Pitkin County

PITKIN COUNTY BEHAVIORAL HEALTH STRATEGIC PLAN

2026 - 2028

July 31st, 2025

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INTRODUCTION

SHG Advisors, a Colorado-based consulting firm, worked with Pitkin County and community partners over the course of eight months to co-create a behavioral health strategic roadmap. Grounded in community strengths and guided by the insights of those closest to the work, this plan is tailored to meet the unique needs of those who live, work, and play in Pitkin County.

Pitkin County approached this strategic planning effort with a strong foundation and a clear sense of possibility. Years of collaboration, investment, and innovation have positioned the community to take bold, coordinated steps forward. With active cross-sector partnerships, engaged funders, a wide range of services and supports, and deep insight from local data, the county is well-prepared to elevate what works and tackle persistent gaps. This strategic plan builds on that momentum to shape a behavioral health system that is more connected, inclusive, and responsive to the diverse needs of the community.

The strategic planning process began with an in-person kickoff on December 17, 2025, where participants shared their vision for the future of behavioral health in Pitkin County. A visioning exercise captured shared hopes and priorities, reflected in the word cloud below. These ideas helped shape the direction of the work and served as a north star throughout the process. Our hope is that this strategic plan brings those aspirations closer to reality, transforming collective ideas into coordinated action and meaningful impact.

Plan Structure

This plan is organized around six key goal areas. Each goal includes context on background and need, followed by clear recommendations with targeted strategies and tactics. Definitions and examples are provided throughout to support shared understanding and guide implementation. For each goal, the plan outlines the governance or workgroup structure, identifies key partners, and considers resource needs and potential funding sources. Suggested data and outcome measures are included to track progress and assess impact over time.

While the plan identifies longer-term goals and a shared vision for system change, it also emphasizes incremental steps and short-term, tangible actions to build momentum and support early implementation.

As a note, the term “behavioral health” in this plan refers to an individual’s overall mental and emotional well-being and includes both mental health conditions and substance use disorders. Using this broader term allows for a more integrated approach to addressing the full behavioral health continuum.

EXECUTIVE SUMMARY

This strategic plan was co-developed by Pitkin County and SHG Advisors in collaboration with local behavioral health partners. Grounded in the county's strong foundation – including active partnerships, engaged funders, comprehensive services, and rich local data – the plan reflects the unique needs of a rural, resort-based community. This plan is a direct response to what the community envisioned at the outset: a more connected, inclusive, and effective behavioral health system.

While the plan is centered on those who live, work, and play in Pitkin County, it also acknowledges the realities of regional dynamics and shared service needs. Some solutions will extend beyond county lines, even as governance and funding remain locally grounded. The plan also strikes a balance between long-term vision and practical action – pairing ambitious goals with incremental, tangible steps that can drive early progress and build momentum over time.

While recommendations are tailored to Pitkin County's current behavioral health landscape, successful implementation will require continued flexibility and responsiveness as conditions evolve. Several external factors are actively reshaping the environment in which the County operates. These include the statewide shift to Behavioral Health Administrative Service Organizations (BHASOs), the closure of the region's primary psychiatric hospital, and new state licensing requirements for detox facilities. Additionally, recent federal budget cuts and state budget pressures have created uncertainty around future funding. In light of these dynamics, Pitkin County must remain nimble – committed to its vision, but adaptable in its strategies – to ensure a behavioral health system that can meet community needs now and into the future.

Strategic Goals and Key Recommendations

Goal 1: Ensuring that the Strategic Plan is Implemented

Challenge: Past planning efforts in the county lacked sustained follow-through, shared accountability, and role clarity.

Recommendation Highlights:

- Establish a **multi-tiered governance structure** led by Pitkin County Public Health, in partnership with Human Services and the County Manager's Office.
- **Hire a temporary full-time Behavioral Health Champion** to coordinate implementation, governance logistics, partner relationships, and communication.
- Create an **Advisory Group and time-limited Workgroups** to implement the plan's tactics and provide guidance, oversight, and adaptability.
- Develop a **public-facing dashboard and centralized behavioral health website** to enhance transparency and track progress.
- **Develop foundational structures** that define membership, leadership roles, decision-making processes, and public engagement pathways.
- **Align existing committees and initiatives** to streamline efforts.

Year 1 Priorities: Staff recruitment, infrastructure development, launching workgroups.

Long-Term: Explore transitioning governance support to another entity to ensure sustainability over time.

Goal 2: Coordinated Funding to Increase Impact

Challenge: Despite significant local funding, investment efforts remain fragmented and duplicative.

Recommendation Highlights:

- **Convene local funders** regularly to promote learning, coordination, and alignment.
- **Explore aligned grantmaking** by streamlining application and reporting processes.
- **Leverage the Behavioral Health Champion role** to ensure regular convenings and support alignment, information-sharing, and collaboration across funders.
- Encourage funders to **support thoughtful nonprofit development** by promoting collaboration and assessing genuine need.
- Develop a shared approach for **collecting and using meaningful, consistent data.**

Year 1 Priorities: Convene funders, align grant application and reporting requirements.

Long-Term: Establish a formal Funders Collaborative, supported by a dedicated backbone entity.

Goal 3: Build a Coordinated Resource Navigation System

Challenge: Individuals/families and providers face barriers navigating a fragmented network of services and supports.

Recommendation Highlights:

- Launch the Community Access and Navigation Workgroup to **assess existing capacity** and design a county-wide resource navigation system.
- Consider a **hub-and-spoke model** where a centralized "hub" triages individual/family needs and links them to embedded navigators across sectors.
- Improve **coordination across service providers** through short-term steps including building out a shared resource directory, promoting structured collaboration among navigators, and launching a real-time communications platform.
- Explore and begin planning for expanded **tiered case management** that supports individuals with more complex, chronic, or high-acuity needs.

Year 1 Priorities: System assessment and design; coordination improvements.

Long-Term: Develop a community-wide, formalized resource navigation system.

Goal 4: Strengthening the Behavioral Health Continuum

Challenge: Service gaps persist at the higher levels of treatment and recovery, with limited local or regional options for individuals with more acute behavioral health needs.

Recommendation Highlights:

- Assess and build up **community-based alternatives to inpatient care**, including the Intensive Stabilization Program (ISP) and new Intensive Outpatient Program (IOP).
- Evaluate the needs and feasibility of **reserving inpatient beds** for Pitkin County residents at the new Vail Health Precourt Healing Center.
- Promote the use of existing **telepsychiatry consultation programs** to bolster capacity of local primary care providers.
- Reimagine **recovery-oriented facilities** through a local-regional service framework.
- Assess and potentially redirect funding to **strengthen the behavioral health safety net.**

Year 1 Priorities: Strengthen high-acuity community programs, and leverage existing programs and facilities.

Long-Term: Identify and stand up new service types or levels of care that are aligned with community needs.

Goal 5: Increasing and Improving Access to Services

Challenge: Despite a high provider-to-resident ratio, significant behavioral health access challenges exist due to limited insurance acceptance and high costs.

Recommendation Highlights:

- Further **maximize the impact of the Mental Health Fund** by expanding access for priority populations and increasing provider participation.
- Explore and expand incentives, tools, and supports to help behavioral health providers overcome barriers to **accepting commercial insurance.**
- Leverage the **Counseling Compact** to help address workforce shortages and improve continuity of care for mobile and underserved populations.
- Increase awareness and provider engagement around the **Children and Youth Mental Health Treatment Act (CYMHTA)** to expand access to treatment for non-Medicaid-eligible youth.

Year 1 Priorities: Begin exploration of all of these items.

Long-Term: Expand access to affordable care through a more robust, diverse, and insurance-participating provider network.

Goal 6: Ensuring a Diverse, Skilled, and Community-Rooted Behavioral Health Workforce

Challenge: A growing behavioral health workforce shortage is limiting access to care, especially for underserved populations.

Recommendation Highlights:

- Offer **incentives to attract and retain** both current and future behavioral health professionals.
- **Promote behavioral health career pathways** to a wide and diverse range of audiences.
- **Leverage digital platforms** to connect providers and streamline access to services.
- Identify a more coordinated way to **share training opportunities** across systems and networks.
- Explore opportunities to **grow and formalize peer support networks** for greater reach and sustainability.

Year 1 Priorities: Explore incentives, promotion of career pathways, and leveraging digital platforms.

Long-Term: Formalize peer support networks and share professional development and training opportunities across systems and networks.

Cross-Cutting Themes

- **Equity and Inclusion:** Prioritize services that reach historically underserved and high-need populations, including Spanish-speaking residents, LGBTQ+ individuals, and youth.
- **Data and Accountability:** Use process and outcome metrics to continuously evaluate implementation and impact.
- **Sustainability:** Align county investments with state and federal opportunities (e.g., BHA grants, Medicaid, opioid settlement funding, philanthropic dollars).
- **Partnership:** Engage partners and stakeholders early and often, including people with lived experience, to promote shared ownership and adaptability.

This Behavioral Health Strategic Plan sets an ambitious but realistic path forward for Pitkin County. It recognizes that building a comprehensive, person-centered system requires more than just services – it demands effective governance, aligned investments, coordinated access, and the right infrastructure to ensure that no one falls through the cracks.

