I. Section 1: Program Overview

a. Program Title: Douglas County Care Compact
b. Award Category: Human Services
c. Project Year: 5
d. Abstract: Summarize your program in 2-3 sentences. Focus on its purpose, target audience, and outcomes. ***150 words***

The Douglas County Mental Health Collaborative, under the leadership of Douglas County Government, came together in 2014 to examine the current system of mental health care available to County residents, identify gaps, and develop collaborative solutions. Creating a networked system of care by implementing cross-agency care coordination, specifically for people living with complex needs, was an identified gap. The Care Compact (TCC), established in December 2020, serves adults living with mental health conditions, substance use disorder, intellectual, developmental disability/delay and/or unmet basic needs through a network of case management agencies, healthcare, and social services providers. TCC streamlines care and coordinates services across multiple systems, reduces crisis service utilization, and provides a safety net for people traditionally disconnected from support. Today, the TCC network includes over 20 agencies, has served 165 adults and has seen an 87% reduction in crisis service utilization after case closure.

II. Section 2: Program Details

a. Need and Context: Describe the problem or opportunity your program addresses. Include relevant background information or data. ***300 words***

Douglas County has historically experienced challenges in access to and coordination of care, system integration, and gaps in intensive case management. There are fewer behavioral health workers per 1,000 in Douglas County (2.09) compared to the state's overall average (2.44). Douglas County's Community Health Assessment (CHA) also found mental health to be a leading driver of emergency department (ED) visits between 2016 and 2019, with 60.6% of cases mentioning a mental health need. While this was lower than the state rate, it was growing worse, "from 2,266.1 per 100,000 in 2015 to 2,389.7 per 100,000 in 2019." [1] Additionally, the Colorado mental health care system struggles with fragmentation and a lack of integration, negatively impacting care management and follow-up. This is particularly apparent for individuals with serious mental illness (SMI) or co-occurring disorders and needs who often engage with multiple systems (EDs, law enforcement, psychiatric facilities, Co-Responder teams, jails, protection programs, and inpatient settings). [2] This utilization pattern is costly for the person in failed outcomes and for the state and County in unnecessary and ineffective use of public funds.

Additionally, the last state Behavioral Health Needs Assessment identified a need to expand the safety net system for individuals with complex and co-occurring conditions, and those with multi-system involvement. Douglas County implemented TCC to facilitate a networked system of care offering intensive, whole-person, wraparound care coordination for individuals with complex and co-occurring needs. This population is one of the most difficult and costly to serve, but TCC offers a unique forum for all the players listed above, and more, to collaborate on shared care plans. A streamlined approach creates time and money savings for the system and improves the individual's experience.

b. Program Implementation: Outline how the program was developed and executed. Highlight key steps, timelines, and stakeholders involved. ***400 words***

TCC was spearheaded by Douglas County Mental Health Collaborative leaders (formerly Douglas County Mental Health Initiative) in early 2020. Stakeholders were engaged from healthcare and human services sectors, many already having a case management function, such as local hospitals, Department of Human Services, the County's Co-Responder program, Community Mental Health Center, intellectual and developmental disability and/or delay (I/DD) services agency, Regional Accountable Entity (Medicaid), the single-entry point for Medicaid and Brain Injury waivers, and the faith-based community. The goal was to unite agencies with a key role in supporting high-risk, high-need adults where traditionally they operated in silos. Douglas County administrative staff served as the backbone, facilitating the development of the program and organizing funding to bring in Health Management Associates (HMA) during the planning phase.

Stakeholders engaged in planning from June to December 2020. Partner leadership identified managers of case management, clinical directors, and supervisors within their respective agencies to participate in the Care Compact Operations Team (July 2020). The team was responsible for developing a sophisticated model and framework including program criteria, a shared referral form, Universal Release of Information (U-ROI), workflow, partner roles and responsibilities, and the Memorandum of Understanding (MOU). The Operations Team was also responsible for implementation, process improvements and data sharing. In November 2020 the MOU was executed, and in December 2020 the pilot began with the first enrolled client. The County hired a full-time Care Compact Navigator ahead of the pilot in September 2020 to act as the central coordination hub for the network. The Navigator is responsible for receiving referrals, organizing distinct Care Teams for each client based on their needs, ensuring action items are completed timely, and collecting data for program evaluation.

The Care Compact model is a person-centered, no-wrong-door, collective impact approach to realize system efficiencies and improve quality of life outcomes. Agencies that see people in crisis like EDs, law enforcement, Co-Responders, jails, probation, human services, and psychiatric facilities, refer to TCC to end the revolving door of crisis and connect people to care. These entities also participate in Care Teams alongside ongoing healthcare and social service

providers to ensure all needs are addressed. Each client signs a U-ROI authorizing Care Teams to share information and collaborate on action plans. Within the last year, TCC opened referrals to the community at large. Now any individual can refer themselves. A concerned family member or friend can refer as well.

c. Cost and Funding: Provide a breakdown of program costs, funding sources, and major expenses. If no costs were incurred, explain. ***200 words***

TCC began with a Care Compact Navigator funded by County general fund. Partners donated in-kind resources, staff, and time as they learned and realized the benefits of cross-system collaboration.

