

Recommendations for a Coordinated Behavioral Health System in Boulder County

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Submitted to:

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September 2019

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Acknowledgements: OMNI expresses sincere appreciation to the Boulder County Project Oversight team and all community partners who provided knowledge and input for this work. The time and expertise of these individuals were a critical component of the assessment process.

Suggested Citation: The OMNI Institute (2019). Recommendations for a Coordinated Behavioral Health System in Boulder County. Submitted to Boulder County Public Health, Boulder, Colorado

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Overview of Assessment and Recommendations

Vision for a Coordinated Behavioral Health System in Boulder County

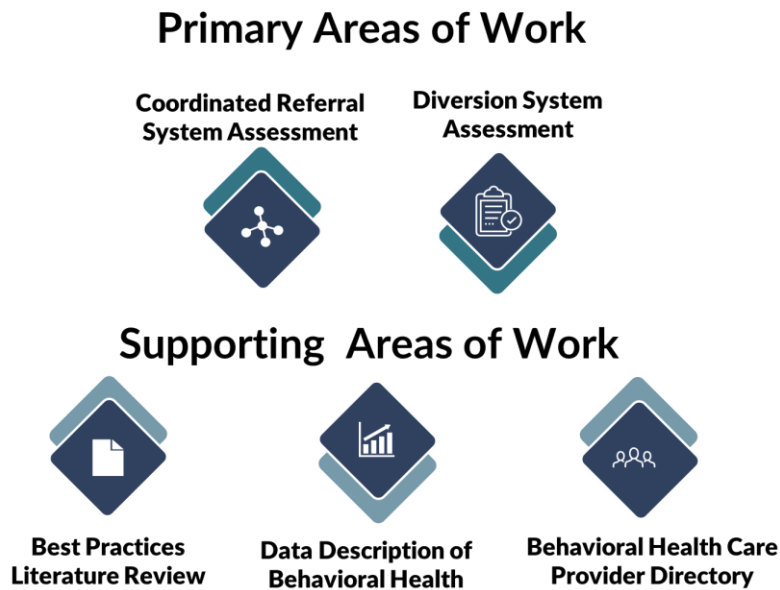
Boulder County Public Health (BCPH) believes that "all people should have the opportunity to live a safe and healthy life." As part of their work to advance this vision, in 2019, BCPH commissioned a county-wide assessment to document needs and identify opportunities for developing a comprehensive and integrated behavioral health system, one that ensures timely access to appropriate care for all individuals. A coordinated response to behavioral health requires multiple systems to work together. As articulated by BCPH, "In Boulder County, many 'gears' are working individually to address many behavioral health situations and needs. To move forward, each of the gears must be synchronized with the others."

BCPH contracted with The OMNI Institute to conduct the multi-faceted assessment, with a central aim of generating clear, supported, and actionable recommendations for developing and implementing a coordinated behavioral health system. OMNI was tasked with answering two overarching questions: 1) Is it feasible to create a coordinated referral system for behavioral health disorders? And 2) is it feasible to scale up a law enforcement diversion and co-responder program across all of Boulder County? The Boulder County Project Oversight Team was formed to guide the work at every stage and included leaders from Public Health, Law Enforcement, Criminal Justice, Community Services, and Housing and Human Services. Diverse stakeholder groups at multiple levels across these sectors were also engaged throughout the process through multiple methods including surveys, interviews, and facilitated meetings. In total, more than 200 individuals generously provided their expertise and input to inform the assessment and resulting recommendations. OMNI worked with the Boulder County Project Oversight Team closely to identify potential key informants, groups for meeting participation, and survey respondents. Although every effort was made to be as inclusive as possible in gathering input from key stakeholders, feedback may not thoroughly cover every group who touches Boulder County's behavioral health system. The County should make continuous efforts to solicit feedback from relevant groups as OMNI's recommendations are considered and an implementation plan is developed.

Below, we provide a brief overview of the various assessment components and the resulting recommended model for a county-wide coordinated response for people with behavioral health needs (henceforth termed the "Hub"). Subsequent sections of the report detail the approach, findings, and recommendations that emerged from each of the interrelated elements of the assessment. Taken together, these sections collectively informed the proposed rationale, design, and approach for implementation of the Hub and its supporting features.

The Assessment

The assessment was conducted between April and September of 2019, and included five areas of work:



Across components of the assessment, OMNI employed multiple methods and data sources including: a review of the research literature, publicly available information about models or systems, and community-level implementations; online surveys to gather diverse stakeholder input; and extensive qualitative information gathering across multiple contexts including key informant interviews, facilitated meetings with key stakeholders, and site visits.

A detailed description of the methods applied across assessment components is provided in Appendix A.

Examine Options for a Coordinated Referral System that connects people with behavioral health needs to appropriate services across the county

Boulder County behavioral health providers and key partners - including emergency departments, urgent care, hospitals, law enforcement, schools, and jails - recognize the importance of a treatment referral system that facilitates timely access to appropriate care for people in need of behavioral health services. An effective coordinated referral system must include, at a minimum, processes for making and tracking referrals, monitoring referral processes, and indicating when a referral is accepted (i.e., "closing the loop" on a referral). Systems ideally also include mechanisms for: sharing screenings, assessments and reports; communicating ongoing needs between providers; and allowing participants (i.e., individuals receiving services) to interact with the system and engage in their treatment plans.

To support Boulder County's work toward a county-wide coordinated referral system for behavioral health, OMNI obtained extensive input from county providers and other partners, conducted a review of technology platforms, and reviewed community-level implementations of other coordinated referral systems. Strengths, challenges, and gaps of existing systems were explored.

Findings indicated a need to move towards the use of a closed-loop case management referral system in which healthcare systems and community service organizations can connect across services to improve referral to treatment, as well as support diverse social service needs (housing, food, etc.), with the help of a robust and scalable technology platform.

Detailed findings and recommendations are summarized in the Coordinated Referral System Assessment Findings and Recommendations sections of this report.

Assess Opportunities for Expansion of Current Diversion Efforts such as law enforcement-assisted diversion and co-responder program models

Individuals with mental health or substance use issues are often unnecessarily involved in the criminal justice system. Emerging public health models can better address the needs of individuals with behavioral health issues through connection to appropriate treatment services. Communities including Seattle, Washington, the state of North Carolina, and others, have implemented programs that help divert people in crisis from the criminal justice system and into treatment. Early evaluations of these efforts have found that such programs can reduce costs, increase public safety, and improve behavioral health outcomes (Collins, Ionczak and Clifasefi, 2017).

Currently, Boulder County's City of Longmont, in partnership with community agencies, is operating a three-year Law Enforcement Assisted Diversion (LEAD) pilot program, and a five-year co-responder program called Crisis Outreach Response and Engagement (CORE). The LEAD program is implemented according to the national model; law enforcement officers identify individuals involved in mental health and/or substance use motivated crimes, and give them the opportunity to participate in monitored, harm-reduction case management. CORE employs a team consisting of a police officer trained in co-response methods, a licensed mental health clinician, and a paramedic that is dispatched to mental health related calls for service. The CORE team's primary response involves assessment, crisis de-escalation, and transportation services. CORE also offers case management and assistance with navigating health services.

To understand the potential for expanding and standardizing implementation of these models and programs across the county, stakeholder input was gathered to explore local context, barriers and opportunities; identify the fiscal resources/costs, staffing and general infrastructure needed for program implementation; and determine the level and nature of buy-in and collaboration necessary for the success of a county-wide model.

Findings guided a recommendation for initial implementation of a mixed model, including both LEAD and co-responder elements, that allows for some community-level variation, with a longer-term goal for alignment of all diversion efforts across the county over time.

Detailed findings and recommendations are summarized in the Diversion Assessment Findings and Recommendations sections of this report.

Develop a Behavioral Health Care Provider Directory that surfaces current service gaps and supports access to the right services at the right time

A coordinated behavioral health system relies on complete and accurate information about the behavioral health services that are available in the community, the level of treatment provided, and a number of other features that guide decision making about whether or not treatment is a good fit for an individual (e.g., availability of services, payment methods accepted, etc.).

Unfortunately, maintaining up-to-date inventories of behavioral health providers has been a persistent challenge, not just in Boulder County, but at state and national levels. Such directories often contain inaccurate, out-of-date or confusing information.

Aided by stakeholder input and background research, OMNI developed a complete directory and searchable Google map of all behavioral health care providers in Boulder County (current as of September 2019). The inventory can be used to help populate provider information to be eventually housed in the technology platform selected by the county.

Recommendations for components of the directory and its maintenance are included in this report. The full Behavioral Health Care Provider Directory may be accessed upon request from Indira Gujral at Boulder County Public Health (igujral@bouldercounty.org).

Identify Best Practices for Behavioral Health Treatment through a comprehensive review of the research literature

Mental health and substance use disorders are common, recurrent, and treatable (SAMHSA, 2013), yet the most effective methods for addressing them are not always apparent or implemented. In an effort to ensure Boulder County is delivering the highest quality of services to its community members who are in need of treatment for mental health, substance use, or co-occurring disorders, a comprehensive literature review was conducted to identify evidence-based best practices across service settings.

The review encompassed best practices for behavioral health prevention, treatment, and recovery across primary care and hospital settings; primary, secondary, and higher education; treatment; and law enforcement and jails. The literature review guided recommendations across components of the assessment.

The Best Practices Literature Review may be accessed through request to Indira Gujral at Boulder County Public Health (igujral@bouldercounty.org).

Synthesize Available Behavioral Health Data to understand the range of behavioral health needs in Boulder County

OMNI reviewed more than twenty publicly available data sources and catalogued over 500 county-level data points to capture the behavioral health status of people across age groups in Boulder County. The result is a comprehensive compilation of indicators that can be sorted by topic area and age group for use by Boulder County Public Health professionals. In addition, OMNI identified key indicators to support a high-level data snapshot of substance use and mental health status for people of different ages and stages in the county.

A PowerPoint presentation that highlights key indicators for each age group was developed for public use. For more information, please contact Indira Gujral at Boulder County Public Health (igujral@bouldercounty.org).

Overarching Recommendation for A Coordinated Behavioral Health Response System: The "Hub"

Findings across components of the assessment culminated in a recommendation for Boulder County to centralize its behavioral health screening, referral, and service navigation through a "Hub" that can be utilized by law enforcement professionals, community partners, and the general public. Its premise and design are grounded in extensive stakeholder input, local Boulder County context, literature on best practices, and a review of behavioral health systems nationwide.

This streamlined point of entry into behavioral health services would be staffed with call-line and co-responder staff who:

- Have expertise in the county's behavioral health systems and services
- Understand the availability of treatment options
- Have strong relationships with providers
- Can provide crisis intervention and screening for participants
- Can provide both short- and long-term behavioral health service navigation for participants

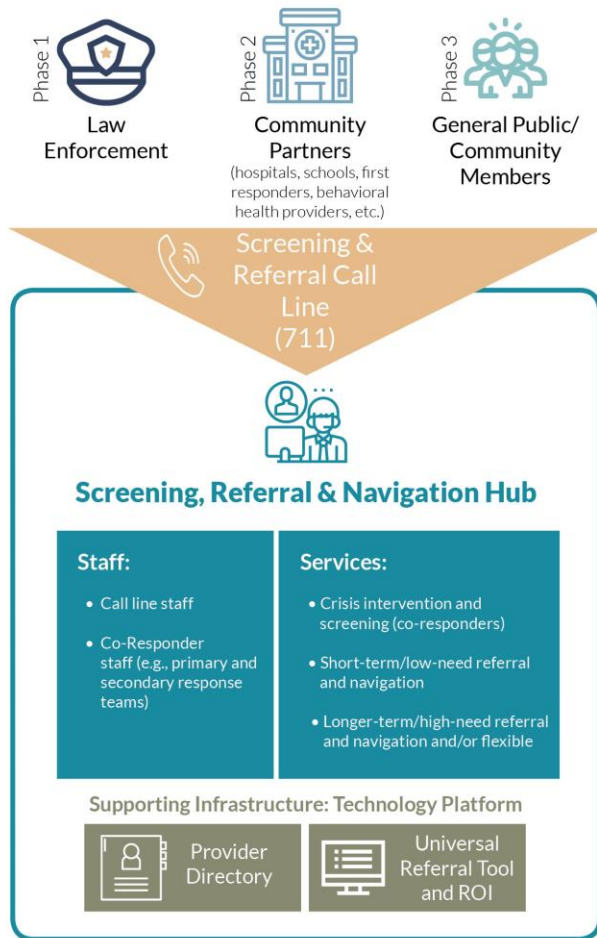
The Hub would serve as: 1) a coordinated referral response team for all people in the county who are in need of behavioral health services; and 2) an enhanced response team for law enforcement professionals so that appropriately identified individuals with behavioral health needs can be offered treatment in lieu of criminal justice system involvement.

The graphic below illustrates the proposed model and structure of the Hub, with narrative descriptions of its primary elements.

Subsequent sections of this report further detail the proposed model and rationale for the Hub, and offer specific guidance for its implementation, including leadership and staffing structures, fiscal considerations, and ongoing monitoring and evaluation of the model's efficacy.

Vision for a Coordinated Response to Behavioral Health Needs in Boulder County

Recommendation: Centralize behavioral health screening, referral, and service navigation county-wide, through a "Hub" that can be utilized by law enforcement, community partners, and the general public as a streamlined point of entry into behavioral health services. The Hub will include clinical staff and key infrastructure (call line and technology platform) to facilitate effective referrals across the county.



Key Hub functions include:

- Screening and referral for participants in need of behavioral health services
- Referral call line for community partners and the general public
- Provider directory to match participants to appropriate services
- Support for law enforcement and diversion efforts through co-responder staff, crisis response, screening and referral, and more intensive navigation for high-frequency utilizers
- Technology platform and support as a key tool for carrying out Hub services



Call line number that is easy to disseminate and facilitates timely access to Hub services



Integrated clinical staffing for county-wide early diversion efforts that may interface with law enforcement in multiple ways (for example, call line, dispatch and co-response teams)



Staff have deep expertise in the county's behavioral health systems and services. Staff understand the availability of treatment options and have strong relationships for referrals with providers.



Housed and maintained within the technology platform and includes up-to-date information about services available and capacity



Universal referral tools and releases of information (ROI) built into the technology platform provide the ability for inter-agency information exchange, facilitate effective referrals, and warm handoffs

Coordinated Referral System Assessment Findings

Boulder County behavioral health providers and key partners recognize the importance of a treatment referral system that facilitates timely access to appropriate care for people in need of behavioral health services.

An effective coordinated referral system must at a minimum include processes for making and tracking referrals, monitoring referral processes, and indicating when a referral is accepted (i.e., "closing the loop" on a referral). Referral systems typically include established processes or systems for doing the work, along with a technology platform that provides supporting infrastructure for the work. Technology platforms are central to a coordinated referral system and ideally include ways to share screenings, assessments and reports, communicate ongoing needs between providers, and provide options for participants to interact with the system and engage in their treatment plans.

To support Boulder County's work toward a county-wide coordinated referral system for behavioral health, OMNI obtained extensive input from county providers and other partners, conducted a review of technology platforms, and reviewed community-level implementations of other coordinated referral systems. Strengths, challenges, and gaps of existing systems were explored. Efforts resulted in recommendations to move towards the use of a closed-loop referral system, supported by staffing and technology infrastructure. The following goals of a coordinated referral system were emphasized by Boulder County stakeholders who took part in the assessment process:

Coordinated Referral System Goals



Coordinated referral system assessment findings are reported below, organized by source/method (Stakeholder Input, Review of Technology Platforms).

Stakeholder Input

As detailed in the Methods Appendix, OMNI gathered extensive stakeholder input through facilitation of meetings and interviews with key partners, along with a larger partner survey to assess buy-in (see Appendix B). Overarching themes from stakeholder input are important to highlight before a deeper exploration of findings:

- Many stakeholders agree that even without adding any new service options in Boulder County, timely access to appropriate behavioral health treatment could be improved with the development of a formalized referral system.
- Stakeholder perspectives differ on possible approaches to creating a coordinated referral system but typically agree that any additional infrastructure and/or process changes would be a significant improvement.

In addition to these high-level themes, most stakeholder input centered on: 1) current challenges; 2) support for a new system; 3) potential challenges and barriers that could be encountered during implementation; and 4) system needs and key features.

Current Challenges

Stakeholder feedback underscored common gaps and challenges within the current process for referring individuals for behavioral health treatment, which included the following:

- **Inadequate information about providers** and where to refer participants for timely access (e.g., basic treatment options, insurances accepted, current wait times or capacity issues, etc.)
- **Highly limited information about what referral processes entail**, exacerbated by staff turnover (e.g., referral contact information, key participant information and/or screenings required, process for submitting information, updated forms, email, call, fax, online database, updated forms, ROI, who to speak with, etc.)
- **Ineffective referral processes** that result in participants learning of ineligibility late in the process (e.g., completing intake appointment and then learning the cost for services is prohibitive or the wait list will delay services for many months, etc.)
- **Duplication in paperwork for participants**, as individuals are often required to complete multiple screenings, assessment, appointments, etc. to share the same information
- **Limited capacity to maintain any knowledge accumulated about providers and referral processes over time** (i.e., referring partners slowly gather knowledge over time, but do not have systems to store information or ensure updates over time)
- **Barriers with information sharing** such as requests for information that are not granted and an inability to share basic client information across partners to better coordinate services (e.g., ensuring that warm handoff occurs between providers; probation or diversion staff requesting general information about whether an individual has attended their appointments, etc.)

Support for a New Coordinated Referral System

- Stakeholders who participated in interviews and meeting discussions were **supportive of a new process to coordinate referrals** and described clear benefits of a technology platform.
- Many emphasized that the **effectiveness of a system would depend heavily on user-friendliness and accessibility**, which directly impacts partner willingness to engage with the system, etc.
- Some were concerned about getting needed partners to use a new technology but believed that **key players would get on board if the platform did not increase burden and if the benefits of utilization were clear**.
- Survey respondents were asked to indicate the level to which they agreed or disagreed with a series of statements related to support for a coordinated referral system (from 1: strongly disagree to 5: strongly agree). Statements included whether a system would improve the capacity of partners to make referrals, improve access to care, reduce partner burden, etc. **Seven of 8 statements had an average rating of 4.4 or above on a 5-point scale, indicating a very high level of agreement** across survey respondents representing core partners.
- Survey items assessing potential barriers also indicated that **respondents were typically not as concerned with partner utilization and community support/buy-in** as they were with other potential barriers.

Potential Barriers to a New Technology

Stakeholders also raised concerns or potential barriers that may be encountered during the process of implementing a county-wide coordinated referral system.

