendations developed through them marked a shift in the way youth were seen, and how they participated in policy-making and delivery of services within child and family mental health systems of care.

In Colorado, the Mental Health Planning and Advisory Committee's Youth and Young Adult Transitions Committee has taken a lead in advocacy for youth and young adults with mental health needs who are transitioning into adulthood. In addition, CDPHE supports the Colorado Youth Development Team in developing positive youth supports across the state.[345]

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342  Huff, B., (1998). Solomon, P., & Draine, J. (2001). Both previously cited.

343  Matarese, M., McGinnis, L., & Mora, M. (2005). Youth Involvement in Systems of Care: A Guide to Empowerment. Technical Assistance Partnership. TAPPublications@air.org.

344  Matarese, M., McGinnis, L., & Mora, M. (2005). Previously cited.

345  For additional information, see: http://www.cdphe.state.co.us/ps/adolschool/healthyyouthcolorado/Initiatives/coloradoyouthdevelopment.html.

## Peer Providers: Moving from Advocacy to Service Delivery

Given the roots of the self-help movement and the empowerment developed by speaking from the perspective of advocacy for oneself and one's peers, the transition to incorporate peers into the mental health and SUD treatment delivery systems has involved a tension between greater involvement and maintenance of an independent, advocacy-focused voice. Colorado key informants we spoke with emphasized both sides of this dichotomy, and pointed out a range of activities in which people receiving services and their families have joined alongside policy makers and the larger system, including:

- **Expansion of mental health and SUD peer-based supports across the state.** While no data were available to us on the availability and distribution of these provider resources, key informants agreed that resources are growing in number, but still are not nearly available enough.

- **Involvement in policy development.** Peer-run groups, including Advocates for Recovery, Colorado CURE, the Colorado Cross-Disability Coalition, the Federation of Families for Children's Mental Health, NAMI Colorado, WE CAN! Colorado, and Mental Health America of Colorado, were integral to the 2009 development of the BHTC. They continue to be active leaders in policy development both independently and as part of numerous coalitions across the state.

- **Involvement in health care reform.** In addition to these advocates, the Colorado Cross-Disability Coalition has played a particularly active role in the development of policies in support of implementing health care reform.

The primary challenge facing these organizations, and the many individuals across the state who provide peer support as certified peer specialists, is to maintain their distinctive, independent voices while moving further into the mainstream of mental health and SUD care delivery. One key construct that can support this is the expansion of peer-run organizations that can provide peer support within the framework of an overall agency run by peers, rather than as employees of a traditional provider agency or as volunteer self-help groups (such as Alcoholics Anonymous). While peer support is certainly a critical service within traditional provider organizations, and volunteer self-help will remain an especially important support, the need for independent peer-run agencies is increasingly being recognized nationally as a critical part of broader mental health and SUD treatment systems.

Peer-run organizations are entities that emphasize self-help as their operational approach and that are owned, administratively controlled, and operated by people, or their families, who receive and/or need mental health or SUD treatment services. These organizations demonstrate the following five qualities:

1. **Independent.** The organization is controlled and operated by peers of the people the agency serves;

2. **Autonomous**. Decisions about governance, fiscal, personnel, policy, purchasing, quality improvement, and all other operational matters are made by the organization and not an external entity;

3. **Accountable.** Responsibility for decisions rests with the organization;

4. **Peer controlled.** At least 51 percent of the governance board are peers of those served; and

5. **Peer workers.** Staff and management have received mental health services (or, for family members, are related to a person who has received mental health services), and they have life experiences that are relevant and similar to the people whom they serve.

To develop more peer-run organizations, resources will need to be committed to their formation, support and ongoing funding, as well as the services and supports they provide. Funding will likely require a mix of sources across agencies, as well as a mix of new and redirected funding. Action is needed in three areas:

• The dedication of specific resources to fund **technical assistance to develop peer-run organizations across the state** at multiple levels of development, including dedicated funding for both the start-up of new organizations in communities that currently lack them, and the enhancement of existing organizations to expand and sustain their array of supports;

• The development of **regulatory requirements to certify peer-run organizations** to allow those organizations ready to seek expanded state and Medicaid funding to do so; and

• **Ongoing funding and evaluation** of peer-run supports to document their benefits, costs, and potential cost-savings to the broader system.

