



**The Status of
Behavioral Health Care in Colorado**
ADVANCING COLORADO'S MENTAL HEALTH CARE
2011 Highlights

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Background

In 2003, the Mental Health Funders Collaborative, a group of eight Colorado grantmaking foundations, commissioned TriWest Group to conduct an assessment and critical analysis of the public and private mental health systems in Colorado. *The Status of Mental Health Care in Colorado* was published that year and revealed alarming data about the lack of mental health care funding and access to care for people in the state. It also published, for the first time, information about Colorado's many overlapping and fragmented systems for providing mental health services.

In response to these findings, four Colorado foundations partnered to create Advancing Colorado's Mental Health Care (ACMHC):

- Caring for Colorado Foundation
- The Colorado Health Foundation
- The Colorado Trust
- The Denver Foundation

ACMHC was a five-year (2005-2010), \$4.25 million project supporting six Colorado community collaboratives that brought together mental health care providers, human services agencies, and other local partners to address the tremendous needs detailed in the 2003 study. These collaboratives were:

- El Paso County Co-occurring Disorders Collaborative
- Creating Integrated Services for People with Co-occurring Disorders, Larimer County
- Expanding the Circle in Mesa County
- Summit County Collaborative
- Denver Public Schools Integration of Schools and Mental Health Systems Project
- Prowers County Behavioral Health Integration Project

In 2010, as part of the larger project, ACMHC commissioned TriWest Group to develop a comprehensive assessment of the strengths and weaknesses of Colorado's behavioral health (mental health and substance use disorder (SUD) care) systems. TriWest interviewed 89 key informants actively involved in mental health and SUD treatment delivery and policy development, including members of the Behavioral Health Transformation Council; expanded the 2003 data to include information on SUD services and current data on mental health care across state agencies; examined the overall findings and lessons learned from the six ACMHC grantee projects; and completed an extensive literature review of key issues identified through ACMHC's work.

The Status of Behavioral Health Care in Colorado provides comprehensive information about the current landscape of public and private mental health and SUD care in Colorado to support the efforts of those working to improve behavioral health care. The full report, including citations for all data and literature, is available online at www.ColoradoMentalHealth.org.

THE STATUS OF BEHAVIORAL HEALTH CARE IN COLORADO IN 2011

While some elements of the 2011 Status Report can be compared to the 2003 report, data are not one of them. The following data outlining the behavioral health needs of residents should not be used as a comparison to data reported in 2003 given that methods and approaches for measurement have changed over the last eight years.

Needs of Coloradans

- Three in 10 Coloradans are in need of mental health or SUD care (1.5 million people). Nearly 1 in 12 have a severe need (450,000 people).
- When they do receive care in Colorado, youth and adults of color are disproportionately served in public human services settings, including child welfare, juvenile justice, and corrections.
- Colorado ranks sixth among states for its rate of suicide, with the highest single-year total of deaths in the state's recorded history reported in 2009.

Access to care

- The number of mental health and SUD practitioners in Colorado has increased since 2003 from 10,564 to 14,217. However, there remain too few providers with specialized skills willing to serve those with the most complex behavioral health needs, given current reimbursement rates and gaps in specialized training.
- The greatest need for providers is in rural and frontier areas of the state. Eighty-two percent of practicing psychiatrists, 86 percent of child psychiatrists, and essentially all psychiatrists specializing in SUD treatment are located in the Denver and Colorado Springs metro areas.
- A 72 percent increase in Medicaid enrollment from 2002 to 2010 has driven much of the increased demand for publicly funded mental health services in Colorado. Data show that more people are served in the community, and fewer people are served in psychiatric hospitals of any kind today. The availability of SUD services, however, remains well below need as of 2011.

COLORADANS WITH THE MOST COMPLEX BEHAVIORAL HEALTH CARE NEEDS OFTEN ACCESS SERVICES THROUGH MULTIPLE SYSTEMS. THIS INCREASES OVERALL HEALTH AND HUMAN SERVICES COSTS AND, IN TOO MANY CASES, RESULTS IN INEFFECTIVE, UNCOORDINATED CARE.