- **Data-sharing** was the most commonly selected barrier on the survey and most frequently mentioned barrier throughout interviews and meeting discussions
- **Technological maintenance** (e.g., keeping the data in the technology platform up-to-date with accurate provider information and needed functions) was also among top barriers
- **Replacement of individualized referrals and warm handoffs with a technology platform** was another common concern, as stakeholders want to ensure that any new technology is still complemented by adequate staffing, with individuals who can build relationships with partners and participants and follow up on referral successes and barriers over time
- Though stakeholders had fewer concerns about partner buy in and willingness to use the technology, more than half of survey respondents (61%) indicated that **consistency of system use** was a concern.
- Interviews and meeting discussions underscored that **training and support** would be essential to ensuring a coordinated referral system and corresponding technology platform are used appropriately and consistently across partners over time.

Technology Platform Needs and Key Features

Feedback related to what partners would need in a technology platform for a coordinated referral system were clear. Top system needs and key features from both survey and qualitative data were the following:

- **Easy to use/accessible**
- Ability to make **referrals**, coordinate **warm handoffs**, and close communication loops
- Cross-provider **communication**
- **Search functions to** access provider information, identify services, and assess provider capacity/ Search and filter functions greatly increase the ease with which users can navigate the system and find providers that can address people's behavioral health needs. For example, easily finding providers in certain locations, that accept certain payments, that provide the needed services, etc.

Interview and meeting discussion participants also emphasized the following features that would be critical to successful implementation:

- **Ability for a technology platform to be added and/or embedded into current systems to minimize partner burden**
- **Standardized release of information (ROI)** that could either be built into the system or have a function to indicate consent in the system once a standardized ROI process has taken place
- **Standardized screening** with basic participant information that can be shared to determine eligibility for services and initial treatment steps
- **Information about provider capacity** (i.e., wait time for services) to determine whether alternative options should be pursued

Stakeholders also had **mixed views about current technology systems** and whether a coordinated referral system could feasibly be built into an existing platform in Boulder County. Though some acknowledged that current systems have been effective for intended purposes, others shared concerns that configuration to meet the intended goals of a coordinated behavioral health referral system would lengthen the process significantly and potentially increase costs. Many stakeholders were supportive of the possibility of **a new technology platform**, specifically for coordinating behavioral health referrals. Some also mentioned that a core need for implementing a new technology platform would be to provide critical training for system users and maintain up-to-date provider information over time.

Review of Technology Platforms

Effective coordinated referral systems rely on the provision of relevant and current information about providers and individuals in need of services so that referrals facilitate timely access to appropriate behavioral health services. To be widely adopted and supported by partners, a system must benefit those involved through increased efficiencies, reliable access to updated, real-time information, and improved access to care for participants. OMNI completed a structured review process to assess various technology platforms and their alignment with Boulder County's vision of a coordinated referral system for behavioral health.

OMNI began reviewing general information about technology platforms early in the assessment process. Initial steps included:

- Preliminary conversations with stakeholders about current systems in use within Boulder County, how systems were working, the feasibility of adding on needed components, the timeliness of potential changes, etc.
- Initial communications, informational phone calls, and review of platform informational materials, websites, etc.

Overarching findings related to technology platform features included:

- Though technology systems often appear similar at initial review, their functions can be focused on very different elements of care coordination. There were three primary focuses of the systems reviewed:
 - Referral processes and maintaining up-to-date information on providers and services offered, participant-service matching, etc.
 - Inter-provider communication and reducing barriers to information sharing
 - Legal issues related to consent, compliance, real-time data exchange, filtering needed information, etc.
- Several companies provide comprehensive implementation support, including training for system users, workflow planning and maintenance of up-to-date provider information; lower-cost systems do not typically include training and ongoing maintenance
- Some include client interface capabilities, should Boulder County wish to build on later elements that can engage participants in their own care coordination

Once the initial review process was complete, OMNI reviewed partner survey findings as well as ongoing stakeholder feedback from interviews and meetings to focus the next phase of review. Based on the criteria outlined above, OMNI selected six platforms for more in-depth exploration and consideration. Additional calls and/or virtual meetings with several platforms were coordinated to review live demos, share more about the vision for Boulder County's referral system, dive deeper into needed functionalities and estimate potential costs and implementation timelines. Key platform characteristics reviewed included the following:

- Existing platform use and/or platform ability to integrate into existing systems (e.g., add on, web-based, capacity for integration into existing systems, etc.)
- Capacity to contain extensive provider directory information, with the ability to search and filter by key criteria such as modality, location, populations served, insurances accepted, program functions and hours, etc.
- Capacity to house consent and secure all information exchanged; HIPAA and 42CFR Part 2 compliance
- Ability for providers and partners to communicate in both directions; closed loop referral system
- Training and ongoing IT support
- Extent of use (i.e., local use and extent of implementation in other communities)
- Any additional information/context (e.g., existing use or local partnerships, etc.)
- Costs/pricing models
- Estimated timelines for implementation

It is important to note that comparing concrete information about costs and estimated implementation timelines across platforms was highly challenging for several reasons. Though larger technology platform companies were able to provide high-level pricing models and general timeframes for implementation (e.g., 12 weeks-1 year), others required more information, such as:

- Estimated number of community organizations/partners that will be using the platform
- Estimated number of staff users within each partner organization
- Intended client interactions with the platform, if any
- Level of customization and reporting functionalities desired
- Need for integration into other platforms, including information about the purposes of these platforms and their functionalities

Companies differ significantly in the pricing structures and cost models used to estimate costs for implementation and ongoing maintenance. For example, some provide monthly costs through a tiered structure based on the number of sites and users, with varying definitions and language to describe sites. Some embed training and support in this monthly cost, while others provide up-front implementation costs that reduce over time.

Finally, OMNI's search for information on costs and implementation timelines from other communities also yielded limited results. To serve as a reasonable comparison, a community would need to be implementing a system on a similar scale (i.e., similar community size), with the same purpose and primary functionalities. Though OMNI explored implementation of a similar system in North Carolina (NCCARES360), this system is used at the state level and for diverse community services and partners outside of behavioral health.

All informational materials gathered, including more detailed pricing model information and any cost estimates obtained, were provided to Boulder County Public Health. See 'Recommendations for a Coordinated Referral System' for OMNI's final recommendations. General information for each platform is listed below, as provided by each company. The graphic following these descriptions then provides a summary snapshot of information gathered through the review process.

Technology Platform Descriptions

<p>Boulder County Connect https://bouldercountyconnect.force.com/Home</p>	<p>Boulder County Connect is an online tool that helps people manage their own supports and benefits, learn about others for which they may qualify, and connect with county staff who can help them.</p> <p>Boulder County Connect offers information on a variety of programs administered by Boulder County’s Department of Housing and Human Services (BCDHHS), from Food Assistance (SNAP) to Colorado Works (TANF), and from Housing Choice Vouchers to the Child Care Assistance Program (CCAP), and everything else in between. Visitors can see basic program information such as eligibility requirements, and can download the forms and other materials needed. During business hours, the site has supports specialists available to help visitors via a live chat function.</p>
<p>Cloud Privacy Labs https://www.linkedin.com/company/cloudprivacylabs</p>	<p>Cloud Privacy Labs offers innovative privacy solutions that help businesses comply with new regulations, such as CCPA and GDPR, and integrate user choices into all business practices.</p> <p>Products:</p> <p>ConsentGrid™ is a cloud-native software for organizations that use and exchange personal data. It provides the back-end platform to create consent models, capture consent, and fully integrate consent into all aspects of data use. ConsentGrid™ uses patent-pending SmartConsent™ technology that puts consent into action by managing data flow.</p>
<p>Julota https://www.julota.com/</p>	<p>Julota is a patented, award-winning community interoperability platform that manages consent and multidirectional sharing of sensitive information between software systems for healthcare, EMS, law enforcement, behavioral health, social services, and all other local nonprofit and for-profit organizations.</p>
<p>NowPow https://www.nowpow.com/</p>	<p>NowPow’s platform supports participants in the referral process by building and managing community resource networks. With a focus on referrals that address basic needs and chronic disease management, NowPow partners with healthcare providers and community-based organizations to identify these needs, provide highly matched referrals, facilitate closed loop referrals, support bi-directional patient engagement, and document referral outcomes. NowPow is based on the research of founder Dr. Stacy Lindau, who established the idea of an “e-prescribing community” to connect health care to self-care. In addition to delivering targeted self-care interventions, NowPow also supports automated interventions that build resource awareness across large populations. Through its community resource network management strategy, NowPow supports ecosystem data aggregation to capture insights at a macro level.</p>
<p>REDCap https://projectredcap.org/</p>	<p>Research Electronic Data Capture, or REDCap, is a secure web application for building and managing online surveys and databases. While REDCap can be used to collect virtually any type of data (including 21 CFR Part 11, FISMA, and HIPAA-compliant environments), it is specifically geared to support online or offline data capture for research studies and operations. The REDCap Consortium, a vast support network of collaborators, is composed of thousands of active institutional partners in over one hundred countries who utilize and support REDCap in various ways.</p>
<p>Unite Us https://www.uniteus.com</p>	<p>Unite Us is an outcome-focused technology company that builds coordinated care networks that connect health and social service providers together. The company helps systems and communities efficiently deliver care and services by inter-connecting providers around every patient, seamlessly integrating the social determinants of health into patient care. Providers across the service continuum can receive and send external referrals and track every patient’s total health journey while reporting on all tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem. This social infrastructure helps communities move beyond legacy resource directories and transform their ability to measure impact, improve health, and track outcomes at scale. Unite Us is headquartered in New York City, with offices in Raleigh and Portland.</p>

Technology Platform Review Snapshot

Platform	Boulder County Connect	Cloud Privacy Labs	Julota	NowPow	REDCap	Unite Us
System Integration (ability to add on and/or integrate into current systems)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Offers single sign on with link in current systems or integration	<input checked="" type="checkbox"/> Installed on local web server (not considered open-source)	<input checked="" type="checkbox"/> Offers single sign on with link in current systems or integration
Provider Directory Information (essential to appropriate referrals)	<input checked="" type="checkbox"/> Available behavioral health provider information is limited at this time	Not at this time	<input checked="" type="checkbox"/> Not core function; utilizes another system such as auntbertha.com or 211 to access this data; not maintained by company at this time	<input checked="" type="checkbox"/> Core function; maintained and updated by company; includes ability to search and filter by multiple provider characteristics, maps, and client facing component if chosen	Not at this time	<input checked="" type="checkbox"/> Core function; maintained and updated by company; includes ability to search and filter by multiple provider characteristics, maps, and client facing component if chosen
Consent & Secure Information Exchange with HIPAA & 42 CFR Part 2 Compliance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Core function	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Bi-Directional Information Exchange & Closed Loop Referral	<input checked="" type="checkbox"/>	No communication mechanism; data exchange built into existing systems	<input checked="" type="checkbox"/> Core function is ongoing care management/provider communication	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Reporting & Analytics (available to partners in real time)	Reports for partners available on request; Ability for population-level analytics and use of local data to inform services	Not at this time	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Interactive, user-friendly data dashboards with real-time data	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Interactive, user-friendly data dashboards with real-time data

Technology Platform Snapshot (...continued)

Platform	Boulder County Connect (cont.)	Cloud Privacy Labs (cont.)	Julota (cont.)	NowPow (cont.)	REDCap (cont.)	Unite Us (cont.)
Training, Technical Assistance & Onboarding Support	Training and support infrastructure still developing	New system/ Training and support infrastructure still developing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Extensive training and implementation support	Information is highly technical; "unable to provide demonstrations, phone support, personalized consultations, or teleconferences"	<input checked="" type="checkbox"/> Extensive training and implementation support
Typical Implementation Timeframe (according to company)	Unknown at this time	Unknown at this time	Unknown at this time	~8-12 weeks for build and initial sites/pilot launch; ~1 year for full implementation	Unknown at this time	~ 12 weeks for build and launch
Extent of Use & Additional Context	Used by ~12 agencies in Boulder County; goal of expansion to other counties; local community partnerships such as those with CORHIO and RAEs; access to population-level data from several county or statewide systems	Currently offering free pilots with appropriate communities	Over 60 communities and 3 states Longs Peak Hospital considering through Prime Health Innovation Challenge 2019 http://primehealthco.com/prime-health-challenge/	NowPow is in 12 states + DC 7M+ patients 20K+ professional users 1.6K+ referral receiving organizations 50 proprietary condition algorithms	131 countries and 773k projects; free trial accounts available	25 states and have built 50+ coordinated care networks; key staff member has extensive local Colorado/Boulder County knowledge and context

Recommendations for a Coordinated Behavioral Health Referral System

The following recommendations are grounded in extensive stakeholder input; a review of technology platforms, and a high-level scan of coordinated referral systems being implemented throughout the country. The following key goals for Boulder County's move toward a coordinated behavioral health referral system (See Appendix A for methods and assessment participants and 'Coordinated Referral System Assessment Findings', above). Recommendations are detailed below in the following key areas, followed by a brief rationale and an illustration of the proposed structure and model:

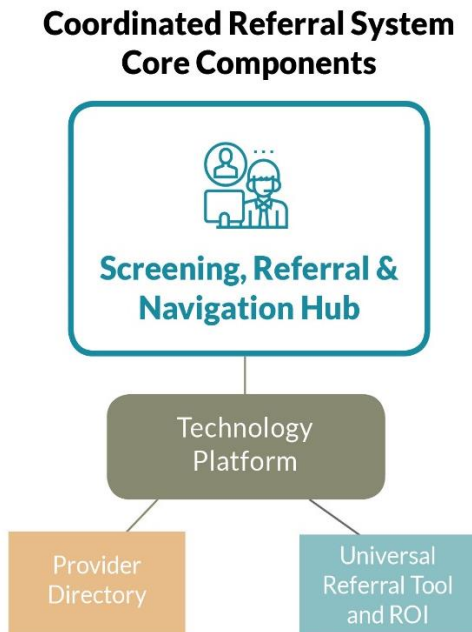
Key Recommendation Areas



Recommendation Area 1: Core Components of a Coordinated Referral System for Behavioral Health

It is recommended that Boulder County's Coordinated Referral System be aligned with county-wide diversion efforts and an overall county-wide behavioral health response system (see the 'Recommendations for a County-Wide Approach to Diversion' section of this report). The graphic below illustrates the relationship between core components of a coordinated referral system for behavioral health in Boulder County. Primary components include: 1) a centralized Hub with a core team that completes screening, referral and service navigation; 2) development and use of standardized "universal" screening/referral and release of information tools; 3) expansion of a provider directory that is maintained and kept up-to-date over time; and 4) a technology platform

to support all of the Hub's primary operations. Each of these components is outlined in further detail below.



Create Referral Response Team and Call Line

A team of referral staff should be situated within Boulder County's Screening, Referral and Navigation Hub, with a call line that can be accessed by the public as well as community partners, to request assistance with referrals.

Stakeholder input and other community referral systems suggest that a 3-digit number (e.g., 711) for call lines is more easily adopted by the public.

Key Functions of a Referral Response Team and Call Line

- Respond to public calls (e.g., calls from individuals or family members requesting referrals to treatment)
- Respond to community partner calls (e.g., calls from hospitals, law enforcement, other first responders and schools, as well as behavioral health providers that are not yet onboarded to the supporting technology platform - see technology platform recommendations below)
- Conduct screenings to determine participant needs
- Make appropriate referrals, utilizing the technology platform for onboarded agencies and other referral methods (e.g., email/call referrals) for agencies not yet utilizing the platform
- Maintain up-to-date information on providers (see provider directory recommendation below) or coordinate this role with the technology platform company

Rationale

- Aligns with stakeholder feedback, best-practices from the literature, and similar community models, all of which emphasize the importance of a robust referral system that includes staff and technology infrastructure (i.e., centralized staffing complements the use of technology with warm handoffs and follow up as needed)
- Provides a clear point of entry for participants, reducing confusion and complexity of referral processes
- Ensures that staff are similarly trained in overall philosophy, approach, and overarching program goals
- Positions the County to oversee and guide how the program team operates, leverage funding opportunities, and reduce potential challenges with contractors (e.g., contract agreements, philosophy and approach, training, etc.)
- A strong staff team with knowledge of Boulder County partners and referral processes that can cover gaps that may remain as community partners are phased in to use the technology platform (described below). Partners would eventually utilize the platform and the Hub staff less, primarily for back up or support with more intensive cases
- Hub staff will require a call line to receive referrals, even with the adoption of a technology platform. Some stakeholders also indicated that the current statewide crisis line number (1-844-493-TALK) is difficult for people to remember and use. A number like 711 could easily be disseminated in local public health campaigns, on the sides of buses, at bus stops, community events, etc.

Develop Universal Screening/Referral and Release of Information Processes

A key initial goal for Boulder County should be to create a universal screening/referral tool and release of information (ROI) form that can be utilized across systems.

Universal referral and ROI tools will allow for standardization of referral processes across providers, improve information-sharing among partners, and increase the efficiency of both processes. The development of tools should include: 1) a review of currently utilized basic screeners, referral forms, and ROIs (Boulder County Connect has already developed tools that could be reviewed as a potential starting point); 2) development of draft tools based on the review; and 3) an opportunity to provide final input/comment from agencies who will eventually participate in the coordinated referral system. Once finalized, the referral tools and ROI functions should be integrated into the selected technology platform. Stakeholder input and review of commonly used tools suggest the following elements be included in the universal tools, at a minimum:

Universal Referral Form	Universal Release of Information
Basic demographic information (e.g., name, contact info, date of birth, gender, race/ethnicity)	Basic participant identifiers
Insurance information	'Referring Agency' and 'Receiving Agency' information and contacts
Checklist of basic behavioral health needs (e.g., diagnoses, substances used, etc.)	Informed consent elements, including information about HIPAA, 42 CFR Part 2, FERPA and/or FIPS as appropriate
Screenings and/or assessments completed	
Housing status and general income information	
Other services received	
Basic participant treatment goals	

There are also a wide-range of more in-depth mental health and substance use screening and assessment tools currently utilized by providers and community partners. A later-stage goal of a coordinated referral system should be to work on aligning, *as appropriate*: 1) brief screening tools used across partners (e.g., primary care physicians, hospitals, etc.); and 2) clinical assessment tools used across behavioral health providers.

Rationale

- Aligns with stakeholder feedback, literature, and similar community models, all of which underscore that standardization of screening tools and ROIs are critical to facilitating timely and appropriate referrals
- Standardized tools minimize burden for both participants and partners, and increase the overall efficiency of the process
- Development of these tools as a key initial goal will ensure that Boulder County has the key infrastructure in place when implementation of the coordinated referral system begins

Expand Provider Resource Directory

Boulder County should build upon the existing provider directory and integrate provider information into the Technology Platform used for referrals.

As part of this assessment effort, OMNI developed an up-to-date, comprehensive directory of behavioral health care providers in the county. The directory includes a set of core data elements vetted by key stakeholder groups, including representatives from Boulder County's Substance Use Advisory Group (SUAG). Examples of core data elements include:

- Provider contact information (e.g., website, phone numbers, address, etc.)
- Population(s) served
- Levels of care
- Admission criteria
- Insurance information/service costs
- Capacity/average wait time for intake and actual services

For the full recommended list of provider data elements, see the 'Boulder County Provider Directory Implementation Recommendations' section of this report. Information from the provider directory should be integrated into a technology platform (see below) that is easily queried/searchable, filtered, and regularly updated.