One important lesson from other states is that, while state government and other authorities can support the development of peer-run organizations, the effort to form them will always need to reside foremost at the grassroots level.[346] Initial, developmental, and ongoing technical assistance, however, remains essential to helping these organizations thrive. Technical assistance is needed at each of several developmental levels: pre-implementation to discover resources, develop leaders, plan the organization and start-up; post-implementation to establish the organization, develop needed business processes, and enhance competencies; and during the maturation process necessary to progress to eventual credentialing as a provider. Underlying all levels of needed technical assistance is the recognition that peer-run programs are unique, peer-driven organizations providing critical services and supports as a complement to the broader mental health and SUD service systems.

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346 The State of Washington Mental Health Transformation Work Group (2010, September). Our Journey of Mental Health Transformation in Washington State: An Assessment of the Washington State Mental Health Transformation Project. Seattle: TriWest Group.

## The Future of Peer Support:
## The Example of Vets Prevail/Warriors Prevail

By far the most impressive peer support programs we have ever reviewed were the Vets Prevail and Warriors Prevail online communities and peer support resources for veterans, members of the armed forces, and their families. These services may represent at least one future for peer support, leveraging technology to increase access both to evidence-based practices and high quality peer support. Furthermore, the increased visibility of the mental health and SUD needs of returning veterans may end up striking a blow against stigma, as a group widely respected in our country and culture as among the strongest and most admirable comes out more into the open regarding their mental health and SUD needs. To paraphrase a main principle of treatment for post-traumatic stress, mental health and SUD are often normal responses to abnormal events and circumstances. As veterans stand beside the broader group of people in need of mental health and SUD treatment, and as we all consider that the lifetime prevalence of any mental health/SUD disorder is more than 50 percent, peer support becomes something universal rather than something marginal. And when we consider that "patient activation" is a hallmark of medical homes, self-help increasingly becomes something at the heart of medicine rather than the periphery.

# RECOMMENDATIONS TO SUPPORT RECOVERY AND RESILIENCE

Prioritization of supports to promote the resilience/recovery of individuals and families is still needed and largely untapped. Resources can be better leveraged by:

1. **Increasing access to peer support**, employing skills of people with real life experience, and

2. **Expanding the role and development of peer-run organizations** to help individuals, groups and communities take more responsibility for solutions in their lives. Supports can be modeled on successful efforts, such as grass-roots support networks for returning veterans and their families, as well as the many programs across Colorado promoting peer-support in mental health and SUD systems through the Medicaid BHO program, CMHCs, and programs such as ATR.

# Appendix One –
# Key Informants Interviewed
# for the 2011 Update

| NAME | ORGANIZATION / DEPARTMENT |
|---|---|
| **Governor Hickenlooper's Cabinet Members** | |
| Reggie Bicha | Department of Human Services |
| Sue Birch | Department of Health Care Policy and Financing |
| James Davis | Department of Public Safety |
| Henry Sobanet | Director, Governor's Office of State Planning and Budgeting |
| Jamie Van Leeuwen | Senior Policy Advisor to the Governor |
| **Former Governor Ritter's Behavioral Health Cabinet Members** | |
| Karen Beye | Department of Human Services |
| Shannon Breitzman | Department of Public Health and Environment |
| Joan Henneberry | Department of Health Care Policy and Financing |
| Susan Kirkpatrick | Department of Local Affairs |
| Don Mares | Department of Labor and Employment |
| Todd Saliman | Governor's Office of State Planning and Budget |
| Kathy Sasak | Department of Public Safety |
| Ken Weil | Governor's Office of Policy and Initiatives |
| **Behavioral Health Transformation Council Members** | |
| Cindy Acree | Colorado House of Representatives, District 40 |
| Polly Anderson | Colorado Community Health Network |
| Lacey Berumen | NAMI Colorado |
| Marceil Case | Department of Health Care Policy and Financing |
| George DelGrosso | Colorado Behavioral Healthcare Council |
| José Esquibel | Department of Public Health and Environment, Interagency Prevention Systems |
| Cheryl Frenette | Denver Adult Probation Department |
| Joscelyn Gay | Colorado Department of Human Services, Office of Behavioral Health |
| Amanda Kearney-Smith | WE CAN! |
| Julie Krow | University of Colorado at Denver Health Sciences Center, School of Medicine, Department of Psychiatry, Addiction Research and Treatment Services |
| Elizabeth Pace | Peer Assistance Services |
| Stan Paprocki | Department of Human Services, Division of Behavioral Health, Community Prevention Programs |
| Vicki Rodgers | Jefferson Center for Mental Health; Silverprint Colorado |
| Jeanne Rohner | Mental Health America of Colorado |
| Joan Shoemaker | Department of Corrections |
| Jeanne Smith | Department of Public Safety, Division of Criminal Justice |
| Ty Smith | Mental Health Planning and Advisory Council |
| Deborah Ward-White | Colorado Multi-Ethnic Cultural Consortium; Family Agency Collaboration |
| **Other Key Informants** | |
| Jackie Brown | Prowers County Public Health Nursing Service |
| Carl Clark, MD | Mental Health Center of Denver |
| Susan Colling | Colorado State Court Administrator's Office, Division of Probation Services |
| Eric Ennis | Addiction Research and Treatment Services, University of Colorado at Denver |
| Eileen Forlenza and Vickie Thomson | Colorado Medical Home Initiative |
| Liza Fox-Wylie | Colorado Regional Health Information Organization (CORHIO) |
| Marilyn Gaipa | Care Solutions, Inc. |
| Rich Gengler | Vets Prevail |

