Colorado Crisis Steering Committee

Final Report and Recommendations

Prepared by SHG Advisors
June 2018

The Colorado Crisis Steering Committee

The Colorado Crisis Steering Committee is a group of diverse stakeholders who worked together to provide recommendations to the Colorado Department of Human Services (CDHS) on how to improve and enhance the State's behavioral health crisis system. The Committee met to identify gaps in current service delivery, as well as opportunities to increase system efficiencies that will improve response in all communities and reach those populations at highest risk. Additionally, the Committee sought to understand how data could be better used to demonstrate the effectiveness of the system.

This document is the result of the combined efforts of the individuals listed below and the stakeholders and content experts who shared their insights, knowledge, and perspectives to advance the Committee's work.

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Colorado Crisis Services

Established in 2014, Colorado Crisis Services is part of the State's "Strengthening Colorado's Mental Health System: A Plan to Safeguard All Coloradans." It is an initiative championed by Governor Hickenlooper, and is the first statewide resource for mental health, substance abuse or emotional crisis help, information and referrals. Its purpose is to provide greater access to mental health services, ensuring Coloradans get the right services in the right locations at the right time. The system promotes access to the most appropriate supports and resources as early as possible to decrease the utilization of hospital emergency departments, jails, prisons and homeless programs for behavioral health emergencies. This system is revolutionary, and, in its infancy, has already transformed crisis services in Colorado. Yet, there are still challenges to acknowledge and improvements to be made. Ultimately, it will reflect a continuum of care from crisis response through stabilization and safe return to the community with adequate support for transitions to each stage. The crisis system is striving to make a cultural shift, and those types of evolutions – and their impacts – take time.

Colorado Crisis Services currently consists of five modalities:

(1) **Statewide Hotline.** The statewide crisis hotline is a 24/7, year-round, community-based system of crisis intervention services from which people experiencing mental health and/or substance abuse crisis can be safely and effectively stabilized and efficiently linked to appropriate follow-up care and services.

(2) **Mobile Services.** Mobile Services respond to where the client is, within 1 hour in urban areas and 2 hours in rural areas. It is statewide and available 24/7/365. Mobile Services works collaboratively with telephone crisis services, walk-in services, crisis stabilization units and crisis residential- and community-based services. Mobile Services works closely with law enforcement, schools and hospital emergency departments.

(3) **Walk-In Centers.** At the writing of this report (June 2018), there are 12 Walk-In Centers across the State. Walk-In Centers are open 24/7 and offer confidential, in-person assistance. Services are provided to customers within 1 hour of arrival time, and customers can stay for up to 23 hours. The focus of Walk-In Centers includes intervention, education, connecting to community resources and referrals to higher levels of care (if applicable).

(4) **Crisis Stabilization Units.** Crisis Stabilization Units (CSUs) provide onsite therapy for up to five days. The support may be in the form of one-on-one counseling, group therapy, medication management, or a combination of all services. CSUs are available for involuntary and voluntary admissions. After stabilizing the crisis, therapists in the unit work with the patient to create a long-term treatment plan and help them reintegrate back into the community. Across Colorado, there are 107 CSU beds available as of June 2018.

(5) **Respite.** Respite care services provide therapy management, medication management and in-patient mental health treatment for up to 14 days. Colorado's mental health crisis system has two types of respite services, one for adults and another for children and adolescents. Adult respite services connect patients to designated beds in the community, where they can remain for up to 14 days. Respite care locations offer counseling, medication management, and support for families and caregivers. Respite services are available for voluntary admissions only.

Committee Purpose

The Colorado Crisis Steering Committee was formed in early 2018 to:

- Identify gaps in current service delivery or access.
- Address the use of data to demonstrate the effectiveness of the system.
- Increase system efficiencies for crisis services and improve mobile response in communities.
- Establish services and clinical standards to meet the needs of the intended population.
- Ensure that services are reaching those populations at highest risk of suicide including adolescents, adult men and veterans.
- Address licensing challenges and prioritize regional solutions for co-located and fully integrated services.

The Committee is tasked with describing the recommendations it would like to see implemented. OBH will determine the "when" and the "how."