Implement a Technology Platform

A shared technology platform should be utilized across behavioral health care providers and community partners, with the referral response team staff at the Screening, Referral and Navigation Hub serving as the primary initial users.

Based on stakeholder input, other priority initial users of the technology platform should include core behavioral health providers and law enforcement co-responder staff who will be utilizing Hub services for diversion efforts.

Key Initial Functions of the Technology Platform

- Allows for a **closed-loop referral process** between participating agencies (agency receiving referral is alerted → accepts or declines the referral → referring agency is notified when: a) the referral is accepted/declined; and b) when/if participant follows through with referral)
- Ensures capacity for **real-time communication** among providers
- **Includes a universal referral tool** with all information needed for participating agencies to determine whether to accept or decline referrals
- Includes **built in consent and release of information (ROI)** functions that allow treatment participants to: a) consent to specified information in the system being shared across participating agencies; and/or b) select specific agencies to be granted access to specific information (e.g., list of agencies with checkboxes configured into the platform so that participants may opt out of certain agencies)
- Houses and maintains the **Provider Resource Directory**, serving as a provider search database for any system user

- Houses additional client information to promote **general treatment monitoring** such as appointment dates and attendance, etc.
- Contains the capacity to track:
 - **Web analytics** such as system use patterns, client reach, and populations served, referral summaries, etc.
 - **Data indicators for measuring key outcomes** over time
- Includes capability for eventual **client interface**, with ability for service recipients to take part in their own service management, treatment planning, and information-sharing across providers

Selecting a Technology Platform and Rationale

OMNI reviewed a range of potential technology platforms and selected six platforms for more in-depth review and consideration. Key characteristics reviewed for each platform are listed below (See 'Findings' for OMNI's review methods as well as complete information on each platform, including typical implementation timeframes).

- Existing platform use and/or platform ability to integrate into existing systems (e.g., add on, web-based, capacity for integration into existing systems, etc.)
- Capacity to contain extensive provider directory information, with the ability to search and filter by key criteria such as modality, location, populations served, insurances accepted, program functions and hours, etc.
- Capacity to house consent and secure all information exchanged; HIPAA and 42CFR Part 2 compliance
- Ability for providers and partners to communicate in both directions; closed loop referral system
- Training and ongoing IT support
- Extent of use (i.e., local use and extent of implementation in other communities)
- Any additional information/context (e.g., existing use or local partnerships, etc.)
- Costs/pricing models
- Estimated timelines for implementation

OMNI reviewed the above characteristics, along with extensive stakeholder feedback gathered via online survey, interviews and group dialogue to inform the following recommendations about a technology platform. Given the need for Boulder County to move forward with diversion efforts supported by a coordinated referral health system, implementation timelines were a primary consideration.

To facilitate rapid implementation of a coordinated behavioral health referral system, based on assessment criteria for technology platforms and stakeholder feedback, OMNI recommends consideration of Unite Us or NowPow as referral systems that can have broad community use. Both technology platforms have the infrastructure and scalability capacity to enable more immediate implementation. They also include formalized training and onboarding support.

To ensure county-wide alignment in technology investments and use of supporting resources, OMNI recommends a county-level review of these findings and recommendations prior to any decisions on implementation. Key participants should include the Project Oversight Team for

OMNI's assessment, key county-level leaders and partners and the Boulder County Data Governance Committee. Among other technology recommendations, it will be important to assess whether Boulder County Connect is positioned to meet the requirements identified as most important to partner survey and interview respondents for an effective referral system as well as other criteria identified in the assessment of technology platforms. This is vital given the considerable investment and energy that has already been made in Boulder County Connect and the ongoing commitment to its success.

Example Coordinated Referral System Scenarios

The following scenarios outline the various ways that providers, partners, and community members may interact with and utilize the referral response team, call line and technology platform. It is important to note again that the referral response team would be housed within the **Screening, Referral and Navigation Hub** and therefore utilize some of the same staff and services that county-wide diversion efforts utilize (see also, example scenarios for County-Wide Diversion Model Recommendations).

Scenario 1: Community Partner Calls for Referral Assistance

- Community partner (e.g., ER, law enforcement, other first responders), encounters individual presenting with behavioral health issues
 - For acute crisis situations: Partner/community member contacts on-call team at **Screening, Referral and Navigation Hub**, which then sends mobile response
**Note that some community partners and the general public will require training on distinguishing between the need for mobile crisis response team versus 911*
 - For non-emergency referrals: Partner/community member contacts **Screening, Referral and Navigation Hub** which then schedules screening and referral assistance within determined timeframe (e.g., 48-72 hours)
- Hub team conducts appropriate pre-screening/referral form (using universal tools) to determine potential referrals needed
- Hub team utilizes standardized referral form and ROI housed on the technology platform to send basic participant information to receiving agencies (transmitted via the technology platform to onboarded/participating agencies, and via email or other method for non-participating agencies)
- Receiving agencies who are onboarded respond via the technology platform to close the loop, while those who are not yet participating require warm hand-off
- Follow-up is completed with participant and communication among agencies as needed

Scenario 2: Partners or Providers Initiate Referrals to Other Partners or Providers

- Community partners and behavioral health providers who have been onboarded to the system make referrals for services through the technology platform, utilizing the universal screener and ROI.
- Community partners and behavioral health providers who have not yet been onboarded to the platform utilize the Hub for referral support until they are fully integrated into the system.
- Follow-up is completed with participant and communication among agencies as needed.

Recommendation Area 2: Buy-in, Training and Roll Out

To support successful implementation of a county-wide coordinated behavioral health referral system, it is critical to ensure effective communication with key stakeholders, including funders, and to generate buy-in from policy makers, key decision makers in county agencies, and the community at large.

The following elements of the system and its implementation should be addressed:

- Overall vision and intended goals of a coordinated referral system
- Plan for initial system roll-out with timelines
- Potential evolution of the system over time/longer-term system goals
- Ongoing reporting of implementation progress including partners onboarded, etc.
- Plans for reporting progress on intended outcomes
- Fact sheet for community members outlining purpose and intended uses (i.e., use of behavioral health call line versus 911)
- Community awareness-building efforts to combat stigma and enhance recognition of behavioral health symptoms

Training for participating agencies should include:

- Thorough overview of system and vision
- Legal and privacy issues related to universal referral tool and ROI
- Training and onboarding for the technology platform
- Workflow planning to outline roles, intended uses of the system, processes to ensure efficient and appropriate use of the system, etc.

Recommendation Area 3: Oversight and Coordination

Several key groups and roles will need to be established to oversee and implement coordinated referral system efforts. As noted in 'Recommendations for a County-wide Approach to Diversion', Boulder County should consider merging efforts or broadening charges of existing groups before forming new groups, to streamline efforts and reduce duplication. Current groups to consider for membership and involvement include:

- Diversion Task Force (currently the "LEAD Task Force"; focused on county-wide diversion efforts)
- Behavioral Health Task Force (focused on county-wide behavioral health efforts)
- Healthy Futures Coalition (focuses on community engagement for substance use primary prevention among youth with significant school system involvement; could expand to include mental health)
- Substance Use Advisory Group (focuses on community engagement for early intervention and treatment with significant healthcare system involvement; could expand to include mental health)
- IMPACT Executive Board (focuses on high acuity youth touching multiple systems)
- Municipal level groups such as the behavioral health community-based groups in Longmont
- Groups involving inter-governmental technology and data governance
- Other groups interfacing with behavioral health efforts

Leadership and Implementation Team

Boulder County should develop a leadership and implementation team, comprised of core behavioral health providers and key community partners such as local hospitals providing behavioral health services and law enforcement. Both leadership and line-level staff should be represented consistently.

Additional community partners should be brought in regularly (e.g., quarterly), such as emergency assistance, first responders, local shelters and other organizations serving or interfacing with individuals with behavioral health issues. Develop workgroups with specific charges until key workgroup goals have been met and sufficient infrastructure has been built. The following is an example of how this structure may work. Core responsibilities of the leadership and implementation team and its workgroups may include:

Core Responsibilities	
Full Leadership & Implementation Team	<ul style="list-style-type: none"> • Maintain high-level oversight of coordinated referral system efforts, including *coordinating with county-wide diversion efforts* • Ensure that the work complements other care coordination efforts to reduce duplication and effectively use available funding and resources • Determine communication needs and review communications developed by project manager • Review and finalize tasks or deliverables completed by workgroups
Universal Screener and ROI Workgroup	<ul style="list-style-type: none"> • Review existing screeners and ROI forms utilized across the county, determining areas of alignment as well as less commonly used areas that could be eliminated • Draft tools and provide opportunity for input (e.g., public comment) from community partners • Revise tools with any relevant community partner input, for final review by designated legal consultant and full Leadership and Implementation Team
Call Line & Public Education Workgroup	<ul style="list-style-type: none"> • Determine plan for call line, including logistics and costs, staffing needed, etc. • Determine public education needs related to call line and plan efforts
Technology & Workflow Workgroup	<ul style="list-style-type: none"> • Work with technology platform company to advise: <ul style="list-style-type: none"> ○ Key initial functions of the system and longer-term plan ○ Onboarding and training plans ○ Referral mapping and recommended agency-level workflows

Program Manager/Hub Manager

Identify and fund a dedicated manager position to guide and communicate across teams and maintain the momentum of efforts, independent of political interests.

Given the need to coordinate efforts and the similarity of responsibilities for the Coordinated Referral System Manager and the Manager for diversion efforts (see, 'Recommendations for a County-Wide Approach to Diversion' report) Boulder County should consider whether a dual program manager position is appropriate.

Core responsibilities of the manager would include:

- Communicate between partners and across leadership and workgroups (including technology platform company)
- Coordinate meetings, agenda development, facilitation and other logistics
- Delegate responsibilities to teams and individuals as needed
- Draft program materials and larger communications for core team review
- Hub operational oversight

Technology Platform Oversight and Support

Utilize the training and technical support of the technology platform company to ensure a highly-detailed and consistent approach to platform onboarding, training and ongoing use.

It is recommended that the county select a technology platform that includes integrated support for users, thus the core support functions will be integrated into the platform itself.

Core responsibilities of the training and technical support team would include:

- Build and maintain system, including integration of service provider directory, consent and key screening tools, referral workflow and key functions, and analytic reports
- Communicate with leadership team and workgroups to coordinate efforts
- Onboard new partners with thorough platform demonstrations, training, and workflow determination processes
- Provide ongoing technical support

Recommendation Area 4: Evaluation

Evaluation efforts for Boulder County's coordinated referral system should be aligned with the evaluation of the County's diversion system (see 'Recommendations for a County-Wide Approach to Diversion' report). Evaluation should be utilized to assess program impacts and outcomes over time and inform program improvement/refinement efforts. For program accountability, OMNI recommends a rigorous evaluation plan that includes both primary data related to referral functions as well as secondary data collected at the county-level, and that both process and outcomes measures are collected.

The following example evaluation indicators are recommended in alignment with evaluation recommendations for the County-Wide Diversion evaluation:

- **Program-level Process Measures**
 - Participant characteristics/population reached through the program
 - Training efforts
 - Staffing patterns
 - 911 call volume and volume of calls received through new Call Line
 - Referrals made; referrals received; % of referrals with closed loop
 - Period between referrals to service initiation (time to treatment)
 - Treatment services provided
- **Participant Outcomes**
 - Treatment engagement
 - Recovery time/sobriety
 - Housing
 - Employment
 - Participant satisfaction
- **System and Cost Impacts**
 - Program administration costs vs. costs for system as usual/prior to coordinated referral implementation

Diversion Assessment Findings

Frequently, individuals experiencing behavioral health needs are unable to connect with appropriate treatment services and end up interacting with the criminal justice system (Torrey, Kennard, Eslinger, Lamb & Payle, 2010). Law enforcement personnel are often who we depend on when individuals' mental health and/or substance use needs are not met, and ultimately reach crisis levels. This strain on law enforcement personnel and misuse of criminal justice systems and resources, results in increased costs to the community. An effective strategy to address this systemic challenge is diverting people with behavioral health needs into treatment before they become involved in the criminal justice system. As the frequent first point of contact, law enforcement needs to be equipped with support from behavioral health partners and needed training to effectively implement diversion efforts.

To support Boulder County's movement toward a county-wide approach to diversion, OMNI assessed the feasibility of implementing specific diversion models and programs (for example, LEAD, Co-responder, and/or others). The assessment included consideration of existing support and buy in, potential barriers, fiscal resources/costs, staffing and general infrastructure, and community partnerships needed for implementation. The City of Longmont also provided their expertise and early learnings from implementations of LEAD and Core in their communities.

Diversion assessment findings are reported below, organized by source/method (Stakeholder Input, Review of Models and Community-level Implementations).

Stakeholder Input

As described in the methods section of this report (see Appendix A), OMNI gathered extensive stakeholder input through facilitation of meetings and interviews with key partners, along with a survey of line-level police officers (see Appendix C). Several overarching themes from this input emerged:

- Stakeholders shared the general belief that from a criminogenic perspective, the risk of recidivism increases through exposure to the criminal justice system
- Most expressed broad support for the general philosophy of diverting people with behavioral health issues to treatment, with varying perspectives on approach and starting points for Boulder County
- Officer support for diversion was more nuanced as there was broad support for diversion, mixed with concerns about the implications for everyday work. Officer feedback also provided clear information on training needs and potential strategies for successful implementation

In addition to these high-level themes, most stakeholder input centered on: 1) potential challenges and barriers that could be faced during implementation; and 2) key implementation considerations such as perspectives on specific diversion approaches, officer training needs and key infrastructure.

Potential Challenges and Barriers

Several potential barriers to implementing diversion efforts were raised consistently across stakeholders and included: 1) service access; 2) service quality and gaps; 3) systems issues; and 4) buy-in.

Service Access


Stakeholders most commonly reported challenges and concerns related to participant access to services. Many emphasized that the effectiveness of a diversion program depends heavily on the services to which people are diverted, and that a robust network of providers is critical for success. Some stakeholders emphasized current gaps in Boulder County services, while many others believed that even without adding new services, timely access to care would be increased by addressing process and system-related issues. Key issues related to service access involved referral systems and processes such as the following:

- **Unclear and inconsistent referral processes**, with limited clarity about where to refer in which scenarios, what referral processes entail, and clear and reasonable admission criteria across providers. Some stakeholders reported delays in services due to scenarios such as a client completing a lengthy intake before learning they are not eligible for services.
- **Lack of timely communication** from providers about referral acceptance for immediate services (e.g., mental health holds), which is critical to minimize officer time spent communicating and transporting people to various treatment locations
- **Limited staffing**, including limited trained intake staff which is critical to treatment access at the point of entry.

Service Quality and Gaps

Stakeholders who emphasized gaps in services and quality issues reported the following:

- **Lack of service options for participants** with:
 - Co-occurring mental health and substance use issues
 - Long-term involvement in services and/or the criminal justice system
 - Addictions to substances other than opioids
 - Medicaid or no insurance


"There isn't any place to hold the client while everyone is talking about ways to help the client."

-Boulder County Partner

- **Lack of service options in additional key areas**, such as:
 - Emergency services for homeless participants
 - Emergency/temporary services for participants with substance use disorder still using and awaiting more intensive treatment
 - Culturally and linguistically responsive services
 - Options for participants who may have had negative prior experiences with specific providers
 - Accessible treatment locations, transportation and hours of program operation
 - Robust peer support and recovery specialist options which are critical for relational elements of the program
- **Limited availability of emergency hospitalization options**, as hospitals are often at full capacity (e.g., “psych divert”) and mental health holds can be released quickly or immediately
- **Challenges with current mental health services providers**, including organizational issues, staff training, referral processes, service availability and quality of services.

Systems Issues

Several potential barriers related to larger systems issues also emerged, including:

- **Privacy and participant data-related issues** such as ensuring HIPAA compliance while also sharing needed information to improve coordination of participant services
- **Communication and coordination across systems-level efforts** (e.g., task forces, advisory groups, etc.) which can lead to duplication of efforts and competition for the same resources
- **Challenges with adequate funding and resources** for behavioral health coordination
- **Alignment of county and municipal approaches** to address inequities in how cases are treated throughout Boulder County; participants are currently offered different opportunities, depending on where they interact with law enforcement throughout the county,
- **Consideration of unique, community-level needs** and adaptations as appropriate (i.e., not forcing a one-size-fits-all approach)

Buy-in

Finally, stakeholders noted a few potential challenges related to ensuring buy-in from law enforcement officers, elected officials, partners and the general public, which included:

- Potential **front line officer** concerns about: 1) lack of accountability for people interacting with law enforcement or risk of people “falling through the cracks”; 2) the additional burden of a diversion program on line officers; and 3) officer liability if a diverted participant commits a more serious offense.
- **Elected officials** who answer to the public may have concerns that if one participant commits a crime/violates public safety, diversion support from their constituency will be at risk.
- **Partners and the general public** must have confidence that efforts will increase or at least maintain the current level of public safety in Boulder County; program accountability and demonstrating impact with data will be critical.

Implementation Considerations

Stakeholders also provided input specific to implementation in the following areas: 1) approaches to diversion; 2) important officer considerations and training needs; and 3) priority initial steps.

Diversion Approaches

Stakeholders had a range of views about approaches to diversion and how to make the greatest impact in scaling up diversion efforts county-wide. The following areas surfaced broadly across feedback:

- The importance of an **equitable county-wide approach** to diversion that ensures individuals with behavioral health needs in any location in Boulder County receive the same opportunities to seek treatment and avoid further involvement in the criminal justice system
- **Philosophical alignment county-wide**, including alignment on both harm reduction and treatment-based approaches, and ensuring fidelity to the models and practices that are chosen
- **Critical collaboration among key partners** (e.g., clinical staff, law enforcement and District Attorney staff) to establish agreement on criteria for diversion, and ensuring that roles are clear, aligned, and complimentary, allowing each partner to utilize their expertise and serve their intended functions
- **Clear and straightforward criteria for diversion involvement** that minimizes points of confusion for officers and partners, particularly in early stages of implementation

Though the areas above aligned across most stakeholder input, perspectives on the areas listed below varied widely:

- **Priority focus populations** for diversion programs, for example, whether the focus of efforts should include low-level offenders, high-need populations who have frequent interactions with law enforcement, or multiple populations
- Initial focus on **intensive and flexible case management (e.g., LEAD) versus co-responder models** that involve police and behavioral health clinicians responding in partnership
- **Balance of county-level alignment with local-level needs**; aligning efforts to secure needed resources and maximize impact versus allowing local-level adaptations or programs to better match local needs
- **Acknowledgement of unique sub-population needs** (e.g., older adults with mental illness; individuals who have committed crimes) rather than a “one-size-fits-all” approach that groups people together, potentially decreasing intervention effectiveness and increasing safety risks

Officer Considerations and Training Needs

Officer survey respondents and law enforcement leadership provided helpful considerations for implementation, as well as training needs that should be prioritized (see Appendix C for a full report of officer survey findings).