| NAME | ORGANIZATION / DEPARTMENT |
|------|---------------------------|
| Alexis Giese, MD | Colorado Access |
| Larry Green, MD | University of Colorado, Department of Family Medicine, School of Medicine |
| Marjie Harbrecht, MD | HealthTeamWorks |
| Liz Hickman | Centennial Mental Health |
| Devin Holmes | Warrior Gateway |
| Regina Huerter | Denver Crime Prevention and Control Commission |
| Laurie Ivey | Swedish Family Medicine & The Colorado Health Foundation |
| Michael Jenet, Erik Stone and Lisa Gawenus | Signal Behavioral Health Network |
| Phil Kalin and Jenny Nate | Center for Improving Value in Health Care (CIVHC) |
| Carlos Martinez | The Center/LGBT Community Center of Colorado |
| Lorez Meinhold | State of Colorado, Health Reform Implementation |
| Laura Michaels | Colorado Psychiatric Society |
| Stacey Moody | Colorado Association for School-Based Health Care |
| David Murphy | Arapahoe House |
| Larry Pottorff and Jackie Kennedy | North Range Behavioral Health |
| Sara Qualls | University of Colorado at Colorado Springs, Psychology Department |
| Sharon Raggio | Colorado West Regional Mental Health, Inc. |
| Julie Reiskin | Colorado Cross-Disability Coalition |
| Anita Rich | Colorado Children's Healthcare Access Program (CCHAP) |
| Renée Rivera | NASW, Colorado Chapter |
| Donald Rohner | Foothills Behavioral Health |
| Arnold Salazar | Colorado Health Partnerships |
| Charles Smith | Department of Human Services, Division of Behavioral Health |
| Scott Thoemke and Joan DiMaria | Arapahoe Douglas Mental Health Network |
| Marshall Thomas, MD | Colorado Access |
| Barbara Van Dahlen | Give an Hour |
| Karen Wojdyla | Colorado Psychological Association |
| **Signal Behavioral Health Network SUD Treatment – Webinar Participants** | |
| Irene Arguelles | ARTS |
| Julie Bellum | The Council |
| Steve Clark | Sun Luis Valley Mental Health Center |
| B.J. Dean | Arapahoe House |
| Bill Dolan | Sobriety House |
| Lisa Gawenus | Signal Behavioral Health Network |
| Spencer Green | Centennial Mental Health Center |
| Michael Jenet | Signal Behavioral Health Network |
| Mary Joy Kogovsek | Crossroads' Turning Points |
| Mary McMahon | Centennial Mental Health Center |
| John Lundin-Martinez | Denver Health OBHS |
| Tamara McCoy | North Range Behavioral Health |
| Ben Montano | IDEA |
| Marcela Paiz | IDEA |
| Erik Stone | Signal Behavioral Health Network |
| Audrey Vincent | Denver Health CARES |
| John Wilde | Larimer Center for Mental Health |

# Appendix Two –
# Summary of HJR-1050 Recommendations

**In 2007, the Colorado Legislature passed House Joint Resolution (HJR) 07-1050, creating a task force to study behavioral health (mental health and SUD) funding and treatment in Colorado. The HJR-1050 Task Force developed 11 recommendations the state could follow to improve behavioral health services.**

TriWest developed the following outline to summarize the HJR-1050 recommendations for participants in the Colorado Transformation Transfer Initiative forums held in April and May 2009:

1.  **Establish a Behavioral Health Commission.** This would be an official governmental body with authority to bring together state government leaders, adult and youth consumers, parents, caregivers, families, providers, other local agencies, communities, and others to guide change and promote the development of integrated behavioral health systems in Colorado.