Process

The Steering Committee met eight times between March and June 2018. All meetings were open to the public, with observers in attendance, and included opportunities for public input. SHG Advisors, a local consulting firm, facilitated and documented the process.

Over the thirteen-week period during which it met, the Steering Committee spent time understanding how the current system is functioning. Two surveys were disseminated across the State: one to solicit input from stakeholders, especially those in rural areas; and another survey to solicit input from consumers (or family/friends of consumers) who have used the crisis system. Two sub-groups formed (one for the hotline & Mobile Services; and the other for walk-in centers, crisis stabilization units and respite) to identify prioritized recommendations. These recommendations were presented at an all-day workshop on May 18th, at which time Committee members informally voted on the recommendations they most supported. These recommendations were compiled and distributed to the full Committee for an electronic vote. (See *Appendix B: Summary of Task Force Meeting Agendas and Presentations*. See the CDHS Crisis System Executive Steering Committee website for meeting agendas, presentations, minutes, and related materials.)

In its first meeting, the Committee discussed and agreed upon the following mechanism to make decisions going forward:

- Upon voting, the majority vote wins.
    - If a Committee member(s) votes in the minority, they have the option to write and submit a summary of their opinion.
    - The Committee will vote on the minority report to ensure that it accurately reflects the conversation when the vote took place. If voted in the affirmative, the minority report will be included in the final report submitted to the CDHS Director.

On June 15, 2018, the Steering Committee approved the recommendations shared in this report.

Recommendations

The Crisis Steering Committee embraced the idea of "No Wrong Door." In other words, if a person is in need of crisis services, they should be able to access services using any of the modalities available through the crisis system. The crisis system aims to provide the right services, in the right locations, at the right time. It should be a flexible, integrated system that meets the community needs *and* acknowledges each community's nuances. Given the ever-changing environment in which we live, the system should remain current and relevant.

Acknowledging that the crisis system needs to provide greater access to mental health services to ensure Coloradans get the right services in the right locations at the right time, these recommendations were supported by the majority of Committee members who voted:

Recommendation One: Increase the breadth and depth of services for youth and children. There are a number of steps that CDHS can take to ensure that youth and children have access to behavioral health services:

- **Launch a targeted marketing campaign.** Review the results from the pilot conducted in Colorado Springs (targeted at 10-16-year olds) and, if successful, consider scaling.
- **Youth Mental Health First Aid (YMHFA).** Expand YMHFA training to parents, family members, caregivers, teachers, school staff, and peers. Instruct partners that any State-sponsored or State-funded activity/initiative in which youth participate requires that the Colorado Crisis Hotline number is added to the youth's cell phone.
- **Increase bed capacity.** Increase options for youth with substance use disorders, either as respite or longer-term placement. Improve residential treatment capacity. This could improve given Medicaid's recent efforts to obtain a waiver to provide inpatient and residential substance use disorder treatment.
- **Increase respite capacity.** In the last legislative session, the finance committee approved an increase in money for in-home respite. Ensure that this is being used effectively.
- **Offer two-way texting capacity.** This technology offers a conversational nature of texting, and enhances the SMS conversation by actively engaging youth. Youth could indicate if they are "okay" or not. Depending on the response, the youth would be connected to a "live" person.

Recommendation Two: Increase peer support in all areas. Peer support specialists (PSS) are people living in recovery with mental health conditions and/or substance use disorders who have been trained, based on core competencies. Peer support works when individuals are trained and have proper supervision and support. Peer-run services are not truly peer-run unless peers are involved – truly involved – every single step of the way in building those services.
There are several steps that CDHS can take to effectively increase PSS:

- **Define training standards (models for this exist) for PSS.** In Colorado, peers are currently made PSS by many different standards. The ideal standard for a PSS training program is one based off of feedback from the peer community. People with lived experience should be the ones creating and defining what that training looks like.
- **Address and ensure appropriate and supportive supervision.** Establish standards for peer supervision so that PSS will avoid burnout more easily. Consider using the 5 Pillars of Peer Support Supervision.
- **Offer peer respite.** Peer respites are most often overnight/short-term programs that are completely voluntary. Peer respites have a staff and leadership that are 100% people with lived experience of mental health conditions and/or substance use disorders, the behavioral health system, and/or crisis system experience, or **at least** that the majority of the staff have lived experience. Peer respites often vary in services, policies, size, and more, but the one thing that is common across peer respite is that they are voluntary, recovery-focused, trauma-informed, and are run and operated by the peer community.