ACKNOWLEDGEMENTS

Developing this plan required authentic partnerships. These partnerships were crucial to ensuring an inclusive approach to this work and inspired and deepened the community's ongoing commitment to expanding and improving Pitkin County's behavioral health system. While it's impossible to list the dozens of individual partners who worked with us on this plan, we do want to acknowledge the numerous sectors that participated:

- Health care providers – including mental health clinicians, primary care physicians, hospital representatives, and crisis response teams
- Education professionals – from early childhood through higher education, helping align support services for youth and families, and addressing the workforce shortage
- Law enforcement and first responders – ensuring public safety perspectives and crisis intervention practices were integrated
- Local government agencies – providing leadership, policy alignment, and long-term systems planning
- Nonprofit organizations – representing vulnerable populations and delivering on-the-ground services
- Community-based organizations and advocacy groups – voicing lived experiences and ensuring equity and access remained central
- Business and philanthropic partners – offering funding, strategic guidance, and a commitment to community wellness

We are grateful to each sector and every individual who contributed their time, expertise, and passion to this collaborative effort. Together, we have laid the foundation for a behavioral health system that reflects the unique needs, values, and strengths of Pitkin County.

Jordana Sabella
Director, Pitkin County Public Health

Lindsay Maisch
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UNDERSTANDING THE REGION

Pitkin County is nestled within the White River National Forest, surrounded by the stunning peaks of Colorado's central Rocky Mountains. Aspen, the county seat and largest city, anchors a rural region made up of close-knit communities and abundant recreational opportunities.

This behavioral health strategic plan is centered on the people who live, work and play in Pitkin County, with a goal of increasing access to care and improving behavioral health outcomes for this population.

Throughout the planning process, stakeholders consistently emphasized the importance of recognizing Pitkin County as part of a broader region that extends from Aspen to Parachute. To effectively serve the population, some solutions may need to span county lines and adopt a regional approach. In evaluating strategies, the following factors were considered:

- Shared demographic trends and behavioral health needs across counties
- The geographic realities of the region and how people move throughout the valley
- Availability and accessibility of services and resources

Although the primary focus remains on Pitkin County residents and workers, a more robust and connected system of care could benefit a broader population across the region. While certain strategies may take a regional form, governance and funding coordination will remain specific to Pitkin County.

FIVE POTENTIALLY LARGE IMPACTS ON PITKIN COUNTY'S BEHAVIORAL HEALTH SYSTEM

The landscape shifted considerably over the course of this planning effort, requiring the team to continuously adapt to evolving circumstances. Five key developments were consistently considered throughout the process:

- As of July 1, 2025, **Behavioral Health Administrative Service Organizations (BHASOs) began operating** across Colorado, consolidating mental health and substance use disorder services. These organizations are tasked with expanding provider networks and coordinating care. Rocky Mountain Health Plans serves as the BHASO for Pitkin County's region. While this transition offers potential benefits, the full impact on local service delivery remains unclear.

- The **primary safety net provider for the region has undergone multiple transitions**, most recently being acquired by Health Solutions West (HSW) in spring 2025. HSW has confirmed that the inpatient psychiatric hospital in Grand Junction will remain permanently closed—previously the closest option for Pitkin County residents. A newly opened facility in Eagle Valley may help bridge this gap, but HSW's long-term role in the region is still being defined.

- In response to updated American Society of Addiction Medicine (ASAM) criteria, Colorado will implement **new licensing requirements for detox facilities** beginning in July 2026. These changes affect current services in Pitkin County, but also create an opportunity to reimagine and expand needed supports within the local system.

- The Department of Health Care Policy & Financing (HCPF) is working toward expanding and improving implementation of Intensive Behavioral Health Services that include intensive in-home and community-based mental health services, intensive care coordination, mobile crisis intervention, and stabilization services. This will support Colorado Medicaid beneficiaries under the age of 21 who have been diagnosed with a mental health or behavioral disorder and for whom these services are medically necessary. The improved services will be culturally relevant, family-centered, and child-driven so that these services are provided in the most integrated and least restrictive setting. The system of care plan that HCPF developed in collaboration with stakeholders must be implemented, under a Federal court order. It will have a significant impact on the **delivery of children and youth services to Medicaid beneficiaries** over the next five years.

- The new federal administration, which took office in January 2025, implemented significant budget reductions and terminated key public health and human services contracts. As a result, state-level **funding has decreased substantially**, impacting counties across Colorado, including Pitkin. At the time of this plan's completion, many questions remain about what services and programs will continue to receive funding. Therefore, it is recommended that any major investments outlined in this strategic plan be considered for future implementation, rather than pursued immediately.

DATA AND OUTCOME MEASURES

As part of the Pitkin County Behavioral Health Strategic Plan, multiple levels of data will be used to track progress, guide implementation, and ensure transparency. These efforts are designed to not only monitor how well the plan is being implemented but also to assess whether it is achieving meaningful impact for individuals, families, and the broader community.

At its core, the County will implement a **public-facing dashboard** to deliver clear, timely insights into the advancement of this strategic plan (See Goal 1). This platform will function as a transparency and accountability tool, enabling community members and partners to observe completed actions, ongoing initiatives, and areas where challenges persist. Regular updates will ensure the dashboard reflects the current status of key initiatives and milestones across various goal areas.

Within each goal area of the strategic plan, there are specific suggestions for both **process measures and outcome measures** *(see Appendix D for the full list of suggested process and outcome measures).* Process measures help assess the extent to which recommended actions are being implemented as intended (e.g., the number of staff trained, the establishment of new partnerships, the development of protocols and tools). Outcome measures are designed to capture changes in the system or in community well-being, such as improved access to services, reductions in wait times, or increased client satisfaction. Together, these measures provide a comprehensive view of how the strategic plan is translating into practice and impact.

In addition to tracking progress related to this strategic plan, the County is also launching a **Behavioral Health System Report Card**, which is a curated set of key indicators related to mental health and substance use in the community. This report card will serve as a long-term monitoring tool, offering a snapshot of overall system performance and trends over time. It will include measures such as age-adjusted suicide rate, youth substance use, and poor mental health days. By tracking these indicators consistently over time, the County can better understand how system-level changes are affecting community outcomes, and adjust strategies accordingly.

Together, the dashboard, goal-specific measures, and report card represent a layered and intentional approach to data. They provide visibility at multiple levels, ensuring that Pitkin County stays aligned with its vision for a more effective, coordinated, and responsive behavioral health system.

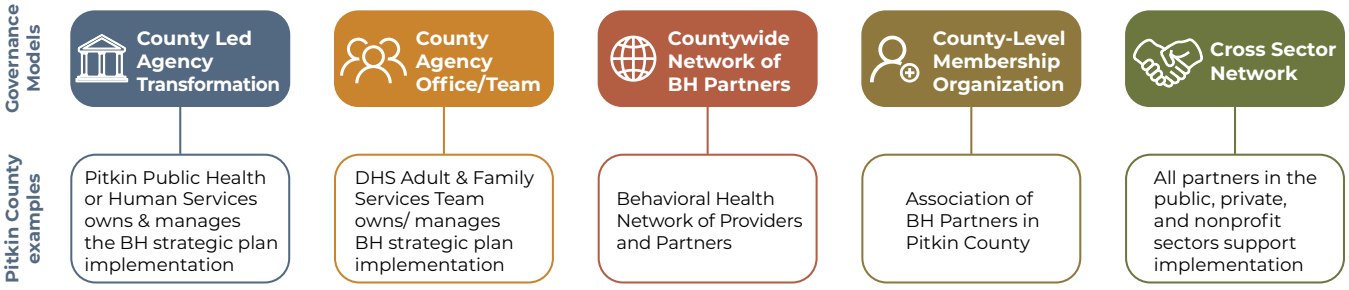
GOAL 1:
ENSURING THAT THE STRATEGIC PLAN IS IMPLEMENTED

Background and Need

A clear and intentional governance structure is critical to the successful implementation of this behavioral health strategic plan. It establishes the foundation for defined roles, decision-making authority, and accountability. With numerous partners involved in Pitkin County – including service providers, funders, local government, and community organizations – effective governance is essential to ensure alignment around shared goals, coordinated action, and efficient use of resources. It also provides the infrastructure needed to monitor progress, address emerging challenges, and adapt strategies over time.

Previous strategic planning efforts in Pitkin County have encountered difficulties in establishing clear roles and enforcing accountability. While many organizations contribute meaningful work, past plans were often perceived as additional tasks rather than integrated priorities, lacking clear ownership and follow-through. By clarifying roles and responsibilities within a governance structure, the County can ensure that strategic priorities are not only identified, but actively pursued by the right partners with shared accountability for results.

To develop a governance recommendation for Pitkin County, several models and approaches were studied:



Several key factors were considered in identifying the most appropriate governance model for Pitkin County, including:

(1) demonstrated success in comparable communities,

(2) the level of resources required and those available locally, and

(3) the model's ability to support strong accountability mechanisms.