- Overall, **officers indicated support for a county-wide diversion program, with more mixed views about concerns about for their everyday work.**
- Officers and law enforcement leadership emphasized that a diversion **program must require no more officer time and resources than would be required to make an arrest**
- Officers also indicated several priority training needs:
 - In quantitative (closed-ended) survey responses, officers indicated that **clear and easy protocols for diverting individuals** would be the most important training element for implementing a county-wide diversion effort.
 - The most common open-ended responses about training needs included: 1) **behavioral health training and/or collaboration with behavioral health clinicians** to be able to effectively identify and handle cases, and make diversion decisions; and 2) **general program training**, including expectations for officers, roles for officers and mental health professionals/co-responders, safety protocols, clear guidelines for discretion, and clear referral processes

Key Infrastructure

Finally, stakeholders shared a number of key infrastructure pieces that would be vital to successful implementation. These included:

- **Communication that shares critical program information** such as implementation plans, phases, approaches, and progress, with officers, partners and the community at large.
- **Information-sharing agreements and clear referral processes** for all involved partners.
- **Opportunities for ongoing input and collaboration**, ensuring that all partners are able to share perspectives, weigh in on successes and areas for improvement and refinement.
- **Consistent data collection** practices across partners (e.g., coding for call type) to ensure program impacts can be evaluated and shared with the public and the broader community.

Review of Models and Community Level Implementations

In addition to extensive efforts to gather stakeholder input, OMNI completed a review of the literature on police and behavioral health collaboration models, to identify core principles and best practices. Two models, LEAD and Co-responder, are featured here (other models are reviewed in the comprehensive review of the research literature on best practices for behavioral health treatment, that is available upon request from Boulder County Public Health). OMNI also conducted a site visit with the City of Longmont, to learn about the models in practice. It will be important for Boulder County to consider learnings from Longmont to inform implementation in county-wide diversion efforts.

An ideal outcome for individuals experiencing mental and/or substance use disorders who encounter law enforcement personnel is diversion into treatment and away from the criminal justice system (Naples & Steadman, 2003; McNiel, Binder & Robinson; Warner & Kramer, 2009).

Successful diversion can lead to reduction in criminal justice involvement and burden on law enforcement (Cowell, Broner & Dupont, 2004), achieving better treatment outcomes for people in need of service (e.g. Hodges, Martin, Smith & Cooper, 2011, and cost savings (e.g. Steadman & Naples, 2005). Broadly, there are two types of criminal justice diversion: pre-booking (i.e., early), and post-booking (Steadman et al., 2001). While post-booking diversion identifies and diverts individuals with mental health and/or substance use disorder after they have been booked, early diversion keeps these individuals out of jail altogether.

There are various early diversion models (Puntis et al., 2018), however most involve some type of specialized training for police officers to recognize and respond to individuals experiencing mental health and/or substance use symptoms, and/or the collaboration of officers with trained behavioral health specialists (i.e. co-responder models) or 24-hour crisis centers (Steadman et al., 2001). Two such models are Law Enforcement Assisted Diversion (LEAD), and the co-responder program Crisis Outreach Response and Engagement (CORE).

LEAD

LEAD is a community-based early diversion program designed to divert individuals from the criminal justice system into behavioral health case management (Beckett, 2014). LEAD was established in Seattle, Washington in 2011 as a community-based harm reduction, early diversion program intended to divert individuals who commit low level drug and/or prostitution crimes to social and legal services (Beckett, 2014). After arrest and prior to charges or incarceration, individuals eligible for LEAD services are identified by an on-duty police officer and referred to a LEAD case manager. Then they are diverted to voluntary counseling and/or clinical services and receive harm-reduction case management as well as legal advocacy services (Collins, Lonczak & Clifasefi, 2017).

LEAD Benefits

- An independent evaluation found that LEAD participants were 58% less likely to be arrested after enrollment (Collins, Lonczak & Clifasefi, 2017).
- LEAD-based case management plays a significant role in improving housing and employment outcomes among participants (Clifasefi, Lonczak & Collins, 2017).
- The LEAD program has contributed to reconciliation and healing among police-community relations (LEAD National Support Bureau, n.d.).
- LEAD facilitates multi-sector collaboration between stakeholders (LEAD National Support Bureau, n.d.)
- In 2019, LEAD programs or other diversion programs that align with LEAD core principles are currently in development, launching or operating in 60 cities/counties nationwide, and 42 city/counties are exploring the program's implementation (LEAD National Support Bureau, n.d.).

Co-response Teams

Co-response is a team strategy that consists of a specialty trained police officer being partnered with one or more behavioral health or paramedic professional who provide on-site services to individuals experiencing mental health and/or substance use disorders (Shapiro et al., 2015). Co-

responder teams were first developed in Los Angeles and San Diego, California (Schwartzfeld, Reuland & Plotkin, 2008). Though co-response models/programs in the United States can vary in their implementation and terminology (e.g. “mobile response team” and “crisis outreach”) (Patterson, 2004), the central idea of co-response is that “the more police and mental health workers collaborate, the better the two systems can serve consumers and each other” (Rosenbaum, 2010, p. 176). For example, in Longmont Colorado’s Crisis Outreach Response and Engagement co-response program (CORE), a behavioral health clinician, paramedic, and specially trained police officer respond to emergency calls that involve a mental health or substance use issue (City of Longmont, 2019). The CORE program provides behavioral health assessment, crisis de-escalation, transportation to services, and case management services to individuals in need.

Co-response Team Benefits

- Co-responder models are increasing in popularity among police departments in the U.S (Rosenbaum, 2010; Shapiro et al., 2015). Though no national co-responder agency exists to track or evaluate the extent of programs being implemented across the country, internet searches document virtually every state uses at least one co-responder program.
- Service users in co-responder programs report less distressing and/or criminalizing responses from police officers and quicker access to mental health support when in crisis (Puntis et al., 2018).
- Co-responder models appear to be among the most cost-effective police/mental health collaborations as a result of reduced police costs (USDJBJA, 2019; Rosenbaum, 2010).
- Co-responder models facilitate proactive responses for individuals with multiple contacts with police to connect them to services (e.g. The City of Portland, 2019).

Best Practices

OMNI reviewed best practices and lessons learned from communities implementing LEAD and Co-responder program. Below is a high-level summary of findings; for more information please see the comprehensive review of the research literature on best practices for behavioral health treatment, that is available upon request from Boulder County Public Health.

LEAD (National Support Bureau, 2017)

- Command and officer-level buy-in are critical
- Core principles of LEAD are its harm-reduction and housing-first frameworks, rather than an exclusive focus on sobriety.
- LEAD is as much a voluntary collaboration between community stakeholders as it is a service for clients in need of behavioral health care. Stakeholder include the local business community and community public safety leaders.
- Resources must be adequate to ensure existing behavioral health clients are not displaced from services so that the entire community benefits from LEAD.
- A comprehensive resource for LEAD core principles, implementation, and special considerations is available at [The LEAD National Support Bureau](#).

Co-responder programs

- Establish clear policies and procedures of the program to reduce role ambiguity between officers and behavioral health specialists working together, and improve consistency between collaborating agencies (Allen Consulting Group, 2012).
- Behavioral health clinicians should be selected who have the right skill set and disposition for working closely with law enforcement personnel.
- Provide the ability to code or label dispatch calls as behavioral health to anticipate a co-response situation.
- Training for officers, behavioral health specialists, and call dispatchers should include de-escalation techniques and knowledge of mental health disorder signs and symptoms (Council of State Governments, n.d.).

Fiscal and Infrastructure Information

Many communities fund LEAD implementation through large grants, private foundations or tax funds. Most costs were associated with administration of the program and housing assistance for clients. The Colorado Office of Behavioral Health received \$2,300,000 annually for three years to pilot up to four LEAD programs (CDHS, 2019a). Co-responder programs are typically funded through federal grants (e.g. USDJBJA, n.d.), state government commissions (e.g. Pennsylvania Commission on Crime and Delinquency; Pennsylvania 211, 2019), state excise taxes (e.g. marijuana tax cash fund; CDHS, 2019b), and city governments (e.g. Depuvoir, 2017).

The table below provides some example costs for LEAD and co-responder implementation in various municipalities. Most available reports discuss “cost savings” in general terms and do not include total program costs.

Program	Cost per participant per month	Overall Program Costs	Funding Mechanisms
LEAD: Seattle, WA ¹	\$899 at program startup, \$532 after two years.	Not available	\$4 million from private foundations for four year pilot. City of Seattle committed funds for scaling up.
LEAD: Santa Fe, NM ^{2,3}	\$629	Not available	Federal, State, City, private
LEAD: Albany, NY ⁴	Not available	Not available	NYS Health Foundation, \$70,000 grant from the Touhey Family Foundation
Co-Responder: Boulder EDGE ⁵	Not available	\$600,000, program cost from 2014-2016	\$900,000 SAMHSA grant
Co-Responder: Mental Health Center of Denver with Denver Police Department ⁶	Currently under evaluation	\$566,000, total costs in 2016	Contract with City & County of Denver, Medicaid, Veteran's Administration, and third party.
Co-Responder: Colorado Springs Crisis Response Team ¹	Not available	\$600,000 annually	Colorado Crisis contract, police and fire department personnel contributions

1. (CBHC, 2016) 2. (Drug Policy Alliance, 2018) 3. (New Mexico Sentencing Commission, 2018) 4. (Brown, 2017) 5. (Amell, 2019) 6. (MHCD, 2019)

Screening, Referral and Navigation Teams

Service systems implementing LEAD and co-responder models often employ a centralized team that coordinates referrals, care, navigation and/or case management for individuals receiving services. These teams typically include clinical staff with specific roles as well as infrastructure such as call lines and technology platforms to support their work.

Teams like these are currently in service in communities across the nation. The Mount Carmel Health System in Ohio uses a case management team or “hub” as a part of their urban health management services that address needs of people affected by social determinants of health (e.g. socioeconomic, language, transportation barriers) (Mount Carmel Health System, 2019). The hub consists of trusted and knowledgeable community health workers who serve as liaisons between health and social services and the community. The hub accepts both agency- and self-referrals for

people in need, assists clients in accessing appropriate resources, and builds community capacity through outreach and community education activities.

Similarly, Texas's Ascension Seton non-profit health care system (Ascension Seton, 2019), and the Mental Health Association in Pennsylvania (MHAPA, 2018) employ behavioral health navigators who assist individuals and professionals in need of guidance when using mental and/or substance use services and supports, such as therapists, support groups. Behavioral health navigators are licensed behavioral health clinicians, and enlisting assistance from them is free. Navigators help develop action plans for engaging in services and understanding insurance coverage options and follow up with clients to make sure they have connected with their desired service effectively.

Recommendations for a County-Wide Approach to Diversion

The recommendations provided within the four areas below reflect extensive stakeholder input and are supported by literature and lessons from other communities implementing larger scale diversion efforts (See Appendix A for methods and assessment participants). Recommendations are followed by a brief rationale and an illustration of the proposed structure and model for aligning diversion efforts across Boulder County.

Key Recommendation Areas

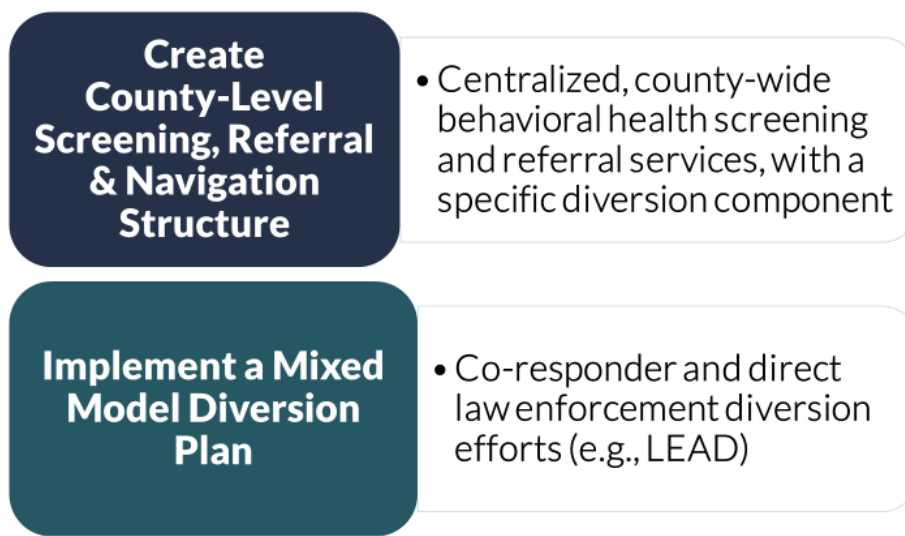


Recommendation Area 1: County-Wide Diversion Efforts

Literature on early diversion best practices, lessons learned from other communities, and Boulder County stakeholder input all suggest that the effectiveness of a county-wide diversion program depends heavily on:

1. the availability of timely and appropriate services for program participants;
2. the support and readiness of law enforcement, including both leadership and line level officers; and
3. community-level adaptations based on local population needs (e.g., differences in staffing levels, target populations or criteria for diversion, etc.).

The approach outlined below carefully considers all of these factors and is grounded in both literature and perspectives across stakeholder groups. The following proposal would formalize a county-wide early diversion approach for individuals with behavioral health issues who are involved with law enforcement (for example, at the point of arrest) and better align efforts across municipalities, while still allowing some tailored, community-level efforts that complement the county-wide approach. This recommendation area includes two core elements, outlined further below.



Core Element 1: Create County-Level Screening, Referral and Navigation Structure

Collaborate with key partners from Coordinated Referral System efforts to create a centralized screening, referral and navigation system or "Hub" that includes a specific diversion component, providing infrastructure and clinical staff for early diversion efforts in Boulder County.

Many stakeholders emphasized that even with current gaps in Boulder County service capacity, treatment access issues could be improved by centralization of screening and referral services, warm handoffs to providers, and consistent follow-ups with participants over time. As described in 'Recommendations for a Coordinated Referral System', the Hub would be comprised of clinical staff working in a centralized team and located in a county-level office (e.g., Boulder County Public Health, Community Services, or Housing and Human Services). Hub staff would provide screening, referral and navigation services, as well as longer-term navigation and follow-up that may be necessary for higher-need diversion participants. A subset of staff from the Hub would have a specific focus on diversion efforts and serve in a secondary Co-responder capacity as appropriate. See recommendations related to Co-responder efforts below.

Rationale

- Aligns with stakeholder feedback, literature, and similar community models, all of which emphasize the importance of a robust referral system that includes staff along with technology infrastructure
- Facilitates rapid handoff by law enforcement to appropriate behavioral health services
- Provides a clear point of entry for participants, reducing confusion and complexity of referral processes
- Allows for various county-wide diversion efforts to occur simultaneously and evolve over time, feeding back to the Hub for connection to services and ongoing monitoring of participant outcomes
- Offers flexibility for current local-level efforts with their own teams to utilize the county Hub for backup as needed, with the goal of merging with Hub efforts over time
- Ensures that county diversion efforts are aligned and complement one another, and that staff are similarly trained in overall philosophy, approach, and overarching program goals
- Positions the County to oversee and guide how the program team operates, leverage funding efforts, and reduce potential challenges with contractors (e.g., contract agreements, philosophy and approach, training, etc.).

"A diversion program is only as effective as the network of services to which it refers its participants."

Key Hub Functions and Core Responsibilities:

- Respond to law enforcement diversion and any other designated community referral sources within a specified timeframe (e.g., 48 to 72 hours) to complete a standardized screening and intake process.
- Provide virtual (phone) screening and referral services as well as on-the-scene (mobile) services, including secondary Co-responder support for crisis situations and supporting high utilizers
- Deliver flexible, referral-focused navigation that responds to unique individual needs and utilizes a harm reduction philosophy to assess participant readiness for change
- Work with patients to determine needed and desired services (prioritizing most critical needs) and provide warm handoffs to services and treatment; follow up with participants over time to ensure that they successfully connect to services
- Utilize peer support staff as feasible, to serve appropriate functions

Core Element 2: Implement an Initial County-Wide Mixed Model Diversion Plan

Launch initial diversion efforts that will be implemented county-wide, with a mix of both LEAD elements and Co-responder programming.

The extensive stakeholder input gathered for this assessment varied greatly in terms of: 1) preferred diversion approaches (e.g., Co-responder, LEAD model, etc.); 2) timing of efforts or

"where to start" (e.g., population of focus or municipalities); and 3) law enforcement preferences for needed training and decision-making authority versus on-the-scene support from behavioral health partners.

OMNI therefore recommends an initial mixed model including both LEAD and co-responder elements, and a longer-term goal for all county diversion efforts to fully align over time. More detail is provided below on implementation of LEAD and Co-responder elements. Additional information on best practices can be found in 'Diversion Assessment Findings' and 'Best Practices for Treating Mental Health and Substance Use Disorders Literature Review'.

Direct Law Enforcement Diversion Efforts

Launch diversion efforts with highly specified target populations, criteria for program involvement, and guidance for officers.

The following populations are common initial LEAD criteria: first time offenders; specific low-level offenses; high frequency users. OMNI recommends the following criteria and exclusions (for review by the LEAD Task Force):

- **Eligibility criteria:**
 1. low-level, non-violent offenses (e.g., possession; open container, trespassing, loitering, littering, misdemeanor larceny/shoplifting/concealing merchandise);
and
 2. expressed interest in/agreement to receive services.
- **Exclusions:**
 1. individuals with violent offense history in the last 10 years including weapons, assault, domestic violence and sex offenses (*other possible exclusions to consider: promoting prostitution, drug trafficking);
or
 2. individuals who do not agree to receive an assessment and/or services.

All of the above criteria and exclusions should be outlined in writing, using law enforcement policy and coding language. The broader Longmont LEAD guidelines that include a high level of officer discretion are not recommended as a county-wide approach at this time. Guidelines may be expanded once officer training is up-to-date, officers have successfully adopted the approach, and preliminary efforts are evaluated.

Co-responder Programs

Initiate Co-responder efforts with variations/adaptations based on geographic area and/or population needs as appropriate.

OMNI recommends a **secondary** response team that would be housed within the county-level Screening, Referral and Navigation Hub (described above), with additional **primary** response teams launched as needed, depending on geographic needs (e.g., highly populated areas with heavy call volumes). Officers reported mixed views about Co-responder models; some have concerns about the safety of a Co-responder and potential role confusion, while others prefer the support and

reduced burden that a behavioral health co-response brings. The distinctions between these two types of responses are outlined in the table below. Boulder County should utilize this information to assess the need for any primary response teams in targeted areas of Boulder County.