Recommendation Three: Leverage technology to connect and simplify the state and local crisis lines. There are two options that CDHS could explore under this recommendation:

- Create a GPS-enabled app that people can use to find the crisis resources closest to them. This option offers a local- and regional-based face-to-face service choice at point of access. This option could include the ability to talk to a counselor on the telephone via the state or local agency call line. The state hotline could use the same technology to triage to the local/regional-based face-to-face option. It would be beneficial for all parties to have shared Electronic Health Records so that clients can be tracked, medical histories are accessible, and responses are consistent throughout the crisis system.
- Maintain a statewide hotline in the Colorado Crisis Services program and create an app for customers to access the hotline/text/peer support line and navigate Colorado Crisis Services as a program (an app name could be easier to remember than a phone number). The state hotline

could also use the technology to locate in-the-moment walk-in capacity, wait times, etc., as well as locate and dispatch mobile crisis directly to where the client is located. It would be beneficial to share crisis system client data so that clients' histories in the crisis system are known across all modalities, and follow-up is consistent, and data comprehensive and meaningful.

Recommendation Four: Determine how the Co-Responder Model & Mobile Services can be used in a crisis situation. The Co-Responder Model, launched in 2018, partners law enforcement officers with behavioral health specialists to intervene on mental health-related 911 calls. These two-person teams work to de-escalate situations by diverting individuals in crisis for immediate behavioral health assessments instead of arrest. Because the Co-Responder model is so new, its implications and impact are not yet clear. The Co-Responder Model in not formally a component of Colorado Crisis Services; however, it would be worthwhile to understand the impact on each system, how to minimize redundancy, and how to better leverage related or overlapping services as data is collected throughout the Model's implementation.

Recommendation Five: Develop and implement an outcome evaluation system. The crisis system was developed with the intent of providing greater access to mental health services, ensuring Coloradans get the right services in the right locations at the right time. *How* this is measured and to what can be attributed to progress is unclear. An outcome evaluation system will investigate the extent to which the crisis system is achieving its short-term and medium-term outcomes once those outcomes are defined. It will generate data that can determine to what degree those outcomes are attributable to the system itself. It could measure the effectiveness of the system, and ultimately make it more effective in terms of delivering the intended benefits. An outcome evaluation is typically implemented after a program has operated for a period of time, and should measure outcomes against set targets – which means that targets need to be established for the crisis system. Course corrections can be made when targets are not reached. Because this area is so specialized, the State will need to contract with a firm to develop and implement the outcome evaluation system.

Recommendation Six: Establish a Leadership Committee. The purpose of the Leadership Committee is to provide a consistent quality review of the Colorado Crisis Services. The Leadership Committee would include a diverse set of members, including consumers, community members, hospitals, law enforcement, and representatives from public health, human services and advocacy organizations. The Committee will review progress toward outcomes, as well as identify barriers to achieving outcomes. The Leadership Committee will also identify new needs (e.g., public safety) and determine how the crisis system can address those needs. Having a Leadership Committee in place could prevent the ongoing need for additional committees and taskforces to review and make recommendations relevant to the crisis system. Additionally, the Committee should ensure that the voices of diverse consumers and families are integrated into their meetings and conversations, and the Committee should solicit ongoing feedback from these key stakeholders.

Recommendation Seven: Improve integration of services for mental health/substance abuse disorder within Crisis Stabilization Units. Many patients have co-occurring diagnoses. Currently, the Uniform Service Coding Standards coding manual states that no other SUD services can be reimbursed if they are billed on the same day as detox. OBH regulations currently state, "In no event shall a facility admit or keep a client who…has acute withdrawal symptoms, is at risk of withdrawal symptoms, or is incapacitated due to a substance abuse disorder." At present, per licensing rules, Mental Health and Substance Use Disorder clients must be kept separated. Creating separate silos for Mental Health and Substance Use Disorder cases is counter-intuitive. Many consumers admitted for detox also have mental health and medical needs. Addressing these needs would help reduce recidivism and contribute to better psychological adjustment. In rural areas, there is a need to combine Mental Health and Substance Use Disorders due to limited space (i.e., smaller facilities with few beds) and limited resources. To fully staff a detox facility *and* a CSU facility side by side, with only a few beds in each, is inefficient and too costly in rural areas.