Recommended Governance Structure

Key Components

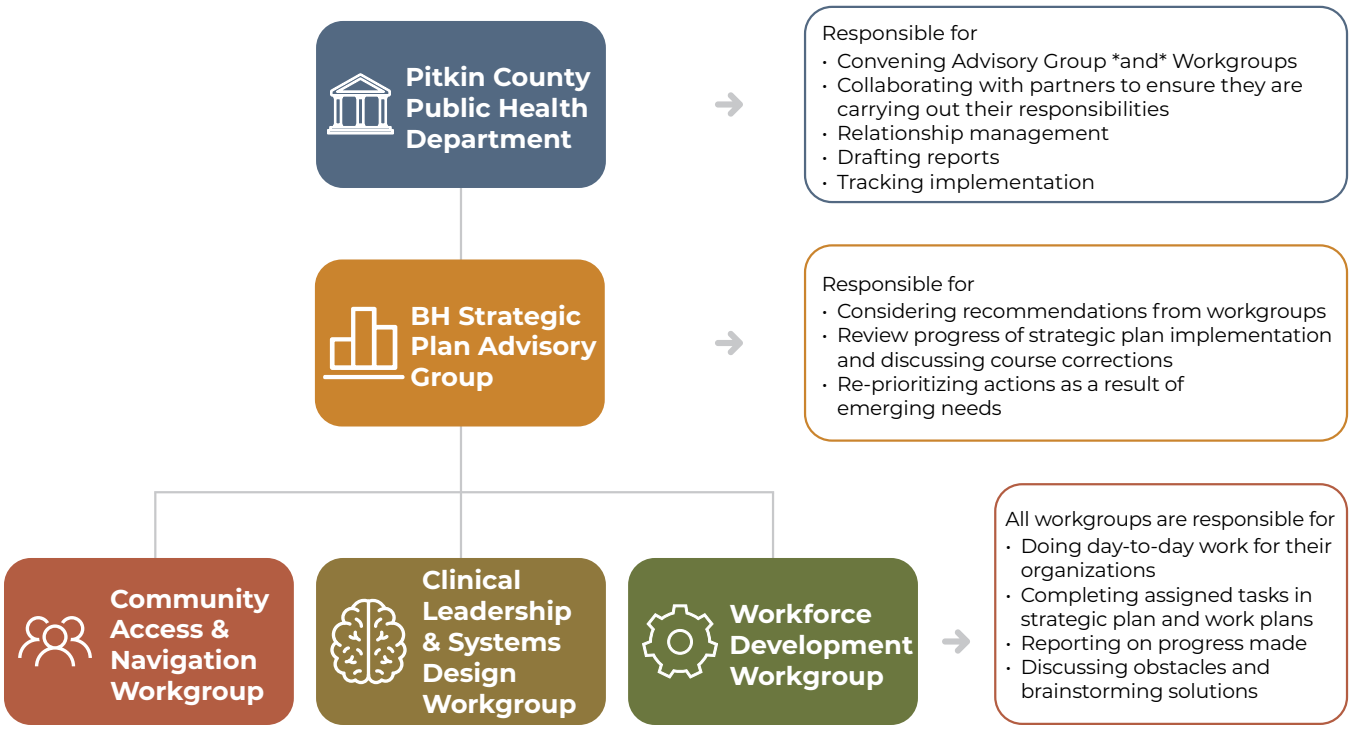
A **county-agency-led governance model** offers a strong foundation for accountability while fostering collaboration with the broader community to implement the strategic plan. Due to limited capacity within the County government, the Public Health Department has emerged as the lead entity in advancing behavioral health initiatives – in partnership with Human Services and the County Manager's office. By adopting a multi-tiered approach, the department can expand partner engagement, promote shared ownership, and ensure that implementation efforts are inclusive and coordinated. To successfully establish and sustain this governance structure, dedicated resources will be essential to support coordination, communication, and consistent follow-through.

Evidence-Based:

The California Health Care Foundation documented that fragmented mental-health and substance-use systems contribute to poor outcomes, homelessness, and a lack of continuity of care for people seeking services. Coordinated structures result in improved access.

– Hargreaves, J., & O'Brien, J. (2021). *In their own words: Fragmented care harms people with mental illness and substance use disorder.* California Health Care Foundation.

https://www.chcf.org/wp-content/uploads/2021/08/InTheirOwnWordsFragmented-CareMentalIllnessSUD.pdf



The **Workgroups** shown in the diagram above are expected to evolve over time as implementation of the strategic plan progresses. Members of these Workgroups will likely include representatives from organizations already engaged in related efforts. To ensure strategies are responsive and effective, it will be important to include individuals with lived experience who can provide insights into what approaches truly serve those in need. Workgroups are encouraged to take on manageable, discrete projects from 3 months to 1 year – and then there should be an assessment of whether there needs to be a different workgroup to focus on a new and specific project.

As Workgroups implement specific tactics outlined in the strategic plan, they will regularly report their progress to the Advisory Group. If challenges arise that hinder progress, the Workgroups will collaborate to identify potential solutions and present recommendations to the Advisory Group for consideration. The Workgroups should be reviewed annually to determine if they are still needed, or if emerging needs warrant a different workgroup.

The **Behavioral Health Strategic Plan Advisory Group** will be composed of individuals from diverse sectors within the behavioral health field. Serving as the decision-making body, the Advisory Group will review Workgroup progress, provide feedback, offer guidance, and reprioritize actions in response to emerging needs. Additionally, the Advisory Group will receive regular updates on funding decisions and investments within the County.

A representative from **Pitkin County Public Health Department** will serve as Chair of the Advisory Group. In addition, a temporary staff member will be hired to support the overall governance structure. This individual will coordinate logistics for both the Advisory Group and Workgroups, monitor progress, and provide support where needed. They will also manage relationships, fielding questions and feedback from group members and the public.

Pitkin County Public Health will be responsible for tracking implementation of the strategic plan and providing updates to the Board of County Commissioners and other stakeholders as needed. An annual assessment will be conducted to evaluate the effectiveness of the governance structure and recommend any necessary adjustments.

Year 1 (Jan - Dec 2026)	***Action Item 1.1:*** Pitkin County Public Health will hire a full-time temporary employee – a Behavioral Health Champion – to convene partners regularly for information sharing. The responsibilities of the Behavioral Health Champion will be split between the governance and funding work outlined in Goal 2. See Appendix C for a draft position description. This individual will also be responsible for developing the recruitment and selection process for Advisory Group and Workgroup members, regularly updating content for a dedicated landing page, and fostering relationships with behavioral health partners. Public Health will coordinate closely with Human Services and the County Manager's Office throughout this process. ***Action 1.2:*** The Behavioral Health Champion will launch the recruitment and selection process and begin convening the Advisory Group and Workgroups on a regular basis.
Year 2 (2027)	Pitkin County Public Health, in continued partnership with Human Services and the County Manager's Office, will maintain its leadership role in convening the groups, collaborating with partners, and overseeing implementation of the strategic plan.
Year 3 (2028)	Public Health will maintain its leadership role while also exploring the possibility of transitioning governance support to an existing organization or a new entity with the capacity to effectively take on this role.

Key Steps to Establish the Governance Structure for Success

As the governance structure becomes more formalized, several foundational steps will be necessary to ensure clarity, transparency, and effective coordination:

- **Launch a County Behavioral Health Landing Page:**
  Create a centralized online hub to share progress on the strategic plan, post meeting summaries, and provide information on upcoming meetings and engagement opportunities.
- **Define Membership Structure and Selection Process:**
  Determine the number of participants for each Workgroup and the Advisory Group, and establish a clear, transparent process for recruitment and selection (e.g., application-based versus open volunteering).
- **Clarify Public Engagement Opportunities:**
  Outline how members of the public can participate in or contribute to the work of the Advisory Group and Workgroups.

The Behavioral Health Leadership Group (BHLG), facilitated by HeadQuarters, brings together local stakeholders, organizations, and municipalities across the Roaring Fork Valley to collaborate on improving behavioral health outcomes by enhancing awareness, access, and affordability, while also coordinating funding requests and distribution. Active for approximately 18 months, the BHLG has invested significant effort in understanding community needs and identifying potential solutions for Pitkin County. As governance structures are developed, the BHLG should be engaged to ensure alignment and coordination of efforts.

- **Align efforts:**
  Map existing committees and workgroups, and assess opportunities to consolidate or align efforts in order to streamline activities, reduce duplication, and improve coordination across initiatives. This could include presenting to the Boards of Directors of various organizations to raise awareness of the efforts to streamline initiatives to increase effectiveness.

- **Establish Leadership Roles and Connections:**

  Document how leadership positions—such as Chairs and Vice Chairs—will be appointed, and clarify whether and how Workgroup Chairs will serve as liaisons to the Advisory Group.

- **Determine the Flow of Communication:**

  As outlined in Goal 2, the funders will inform the Advisory Group via the Behavioral Health Champion what decisions and investments have been made. There will also need to be expectations set on how the Advisory Group provides suggestions and/or recommendations to funders, especially the Vital Mental Health Services funders.

- **Assess the Need for an Executive Committee:**

  Consider forming a smaller Executive Committee within the Advisory Group to manage political dynamics and communication strategies.

- **Develop Member Expectations and Governance Guidelines:**

  Create clear guidance outlining roles, responsibilities, decision-making protocols, attendance expectations, proxy use, term limits, and other key governance practices for all Advisory Group and Workgroup members.

- **Provide Onboarding and Training:**

  Offer orientation and training to ensure all members understand their roles and responsibilities. This includes protocols such as referring media inquiries to the Public Health Department.

- **Establish a Meeting Schedule:**

  Set a regular cadence for meetings of both the Advisory Group and Workgroups to ensure consistent progress and coordination.