2.  **Shared outcomes across state agencies.** Different state agencies trying to help people with mental health and SUD needs would agree on shared goals (often referred to as "outcomes") that they all would work together to try to achieve. Shared goals would be developed for both how systems work and how helpful they are to people served.

3.  **Aligned service areas.** Colorado is a big state, and state agencies divide the state into regions in order to organize their services. Different state agencies divide it up in different ways, including the state's 64 counties, 22 judicial districts, five Medicaid behavioral health regions, and four youth corrections regions. One idea to improve state services is to better align service areas so systems are less confusing.

4.  **Joint auditing/oversight.** Different state agencies often oversee or audit the same programs. For example, a Medicaid provider would have to comply with requirements from the Departments of Health Care Policy and Financing and Human Services (often multiple subdivisions within DHS), as well as requirements for specialty programs through other department (such as Corrections and Public Safety), local school districts, local departments of health, and other agencies. As a result, providers have to prepare for, host and respond to multiple audits whose requirements often overlap or conflict. One idea is to have state agencies work together on these audits so programs spend less time on audits and more time on services.

5. **Joint budget planning.** Dozens of different state agencies provide funding for mental health and substance use disorder services, making it confusing and difficult for providers to even know about, let alone make use of, so many funding streams. If state agencies developed joint budgets, providers could spend more time providing services and less time sorting through requirements. Also, the state could possibly better address shared needs and make better long term plans.

6. **Streamlined rules and regulations.** With so many different state agencies providing oversight, programs and clinicians spend a lot of time figuring out how to follow the rules. One idea would be to simplify, streamline and integrate rules.

7. **Financing reform.** Currently, funding levels are not equal across different parts of the state or for people with different needs. This came about because programs and services grew at different rates, and because some needs were recognized and addressed and others were not. One idea would be to try to make funding fairer, raising it for some regions and groups of people in need, but also lowering it for others. This is different than spending more; it means spending money differently.

8. **Electronic data sharing.** Often people receive services from different parts of state government. Many people believe that if it was easier for state agencies to share information with each other, they could do a better job coordinating services. Ideas range from electronic health records that follow people across providers to state agencies sharing information on services used and outcomes. Confidentiality safeguards are a critical consideration, and confidentiality would need to be protected.

9. **Cultural competency.** Colorado is a diverse state in terms of race, ethnicity, the languages people speak, where people live, and how people live their lives. Developing standards and requirements to make sure that mental health and substance use disorder services respond appropriately and fairly to people's diverse strengths and needs could improve the quality of services. This is sometimes referred to as "cultural competency."

10. **Consumer and family involvement.** The term "consumer" is sometimes used to refer to people who receive mental health and substance use disorder services, and this includes children, youth, adults, and older adults. Also, families are often very involved in the services provided to their family members, especially for parents and caregivers of children. Many believe that the state could do more to solicit, value and be responsive to the input and guidance of people and families receiving services by developing standards and requirements to support their active (and welcomed) involvement.

11. **Workforce development.** It can be difficult to find the right people to provide services. Doctors, nurses, therapists and other professionals are in high demand, especially for children, diverse cultural groups, people who speak languages other than English, and people who live in rural/frontier areas. Many believe the state can help build behavioral health workforces.

# Appendix Three –
# Summary of ACMHC Grantee Achievements

**The 2003 report *The Status of Mental Health Care in Colorado*[347] brought together for the first time information about Colorado's many overlapping and fragmented systems for providing mental health services. In response to this, four foundations – Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and The Denver Foundation – created Advancing Colorado's Mental Health Care (ACMHC).**

ACMHC was a five-year, $4.25 million project to support community collaboratives bringing together health care providers, human services agencies, and others to integrate mental health care. This project funded six initiatives:

1. Two projects integrating mental health and SUD services, one in Larimer County (Fort Collins) and one in El Paso County (Colorado Springs);

2. Two projects integrating mental health and primary care services, one in Mesa County (Grand Junction) and one in Summit County; and

3. Two projects integrating mental health services within school settings, one with Denver Public Schools and one in Prowers County.[348]

The main objective of the ACMHC project was to improve the integration and coordination of mental health services for adults with SMI and children with SED. Each grantee received funding for a year of implementation planning, initial implementation by year two, and achievement of sustainability by year five. TriWest Group served as Project Coordinator, facilitating communication, reporting and accountability; supporting grantees in their development and implementation activities; and identifying additional technical assistance needs and procuring help using funding set aside for this purpose. The Heartland Network for Social Research conducted an external program evaluation.