- Because most mental health and SUD care is now delivered through primary care settings (just over 50 percent), it is promising that Colorado is a leader in promoting integrated care. In Colorado, integrated care is offered in such diverse settings as federally qualified health centers, rural health centers, and community clinics, as well as independent practice groups throughout the state.

Costs and resources

- The most current data (2007) rank Colorado 32nd nationally for publicly funded mental health care. Data on recent spending for SUD care in Colorado show rates one-third the national average.
- Coloradans with the most complex behavioral health care needs often access services through multiple systems. This increases overall health and human services costs and, in too many cases, results in ineffective, uncoordinated care. For instance, health spending for those with Medicaid coverage who accessed five or more state agencies in 2010 was more than \$30,000 per person – nearly 10 times the cost of typical Medicaid medical claims.
- Spending on public mental health care in Colorado rose substantially from 2002 to 2009, with an increase in spending of \$62 per capita to \$84 per capita and \$1,664 to \$2,256 per person in need. Spending on SUD care has also risen substantially, reaching a high point of \$9.44 per capita in 2009, before falling back somewhat following cuts in 2010.
- A low estimate put the amount spent on people with behavioral health needs in the Colorado criminal justice system in 2010 at more than \$93 million. This estimate only includes metro Denver counties, but it alone represents more than one-fifth as much as is spent overall through the formal public behavioral health system.

Systems and care improvement

- Several steps have been taken to reduce systems fragmentation since 2003, including the integration of state mental health and SUD oversight through the Division of Behavioral Health, expanded availability of medical homes for children and others, system reform efforts by the House Joint Resolution (HJR) 07-1050 behavioral health task force, and the formation of the Behavioral Health Transformation Council.
- The evidence base for effective care, including peer support, for both mental health and SUD needs is substantial and growing. Efforts to promote evidence-based care now extend beyond the formal mental health and SUD service systems to include other state agencies, such as corrections.
- The recognition of the value and role of peer support has also increased considerably. One of the ACMHC grantees – El Paso County Co-occurring Disorders Collaborative – developed a Resource Advocacy Program based on an evidence-based peer support model. Leveraging the real life experience and mutual support of Resource Advocates helped extend thinly stretched resources in that community for uninsured people with co-occurring mental health and SUD needs, and achieved a range of outcomes, including sustained housing for many homeless people served.

SEVEN OBSERVATIONS

1. COORDINATION AND INTEGRATION OF SERVICES HAVE IMPROVED, BUT ARE NEEDED MORE THAN EVER.

Current systems for delivering mental health and SUD care continue to be multiple and varied by funding source, focus of care, and geography. These systems also include an array of additional human services agencies that deliver their own mental health and SUD services (i.e., education, child welfare, juvenile justice, state and local adult corrections) or offer other critical support services to people with mental health and SUD needs (i.e., education, vocational rehabilitation, employment, housing). Less explored frontiers involve prevention, and evidence is growing that intervening earlier can be more cost-effective.

Since 2003, Colorado mental health and SUD care-delivery systems have taken important steps to reduce fragmentation. As a result, state agencies with a core mission to deliver mental health and SUD services are working better together and coordinating with other agencies that may deliver the same services as part of a different core mission. They are also better aligned with other state agencies that play an important supportive role. These efforts have demonstrated incremental and meaningful change in health and human services.

Despite this progress, the primary challenge confronting Colorado's health systems remains uncoordinated care for people with severe and complex needs. Among those with the highest cross-system mental health and SUD service use, poor physical health status increases costs even more than behavioral health need, arguing for more wholistic treatment and specialized supports to coordinate care.

COLORADANS LIVING IN RURAL AND FRONTIER AREAS STRUGGLE MUCH MORE THAN URBAN OR SUBURBAN RESIDENTS TO ACCESS BEHAVIORAL HEALTH CARE. CRITICAL SERVICES SUCH AS PRESCRIBERS, ACUTE CARE FACILITIES (INPATIENT AND DETOX), AND INTENSIVE COMMUNITY-BASED SERVICES ARE OFTEN 100 MILES OR MORE AWAY.