Alternative Approaches to Strengthen Governance and Accountability

If establishing a formal governance structure is not immediately feasible, there are several lower-lift strategies that can enhance coordination, transparency, and accountability in the interim:

- ***Action Item 1.3:*** **Convene Quarterly Partner Meetings**

  Pitkin County Public Health can host quarterly meetings with behavioral health partners to facilitate information sharing, provide updates on current initiatives, and discuss emerging needs and trends. These gatherings should be well-structured, interactive, and designed to foster meaningful collaboration among participants.

- ***Action Item 1.4:*** **Launch a Centralized Behavioral Health Landing Page**

  Develop and maintain a regularly updated web page that serves as a central hub for behavioral health efforts across the community. The page should include meeting schedules, partner updates, progress on the strategic plan, available resources, funding opportunities, and other relevant information. Importantly, the content should reflect the full landscape of behavioral health activities—not just those led by the County.

Key Players

The Advisory Group should encompass a wide range of behavioral health leaders from across the County. The Workgroups should reflect people who are doing the "on the ground" or "frontline" work. The Public Health Department will have to determine how best to recruit and select members. Partners essential to the Advisory Group should include (but not be limited to) these representatives:

- Providers (e.g., organizations, private-practice therapists, and hospitals)
- Social Services (e.g., housing and homelessness support; food security; domestic violence support)
- Education (e.g., public school systems (K-12); early childhood education; adult education and literacy)
- Workforce and Economic Development (e.g., job training and employment; vocational rehabilitation)
- Legal and Advocacy Services (e.g., legal aid; immigration support)
- Faith-Based and Community-Based Organizations, especially those representing historically underrepresented and marginalized populations (e.g., Latiné community, LGBTQ+)
- Public Sector (e.g., city/county government agencies; law enforcement)
- Intermediaries (e.g., Behavioral Health Administrative Service Organizations)
- Representatives from the various jurisdictions (e.g., Aspen, Basalt, Town of Snowmass Village)
- Lived Experience Experts (e.g., individuals with firsthand experience navigating community systems; peer support specialists)

An Important Note about Partnerships and Collaboration

While many stakeholders praised the strong collaboration throughout Pitkin County – acknowledging its improvement in recent years – some also noted a significant increase in the number of nonprofits. This growth has intensified competition for funding. The current governance structure offers a valuable opportunity for organizations to collaborate more closely and strengthen relationships. It facilitates honest, sometimes difficult discussions around issues such as overlapping programs, referral processes, and funding pursuits. ***Action Item 1.5:*** To support these challenging conversations, it will be beneficial for workgroup co-chairs – as well as Advisory Group members – to collaboratively establish group agreements, adequately prepare for meetings, and create a space to have difficult conversations. Co-chairs should receive regular training on "conflict conversations" to help create a safe and constructive environment.

Resources Required

If Pitkin County moves forward with hiring a full-time temporary employee immediately, the estimated cost is approximately $175,000. This figure includes salary and benefits for the staff member, a portion of a supervisor's time, and necessary materials and operational expenses. It is assumed that in-person meetings can be held in donated or no-cost spaces. This position will be split between governance and funding duties, and a position description can be found in Appendix C.

The individual hired to lead these efforts will serve as Pitkin County's primary Behavioral Health Champion. This person will consistently advocate for behavioral health across all settings, ensuring it remains a central consideration in planning and decision-making. They will act as the go-to contact for partners—ready to answer questions, facilitate collaboration, convene discussions, and explore new opportunities to strengthen the system.

Potential Funding Sources to Explore:

- **Vital Mental Health Funders:**
  This group currently funds staffing to collect mental health data and facilitate the Mental Health Access Program (MHAP) and could consider shifting staffing priorities to support a Behavioral Health Champion.
- **Healthy Community Fund:**
  As an existing source of community investment, the Healthy Community Fund could be considered for additional funding. This may require a change to how the Healthy Community Fund is currently allocated.
- **Private or Philanthropic Grants:**
  Given the temporary nature of the role, philanthropic support could be a strong fit. Potential funders include the Aspen Community Foundation, Colorado Health Foundation, or other organizations focused on public health, behavioral health, or systems coordination. The long-term goal would be to transition governance support to another entity in the coming years.

GOAL 2:
COORDINATED FUNDING TO INCREASE IMPACT

Background and Need

Pitkin County is fortunate to have a wide range of resources dedicated to enhancing its behavioral health system, with over $1.1 million annually in total investments. These funds come from a variety of sources:

Note that this graphic does not reflect all of the Federal and State funding that PItkin County receives for behavioral health services.

The Mental Health Fund, administered by HeadQuarters, is supported by the Aspen Community Foundation as well as other donors. This fund offers financial support to individuals and families who are unable to afford necessary mental health services, helping to subsidize short-term, solution-focused therapy. In 2024, more than $162,000 was distributed to 53 providers, enabling 152 individuals to access care and funding over 2,000 therapy sessions.

The top needs identified by the Mental Health Fund include Post Traumatic Stress Disorder (PTSD)/trauma, anxiety, emotional regulation/stress, and depression.

The Region V Opioid Abatement Council – one of 19 regions across Colorado designated by the Colorado Attorney General's Office— includes Eagle, Garfield, Lake, Pitkin, and Summit Counties. The region is slated to receive $9.1 million in opioid settlement funds between 2022 and 2038 to support prevention, harm reduction, treatment, and recovery initiatives. To date, funding has supported mobile harm reduction services, the development of a regional data dashboard, and a public anti-stigma campaign. Looking ahead, Region V will focus on expanding youth programming and improving coordination between treatment and recovery services. In 2024, Pitkin County invested $9,000 in public education from local opioid funds, and approximately $620,000 was spent region-wide on various initiatives.

An affinity group called the Regional Grantors Group brings together local funders—including the Aspen Community Foundation, Aspen One, City of Aspen, and Pitkin County—to explore opportunities for coordination around grantmaking and impact measurement. While this group is not currently distributing funds, it serves as a collaborative learning space and may help streamline future investments.

Pitkin County benefits from a dedicated property tax that supports the Healthy Community Fund, which has invested millions of dollars into organizations that advance the social, emotional, physical, and economic well-being of families, youth, and seniors. This Fund has been a vital source of support for nonprofits working in public health and human services. Originally approved by voters in 2002, the countywide property tax has been renewed in 2006, 2011, and 2018. With the current authorization set to expire in 2027, Pitkin County should not only encourage continued voter support for the Healthy Community Fund but also explore the possibility of a modest increase to ensure it keeps pace with growing community needs.

The HCF supports nonprofit organizations providing critical health and human services, including core function services such as withdrawal management (detox), integrated healthcare, and discretionary mental health and substance use prevention grants. A citizen board appointed by the Board of County Commissioners reviews the discretionary grant applications and makes funding recommendations.

The Vital Mental Health Services (VMHS) is a collaborative funding initiative focused on prevention, intervention, crisis stabilization, treatment, and case management. It is partially supported by the Healthy Community Fund (HCF), as well as by contributions from other local entities, including Aspen Valley Health, City of Aspen, Town of

Snowmass Village, and the Aspen School District. In 2025, VMHS awarded nearly $625,000 to three organizations. This funding supports:

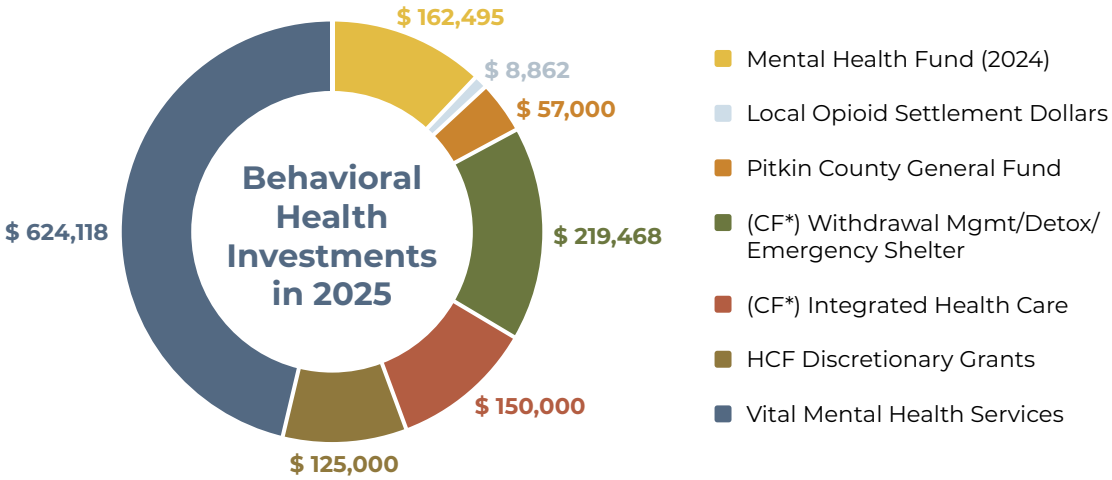
School-Based Mental Health Care. The contractor provides Aspen School District (ASD) and Aspen Community School (ACS)-based clinician services via clinicians who support mental health and wellness classroom learning, work with small groups of students, and also offer individual support for students experiencing identifiable mental health concerns.

Integrated Care Team Services. The contractor provides outpatient services for families, relationship counseling, substance use disorders, trauma, Medicated Assisted Treatment for (MAT) for substance use disorder withdrawal and other evidence-based therapies. Behavioral Health Advocates assess the determinants of health and assist the patient in addressing barriers and increase access to services, in both English and Spanish.