Recommendation Eight: Offer a statewide-integrated data and resource system for the Hotline. An integrated crisis system database would allow for all crisis providers to document and guide crisis system activity. Regional providers would have increased confidence in the assessment and triage recommended by the crisis line provider because of the additional knowledge of clients being considered. Although each individual provider currently has internal and external facing dashboards on coloradocrisisservices.org, dashboard activity could be expanded to the operations side of crisis services. Clients would be better

served, as service providers would have access to understand their history and how their needs can best be met. It would be easier to follow up with clients and/or track where they received services following a referral or "warm hand-off."

Recommendation Nine: Implement targeted marketing for those populations not served by the crisis system. There needs to be an analysis completed to understand *who* is currently not being served. This could be better understood by a streamlined data collection and reporting system. Only then can an appropriate marketing strategy be developed and implemented to ensure that the crisis system reaches all populations.

Recommendation Ten: Explore using a 3-digit number for crisis line. The current statewide hotline number is 844-493-TALK (8255). In a crisis, it is a long number for a person to remember. It may be beneficial for the statewide hotline to use a new or existing 3-digit number (such as 2-1-1, which currently provides connections for food, housing, rent/utility aid, emergency shelter, etc.). The functions of the hotline and 211 are very different and could change the experience of the caller dramatically. There is national legislation already underway to explore this option for the national suicide prevention lifeline, which would impact Colorado Crisis Services line volume as well. Caller experience, capacity, expertise and costs are important to consider and need to be studied closely before a decision is made.

A list of other widely supported recommendations can be found in Appendix A.

Additional Recommendations: Data

The Colorado Health Institute (CHI) was engaged to complete data analysis throughout the time frame that the Steering Committee met. Three major themes around data analysis emerged as part of this work: consistency, accuracy and the presence of data gaps.

Data consistency refers to the presence of contradictory information depending on the source. Accuracy points to concerns of the overall correctness of data. Finally, the presence of data gaps refers to the inability of data to answer key questions raised by the Committee.

TABLE 1: Summary of Data Analysis Themes

Theme	Description	Examples
Consistency	Different values in different systems	Slightly different values of client demographics in reports from CSOs versus compiled data from OBH based on monthly CSO data submission
	Inconsistent definitions	Differences between CSOs on how they define denominator for non-dispatched mobile services Different definitions of "respite"
Accuracy	General concerns	Possible incorrect locations coded for some mobile services
	Administrative errors	Invalid Medicaid IDs in HCPF-supplemented claims data set Invalid values in claims data cells (e.g., first names listed under DOB)
Presence of Data Gaps	Data silos	Unable to connect hotline data to CSO service provision
	Data incompleteness	Unable to answer questions such as payer mix of clients

Potential solutions to these issues were identified during CHI's data analysis, stakeholder feedback and conversations with the Steering Committee, OBH and CBHC. These are discussed below in order of scope.

- A **centralized data and reporting system** will address many of the problems identified. This system would create a direct connection between a shared crisis systems database and electronic health records, or designate a spot for regular data uploads from crisis service providers. All data pulls, including dashboards and key indicators, could be built off a shared system and available to users designated through a data agreement.

  This system addresses the problem of consistency by eliminating the possibility for competing values. It addresses accuracy by limiting administrative errors due to typos, which often occur when processes are manual. Finally, shared databases allow more flexibility in answering questions—for example, queries may be run on custom age groupings, or cross-tabulations can be done by gender and care setting.

- Whether on its own or part of a centralized reporting system, the development of a **data dictionary** will greatly improve the data quality in the crisis services system, and therefore allow for more robust analyses. A data dictionary will offer standard and complete definitions for every piece of data collected so that there is uniformity across locations and services. This will alleviate many of the issues touching on consistency.