2. MANY PEOPLE STILL CANNOT ACCESS NEEDED CARE – DESPITE SOME GAINS AND THE HOPE OF HEALTH REFORM.

Increasing challenges:

More Coloradans than ever (1.5 million people) need mental health or SUD care.

Coloradans living in rural and frontier areas struggle much more than urban or suburban residents to access behavioral health care. Critical services such as prescribers, acute care facilities (inpatient and detox), and intensive community-based services are often 100 miles or more away, and sometimes even primary care is not easily accessible. These challenges have increased over the past few years following population losses and the disproportionate effects of the recession on jobs in small towns and rural areas. In response, payers and providers are developing integrated care models and multi-agency partnerships to address the growing needs with too few providers.

Other specific needs include:

- Veterans who have served in Afghanistan and Iraq since 2001 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. Despite this, emerging behavioral health supports for veterans nationally are among some of the most innovative, and include web-based and peer supports outside formal veteran and active duty health systems.
- Concerns continue statewide that youth and adults of color, particularly African American, Latino, and American Indian, are disproportionately served in correctional settings. However, data on race and ethnicity are not reported on a relatively large proportion of Medicaid members, which substantially impedes the ability of the system to track progress on health disparities.

- People who are lesbian, gay, bisexual, or transgender (LGBT) continue to face barriers to accessing mental health or SUD care, particularly a lack of organizations sensitive to LGBT concerns, developmental challenges, and needs.
- Those with hearing, mobility, and vision disabilities are at greater risk for depression, and experience a wide range of physical, linguistic, and cultural barriers to care.

3. OVERALL, FUNDING FOR MENTAL HEALTH SERVICES CONTINUES TO BE INSUFFICIENT TO MEET OVERALL NEEDS, AND FUNDING FOR SUD SERVICES AND PREVENTION IS EVEN LESS SUFFICIENT; HOWEVER THE SITUATION HAS SOMEWHAT IMPROVED.

In spite of the 2008 recession, Colorado has to a large degree maintained its overall investment in mental health and SUD services. Spending on both mental health and SUD treatment in the state has actually increased per capita since the 2003 report, though not as quickly as this spending has increased nationally (as health systems have better addressed previously unmet needs). Of the \$887 million in known expenditures for behavioral health in 2010, just over 53 percent was spent through Colorado's formal public behavioral health system.

While full data on Medicare and private sector spending in Colorado were not available to this study, national figures were. Unlike overall health spending, public spending has always been the primary payer for mental health and SUD care. From 1986 to 2005, private insurance spending nationally on mental health increased nearly five-fold; however, during that same period, private insurance spending on SUD was basically unchanged. While comprising a relatively smaller portion of overall funding than Medicaid and the private sector, Medicare spending nationally has increased dramatically – more than four times since 1986 for mental health and more than double since then for SUD.

4. IMPROVED INTEGRATION OF SERVICES IS REQUIRED TO SLOW COST INCREASES AND IMPROVE HEALTH OUTCOMES.

Multiple studies in recent years have replicated national findings with Colorado Medicaid populations, showing that overall health spending is dramatically higher per person for those with a mental health or SUD diagnosis than for those without one. The primary driver is unmet health needs, and costs often include the use of multiple human services agencies (i.e., corrections, child welfare, housing).

At the same time, Colorado's mental health and SUD service systems are reaching more people than ever before. The remaining challenge is how to leverage successful connections to health and SUD care to improve overall health status, as well as to expand access to needed behavioral health care for people that continue to not receive care until they present in correctional systems, child welfare settings, homeless shelters, or other adverse situations.

The concept of health care reform is top of mind for funders, systems, and providers in 2011, often with an emphasis on the "Triple Aim," a three-fold simultaneous goal of improving the health of the population, enhancing the care experience, and reducing, or at least controlling, the per capita cost of care. Data gathered for the 2011 report show incremental steps being taken to achieve the Triple Aim for behavioral health services in Colorado. For example, behavioral health organizations (BHOs) have substantially reduced use of acute psychiatric inpatient care, and expanded access to best practices, allowing BHO rates per member to remain relatively stable while covered populations have expanded, and numbers served have grown considerably over the past decade. The next challenge is to integrate and build on successful behavioral health service models within the broader framework of health reform, medical/health homes, and regional care collaboration.