Intensive Wrap-Around Services. The contractor provides wrap-around services at its Withdrawal Management Facility and Winter Overnight Shelter. Case Managers serve as gatekeepers for Coordinated Care efforts and community referral through various platforms, as well as distribute wrap-around funds.

While it is recommended that VMHS continue supporting these three critical areas, it is equally important to use data to evaluate whether these investments are achieving their intended outcomes. With new state regulations resulting from updated ASAM requirements that will lead to potential modifications to existing programs in July 2026, VMHS should assess the continuation of its intensive wrap-around services. This review will help determine whether these services should remain in place or if resources would be better allocated to other high-need areas.

A detailed breakdown of contributions to behavioral health in Pitkin County is provided in the table below:



This charts represents *contributions* to nonprofit organizations in Pitkin County

*CF = Core Function of HCF

This chart does not include local investments in PACT or funds allocated directly to safety net providers from the State.

During one-on-one conversations with organizations traditionally viewed as funders, it became clear that not all of them identified with that label. Some preferred to see themselves as partners in the work rather than funders, and expressed discomfort with the term. While there is a shared belief that greater collaboration could lead to more meaningful impact, many funders in Pitkin County remain uncertain about the most effective ways to contribute and create lasting change.

Recommendations for Coordinated Funding

Several case studies were reviewed to better understand the advantages and challenges of funders collaboratives. While each collaborative is unique, several common themes emerged:

- There is often limited awareness among donors about the benefits of a collaborative funding model. However, when donors come together to learn, share insights, and explore strategic investment opportunities, they can amplify their collective impact, increase visibility of the need, and potentially attract more contributors.

- Successful collaboration requires dedicated effort, including time for shared priority-setting and group decision-making.
- Measuring Return on Investment can be difficult, as it is often hard to directly attribute nonprofit outcomes to any single funder.
- Sustained success depends on ongoing efforts to diversify and grow fundraising across multiple sources.
- Identifying a lead entity to provide operational and financial support for the collaborative can be a significant hurdle.

Evidence-Based:

Research completed by The Bridgespan Group indicates that funding collaboratives give more unrestricted funding, reduce grantee reporting burdens, and support strategic on-the-ground solutions.

The Bridgespan Group. (2023). *Philanthropic collaborative landscape: An emerging opportunity to accelerate impact.* https://www.bridgespan.org/insights/philanthropic-collaborative-landscape

What is a Funders Collaborative?

According to the Association of Charitable Foundations (ACF), a funder collaborative is when grantmakers with a shared focus come together to achieve more collectively than they could individually. These collaborations can range from informal information sharing to formal joint funding programs, all aimed at maximizing impact through pooled resources and expertise.

Key aspects of funder collaboratives, as defined by ACF and other sources:

Shared Focus:

Funders collaborate when they recognize a common interest or goal and believe working together will be more effective.

Diverse Approaches:

Collaborations can involve various activities, including:

- Learning Networks: Sharing knowledge and strategies related to a specific issue.
- Strategic Alignment: Developing complementary funding approaches or aligning grantmaking.
- Joint Funding Programs: Pooling resources to support specific projects or organizations.
- Information Sharing: Informal networks for sharing insights and best practices.

Increased Impact:

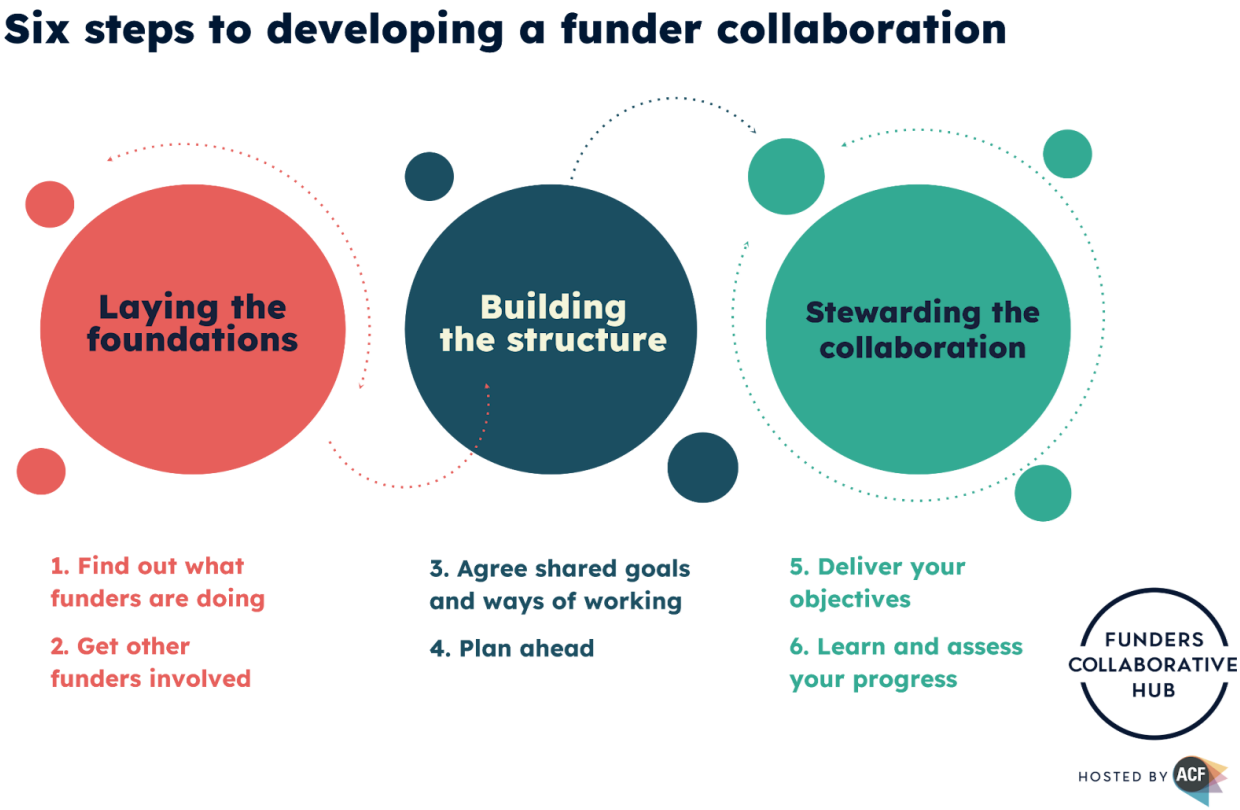
Collaborations aim to achieve greater impact than individual funders could alone, often through increased resources, shared expertise, and reduced duplication of effort.

Adaptability:

Funders adapt their collaborative approaches to address specific needs and goals, whether it's a project-based initiative or a broader systemic change.

The Incremental Steps to Establish a Funders Collaborative

Building a funders collaborative is a process that takes time. Contributors must first develop a strong understanding of each other's work and existing investments. It's essential to identify common goals, create a shared plan of action, and, most importantly, establish mutual trust. According to the Funders Collaborative Hub, there are six key steps involved in forming a successful collaborative:



In 2025, funders in Pitkin County came together to explore the idea of creating a formal funders collaborative. While there was shared interest in continuing the dialogue, the group wasn't ready to commit to a formal structure just yet. As a result, rather than moving immediately toward formalization, a series of gradual, strategic steps can be taken to build momentum:

Action Item 1.1: Hire the temporary employee (referenced in Goal #1 as the Behavioral Health Champion) who will support both the governance and coordinated funding work. See Appendix C for a position description.

Action Item 2.1: Convene VMHS funders during the 2nd quarter of each Calendar Year. Convene all behavioral health funders in the 4th quarter of each calendar year, at a minimum. These gatherings can serve as a platform to exchange information about current investments, identify areas for alignment, and discuss emerging trends or shared observations.

Action Item 2.2: Continue conversations around aligning grant applications and reporting requirements. Streamlining these processes will reduce the administrative burden on grantees and allow for better comparison and analysis of data across programs.

Data-Driven Decision-Making

Funders hold a distinctive role in ensuring organizations are accountable for achieving their intended outcomes. Data is central to this accountability. A data-driven approach enables funders to evaluate the impact of their investments and ensure resources are allocated efficiently and transparently. However, nonprofit organizations often face obstacles such as difficulties in identifying meaningful data, limited technical expertise, and challenges in prioritizing data-related work. While effective data use can generate significant value, it also carries risks like mission drift and staff resistance. Moreover, funders frequently shape which data nonprofits collect through their reporting requirements.

Action Item 2.3: Pitkin County will convene a subset of funders to provide a recommendation on how funders can and should align on collecting and reporting consistent, meaningful data that guides decision-making; this allows organizations to better focus on delivering their programs and services. This alignment also allows funders to make tough funding decisions—an increasingly important capability as resources grow more limited in the coming years. Ultimately, leveraging data in funding decisions helps ensure that community needs are met effectively.

Long-Term Goal: Establish a Funders Collaborative

In the years ahead, Pitkin County should work toward establishing a formal Funders Collaborative, supported by a dedicated backbone entity ***(Action Item 2.4)*****.** This entity would be responsible for convening funders, facilitating the exchange of information, coordinating investments, and—when appropriate—managing the distribution of funds. The goal is to reduce duplication, promote complementary investments, and enable funders to take a more strategic, long-term approach. Additionally, this structure would improve communication between funders, current grantees, and potential applicants.