- Currently, few checks exist to ensure the validity of data collected within crisis services. A third recommendation is to implement **data validation** systems and processes. Data validation can involve relatively simple changes, such as the use of a form that does not allow users to submit values that are invalid (e.g., characters in a numeric field) or nonsensical (e.g., a number of clients that exceeds the number of visits).

  The use of data validation is key to addressing concerns about data accuracy by preventing errors due to typos or misunderstandings of questions at their source.

- A fourth solution to data issues is, for those wanting to learn more about the crisis system and its performance, to **identify the required data** they will need to get a complete picture. The Steering Committee, service providers and other stakeholders should take a proactive approach in identifying what they will need to properly understand the system. While a shared database would go a long way to addressing this problem, as the system exists today, data of interest must be identified at the start of service provision—it cannot be deduced after the fact if it has not been tracked all along. This addresses issues with data gaps by ensuring that questions asked by stakeholders will be answerable in the future.

- A **streamlined data reporting process** can solve many of these problems as well. Streamlined reporting can be accomplished with a shared database; yet even in the absence of a shared database, a more streamlined process is possible. The process should limit manual or duplicative procedures. For example, when crisis providers report data to OBH, OBH should use a macro to have this data automatically input into a table, rather than using a manual entry process. This addresses accuracy concerns by limiting administrative errors.

- The **integration of data collection systems** will allow for more robust reporting on crisis services. One frequently cited example was a request to integrate hotline and mobile response data collection systems, but CHI suggests integration between all services provided, including walk-in, crisis stabilization and respite.

  This integration will serve to address two of the themes identified. Accuracy will improve because data from multiple systems can now serve as cross-validation—for example, when values on mobile dispatches exceed values of mobile requests, this flags an inconsistency in one system. Integrated systems will also allow for more robust questions asked by stakeholders at many of these meetings to be answerable in the future.

- Finally, a relatively simple way to address some data concerns is to **identify the timeframe** within which data is truly needed. Within the crisis services reporting infrastructure, a premium is currently placed on data freshness over completeness or accuracy. Data submitted by CSOs is often changed after-the-fact due to resolutions in claims or other edits. OBH may consider whether January data is truly needed in February, or if this information can wait until March. Less timely data may be an acceptable cost for the benefits.

Improvements in consistency will naturally follow by minimizing the number of data sources with differing values—for example, "January" values reported in February will now match those reported in March. Data will also be more accurate because of the increased confidence in correct values at the time these are submitted.

There is certainly acknowledgement among the Steering Committee, CHI and other stakeholders that none of these recommendations come without challenges and considerations. A shared statewide database, while addressing many data concerns, is a high-cost and high-effort solution, especially upfront. It also may require providers at the CSOs to conduct their work across two platforms—one that feeds into the shared database and another used for their non-crisis work. In addition, every additional data point collected is an extra burden on providers, and this must be weighed against the desire for more robust information.

Finally, as new efforts are undertaken, the crisis system must remain vigilant that every change provides a tangible benefit to the clients who need these services. Data improvements must always be made in the context of a direct benefit to these Coloradans.

Additional Considerations

Throughout the course of the Committee meetings, there were additional considerations that were consistently raised:

- **Workforce.** Colorado is fortunate to have a strong, growing economy. The negative result of that growth is the ongoing challenge to fill much-needed positions in critical fields –including behavioral health. It is difficult to recruit qualified individuals who are willing to work evenings and weekends with a population who has critical health needs – especially when licensed professionals can earn a higher salary in private practice and set their own office hours. It is equally difficult to retain those employees. Positions in the behavioral health field are often stressful, which leads to increased turnover. This only impedes the system's ability to serve people who are in need of services. It is even more challenging in the rural and frontier areas of the State. Because there are so many different professions that are struggling to recruit and retain qualified employees, it will be critical for the Behavioral Health system to develop creative initiatives to attract the right workforce. There are a number of ways in which the workforce challenge could be addressed:
    - Launch loan forgiveness programs that include non-traditional outpatient services
    - Offer ongoing workforce development for professional staff in the area of Crisis Services (i.e., a "crisis track" at universities, colleges, etc.)
    - Create partnerships between urban and rural providers to leverage the use of tele-health

- **Stigma.** Almost everyone agrees that stigma is a huge issue and needs to be addressed**.** There are a lot of steps that can be taken to reduce stigma – including public education, thoughtful use of language, integrating physical and mental health – but it is a massive hurdle to overcome, and a mindset that will not be easily changed. And yet it cannot be ignored.