<h3>Primary Response Team</h3> <p>"On duty" alongside officers during designated times, as well as monitors and responds to dispatch.</p>	<h3>Secondary Response Team</h3> <p>Called in by officers as needed and can include a variety of approaches including mobile response teams, virtual assessment center, etc.</p>
<p>+ Can be highly effective support for de-escalation and behavioral health crisis situations</p>	<p>+ Can be more cost-effective if call volume and patterns are unclear or for low call volume/rural areas</p>
<p>+ Enhances information-sharing across response team and systems (i.e., law enforcement and behavioral health/case management team)</p>	<p>- Can miss behavioral health crisis calls and opportunities for early de-escalation and redirection to treatment</p>
<p>- Costly to implement county-wide without clear data to inform staffing</p>	<p>- Relies more on officer discretion and early identification of behavioral health needs; can require more behavioral health training for officers</p>
<p>- Maintaining adequate staffing can be challenging depending on typical timing and volume of high-need calls (e.g., standard business hours vs. later when specific call types are more likely)</p>	

Rationale

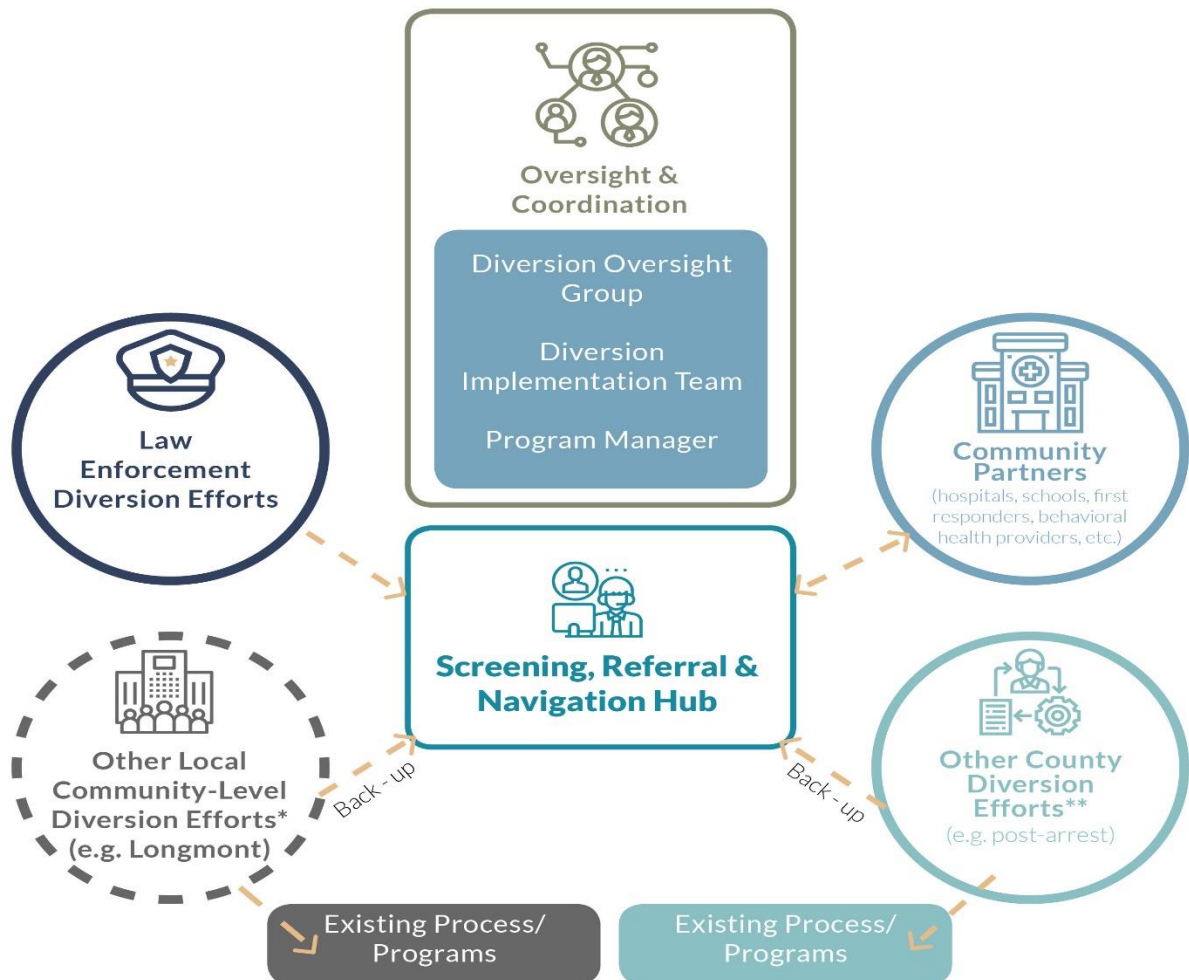
- A mixed-model with both Co-responder and LEAD elements can address a range of needs across the county, tailoring approaches to specific geographic areas and target populations as appropriate
- Creates space for learning and innovation, with strategies that can evolve and converge over time, based on observed responsiveness to community needs and overall effectiveness
- Recognizes the value of current community-level diversion efforts (e.g., Longmont); allows for initial variability across communities; and provides time to secure support and align diversion approaches for more consistent county-wide implementation

Implementation Model Visuals and Example Scenarios

The visuals below outline a phased approach for Boulder County's transition from initial implementation to a more fully integrated county-wide approach within 12-18 months. Potential scenarios outlining how partners may interact with the system are also provided.

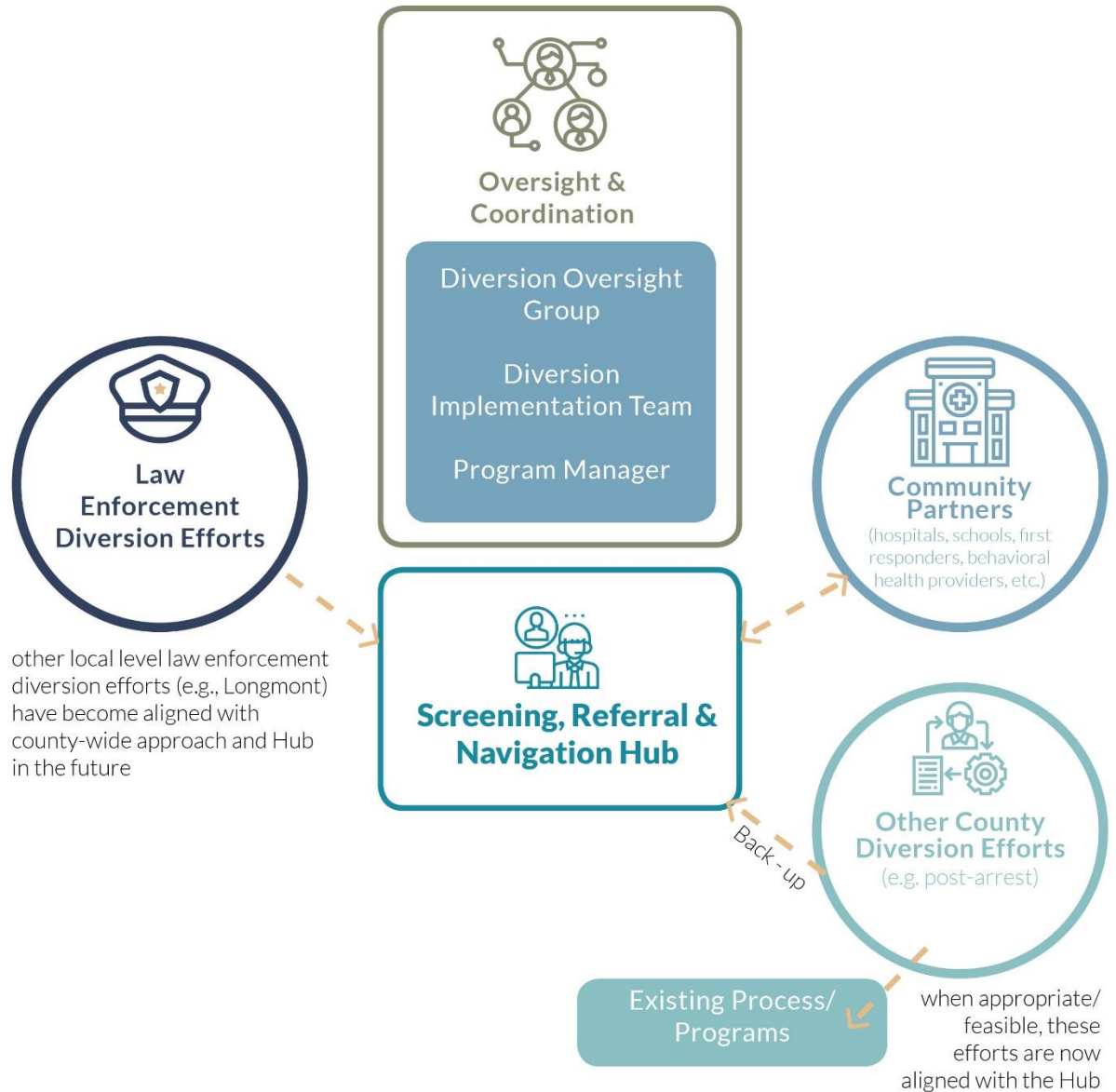
Phase 1: Initial Implementation

- Hub is developed and launched with initial funding and focused on law enforcement diversion efforts
- Local law enforcement diversion efforts (e.g., Longmont) can remain but may utilize the Hub as backup
- Other county diversion efforts can remain but may utilize the Hub as back-up
- Other community partners will begin to utilize the Hub in a phased process, as the county-wide coordinated referral system is implemented



Phase 2: County-Wide Behavioral Health Response System

- Hub has refined its processes, functioning, and sustainability plan for ongoing funding
- Local law enforcement diversion efforts (e.g., Longmont) have aligned with the larger county-wide diversion approach and Hub, and any remaining local programs are designed to complement Hub services
- Other county diversion efforts (e.g., post-arrest) utilize the Hub as appropriate but may remain as additional programs that complement Hub services
- Other community partners utilize the Hub and its expanded functions as the key intake, assessment, and referral mechanism for the County; functions specific to law enforcement diversion remain as a core component of the Hub



Example Scenarios

The following scenarios outline the various ways in which law enforcement and other community partners may interact with and utilize the Hub over time.

Scenario 1: Law Enforcement Referrals to HUB Screening and Referral Services

- Law enforcement in Boulder County (any location) encounters individual in possession of heroin or low-level offense as outlined, presenting with clear behavioral health issues
- Person is not in acute crisis; is interested in and willing to seek treatment
- Officer refers to Hub and individual is assessed within determined timeframe (e.g., 48-72 hours)
- Referral-focused navigation services are provided and may be simple (e.g., referral for harm reduction services, outpatient treatment and minimal follow up required) or more complex, (e.g., multiple referrals and need for longer-term navigation/case management-type services)

Scenario 2: Law Enforcement Requests for HUB Secondary Co-Responder Team

- Law enforcement encounters individual in acute behavioral health crisis in less populated/less active area of Boulder County without a local Co-responder program
- Officer calls in assistance from Hub, requesting staff member from a secondary response team (e.g., clinicians on call from the Hub who respond to acute crisis cases as needed)
- Hub Co-responder staff respond to the scene to complete screening and immediate referrals

Scenario 3: Law Enforcement Requests for Local Primary Responder Team

- Law enforcement encounters individual in acute behavioral health crisis in an area of Boulder County with local Co-responder efforts (e.g., Longmont or other new Co-responder efforts in highly populated areas such as downtown Boulder)
- Local police department has primary response team/ local-level Co-responders who are either monitoring dispatch, or on patrol alongside officer
- Local-level Co-responders complete assessment and make immediate referrals (may include additional navigation services through the Hub)

Scenario 4: Community Member or Other Community Partner Referrals to Hub Screening and Referral Services

- Family member or community partner encounters individual in acute behavioral health crisis.
- Community member or partner calls Hub, requesting clinicians on call from the Hub who respond to acute crisis cases as needed.
- Hub staff respond to the scene to complete assessment and immediate referrals (may include additional assessment or case management services through the Hub).

Recommendation Area 2: Buy-in and Communication

To support the recommendations for a county-wide, mixed model diversion effort that is centralized through a case management Hub, OMNI offers the following recommendations to support effective communication with key stakeholders, including funders, and generate buy-in from policy makers, key decision makers in county agencies, and the community at large.

Name and Brand a County-wide Diversion Initiative

Naming and branding county-wide diversion efforts will allow Boulder County to promote the work and align funding pursuits and public communications. Boulder County should consider broad language when branding this effort, such as the "Boulder County Behavioral Health Response Team," that can encompass a range of strategies and/or programs. Multiple models (e.g., LEAD and Co-responder) may be implemented over time and/or simultaneously in various geographic locations, and additional behavioral health efforts (e.g., coordinated referral system) may later merge with this work. Even utilizing broad language and branding, Boulder County can describe the specific evidence-based practices the county is implementing when pursuing funding.

Develop Clear and Timely Communications about the Plan

Boulder County should ensure that communications about diversion plans are both timely and thorough, with special attention to information-sharing efforts for law enforcement and front line officers in particular. Recommendations for communications include the following:

- **Share data demonstrating the need for these efforts in Boulder County and the effectiveness of other diversion programs** (e.g., develop a simple fact sheet that can be distributed county-wide). Relevant information should include:
 - Indicators such as behavioral health-related call volume, jail overcrowding; percentage of individuals in jail with behavioral health issues, etc.
 - Current system inefficiencies (e.g., officer transport to multiple locations before referral is accepted)
 - Program impacts in similar diversion programs.
- **Communicate planned approach and key steps in the planning process** that need to take place prior to implementation.
- **Share mapping of county-level and local-level efforts and relationships to demonstrate coordination of efforts**, and consider including a central document with a summary of community-level variations. Community-level fact sheets on local approaches and how they relate to county-wide approach may also be useful.
- **Set realistic expectations prior to implementation:**
 - New approaches and programming inevitably experience growing pains so there will be early supporters and later adopters, regardless of pre-planning efforts.
 - Efforts will likely evolve over time as challenges are identified and addressed.
 - Program impacts can take time.
 - Community members must learn to engage with law enforcement differently than they have in the past.

- Recovery for participants with high-level behavioral health needs and histories takes time and some diversion participants may need life-long interventions.
- **Ensure resources for ongoing communications that will be needed to maintain momentum and support once efforts move to action.** This includes addressing political issues that may surface and related public messaging needed, ensuring continued buy-in from key partners experiencing early barriers, etc.

Recommendation Area 3: Oversight and Coordination

To oversee and implement efforts, best practices recommend several key groups and individuals to align efforts county-wide, improve coordination of services, and increase collaboration across partners. As noted in ‘Recommendations for a Coordinated Behavioral Health Referral System’, Boulder County should consider merging efforts or broadening charges of existing groups before forming new groups, to streamline efforts and reduce duplication. In addition to the current Diversion Task Force (currently the “LEAD” Task Force”, some current groups to consider for membership and involvement include:

- Diversion Task Force (currently the “LEAD Task Force”, focused on county-wide diversion efforts)
- Behavioral Health Task Force (focused on county-wide behavioral health efforts)
- Healthy Futures Coalition (focuses on community engagement for substance use primary prevention among youth with significant school system involvement; could expand to include mental health)
- Substance Use Advisory Group (focuses on community engagement for early intervention and treatment with significant healthcare system involvement; could expand to include mental health)
- IMPACT Executive Board (focuses on high acuity youth touching multiple systems)
- Municipal level groups such as the behavioral health community-based groups in Longmont
- Groups involving inter-governmental technology and data governance

Leadership and Oversight Body

Designate a clear leadership group that oversees behavioral health diversion work across the county.

Consider the current LEAD Task Force membership as a starting point, with the addition of core behavioral health and other community partners. Identify any missing partners that would need to join or attend occasional meetings. The IMPACT Executive Board could also serve as a potential starting point for this leadership group. The team should meet monthly during project planning and initial implementation, then moving to quarterly with additional meetings as needed.

Core responsibilities of the Leadership and Oversight Body would include:

- ***Collaborate with the Coordinated Referral System leadership and implementation teams***
- Maintain a high-level view of efforts county-wide, ensuring alignment and reducing duplication of efforts (e.g., county and municipal level efforts)
- Decision-making regarding the overarching county-wide approach to diversion and models implemented
- Monitor of and potential involvement in policy and systems change opportunities that could impact the work
- Coordinate resources, including identifying funding opportunities and approaches to secure resources and sustain efforts over time
- Communicate with coordinated referral system leadership and implementation team

Implementation Team

Develop an implementation team, comprised of law enforcement and core behavioral health providers, including local hospitals that provide mental health and/or substance use treatment.

Additional community partners should be brought in regularly (e.g., quarterly), such as emergency assistance, first responders, local shelters and other organizations serving or interfacing with individuals with behavioral health issues.

Core responsibilities of the implementation team would include:

- ***Collaborate with the Coordinated Referral System leadership and implementation teams***
- Assess service gaps and how barriers to admission can be reduced
- Develop referral processes and practices
- Develop diversion criteria and approaches at the county level
- Discuss additional local-level diversion programs and adaptations
- Identify and coordinate training needs for law enforcement and other direct line staff
- Communicate with coordinated referral system leadership and implementation team

Program Manager/Hub Manager

Identify and fund a dedicated manager position to guide and communicate across teams and maintain the momentum of efforts, independent of political interests.

Given the need to coordinate efforts and the similarity of responsibilities for the manager for diversion efforts and manager for the Coordinated Referral System and (see, 'Recommendations for a Coordinated Behavioral Health Referral System'), Boulder County should consider whether a dual program manager position is appropriate.

Core responsibilities of the manager would include:

- Communicate between partners and across leadership and implementation teams
- Coordinate meetings, agenda development, facilitation and other logistics
- Delegate responsibilities to teams and individuals as needed
- Compile and analyze data (or coordination of this work with a contractor)
- Draft program materials and larger communications for core team review

Community Level Operations Groups

In addition to the above, individual communities with their own initiatives may need their own operational workgroups to coordinate any unique local efforts. To ensure coordination with county-level efforts, communities should plan to send representation from their groups to the Oversight and/or Implementation teams outlined above. Community-level operations groups would eventually merge with the larger implementation team outlined above.

Recommendation Area 4: Evaluation

Evaluation of Boulder County's diversion efforts will be critical to assess program impacts and intended outcomes; examine potential program refinements needed; and demonstrate transparency and accountability to the community. OMNI makes the following preliminary evaluation recommendations for Boulder County's diversion efforts outlined in this report.