TWO OF THE ACMHC GRANTEES, IN MESA COUNTY THROUGH THE MARILLAC CLINIC AND IN SUMMIT COUNTY THROUGH COLORADO WEST, IMPLEMENTED VERSIONS OF THE COLLABORATIVE CARE MODEL, AND THEY ARE LEADERS AMONG THE NEARLY 100 SITES STATEWIDE IMPLEMENTING SOME LEVEL OF INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE.



5. THERE IS INCREASING EVIDENCE ABOUT WHICH BEHAVIORAL HEALTH SERVICES WORK, AND THOSE THAT WORK ARE SOMEWHAT MORE AVAILABLE TO COLORADANS.

The Status of Mental Health Care in Colorado (2003) emphasized the importance of empirically-based approaches to providing care. Efforts to promote a wide range of evidence-based practices have expanded across Colorado and nationally. Yet gaps remain, with very few of those with the highest needs receiving priority evidence-based practices (just three percent of children with severe mental health needs, 10.5 percent of adults with severe mental health needs, and 18 percent of people receiving public SUD services). On the flip side, support has grown across state government, with correctional agencies now helping to expand access to evidence-based practices in Colorado through an array of capacity-building grants. Colorado has also 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, a primary emphasis across Colorado is on person-centered medical homes (PCMHs) to promote higher quality health care that addresses multiple health needs in a coordinated manner, including mental health, SUD, and physical health. Providers statewide have made a major grassroots investment in PCMHs, and multiple efforts have received national recognition.

The collaborative care model is one emerging approach that integrates mental health – and SUD in some applications – into primary care settings. Two of the ACMHC grantees, in Mesa County through the Marillac Clinic and in Summit County through Colorado West, implemented versions of the collaborative care model, and they are leaders among the nearly 100 sites statewide implementing some level of integrated behavioral health and primary care. The primary challenges to such integration center on payment structures that hinder integrated care delivery and the need to retool and redeploy provider workforces. The construct of “health care neighborhoods”

conceptualizes accountable care at a broader level by adding human services partners to the health service framework for people with complex needs in restrictive human services settings such as adult corrections, juvenile justice, and child welfare.

Opportunities to improve care in the short term include better integration of mental health and SUD service delivery in Medicaid regional care collaboratives and other accountable care structures, expansion of health information exchanges, and efforts to address health disparities.

6. THERE ARE TOO FEW PROVIDERS – AND THE NEED IS GROWING.

The number of mental health and SUD practitioners in Colorado has increased since 2003 by nearly 35 percent, more than keeping pace with overall population growth. However, changes in the number of psychiatrists and psychologists relative to the state's population have been modest, even slightly decreasing for psychiatrists per capita by four percent.

As in 2003, Colorado still has a shortage of psychiatrists and other providers with specialized skills. This includes providers trained in empirically based approaches, those who specialize in treating children or older adults, providers who speak languages other than English or specialize in working with minority cultures, and providers to serve people living in rural and frontier areas of the state. The provider shortage is compounded by the fact that too few mental health and SUD providers of the types needed are willing to serve those with the most complex behavioral health care concerns given current reimbursement rates, and other structural issues. The various approaches to integrating mental health and SUD treatment with primary care currently being explored in Colorado are essential to leveraging available providers to meet both current needs, and growing demands expected under health reform.

7. PRIORITIZATION OF RESILIENCE AND RECOVERY IS STILL NEEDED.

Recovery means living a satisfying, hopeful, and contributing life regardless of the limitations caused by illness. It involves the development of meaning and purpose in one's life to help an individual grow despite the wide range of challenges that can accompany behavioral health disorders. Resilience refers to the capacity of children, adults and families to respond to change and stressful events in healthy and positive ways. Both of these concepts were emphasized in the 2003 report and are even more important today as systems seek to engage people as partners in their own health care goals through health homes and accountable care.