- **Cultural Competency.** Colorado has a growing and diverse population. Per SAMHSA, cultural competence, the ability to interact effectively with people of different cultures, helps to ensure that the needs of all community members are addressed. Cultural competence means to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. If the Colorado Crisis System is to serve all persons, it must reflect a culturally sensitive environment.

- **Transportation.** Given the large landmass of Colorado, it is essential to improve and scale up transportation to improve access to crisis services. The system can help get a person in need of services to the right place without involving law enforcement or the expense of an ambulance ride.

- **Awareness.** It is critical to raise awareness of the existence of the crisis system through a stronger campaign – or by whatever methods will make the most significant impressions – so that more Coloradans are aware of it. It is important to especially target at-risk populations, such as adolescents, adult men, and veterans.

- **Cross-Agency Alignment.** The Colorado Department of Human Services should work with the Colorado Department of Health Care Policy and Finance to work together on all the recommendations in this report, to address items such as rates and finances, as well as maximize federal funding.

Appendix A: Committee Voting Tally on All Recommendations

Recommendations to improve the crisis system were presented by two sub-groups at an all-day workshop on May 18th, at which time Committee members informally voted on the recommendations they most supported. These recommendations were compiled and distributed to the full Committee for an electronic vote. The table below reflects the top 10 recommendations voted in favor by the Committee.

TABLE 2: Summary of Recommendations Receiving the Top 10 Votes

Top 10 Recommendations	Yes, I support	No, I do not support	Concerns
Increase the breadth and depth of services for youth and children	13	0	
Increase peer support in all areas	12	1	Sustainability could be a challenge
Leverage technology to connect and simplify the state and local crisis lines	12	1	Resources are too limited to invest in technology
Co-responder model & mobile: Determine how that can be used in a crisis situation	11	2	Sustainability could be a challenge
Develop and implement an outcome evaluation system	13	0	
Establish a Leadership Committee to review and update outcomes, identify additional gaps and needs, etc.	12	1	Unclear on who would be on a leadership committee, how often it would meet and what power it would have; not optimistic that this would be an effective group
Improve integration of services for mental health/substance use disorder within CSU	12	1	Sustainability could be a challenge
Offer statewide integrated data and resource system for the Hotline	12	1	Resources are too limited to invest in technology
Consider targeted marketing for those populations not served by the crisis system	12	1	Sustainability could be a challenge; while supportive of targeted marketing but question the cost and how to do this effectively statewide
Explore using a 3-digit number for the crisis line	8	4	People may think they are calling a gov't number and be less likely to use the hotline; 211 would result in an additional step for people in crisis; 211 does not have clinicians making decisions about whether dispatch is necessary; are there enough calls to justify moving to a 3-digit number?; will only support if services are not transitioned away from RMCP; the complexities of using a 3-digit number are too vast *Note: 1 person recused him/herself*

The Committee developed a number of other recommendations, all of which were supported by the majority of Committee members that voted. Tables 3 and 4 reflect those recommendations.

TABLE 3: Summary of Other Recommendations Supported by the Committee

Recommendations	Yes, I support	No, I do not support	I recuse myself	Concerns
Ensure that the community understands how to access CSU services	12	1	0	Doesn't make sense since you cannot self-admit
Increase marketing to raise public awareness for mobile services	9	3	1	Beyond the scope of this committee; need to ensure that mobile is equipped and ready to manage increased requests for services statewide; marketing dollars should be directed at increasing awareness of the crisis services/system in general and not confusing things by focusing on one component
Market to schools and/or create partnerships for mobile services	12	1	0	Beyond the scope of this committee
Grow the use of walk-in clinics through awareness & referrals	13	0	0	
Broaden referral base for respite beyond crisis clinicians	10	3	0	Beyond scope of this committee; lesser priority given limited resources
Improve cultural & linguistic responsiveness through training, diversification of staff, more welcoming and useful interpretation services	11	1	1	Supportive of cultural awareness but believe the current CSOs already do a good job
Better leverage the use of technology for mobile services	10	3	0	This is a lesser priority given limited resources
Offer mobile training to deliver services to youth	10	2	1	This is a lesser priority given limited resources
Identify better nomenclature or better define respite	12	1	0	Beyond the scope of this committee