The backbone entity would:

- Bring funders together to share information, conduct due diligence, align funding strategies, and distribute resources.
- Monitor and identify emerging needs and trends in the community.
- Lead Collaborative meetings focused on collective funding decisions.
- Support planning around the timing and sequencing of investments.
- Provide regular updates on fund balances and financial activity.

- Review and synthesize grantee reports, highlighting key successes and any areas of concern.
- Verify report content as needed to ensure accuracy and completeness.
- Promote consistency across the Collaborative by encouraging the use of a shared application and standardized reporting requirements whenever feasible.
- Manage communications on behalf of the Funders Collaborative and facilitate dialogue among funders, grantees, and prospective applicants.
- Act as the primary liaison to the Governing Body.
- Seek additional funding opportunities from corporate partners and individual donors.

While the Aspen Community Foundation is a strong candidate to serve as the backbone organization, they are currently engaged in internal discussions to clarify their broader role in the funding landscape. This potential partnership can be revisited as their direction becomes clearer.

Key Players

In the initial stages, all funders in Pitkin County should be included in convenings focused on information-sharing. This should include, but is not limited to:

- Aspen Community Foundation
- Contributors to Vital Mental Health Services (Aspen School District, Aspen Valley Health, City of Aspen, Pitkin County, Rocky Mountain Health Plans/Foundation, Town of Snowmass Village)
- Contributors to Withdrawal Management Services (Aspen Valley Health, City of Aspen, City of Basalt, Pitkin County, Town of Snowmass Village)
- A representative or liaison for the Region V Opioid Council
- Aspen One

If a formal Funders Collaborative is later established, it will be important to broaden participation to include individual donors and corporations that contribute significantly to behavioral health initiatives. At that point, the group will need to determine appropriate participation roles and structure. Contributors may choose to serve as:

- Funders/Contributors – contributing financially to the shared pool of funds;
- Decision-Makers – participating in investment decisions;
- Partners – staying informed of decisions and impact; or
- Non-participants – opting out of the collaborative structure.

A representative from the Funders Collaborative — likely the backbone organization — will serve as the designated liaison to the broader governance body (referenced in the Governance recommendation), sharing updates on funding decisions and associated outcomes.

An Important Note about Partnerships and Collaboration

Many stakeholders emphasized the substantial increase in the number of nonprofit organizations in Pitkin County. Funders have a crucial role to play as new organizations emerge by:

- Reviewing the due diligence conducted to assess whether there is a genuine need for another nonprofit.
- Advising the new entity to engage with existing organizations doing similar work to avoid duplication, and encouraging consideration of integrating as a program within an established nonprofit rather than creating a separate one.
- Promoting collaboration and partnership among nonprofits throughout the community.

Resources Required

Initially, the temporary employee hired by the County — referred to as the Behavioral Health Champion — can also play a significant role in coordinating an informal funders collaborative. This individual could be responsible for ensuring that all funders are convened at least annually (ideally more frequently) and for maintaining regular communication with each funder to support alignment, information-sharing, and collaboration. The estimated cost – as noted in the Governance Section – is approximately $175,000. This position will be split between governance and funding duties.

GOAL 3:
BUILDING A COORDINATED RESOURCE NAVIGATION SYSTEM

Background and Need

A behavioral health system is most effective when grounded in a **whole person approach**, recognizing that mental well-being is shaped by a wide range of factors beyond clinical treatment alone. The **social determinants of health (SDOH)**, such as housing, income, education, food security, and social connection, shape the conditions of daily life in Pitkin County and significantly impact emotional and psychological health.

The following examples come from the 2022 Pitkin County Community Health Assessment:

Housing. In Pitkin County, 17% of households spend more than half of their income on rent or mortgage; 21% of households spend 31-50% of their income on rent or mortgage. Housing insecurity was named the top factor impacting stress and well-being among English-speaking survey respondents.

Income. Pitkin County is an expensive place to live. Non-housing expenses in Aspen are 20-30% higher than in many metropolitan areas. In the most recent City of Aspen Community Survey, younger residents and residents earning less than $100,000/year reported less satisfaction with their quality of life than older residents and those earning more than $100,000/year.

Social Connection. 15.1% of Pitkin County households are linguistically isolated, defined as households where all members over age 14 have at least some difficulty speaking English. Linguistic isolation can lead to adverse health outcomes such as symptoms of depression, delaying needed care, and skipping routine preventive care and testing.

By integrating whole person care with strategies to improve SDOH, a behavioral health system can move beyond treating symptoms. When individuals and families have stable housing, reliable income, and access to essential services, they are better positioned to manage stress, engage in treatment, and sustain recovery. Therefore, ensuring community access to a broad range of resources is a critical **prevention strategy** in the behavioral health continuum of care.

Pitkin County already has a wide range of public programs, nonprofit services, and community supports designed to meet the diverse needs of its residents. From workforce development and early childhood support to food assistance and behavioral health services, the county offers an extensive array of resources. However, these services often operate in silos, without a centralized or coordinated system to help residents navigate this landscape and access the right services at the right time. Residents can easily "fall through the cracks," particularly those who are new to the community, face barriers to access, or have complex needs.

In addition, service providers in Pitkin County report difficulty staying informed about the growing number of local programs and initiatives. Without a consistent system for timely updates, frontline staff risk missing key opportunities to link people with the most appropriate resources, reducing the overall effectiveness of care.

Looking at mental health services specifically, survey data reveals worsening reports of mental health overall along with persistent unmet needs. According to the 2024 Community Engagement & Behavioral Health Survey of 429 adults residing in the Aspen to Parachute corridor, 58.5% of respondents reported experiencing 3 or more poor mental health days in the past month.

This is significantly higher than the Colorado average of 37.4%. Of those who said they needed mental health services in the past year, 24.4% were unable to access care, citing reasons like cost, time, lack of information, and transportation barriers. While 70.4% of residents said they were aware of local mental health resources, 46.8% perceive these services as insufficient or unavailable.

To build a more effective and equitable behavioral health system, Pitkin County must invest in the infrastructure that enables prevention, such as coordinated access, shared information systems, cross-sector training, and strong referral pathways. By doing so, the county can strengthen its capacity to prevent behavioral health issues before they arise, reduce disparities, and ensure that all residents have the opportunity to thrive.

Recommendations

As a **long-term goal**, developing a community-wide, formalized resource navigation system in Pitkin County would help connect individuals/families to the services and supports they need, while also promoting enhanced cross-sector collaboration and coordination.

The steps outlined below represent an **iterative approach** to begin moving in that direction, starting with a robust planning and design process and including phased efforts to strengthen coordination and connection among service providers. Recommendations also include exploring tiered case management as a next step in system coordination.

Evidence Based:

A randomized clinical trial published in the Journal of the American Medical Association (JAMA) assessed virtual navigators for adults in need of behavioral health services. There was a notable decrease in hospital admissions and self-harm follow-up encounters.

– Roberge J, McWilliams A, Zhao J, et al. Effect of a Virtual Patient Navigation Program on Behavioral Health Admissions in the Emergency Department: A Randomized Clinical Trial. JAMA Netw Open. 2020;3(1):e1919954. doi:10.1001/jamanetworkopen.2019.19954

What is Community Resource Navigation?

Community Resource Navigation is the process of helping individuals and families connect to the services and supports they need (such as housing, food, child care, health care, employment, and transportation) by identifying appropriate resources, working to reduce barriers to access, ensuring people are aware of available options, and helping them move through complex systems.

Community resource navigation is inherently **person-centered**, meaning support is tailored to an individual's specific needs, circumstances, and capacity. Some people may only need basic information while others may require more intensive, ongoing support to access and sustain services, especially if they are facing multiple complex barriers like housing instability or language access issues.

From the provider or partner perspective, resource navigation is not just about connecting individuals to services, but also about **strengthening collaboration and sharing knowledge across systems**. A key component is ongoing knowledge sharing and ensuring that front-line staff and service providers are regularly updated on available resources, eligibility criteria, capacity, and referral pathways.

Resource navigation, therefore, is **not only a client-facing strategy but an important cross-sector collaboration tool** that helps align efforts, streamline communication, and create a more cohesive continuum of resources and services for the community.

Advance the Planning and Design of Resource Navigation Infrastructure

Some resource navigation efforts are already in place and actively serving specific populations within Pitkin County. For example, Aspen Family Connections provides comprehensive support to children and families, and Valley Settlement offers trusted outreach and navigation for the Latiné community. Rather than starting from scratch, the opportunity is to deepen understanding of these models and intentionally build on them to create a more inclusive, coordinated system that supports all residents across the county.

Action Item 3.1: **Through the Community Access and Navigation Workgroup, conduct a focused assessment of current navigation capacity to identify system gaps and strengths that can be leveraged.** This assessment should include both qualitative and quantitative methods (e.g., service data analysis, interviews, and focus groups) and result in a shared understanding of the current landscape, gaps, and opportunities. The steps below provide a structured approach:

Map existing navigation services

- Inventory all current resource navigation efforts in the community.
- Identify the target populations currently being served.
- Capture eligibility criteria and access points.
- Document the structure and model of each navigation service (e.g., centralized vs. decentralized; generalist vs. specialist roles).

Highlight strengths and promising practices

- Identify strengths, innovations, and successful practices that could be scaled or adapted across the system.

Analyze gaps and missed populations.

- Use data and partner input to identify unmet needs and under-served groups (e.g., adults without children, residents in outlying areas, individuals with co-occurring needs).