Peer support involves people with mental health and SUD needs sharing their lessons of resilience and recovery to support the journeys of others towards growth and hope. Peer-run organizations emphasize self-help as part of their operational approach, and they are owned, controlled, or operated by people with mental health or SUD treatment needs or their families. These organizations help individuals, groups, and communities take more responsibility for health solutions in their lives. Peer-run organizations are currently operating across the state at multiple levels of development. Regulatory structures are also being examined to help them obtain expanded state and Medicaid funding.

The need for independent peer-run agencies is increasingly being recognized nationally as a critical part of broader mental health and SUD treatment systems. The Vets Prevail and Warriors Prevail online communities are national models that offer peer support resources for veterans, members of the armed forces, and their families.

THE REPORT STRONGLY RECOMMENDS THAT, AS AVAILABLE FUNDS ALLOW, THE STATE INVEST MORE IN MENTAL HEALTH SERVICE DELIVERY, AND SUBSTANTIALLY MORE IN SUBSTANCE USE DISORDER TREATMENT AND PREVENTION SERVICES.



Recommendations

***The Status of Behavioral Health Care in Colorado* includes a number of recommendations for those who strive to improve mental health and SUD care in Colorado, including:**

Integration and access to care

Mental health and SUD integration efforts in Colorado must address the complex details to integrate actual service delivery rather than simply reorganizing existing systems. The Behavioral Health Transformation Council should function as a lead resource to coordinate planning for publicly funded mental health and SUD services, though it will need resources to function well. Opportunities to consolidate state-level delivery and financing for behavioral health services should also be explored in order to align benefits and maximize access to federal funds, particularly for community-level services in correctional, juvenile justice, child welfare, and education systems. Performance indicators for behavioral health should be incorporated into current Medicaid regional care collaborative efforts. Counties also need to be more fully involved in the planning for health systems integration to leverage their broader human services resources, and reduce the costs of jails and other adverse impacts of unmet behavioral health needs.

Policy makers should continue to refine indicators of need by breaking down populations into key groups, both the “few” with severe and complex needs and “the many” who simply need better access to mental health and SUD care in routine care settings. Increasing availability and access to PCMHs that integrate behavioral health and primary care should be a major priority, both in primary care settings for the “many” and specialty care settings for the “few.” This will require redeployment and retooling of the behavioral health and primary care workforces. More broadly, target provider workforce-expansion efforts to two areas: access in communities outside the metro Denver and

Colorado Springs areas and access in specialized areas of need, including trained prescribers, older adult and child specialists, and culturally- and linguistically-competent providers of all types.

In addition, efforts to reduce health disparities among underserved cultural, sexual and gender minorities and linguistic groups depend on first ensuring that data on each individual person's race, ethnicity, sexual and gender status, and spoken and written language are collected in health records and regularly updated. There is also a need to continue to expand access to evidence-based care across the board (while remaining mindful of the limitations of current evidence).

Funding and bending the cost curve

While it is understood that Colorado is still recovering from the effects of the 2008 recession, it is strongly recommended that, as available funds allow, the state invest more in mental health service delivery and substantially more (on a percentage basis) in SUD treatment and prevention services.

To rein in costs, or at least slow down the rate of cost increases, there is a need to better integrate local and regional service delivery systems incrementally. This can begin in the near term by introducing performance indicators related to behavioral health in accountable care and health home models. In the longer term, there is a need to integrate and expand Medicaid mental health and SUD benefits within the broader health system. This can be accomplished by taking additional steps to align performance metrics for service delivery systems while working toward eventual funding stream integration for mental health and SUD services within the evolving Medicaid accountable care structure. Post-integration, continued performance monitoring and improvement for

those with the most complex needs will require continued financial accountability and performance incentives for behavioral health funding that are separate from physical health to ensure that these needs are adequately addressed.

To view a full copy of *The Status of Behavioral Health Care in Colorado*, please visit www.ColoradoMentalHealth.org.

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