**ACMHC Investment in Each Community.** The project took a strategic approach, establishing multi-year local system change processes with relatively modest sums (approximately $100,000 a year per community, plus an additional $10,000 in technical assistance) to fund a coordinator and related infrastructure, to leverage broader system change. In comparison, Colorado was estimated to have spent more than $1 billion in 2010 on behavioral health care,[349] so the ACMHC investment on an annual basis ($850,000 per year) amounts to less than one-tenth of 1 percent of annual behavioral health spending in the state.

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347 TriWest Group. (2003). The Status of Mental Health Care in Colorado. Mental Health Funders Collaborative: Denver, Colo. See http://www.coloradotrust.org/attachments/0000/2200/MHCCfinalreport.pdf to view the report.

348 Two grantees (Prowers, Summit) also implemented coordination of multi-agency support for children/families.

349 TriWest Group. (2011). Status of Behavioral Health Care in Colorado in 2011. Advancing Colorado's Mental Health Care.

**Implementation of Evidence-Based Practices.** Each of the grantees implemented evidence-based practices tailored to the communities served, and all but one was sustained.[350] Across grantees, the estimated value of the sustained, enhanced services on an annual basis is $11.33 million, a single year of value worth between two and three times the overall five-year cost of the grant program.

**People Served.** The ACMHC initiative is estimated to have improved or expanded services that reached more than 18,000 people over the course of the grant, with a per person cost of $181.

**Progress on Promoting Integration.** All of the evidence-based practices implemented were integrated. The independent evaluation by Heartland Network for Social Research[351] focused on the systemic level of services integration by rating grantees on five levels from minimum (Level 1) to full integration (Level 5). All grantees achieved at least a basic level of collaboration (Level 2). Two-thirds of grantees achieved some service integration at the highest level (Level 5). Service integration at Level 5 was achieved in each of the major areas of integration by at least one grantee (mental health/SUD, primary care and mental health, school-based mental health).

**Involvement of People Receiving Services and Their Families.** Grantees involved people receiving services (consumers, clients, patients, students) and their families in a wide range of ways, and those with greater involvement tended to experience broader breadth and depth of system change. Most grantees observed that employment of peers (both individuals served and their families) to deliver services, and the involvement of people served and their families more broadly, was underdeveloped and a resource to leverage further in the future.

**Barriers Encountered, Responses and Lessons Learned.** The major barriers encountered related to: (1) separate policy oversight and funding streams for mental health, SUD and primary care, (2) restrictive fee-for-service funding categories that impeded coordination and delivery of needed supports, and (3) different rules for information sharing. Many of the biggest barriers were related to policy and funding at the state and federal level that were not amenable to change through a local initiative. The following factors helped grantees address these barriers: (1) the collaborative process developed by the participating agencies, (2) flexible technical assistance funding over the entire grant period, (3) targeted technical assistance involving guidance from experts and organizations with past experience regarding such matters, (4) project coordinator with both content knowledge in the areas of focus and skills in facilitating cross-agency collaboration. In terms of specific  technical assistance, the single most endorsed approach across grantees and integration models was sending representatives to national best practice forums.

### LESSONS LEARNED ACROSS GRANTEES FOR KEY STAKEHOLDERS/AUDIENCES

#### Lessons for Community Agencies Pursuing Integration

- Integration within large bureaucratic agencies may require program integration as an interim step.

- Proactively anticipating/addressing organizational and cross-agency barriers promotes success.

- Increased integration is most achievable if the effort is focused in a particular area.

- Specific training of staff regarding the concept of integration, its attributes and benefits, is key.

- Explicit cross-training of staff from the services/systems to be integrated promotes integration.

- Positive incentives (such as access to state-of-the-art training) promote participation in integration.

- Stimulants towards integration from more than one service sector or funder promote integration.

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350  El Paso and Larimer implemented integrated mental health/SUD services (Motivational Interviewing in El Paso, and CCISC and IDDT in Larimer); Mesa and Summit implemented integrated mental health/Primary Care services (Collaborative Care); DPS and Prowers implemented integrated mental health and school services (IDS in Denver and a school-based health clinic in Prowers); and Prowers and Summit implemented integrated coordination of care for multi-agency involved children and families (community resource coordination teams). All but one of those initiatives was sustained (Prowers' community resource coordination team).