TABLE 4: Summary of Other Recommendations Supported by the Committee

Recommendation	Yes, I support	No, I do not support	I recuse myself	Concerns
Improve data collection/ analyze/answer the right questions to understand the impact of the system (to include other stakeholders)	13	0	0	
Have ongoing discussions related to crisis case management/in-home respite	12	1	0	
Establish CSU license	8	2	3	Would prefer to see standard definition of what you get at an ATU versus community clinic with bed capacity; there is already a body reviewing licensing and we should ask them to address this & provide recommendation(s)
Improve transportation options	13	0	0	
Create formal agreement to clarify the relationship between hospitals and mobile services	11	2	0	This is a lesser priority given limited resources; we would be hard pressed to dictate agreements to hospitals
Review protocols for dispatch versus call center (for mobile services)	13	0	0	
Consider expanding the definition or criteria for walk-in clinics	7	6	0	Beyond the scope of this committee; need to understand the existing needs in communities first; too vague; walk-in definition is already broad and appropriate
Include payers in conversation and in educating people about their benefits (for walk-in services)	11	0	1	
Evaluation and capturing of daily census of beds for CSUs to determine best ways to maximize utilization	11	2	0	Beyond the scope of this committee; need to understand the existing needs in communities first; this is a lesser priority given limited resources
Ensure both mental health/substance use disorder needs are met via respite	9	3	0	Beyond the scope of this committee; would only support if we narrow the service to those in crisis, as it seems broader than the scope of crisis services
Review licensing rules to support integrated substance use disorder and mental health services	10	0	2	

Appendix B: Summary of Committee Meeting Agendas and Presentations

Meetings	Committee Meeting Objectives*	Speakers/ Presentations
Mtg. 1 3/9/18	● Introduce role and purpose of Committee ● Review historical narrative of the crisis system, and current stats ● Determine decision-making process and defining success	Summer Gathercole, SHG Advisors; Emily Johnson, Colorado Health Institute
Mtg. 2 3/23/18	**Hotline** ● Review of statewide hotline and possible recommendations	Bev Marquez, Rocky Mountain Crisis Partners; Emily Johnson, Colorado Health Institute
Mtg. 3 4/6/18	**Mobile Services** ● Overview of mobile services and current statistics	Lori Banks, Aurora Mental Health Center; Maureen Huff, Northeast Behavioral Health; Emily Johnson, Colorado Health Institute
Mtg. 4 4/20/18	**Mobile Services** ● Clarification on services ● Billing processes **Lessons from Other States** ● Arizona	Maureen Huff, Northeast Behavioral Health; Jason DeaBeuno, AspenPointe; Emily Johnson, Colorado Health Institute; Camille Harding, CDHS Office of Behavioral Health
Mtg. 5 5/4/18	**Walk-in Clinics, Crisis Stabilization Units, Respite** ● Overview of services and current statistics	Maureen Huff, Northeast Behavioral Health; Barbara Kleve, AspenPointe; Teresa Manocchio, Colorado Health Institute
Mtg. 6 5/18/18	***All Day Workshop*** • Stakeholder Survey Results • OBH's Perspective • Reports from Working Groups (Hotline & Mobile, and Walk-in/CSU/Respite) • Informal Voting on Prioritized Recommendations • Statutory Principles	Summer Gathercole, SHG Advisors; Robert Werthwein, CDHS Office of Behavioral Health; Camille Harding, CDHS Office of Behavioral Health; Various Committee Members
Mtg. 7 6/1/18	● School Toolkit released by Mental Health Colorado ● Consumer Stakeholder Results ● Discussion of draft outline of report and recommendations	Andrew Romanoff and Sarah Davidon, Mental Health Colorado; Summer Gathercole, SHG Advisors
Mtg. 8 6/15/18	● Review and approval of final report	Summer Gathercole, SHG Advisors

* The group agreements and statutory principles were reviewed at the beginning of each meeting.