- Ensure a robust evaluation plan and systematic data collection
- Ensure that evaluation plan includes primary data collection efforts as they relate to the Hub functions and participants, as well as data that are collected at the county level. Both process and outcomes measures should be explored
- Finalize initial core set of indicators to be collected county-wide, ensuring that data collection efforts are consistent and indicators are tracked uniformly across key partners
- Special considerations should be made for collecting evaluation data from program participants who are not closely followed or are typically hard-to-reach
- Ensure that early evaluation findings from the City of Longmont are considered, with early learnings used to inform efforts and next steps for county-wide evaluation

Key areas for evaluation to consider include:

- **Program-level Process Measures**
 - Participant characteristics/population reached through the program
 - Training efforts
 - Staffing patterns
 - Co-responder contacts
 - Case management contacts
- **Participant Outcomes**
 - Recidivism (e.g., arrests, jail bookings, jail days, new misdemeanor and felony cases)
 - Recovery time/sobriety
 - Housing
 - Employment
- **System and Cost Impacts**
 - Utilization patterns for criminal justice, legal and emergency services (average yearly costs pre- and post- program implementation)
 - Program administration costs vs. costs for system as usual/prior to Hub implementation
 - Law enforcement call patterns (volume and type)

Boulder County Provider Directory Implementation Recommendations

An essential part of effective referral to services for individuals with mental health and/or substance use needs is knowing what treatment options are available in the first place. Potential patients, and health professionals providing care and guidance, need to know what providers exist in the community, if their services are appropriate for unique health profiles, how much they cost and their availability, etc. Typically, provider information is stored in online directories, though unfortunately these directories often contain inaccurate, out-of-date or confusing information (Shelton & Chin, 2004). The accuracy of this information is crucial for warm handoff best practices that facilitate patients' adherence to treatment plans all the way to their completion. An up-to-date directory of existing mental health and substance use disorder treatment providers in Boulder County is needed, as well as recommendations on how best to maintain this information to keep up with the changing health industry.

Aided by stakeholder input and background research, a complete directory of behavioral health care providers in Boulder County was developed (for methodology, see Appendix A; the full directory can be accessed upon request from Indira Gujral at Boulder County Public Health (igujral@bouldercounty.org)). The final directory serves as a comprehensive list of publicly, readily available information that is current as of September 2019. Through the considerations outlined in this section of the report, in conjunction with other recommendations made as part of OMNI's broader assessment work, Boulder County has the opportunity to:

1. transfer the information in the provider directory into a web-based, easily filtered and searched directory,
2. maintain current information about provider services in the county over time, and
3. continue to refine and enhance the directory with additional information on the services provided as well as add to the directory with new and non-traditional behavioral health care providers in the County.

In addition to the directory, OMNI created a searchable Google map with the locations of all 132 mental health providers and substance use disorder treatment facilities described in the inventory. The map can be accessed on the internet [here](#), and is provided as a copy in Appendix D. Each point represents one facility and contains a description of the facility's name, address, website, and levels of care provided. Points are colored based on the highest ASAM level of care provided at each facility, ranging from 0.5 to 4, as outlined in the map's legend.

Developing and maintaining a functional, easy to navigate, and regularly maintained and updated behavioral health provider directory is a challenging process that involves multiple interconnected, yet organizationally siloed, community partners and services. The end goal of a provider directory is to connect participants to available behavioral health services in an accurate and timely fashion.

A directory that providers can use to refer participants to available services is at its core a comprehensive list of providers that contains relevant information about services. However, considering the collaboration needed between service delivery settings, the rapid turnover of provider information and availability, and the need to sort, filter, and document provider information for use, a provider directory must also be thought of as a case management support service.

To meet the desired objectives of a county-wide provider directory, OMNI's guiding recommendation is to integrate the provider directory into a county-wide coordinated referral technology platform and assign staff within the the Screening, Referral, and Navigation Hub with directory maintenance.

Key responsibilities for staff within Screening, Referral, and Navigation Hub, as they relate directly to the provider directory would be as follows:

- Collaboration with IT professions on the initial development of the directory within the IT platform that is selected/
- Providing technical assistance for directory users. Case managers within the hub would be the primary users of the directory, but providers in the community, and potentially participants may also have access to the directory.
- Conducting regular maintenance to ensure provider information is current and the directory is performing its function of connecting participants to services effectively and efficiently.

Below we have outlined some additional key recommendations as they relate to policy, implementation/functionality, and sustainability of a provider directory. Recommendations are based on stakeholder input as well as consultation of recommendations and guidance for state-wide provider inventories created by the Colorado Consortium Treatment Workgroup.

Policy Considerations

Recommendation	Rationale
Identify clear goals for the provider directory, as well as roles and responsibilities for the provider directory team.	With multiple stakeholders comes multiple desired goals and priorities which may impede development. Identifying and regularly revisiting the purpose and goals of the provider directory will ensure its use is associated with beneficial health outcomes.
Involve multiple diverse behavioral health stakeholders in the maintenance process.	<p>The maintenance of a provider directory is an iterative process that must consider behavioral health from multiple perspectives and principles. The perspectives of members from the following groups should be considered:</p> <ul style="list-style-type: none"> • Medical providers • Treatment providers • Recovery support • Social services • Law enforcement • Participants / families
Consider multiple types of end users and their needs (i.e., who the tool "faces") and include diverse stakeholders in testing.	<p>The content and ease of use of a provider directory is contingent on the end user experience (e.g., using lay-language, allowing provider control over contact information shown). Consider the perspective of:</p> <ul style="list-style-type: none"> • Health providers • Behavioral health clients of diverse backgrounds • Care coordinators • Family members • Participants
Include IT expertise early in development.	The development of a provider directory involves both behavioral health (content) and IT (functionality) expertise. Key informant input suggests that behavioral health professionals' approach tends to be careful and reasoned while IT professionals' approach tends to be fast, iterative, and quickly adaptive. Both perspectives are necessarily. Consider that tool's content can be shaped by its functionality and vice versa.

Recommendation	Rationale
Consider the intersection of the provider directory with other health data systems and use data to drive decision making around service needs.	The collection of health services usage data can support the assessment of community health and identification of resource surplus/gaps, and geographic gaps in services.
Develop processes for vetting the quality of providers included in the directory.	There should be minimum standards of professionalism (e.g., licensing, certification, etc.) for providers who are included in the directory. Staff responsible for directory maintenance should regularly monitor standards of care.

Implementation/Functionality Considerations

Recommendation	Rationale
Provide the ability to sort/filter/organize providers by their characteristics.	Effective referrals involve specific services that are conveniently located for the participant.
Allow for basic and advanced directory interfaces.	<p>The function of a provider directory is to connect participants to services. It is likely to be a part of the initial contact and referral process which is a sensitive stage regarding adherence to treatment.</p> <p>People may interface better with simple ("lay") terms (e.g., from Psychology Today). At the same time, industry standard terms should be considered for provider use.</p>
Include map interface.	Geographic location of services provides important information about the feasibility of connecting participants to services and a map can help guide decision making around referrals.
Engage in ongoing vetting of provider characteristic elements and directory functionality.	The healthcare industry undergoes frequent legislative, funding, and technological changes. Allow for seamless adaptation of the IT platform and content and maintain consistent end-user experience.
Include user login ability / save search functions.	The behavioral health profile of an individual is unique and changes over time. Participants can use their personalized experience to help guide referrals. Ensure confidentiality/HIPAA requirements are met.
Provide hard-copy support.	Participants with behavioral health treatment needs may not have a dedicated internet access, be homeless, be in transition, and/or lack other resources. Having the option to provide information in hard-copy format ensures accessibility for a broader audience.
Directory functionality should reflect the principles of warm handoff procedures.	<p>Areas to consider to facilitate warm handoffs include:</p> <ul style="list-style-type: none"> • Reason for referral • Urgency level • Patient goals and concerns • Medication status • Participant transition/referral history

Sustainability Considerations

Recommendation	Rationale
<p>Perform regular audits to ensure directory information is up-to-date and accurate.</p>	<p>A fundamental issue with static provider inventories is that they become out-of-date quickly. Ideally, a provider directory would be audited weekly, and be regularly used and maintained through use.</p>
<p>Include a function for providers to update their own information.</p>	<p>Providers know best their organizational capacity and have the most up-to-date status of the availability of their services. Considerations to support providers with regular updates include:</p> <ul style="list-style-type: none"> • Incentivize providers to update information • Require providers to log in regularly (e.g., monthly) • Include a provider responsiveness rating system for participants • Associate registration of provider information in the directory with County provider practice licensing

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Appendix A: Methods

Data collection methods and key stakeholders for assessments overlapped and are therefore presented together. Overarching methods included the following and are further detailed in the graphic on the following page.

- Review of literature, publicly available information about models or systems, and community-level implementations
- Online surveys to gather diverse stakeholder input
- Qualitative information gathering including key informant interviews, meeting facilitation with key stakeholders, and a site visit explore community-level implementations of diversion models within the County

Method	Coordinated Referral System Assessment	Diversion Assessment	Provider Directory
Literature and Community Implementation Scans	<input checked="" type="checkbox"/> Review of literature and publicly available information on coordinated referral systems, community-level implementations, and technology platforms	<input checked="" type="checkbox"/> Review of literature and publicly available information on diversion models, and community-level implementations and adaptations	<input checked="" type="checkbox"/> Review of existing provider directories including locally maintained lists as well as online directories (e.g., Ladders)
Stakeholder Interviews (including 1:1 and small group phone interviews)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Stakeholder Meetings: (including in-person and virtual meeting facilitation)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (also included site visit with Longmont diversion staff to explore community level program implementation)	<input checked="" type="checkbox"/>
Online survey (with quantitative and qualitative data collection) facilitation)	<input checked="" type="checkbox"/> Key partner survey including criminal justice and law enforcement, behavioral health treatment providers, prevention specialists, other community support, medical, and crisis partners	<input checked="" type="checkbox"/> Line-level officer survey	--

Development of Assessment Tools and Analysis

Stakeholder Surveys

OMNI worked closely with Boulder County Project Oversight Team to develop both the Coordinated Referral System Partner Survey and the Officer Diversion survey. Survey items were identified to assess the following key areas:

Coordinated Referral System Partner Survey	Officer Diversion Survey
<ul style="list-style-type: none"> • Overall support and perceived benefits of a coordinated referral system • Priority data needs and system functions • Potential challenges • System access • Likelihood of implementing a coordinated referral system 	<ul style="list-style-type: none"> • Perceived benefits of a county-wide diversion program • Overall buy in and willingness to implement a diversion program • Potential implications for everyday work • Priority training needs • Potential challenges

A total of 210 survey responses were analyzed after data quality assessment and cleaning. Records were excluded when there was insufficient information for analysis, duplicated information, or other data inconsistencies that could not be reconciled. Mean scores and frequency distributions were calculated for all survey items (see Appendices X and X for full survey findings).

Interviews, Focus Groups, and Facilitated Meetings

Qualitative efforts served to explore stakeholder perspectives, explore local context, and deepen understanding of survey findings. Interview and meeting guides were developed by OMNI, with guidance on approaches and general areas of inquiry provided by the Boulder County Project Oversight Team. OMNI implemented various facilitation processes, customized to each stakeholder group to maximize engagement and achieve intended meeting outcomes. Examples include small group discussion and large group brainstorming, gallery walk facilitation methods, worksheet activities conducted in small groups for cross-sharing and generation of ideas, and individual self-reflection. Key areas explored through qualitative efforts included:

Coordinated Referral System Assessment	Officer Diversion Assessment
<ul style="list-style-type: none"> • Strengths and challenges of current systems • Overall support and perceived benefits of a new coordinated referral system • Priority data needs and system functions • Potential challenges with a new system • Likelihood of implementing a coordinated referral system • Potential approaches to implementation 	<ul style="list-style-type: none"> • Perceived benefits of a county-wide diversion program • Overall buy in and willingness to implement a diversion program • Potential challenges • Potential approaches to implementation

OMNI conducted a qualitative, thematic analysis of documented meeting minutes and group activities, transcribed recordings, and interview notes. Analysis was guided by the development of key themes and a standard coding structure. Analyses placed particular emphasis on issues raised by individual groups more than others, across multiple groups, and themes raised with particular intensity. Unique ideas or anecdotes are also included as relevant to specific larger themes. Findings commonly refer to participants as “stakeholders” unless specific issues were raised only by certain groups (e.g., law enforcement officers).

Development of Provider Directory

OMNI relied on multiple stakeholder groups and key informants to provide input on the information that would be most useful for a behavioral health provider directory specific to Boulder County. OMNI met with several key stakeholders and participated in existing meetings to learn about existing provider directories, Boulder County context, and current directory system challenges.

OMNI performed an initial search and compilation of Boulder County behavioral health provider lists/inventories using existing provider lists (including both lists available on the web, e.g., Ladders, and locally maintained lists), guidance from the SUAG members, and internet searches. From the initial information gathering efforts, OMNI drafted a list of provider services (for example, the hours of operation, treatment provided, level of care, etc.) for stakeholder vetting, as well as a comprehensive list of behavioral health care providers in Boulder County. The list of provider services was reviewed and vetted extensively by selected key stakeholders (see 'Participants' section below). OMNI incorporated final input and recommendations from stakeholders into the final draft of the inventory. Available services were documented for each provider in the inventory using website searches and existing inventory cross-referencing. The final provider inventory consists of a list of all known behavioral health care providers in Boulder County as well as the services known to be provided at each facility. In addition to the provider inventory, OMNI created a searchable Google map with the locations of all 132 mental health providers and substance use disorder treatment facilities described in the inventory.

Technology Platform Review

OMNI utilized findings from the Coordinated Referral System Partner Survey (see above) to inform the review of technology platforms. OMNI developed a general rubric for review, based on key system functions most emphasized by stakeholders. See 'Coordinated Behavioral Health System Findings' for more information.

Participants

OMNI worked with the Boulder County Project Oversight Team to develop key stakeholder contact lists, which were used for survey invitations and coordination for interviews and meetings. Outreach for participation was conducted by OMNI and the Boulder County Project Oversight Team through email, meeting announcements, and in person. The participants involved in the assessments and provider directory development are listed below.

210 survey respondents (See Appendices B and D for more information on survey participants and findings)

- 100 partners including criminal justice and law enforcement, behavioral health treatment providers, prevention specialists, other community support, medical personnel, and crisis partners
- 110 officers

14 Facilitated Meeting Discussions with the following groups:

- Behavioral Health Task Force
- Boulder County Home Visiting Collaborative
- Boulder County Project Oversight Team (3 facilitated meeting discussions focused on findings and recommendations, with ongoing input at every phase of the process)
- IMPACT Executive Operation Board
- LEAD Task Force (3 facilitated meetings)
- Longmont case management/clinical staff
- Longmont first responders and law enforcement team
- Substance Use Advisory Group (SUAG)
- Virtual meeting opportunities for partners from schools, Family Resource Network and other community organizations that may serve individuals with behavioral health issues (2 meeting opportunities)

17 interviews with representatives from the following organizations:

- Boulder County Community Justice Services
- Boulder County District Attorney
- Boulder County Public Health Family Health Division
- Boulder County Sheriff's Office
- Boulder Municipal Court
- City of Boulder Police Department
- Colorado Community Health Alliance
- Boulder County Probation
- Health District of Northern Larimer County
- Latino Task Force
- Longmont Public Safety
- Louisville Police Department
- Supporting Action for Mental Health

8 reviews of technology platforms and community implementations, including informational phone calls, online demos and review of materials

- Aunt Bertha
- Boulder County Connect
- Cloud Privacy Labs
- Julota
- NCCARE360
- NowPow
- RedCap (online review only)
- Unite Us

4 information gathering sessions with state-level professionals with provider directory expertise, including informational phone calls and existing meeting participation

- HealthInfosource
- OPISafe
- Participation in a statewide treatment database discussion facilitated by the Colorado Consortium Treatment Workgroup
- SUAG Treatment & Provider Education Workgroup facilitated discussion

4 expert reviewers of provider directory data elements and recommendations including:

- City of Boulder Housing & Human Services policy department
- Colorado Consortium for Prescription Drug Abuse Prevention Treatment Workgroup leader
- Prior experience developing and maintaining the statewide web-based directory of treatment providers for the Office of Behavioral Health (now LADDERS, formerly Linking Care), and understanding of IT platforms more generally, to support final recommendations.
- SUAG leadership members

Limitations

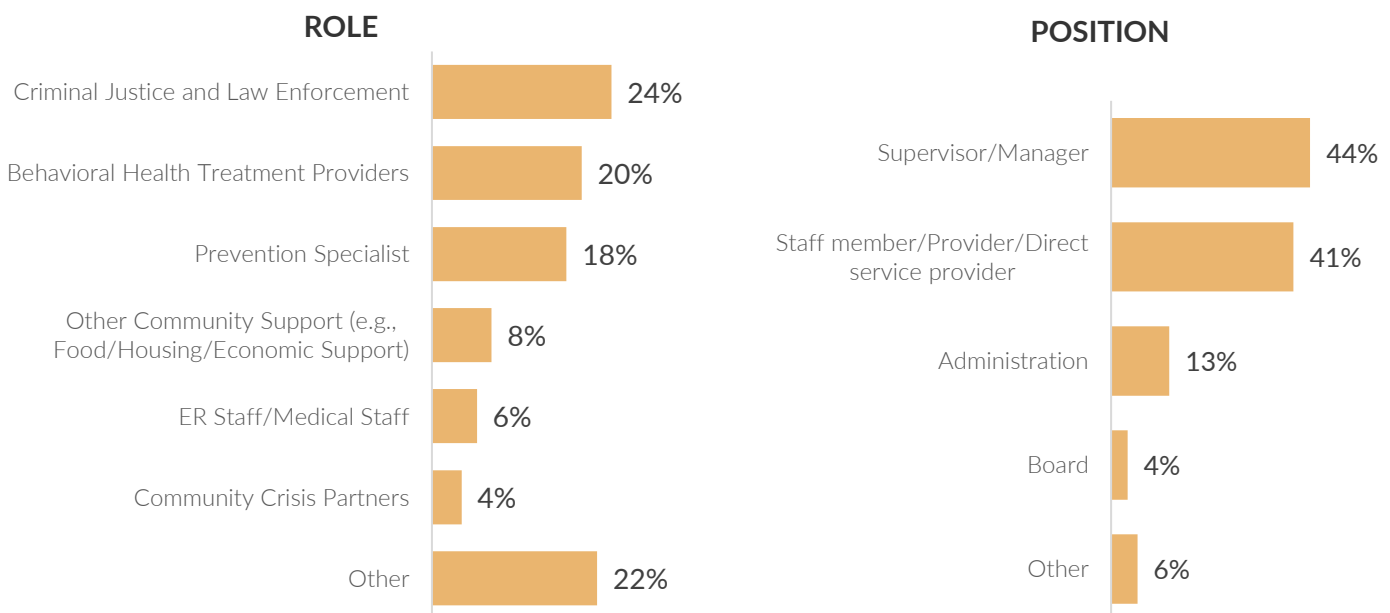
OMNI worked with Boulder County Project Oversight Team closely to identify potential key informants, groups for meeting participation and survey respondents. OMNI worked to ensure that stakeholders were informed of assessment efforts early in the process and were offered the opportunity to participate in one or more information gathering methods (i.e., interviews, groups conversations, meetings and/or surveys). Although every effort was made to be inclusive as possible in participation and to gather input from all key stakeholders, feedback may not be fully comprehensive or thoroughly cover every group who participates in Boulder County's behavioral health system (for example, the perspective of the fire department is under-represented in this report). It is also important to consider that survey respondents self-selected to participate and those who took part in surveys may have had specific interests in responding and/or may differ from those who declined to participate. As the County moves forward with implementation of the recommendations outlined in this report, continuous efforts should be made to continue to gather input and feedback on implementation from all groups.