In May 2022, in partnership with Community Mental Health Center AllHealth Network, the County received a $236,801 grant through the Colorado Behavioral Health Recovery Act. This paid for a dedicated case manager and peer recovery coach (the Dyad) to provide support to TCC clients, improve engagement, and bridge treatment connections during transitions of care. These positions are still in place today and are community-based, payer blind, and enhance communication and connection between the client and Care Team. This grant also provided up to $35,000 of client discretionary funds to overcome barriers to care, and improve access to and engagement in treatment, and up to $57,000 for a consultant (HMA).

In 2023, County Commissioners allocated $1.8 million of County American Rescue Plan Act (ARPA) for TCC expansion. Partners were awarded funding for dedicated staff to coordinate care for mutual clients. Partners have committed to sustaining these positions through Medicaid reimbursement or in-kind contribution. The County promoted the Navigator to Supervisor to oversee the program and hired a new Navigator for day-to-day operation.

III. Section 3: Results and Merit

a. Results and Impact: Explain the program's outcomes using measurable data, success stories, or testimonials. Focus on how it has benefited the community. ***400 words***

TCC's goals:

- Reduce service duplication
- Improve care transitions
- Decrease reliance on emergency/crisis systems
- Bridge gaps and barriers to care
- Streamline connection to services
- Address social determinants of health
- Improve overall quality of life

TCC partner insights on progress during the pilot:

- 73% identified transitions of care improved

- 67% endorsed less duplication of services
- 87% noted improved access/connection to services
- 73% saw improved attention to gaps and barriers to treatment
- 67% saw increased connection to social determinants of health

Partners were also asked for feedback on impact and overall effectiveness:

- "TCC is awesome and a necessary function to meet the needs of those with behavioral health issues."
- "One of our clients has been able to manage living in the community without requiring hospitalizations and over utilization of the ED. Very successful!"
- "Great work on a very complicated case, appreciate all the work everyone did to help care for this patient."
- "Highly beneficial. Coordination of care and communication with community partners has facilitated client success and independence (less utilization of ED)."

TCC has served 167 unique individuals and made over 850 service connections like case management, outpatient behavioral health, applications and benefit support, and disability services. The pilot evaluation comparing pre and post data in the first year demonstrated that TCC reduced law enforcement contacts by 53%, Co-Responder/crisis responses by 91%, and adult protection reports by 100%. After 4 years of program implementation, TCC continues to demonstrate a reduction in crisis and emergency calls as evidenced by an 87% decrease in crisis responses by Douglas County's Co-Responders six months after TCC closure.

"Aaron" was referred to TCC after he was arrested in early 2023. Aaron, 30, had four arrests in 1.5 years that occurred during psychotic episodes. He experienced paranoia, suicidal ideations and attempts. Aaron reached a breaking point when he brought a rope with him to jump off a nearby overpass. After a TCC intervention including probation, the Dyad, clinical leadership, and the Co-Responders, Aaron turned his life around. He started attending therapy, psychiatry, intensive outpatient, and case management appointments. Today, he has had no crisis or law enforcement contacts in a year. For the first time in his life, he obtained his driver's license, a car, and started GED classes. His felony charge was reduced to a misdemeanor and his other charges were dismissed.

b. Innovation: What makes your program innovative, effective, or unique? Why should it be recognized as an award winner? ***300 words***

TCC connects and streamlines coordinators and case management, creating efficiencies within the existing system without duplicating efforts. It is unique in Colorado. When a client moves out of County, they currently don't have access to the same coordinated network of care.

TCC incorporates peer support to engage clients in treatment, an innovative, growing, and evidence-based approach that helps meet whole person needs. A gap following hospitalization is

timely connection to aftercare and support in the interim. Facilitating a warm handoff to peer support helps address the gap in resources between crisis and outpatient services by acting as a "bridge" between one treatment setting, like the ED or inpatient, and their next scheduled outpatient appointments. It's a critical time to maintain engagement as there may be long waits between hospitalization and connection to outpatient care. This also supports expansion of the behavioral health workforce, a central concern for Colorado and Douglas County.

TCC intentionally connects with clients where they are, at home and in community. Case management is intensive and hands on.

The philosophy is person-centered and solution focused. TCC identifies community resources and blends funding to overcome barriers and improve social determinants of health.

TCC was showcased in a state study on effective care coordination, the state Medicaid agency's provider training series, the 2021 Co-Responder Conference before any Co-Responder programs were talking about this level of care for their high-need clients, and the 2024 Colorado Behavioral Health Council Conference.

TCC is situated in the Douglas County Mental Health Collaborative, a 50+ agency group that has worked together for 11 years on behavioral health priorities. The established partnership of this group made convening TCC possible.

Finally, TCC's leaders and operations members address system-level issues by making internal and collective process improvements to meet the needs of Douglas County's most vulnerable residents.