Review and learn from other navigation models.

- Study the structure, staffing, and funding of successful resource navigation systems in Colorado and other comparable regions.
- Identify key design features and implementation strategies that align with Pitkin County's context.

Clarify vision, goals, and scope.

- Facilitate a collaborative process to define the shared vision and long-term goals of a community-wide navigation system.
- Determine the intended scope: what systems, services, and populations should be connected?

Identify capacity needs and embedded navigator roles.

- Determine where additional navigation capacity is needed based on demand, geographic coverage, and gaps in specialized support.
- Define where navigators should be physically or programmatically embedded (e.g., clinics, libraries, housing agencies).

Resource Navigation System Examples

Larimer County: Supported Families Stronger Community (housed within Human Services; focus on families)

Mesa County: Grand Valley Connects (housed within Public Health; all county residents)

Metro Denver Connected Community of Care (more complex regional initiative with coordination technology and backbone organization)

Jefferson County Community Resource Navigation Network (lighter touch approach)

Given the existing navigation capacity, a **Hub-and-Spoke Model** could be well-suited to Pitkin County, consisting of a central coordinating "hub", and "spoke" organizations with embedded Community Navigators.

A hub-and-spoke navigation model includes a centralized access point where individuals and families can easily connect through user-friendly methods and receive a quick, streamlined assessment of their needs. From there, they are linked to a network of community navigators, embedded in key settings like schools, clinics, and housing sites, who provide personalized, relationship-based support. This model is rooted in strong cross-sector collaboration, with service partners regularly coordinating, sharing knowledge, and aligning around common goals, metrics, and training to ensure a cohesive and responsive system of care.

In this model, embedded navigators typically receive a mix of direct and centralized referrals. **Direct referrals** come from within the host organization (the "spoke") where the navigator is embedded. **Centralized referrals** would come through the central hub, which will be coordinating referrals from the broad community intake process.

Both are important. Direct referrals ensure responsiveness to the immediate needs of the population served by the host agency. Centralized referrals promote system-wide coordination, reduce duplication, and ensure individuals get connected to the navigator best positioned to help them.

Jumpstart Coordination Across Service Providers

While a robust planning and design process is critical to developing a long-term, comprehensive resource navigation system, there are also lower-lift, shorter-term strategies that can strengthen coordination and build momentum across service providers. These actions can be implemented in parallel to system design efforts and can help lay the groundwork for future system development.

Action Item 3.2: Leverage ongoing efforts to build a shared resource directory

To improve access to a wide range of services, both the public and providers need reliable, up-to-date information about what resources are available. Pitkin County has several existing directories that are specific to behavioral health and broader community resources, including:

- Pitkin County, Mental Health and Substance Use Resources
- HeadQuarters
- West Mountain Regional Health Alliance, Resource Directory
- Recovery Resources, Resource Directory

In addition to these directories, providers often share information through more informal channels, such as email listservs. Recognizing the need for better coordination, the Behavioral Health Leadership Group (BHLG) has identified the consolidation of these various resource lists into a single, shared, interactive directory as a key priority, and efforts are underway to design and implement this solution.

Progressing on this effort would build on existing momentum and serve as a foundational step toward improved navigation. The following strategies could then help guide next steps for this work:

- Assign “light-touch” maintenance responsibilities (e.g., each agency can update its section monthly or quarterly).
- Consider tagging resources by population served, eligibility requirements, and referral process to make it more user-friendly.
- As capacity grows, explore shifting to a more sophisticated platform or integrating with a broader resource database.

Action Item 3.3: Create a dedicated collaboration hub (i.e., a subgroup within the Community Access and Navigation Workgroup) for navigators to come together

For staff currently engaged in resource navigation, ensure they have a dedicated collaboration hub to foster connection and engage in shared problem-solving. In Year 2, once the Community Access and Navigation Workgroup is stood up and meeting on a regular basis, this could begin as a sub-group to ensure some structure and gain traction:

- Identify a core group of front-line staff or program managers from different agencies and sectors who are actively involved in helping clients access services.
- Convene the group on a regular basis to build relationships, discuss challenges, highlight promising practices, and identify emerging needs.
- Use this space to gather input that can inform the broader system design process and ensure that the perspectives of those doing the work are front and center.
- Consider rotating facilitation or using light-touch coordination from the temporary full-time employee to maintain momentum.

Action Item 3.4: Develop a shared communication channel

Offer a real-time communication and resource-sharing channel among navigators across programs and organizations.

- Set up a simple, no-cost digital platform (e.g., Slack, Microsoft Teams) where navigators can post updates, ask questions, and share referral tips or program changes.
- Promote regular use by posting discussion prompts or quick updates.
- Assign a staff person or moderator to ensure posts remain active and relevant.

Identify one or two cross-system pilots

In later years, depending on how the design and planning process has advanced, it may be time to choose a focused issue area or population and pilot new coordination workflows. Use these pilots to test practical solutions, build trust, document lessons, and build toward system-wide models. Be sure to capture small successes and pain points to demonstrate value, which can help justify future investment in a more formal system.

Explore Tiered Case Management as a Next Step in System Coordination

Tiered case management is a natural next step in system coordination. While resource navigation services play a critical role in helping the broader population access support early and efficiently, they are not designed to provide the sustained, more intensive support needed by individuals with complex or chronic needs. Navigation efforts typically offer short-term, task-focused assistance and are not equipped to support individuals with serious mental illness, co-occurring conditions, or those facing persistent barriers to care.

To meet the full range of behavioral health needs in Pitkin County, consider complementing navigation services with more intensive case management approaches. These services offer longer-term engagement, provide meaningful follow-up after a crisis, and help individuals stay connected to care and other essential supports. Building out this continuum will ensure that residents not only get connected to services, but also have the sustained help they need to remain stable and well.

Similar to resource navigation, Pitkin County is not starting from scratch when it comes to case management. Existing programs already provide some level of case management within specific populations. These efforts reflect valuable local experience and relationships that can serve as a foundation for growth. In Years 3 or 4, after planning is underway with the Community Access and Navigation Workgroup, the opportunity is to further explore and expand upon these strengths to build a more intentional, coordinated, and tiered system of case management that spans the full continuum of need.

See Appendix E for a description of current case management efforts and recommendations for next steps.

Governance & Key Players

Community Access & Navigation Workgroup

This workgroup will be a collaborative planning group focused on designing community resource navigation and promoting coordination across service providers.

The group should prioritize the inclusion of partners with a proven track record in delivering resource navigation and/or case management services, fostering cross-sector collaboration, and demonstrating adaptability in dynamic environments.

Since resource navigation is inclusive of a broad range of services and supports individuals and families may need, the workgroup membership will need to go beyond traditional behavioral health providers and partners. Key sectors that should also be represented include the following:

- Social services (e.g., housing and homelessness support such as the Aspen Pitkin County Housing Authority (APCHA) and Town of Snowmass Village Housing Department; food security; domestic violence support)
- Education (e.g., public school systems (K-12); early childhood education such as Kids First; adult education and literacy such as Colorado Mountain College, English in Action, Raising a Reader)
- Workforce and economic development (e.g., job training and employment; vocational rehabilitation)
- Legal and advocacy services (e.g., legal aid such as Alpine Legal Services; immigration support)

Recommended membership includes (but is not limited to) representatives from the following partners:

- A Way Out
- Aspen Family Connections
- Aspen Hope Center
- Aspen School District
- Behavioral Health Leadership Group
- HeadQuarters
- Department of Human Services
- Mountain Family Health Center
- PACT
- Department of Public Health
- Recovery Resources
- Response
- Valley Settlement
- WMRHA

- Faith-based and community-based organizations
- Lived experience experts (e.g., individuals with firsthand experience navigating community systems; peer support specialists)

For this and all of the Workgroups - while there are many partners to involve, the core group would likely include 10-15 members. A broader set of stakeholders can be engaged through periodic updates, focus groups, or topic-specific working sessions. The Workgroup could also establish task-specific subgroups as needed to carry out particular strategies. These would be time-limited, focused, and report back to the core group. This tiered approach helps ensure broad engagement without diluting focus or slowing progress.

Resources Required

The long-term resources required and funding source considerations for a navigation system are dependent on the structure and services the County decides to pursue. In the short-term, this work would benefit from investments in planning and strategic capacity. For example:

- Technical assistance and consulting for service model design or community needs assessment
- Facilitation and convening support to engage cross-sector partners in collaborative planning
- Community engagement and tools to incorporate voices of people across the County

Funding Sources to Explore

To stand up a resource navigation system, especially one that helps individuals access behavioral health, housing, social services, and recovery supports, Pitkin should be able to draw from a mix of federal, state, local, and philanthropic funding sources. Some options to explore include the following:

- Behavioral Health Administration (BHA) grants that support infrastructure and capacity-building (e.g., support systems navigation, workforce development, and care coordination infrastructure).
- Health First Colorado (Medicaid) funding can support Community Health Workers (CHWs) or Peer Navigators as billable roles.
- Colorado Department of Human Services (CDHS) Community Services Block Grant (CSBG) can be used for anti-poverty initiatives, including resource navigation and referrals.

- SAMHSA Grants can fund navigation for behavioral health and substance use populations.
- Federally Qualified Health Centers can apply for care coordination/navigation enhancements under Health Center Program expansion grants.
- Local and philanthropic funding could provide startup or bridge dollars for a pilot navigation model.