351  Demmler, J., and Coen, A. (June 2011). ACMHC Project: Integration of Mental Health Services.

## Lessons for Funding Agencies

- Integration is possible in all areas attempted: mental health/SUD, primary care/mental health, and school-based mental health care.

- Define the boundaries of integration and included services (system components) beforehand.

- A point person whose primary function is to promote systems change is essential.

- Targeted technical assistance funds can help encourage specific training across agencies and collaboration activities.

- Access to technical assistance is critical from experts in the health areas being integrated, as is commitment to flexible, sustained technical assistance over time, and opportunities for cross-grantee learning.

- Until reimbursement for health care better supports integrated care, agencies must seek other funding sources (braided funds, grants, uncompensated care) to pay for some key integrated services.

## Lessons for Policy Makers

- Reimbursement of health care must change to better support integrated care.

- Policies for critical human services (e.g., public housing) must change to support integrated care.

- State and federal policies on funding and information sharing must change to support integration.

## Lessons for Future Grant Making

- Do it the same way again: a multi-year funding commitment, flexibility to adapt funding and technical assistance over time, and use of a highly competent project coordinator.

- Focus efforts up front by clearly defining the services and using an incremental, stepwise approach.

- Require a full-time project director throughout the entire grant period (at least through year four).

- Continue funder collaboration to "inspire" grantee collaboration and sensitize funders to challenges.

- New initiatives are needed to address state-level funding barriers.

# Appendix Four –
# Counties Included in Each of Colorado's Four Regions

## Denver Metro Area

Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson

## Northeast

Kit Carson, Larimer, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma

## Southeast

Baca, Bent, Cheyenne, Crowley, El Paso, Elbert, Huerfano, Kiowa, Las Animas, Lincoln, Otero, Prowers, Pueblo

## Western Slope

Alamosa, Archuleta, Chaffee, Clear Creek, Conejos, Costilla, Custer, Delta, Dolores, Eagle, Fremont, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Park, Pitkin, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, Teller

### Number and Geographical Distribution of Licensed Psychologists



Practicing psychologists (2010) and population per square mile (2009), Colorado

**Providers**
- Practicing psychologists

**Population per square mile**
- <= 3.0
- 3.1 - 6
- 6.1 - 25
- 25.1 - 250
- 250.1 - 2,500
- >= 2,500

**Data source information**

Data on practicing psychologists provided on 10/19/2010 by Peregrine Management Corporation.

http://www.peregrine.us

Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.

Metro Denver

Map prepared by the
Colorado Health Institute
303 E. 17th Avenue, Suite 930
Denver, CO 80203
www.coloradohealthinstitute.org
Map created October 20, 2010

All maps included in this appendix are from the Western Interstate Commission for Higher Education (WICHE) Mental Health Program's 2010 report on The Behavioral Healthcare Workforce In Colorado, with additional analysis by the Colorado Health Institute (CHI).[352]

## Number and Geographical Distribution of Licensed Social Workers



Social workers (2010) and population per square mile (2009), Colorado

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352 WICHE Mental Health Program. (December, 2010). The Behavioral Healthcare Workforce In Colorado: A Status Report. WICHE: Boulder, Colo. Retrieved from http://www.wiche.edu/info/publications/ bhWorkforceColorado2010.pdf.

Practicing mental health counselors (2010) and population per square mile (2009), Colorado

# Number and Geographical
# Distribution of Certified Addiction Counselors I

Certified Addiction Counselors I (2010) and population per square mile (2009), Colorado

Certified Addiction Counselors II (2010) and population per square mile (2009), Colorado

# Number and Geographical
# Distribution of Certified Addiction Counselors III



Certified Addiction Counselors III (2010) and population per square mile (2009), Colorado

Licensed Addiction Counselors (2010) and population per square mile (2009), Colorado

**Providers**
- Licensed Addiction Counselor (LAC)

**Population per square mile**
- <= 3.0
- 3.1 - 6
- 6.1 - 25
- 25.1 - 250
- 250.1 - 2,500
- >= 2,501

**Data source information**

Data on LACs downloaded on 10/25/2010 from the Colorado Department of Regulatory Agencies.

Population data are from 2009 Claritas Population Facts Data, acquired by CHI on 3/16/2010.

Metro Denver