Appendix B: Partner Survey Findings

OMNI conducted a survey to assess support for and benefits of a coordinated referral system in Boulder County, features of a coordinated referral system that would be necessary for key functionality, barriers for implementation, prioritization of community partners who would need access to the system, and the likelihood of using such a system. The findings from the survey are included in this appendix.

Survey Findings

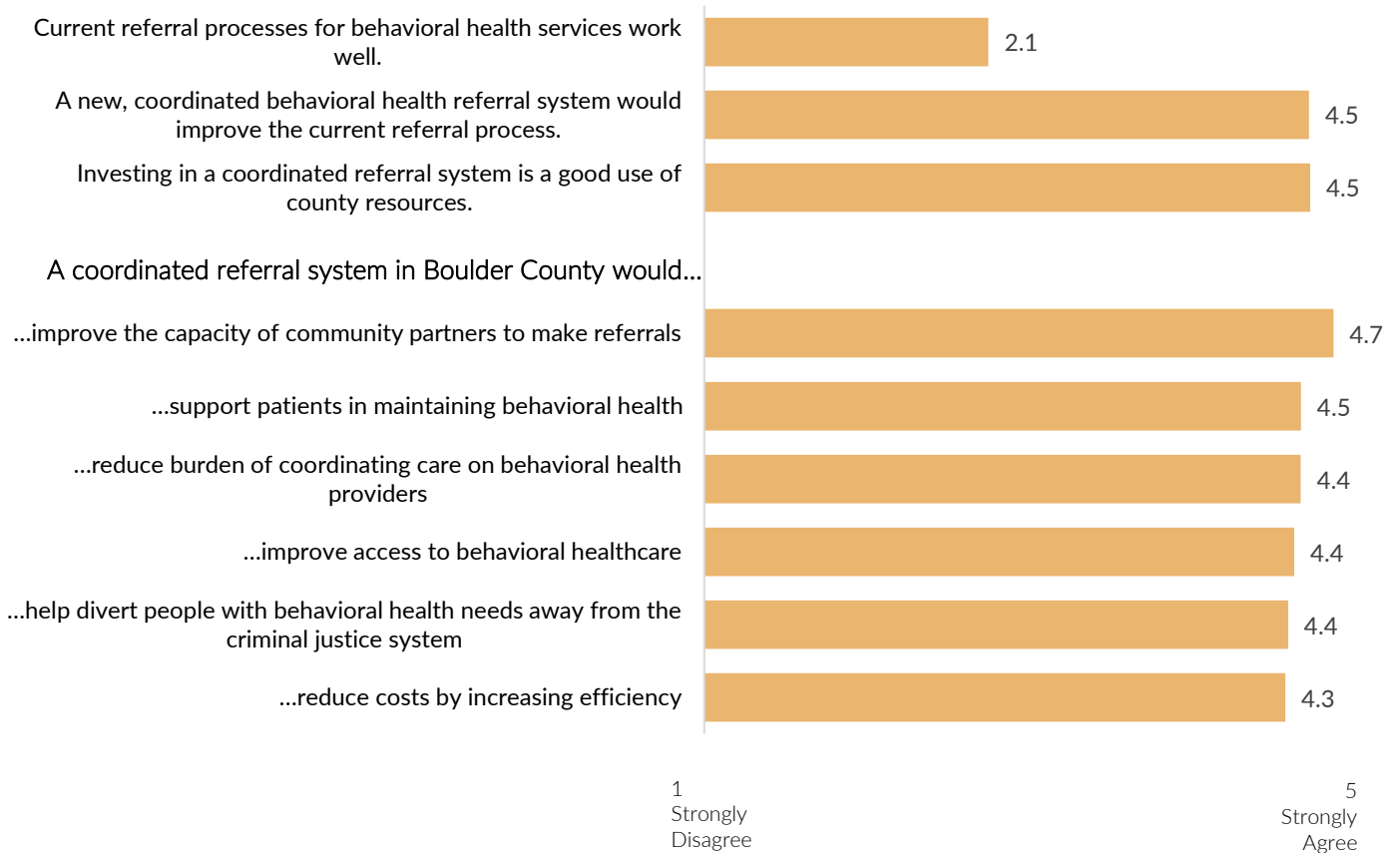
Survey respondents were asked to indicate their position within their organization and broader role in the behavioral health field. The majority of the 100 survey respondents reported having a role in criminal justice and law enforcement, behavioral health treatment, or had a related role that was not listed on the survey such as local government, education or other services (e.g., housing, food, etc.). Most respondents reported holding the position of a supervisor, manager, or front line staff, which includes staff members, providers, and direct service providers.



Supports and Benefits

Survey participants were asked to assess the potential benefits of a coordinated referral system in Boulder County. Participants were asked to indicate the degree to which they agreed or disagreed with a number of statements related to support for a coordinated referral system with 1 indicating "strongly disagree" and 5 indicating "strongly agree". Overall, the survey findings indicate that participants support the implementation of a coordinated referral system.

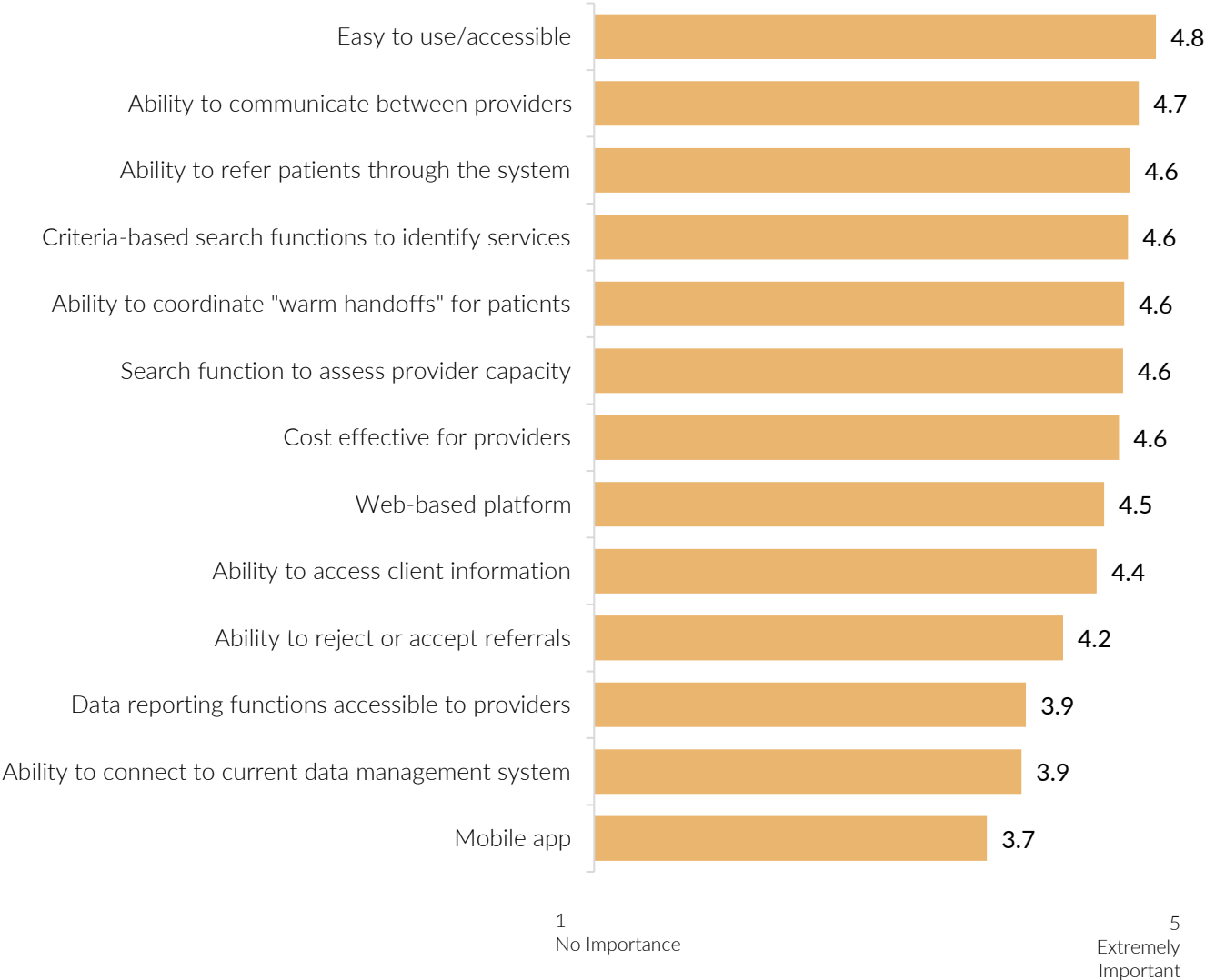
Survey participants agree that a coordinated referral system in Boulder County will improve capacity for community partners to make effective referrals for people who need behavioral health services.



Priority System Features

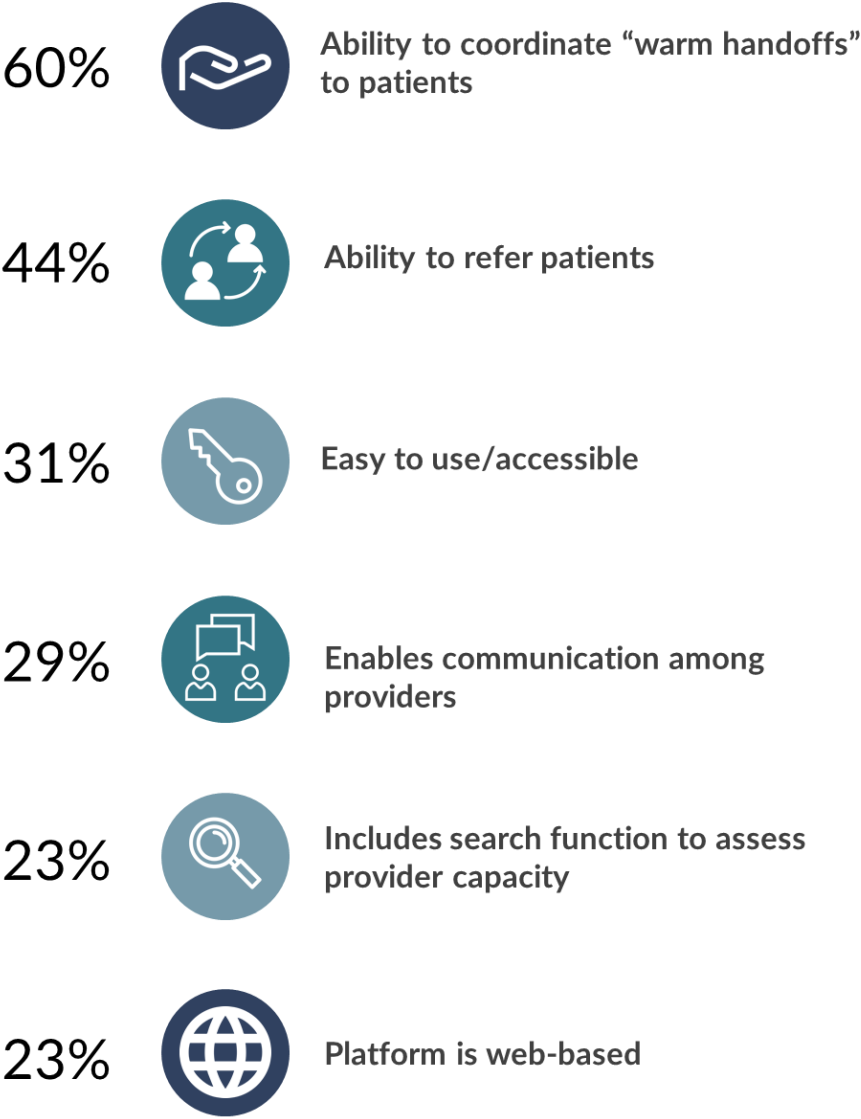
Participants were asked to rate potential features of a coordinated referral system based on how critical they are to system efficacy. Rating was on a 1-5 scale with 1 being "of no importance" and 5 being "extremely important".

Survey participants agreed that a coordinated referral system must be easily accessible and allow both for effective intercommunication among providers and smooth transitions for patients navigating the referral system.



Participants were asked to rank the features listed above in order of importance, indicating their top priorities. The top priorities are listed below, with the percentage of respondents who put each item in their top three priorities listed.

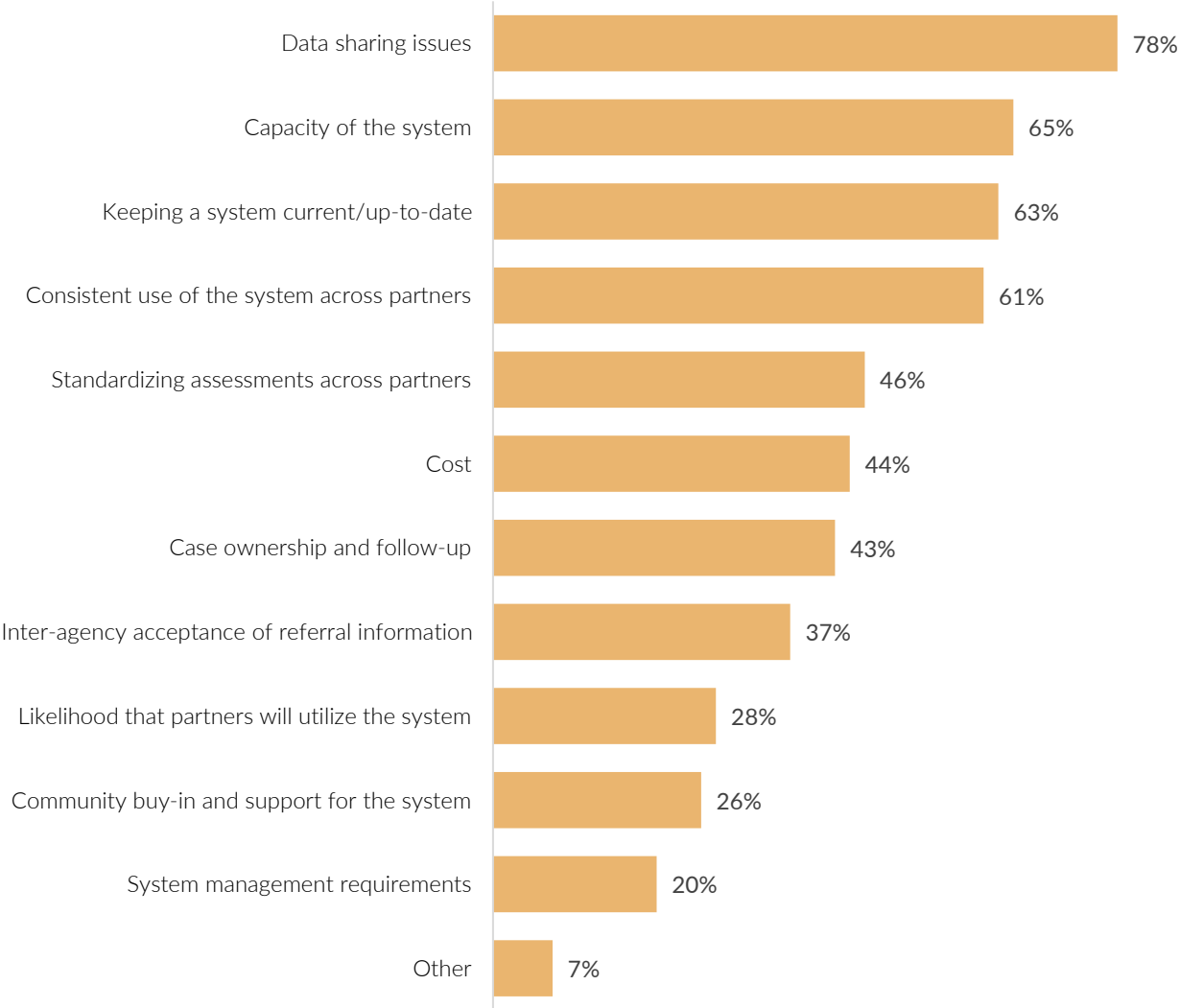
Sixty percent of survey participants indicated that the most important aspect of a coordinated referral system is the ability to coordinate "warm handoffs" for patients.



Barriers

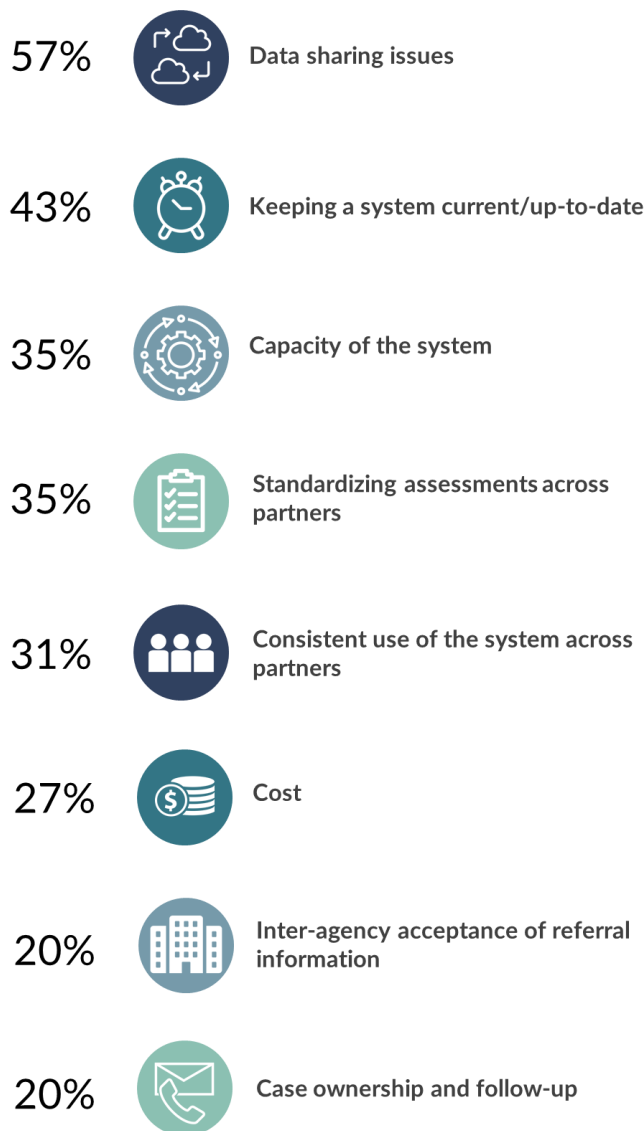
Survey respondents were asked to select which of the barriers listed below could hinder the effective implementation of a coordinated referral system. Percentages refer to the percent of survey participants that selected each option, and participants were able to select multiple options, thus totals add to more than 100%.

The majority of survey participants indicated that the strongest barriers to implementing a coordinated referral system would be problems with data sharing and maintaining the system's capacity to do what is needed.



Participants were asked to rank the features listed above in order of importance/most challenging barriers, indicating their top priorities. The top priorities are listed below, with the percentage of respondents who put each item in their top three priorities listed.

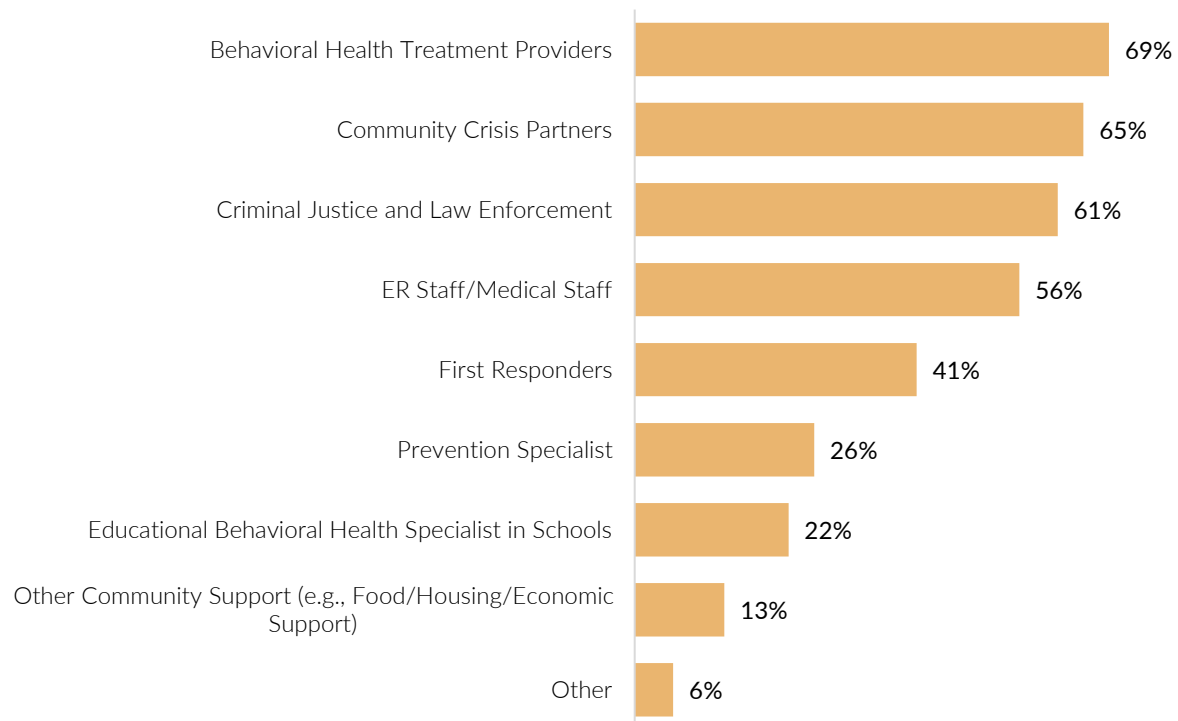
Survey participants' biggest concerns in implementing a coordinated referral system is having data sharing issues and keeping the system up-to-date.



Access to the System

Given that a coordinated referral system would likely be implemented in phases, survey respondents were asked which service providers should have preliminary access to the first roll-out phase of the new system. Participants were allowed to select multiple options, and percentages indicate the percent of respondents to select each option.

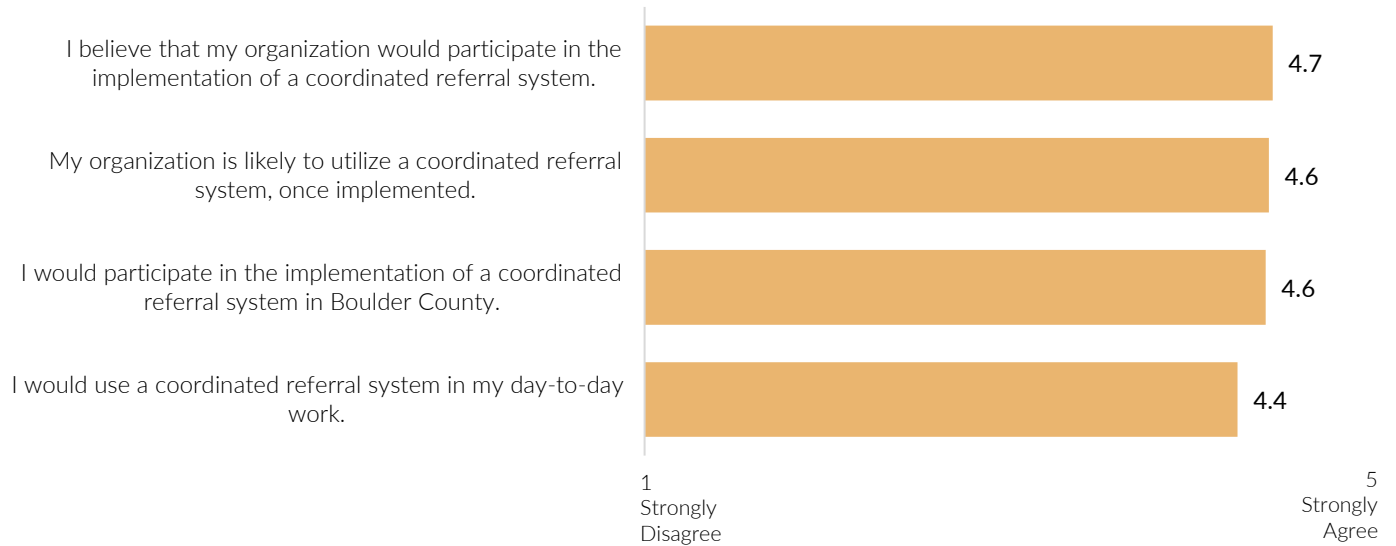
The majority of respondents agreed that behavioral health treatment providers should receive preliminary access to the coordinated referral system, followed by community crisis partners, as well as criminal justice and law enforcement personnel.



Likelihood of Using the System

Finally, survey respondents were asked about the likelihood that they or their organization would implement and use a coordinated referral system. Survey respondents selected the extent to which they agreed with each of the following statements.

Participants agreed that they and their affiliated organization are very likely to implement and utilize a coordinated referral system.



Appendix C. Officer Survey Findings

It was recommended by the LEAD Task Force that line officers working in Boulder County be surveyed to learn more about their perceptions related to law enforcement assisted diversion/co-responder efforts, what the need for diversion is in the county, what barriers would exist for officers responsible for program implementation "on the ground," what training would be necessary for officers implementing diversion efforts, and finally to generally assess buy-in from officers for a county wide diversion approach. Survey invitations were sent to officers by leadership from each police department in Boulder County. The final survey findings represent results from 110 officers working across 7 departments in the County. Among the officers who responded to the survey, 62% had worked in the police force for over 10 years.

Demographic Information

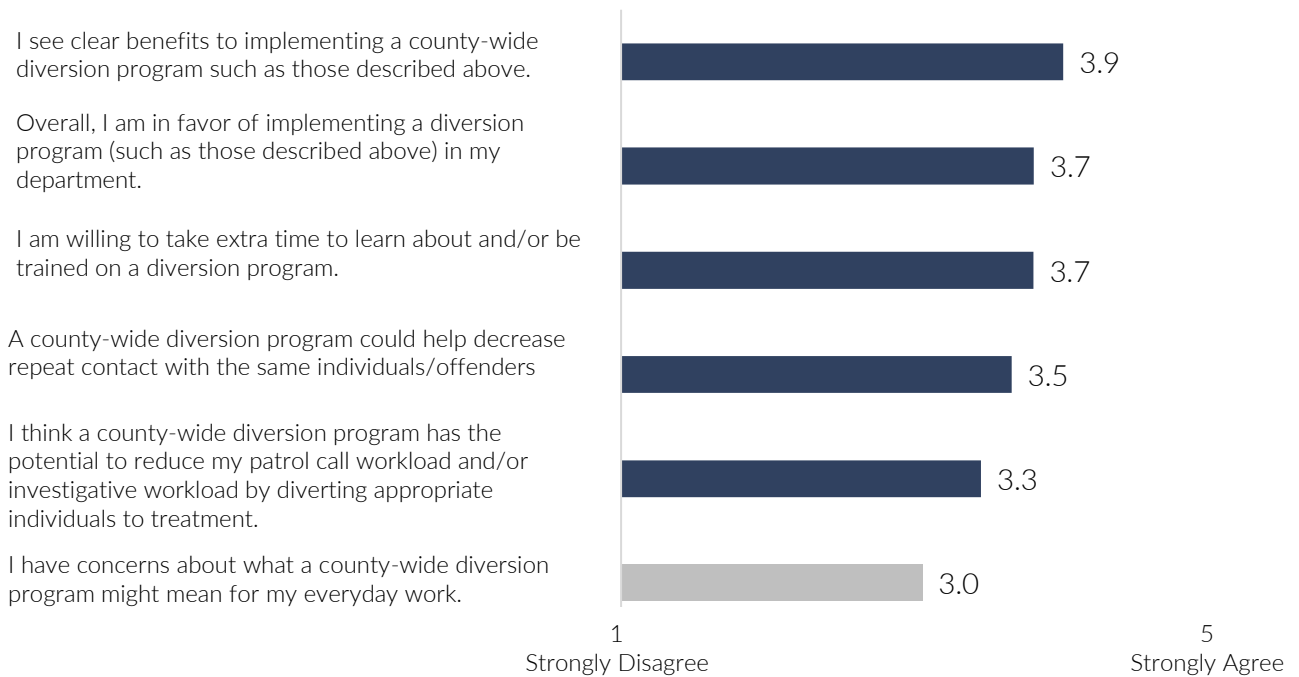
110 officers responded to the survey

62% of officers responding to survey had 10+ years of experience in the police force

7 departments from across the county are represented in the survey findings

Officers were asked to indicate their support for county-wide diversion efforts across a number of dimensions. For each item, officers were asked the extent to which they agreed with the statement on a 1 - 5 scale with 1 indicating "strongly disagree" and 5 indicating "strongly agree."

Overall, officers indicated support for a county-wide diversion program. Officers were mixed on whether they had concerns about the implications for a county-wide diversion program for everyday work.

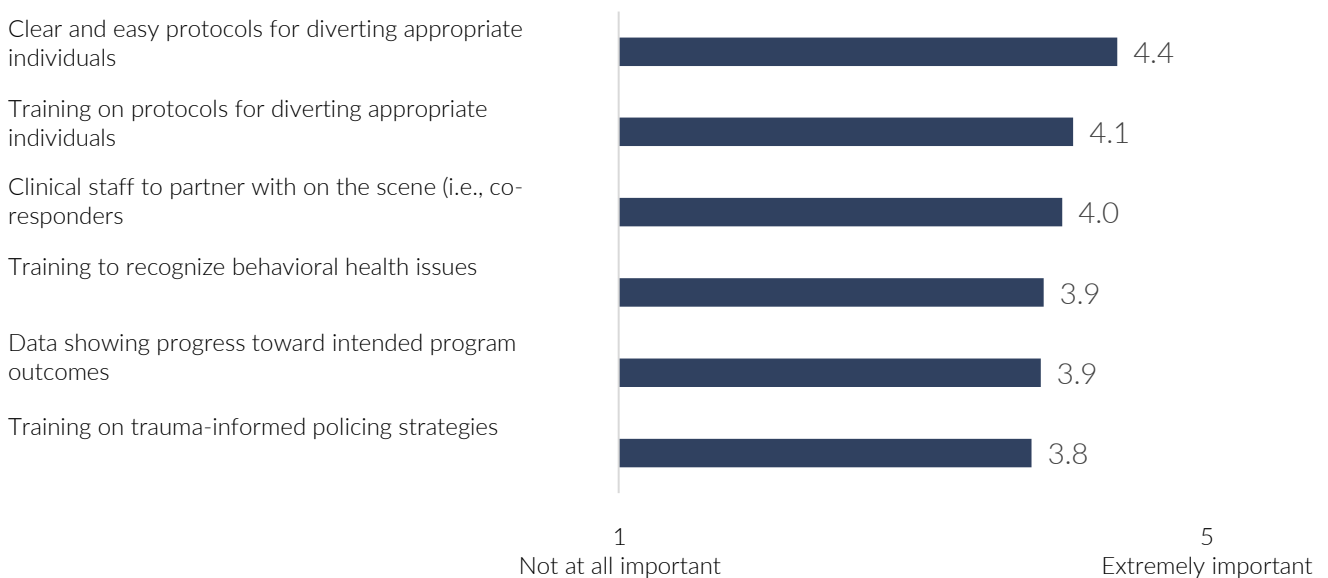


"I think it is a very good idea. We often deal with people suffering from mental health issues and there are not sufficient resources to offer and deputies don't have the time to continue working with these people long enough to make a difference."

-Boulder County, Line Officer Survey Respondent

The survey also asked officers about different elements of a county-wide diversion program that would be necessary for implementation. On a scale of 1 - 5 officers were asked to indicate how important each element would be to them with 1 indicating "not at all important" and 5 indicating "extremely important."

Officers indicated that clear and easy protocols for diverting individuals would be the most important training element related to implementing a county-wide diversion effort.



In addition to rating the areas in the figure above on importance for training, officers were given the opportunity to identify other areas that would be needed for training. The most common training or support areas mentioned by officers were related to:

- Mental/behavioral health training for officers
- Collaboration that would be needed with behavioral health providers/practitioners to be able to effectively identify and handle cases and make diversion decisions

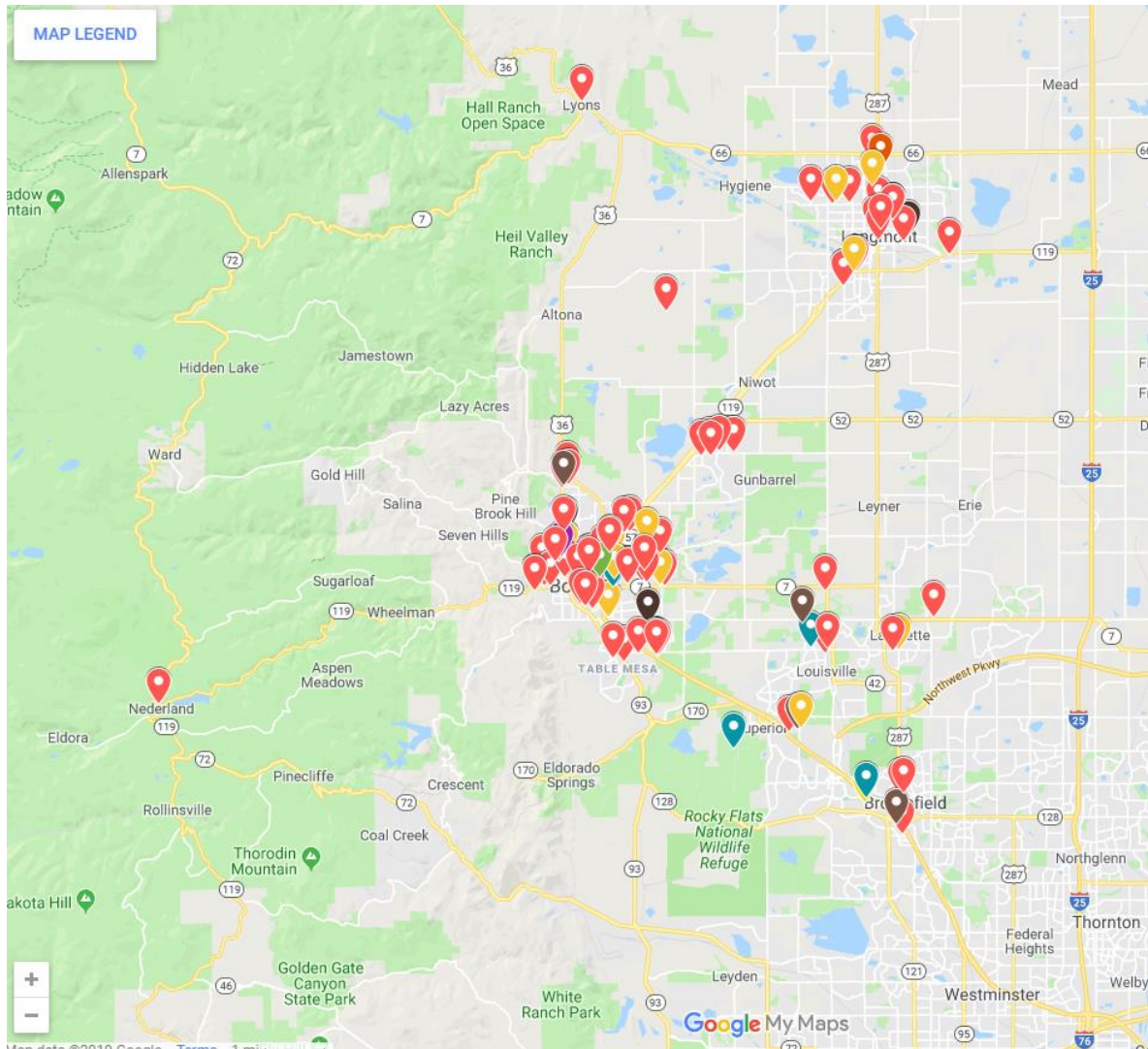
“If a co-responder method is not used, would I have enough training and experience to effectively divert individuals that should be diverted? Could some individuals who are knowledgeable about the program be able to “trick me” into thinking they should be diverted in order to continue to commit crimes and not face the criminal justice system?”

-Boulder County, Line Officer Survey Respondent

General implementation training was also one of the most commonly mentioned areas for concern and needed support. This included:

- Expectations for officers
- Roles for officers and mental health professionals/co-responders, and joint decision-making
- Clear guidelines for diversion decisions and referral processes
- Clear referral processes
- Safety protocols
- Direct-staff communication.

Appendix D: Provider Directory Map



Interactive map can be accessed at:

https://www.google.com/maps/d/viewer?mid=1ldvOzC_6PuSYKOiH3h3J_mYLx6hhnxDa&ll=40.07821213526714%2C-105.12473312128907&z=11