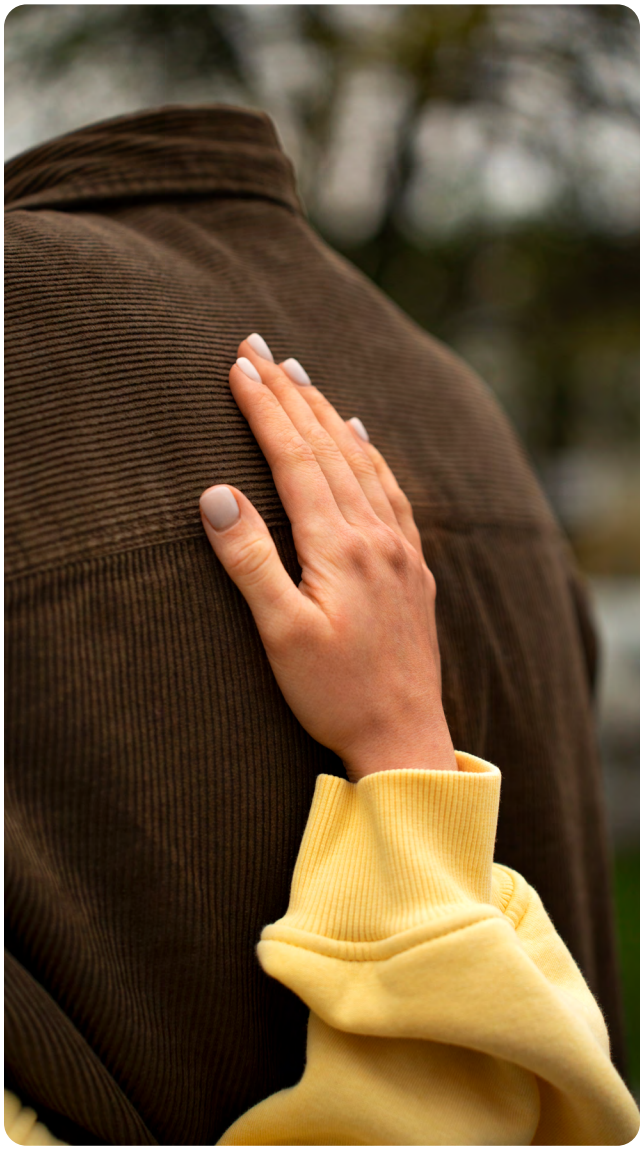
For case management, consider the following:

- Behavioral Health Administration (BHA) grants that support direct services.
- Health First Colorado (Medicaid) covers case management for certain populations, and Colorado's waivers might be able to be used to fund community-based services, including Intensive Case Management (ICM).
- The Regional Accountable Entity and/or Behavioral Health Administrative Services Organization – Rocky Mountain Health Plans – might offer a "value added" ICM service for high-cost members.
- SAMHSA Grants can fund navigation for behavioral health and substance use populations.
- Local and philanthropic funding could provide startup dollars for a "proof of concept" pilot, especially if a specific population is the initial focus.

GOAL 4:
STRENGTHENING THE BEHAVIORAL HEALTH CONTINUUM BY ADDRESSING GAPS IN TREATMENT AND RECOVERY

Background and Need

Pitkin County has invested in building a strong and responsive behavioral health continuum of services, with a wide range of providers and high-performing programs particularly at the prevention, early intervention, and intervention levels of care. Community- and school-based programs and initiatives have created a solid foundation that supports many residents before crises emerge.



However, gaps persist – especially at the higher levels of treatment and recovery. Individuals with more acute behavioral health needs or those seeking long-term recovery services often face limited local or regional options. These gaps have been exacerbated by the recent closure of the inpatient psychiatric hospital in Grand Junction, as well as closure of the inpatient detox center in Glenwood Springs. Individuals with complex mental health or substance use needs are frequently referred to the Front Range, which removes them from their support networks and increases the risk of disengagement or relapse.

Addressing these gaps is especially important in Pitkin County, where substance use is both prevalent and visible. Data points to high levels of alcohol consumption across

age groups, with adults nearly twice as likely to be heavy drinkers compared to the State average (13.1% vs. 7.2%), and 23% reporting binge drinking in the past month (which is higher than the State rate of 18.7%). Among youth, the concern is even more striking – 34.6% of Aspen High School students reported binge drinking, nearly triple the Colorado average (12.5%).

Between October 2022 and April 2024, Aspen Valley Health (AVH) logged 973 encounters for alcohol or intoxication, averaging 54 per month. This high utilization of emergency services underscores the lack of preventative, outpatient, and recovery-oriented options in the community.

Another concern is the lack of providers trained to meet the needs of specific populations, especially:

- Psychiatrists for both adults and children/youth
- Child and adolescent-focused clinicians, especially for ages 0-5 who can integrate play therapy and family therapy
- Spanish-speaking providers

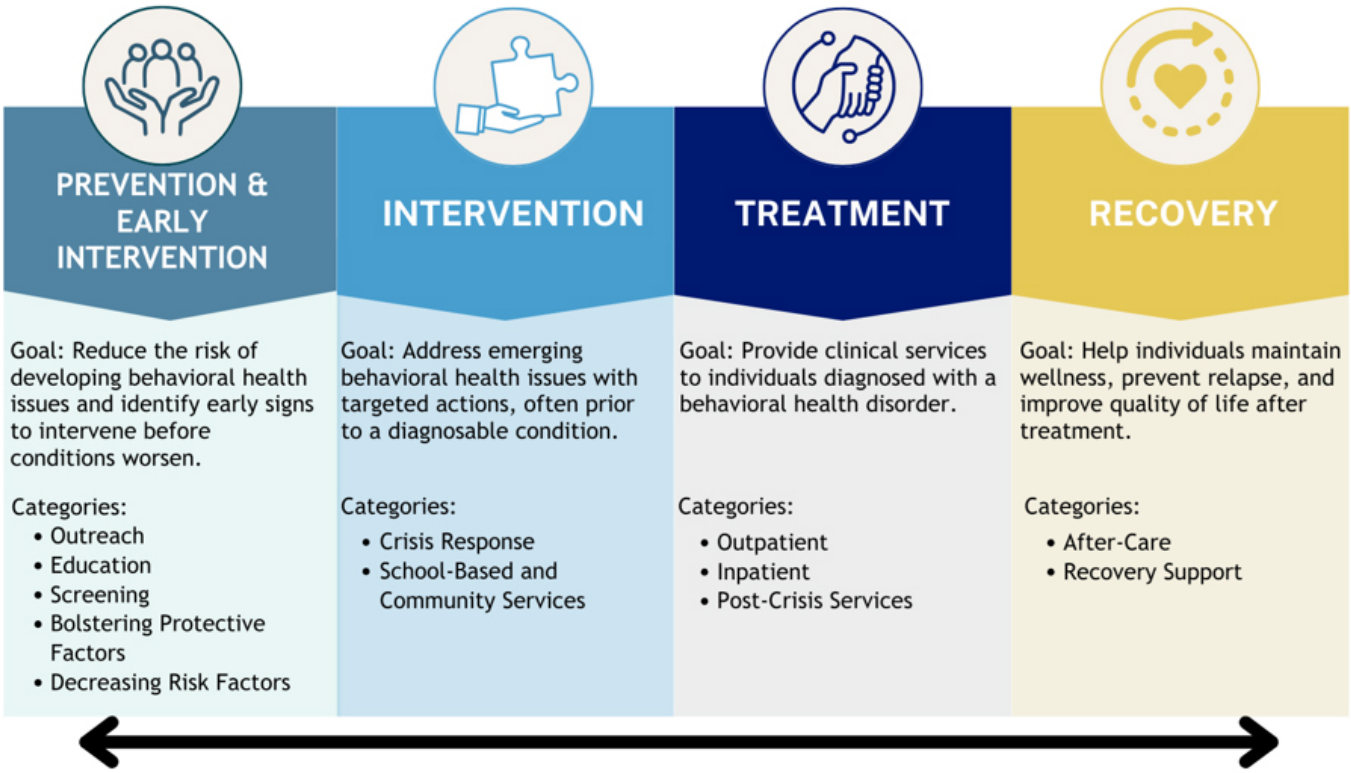
The limited availability of some outpatient providers often results in long wait times for appointments, which can discourage individuals from seeking care altogether.

Of note, in the 2024 Community Engagement & Behavioral Health survey, 82.4% of residents from Aspen to Parachute said they are "very" or "somewhat likely" to use teletherapy if it were available and affordable, and LGBTQ+ respondents indicated the highest likelihood of using teletherapy with 91% reported being "very" or "somewhat likely" to use it. These responses indicate that telehealth could be an effective strategy to close gaps in mental health access, especially where there are provider shortages locally (see Goal 6 for more discussion on this topic, as well as increasing access to Spanish-speaking providers and services for 0-5).

Ideal Continuum of Care

An effective behavioral health continuum in Pitkin County should be tailored to reflect the community's specific needs, demographics, and available resources. Rather than attempting to deliver every service locally, the focus should be on establishing a strategic blend of high-priority, accessible services that align with local demand and geographic context. A coordinated regional approach can supplement this by providing access to more intensive or specialized services within a reasonable distance.

By balancing essential local services with regional partnerships, Pitkin County can build a more comprehensive and sustainable behavioral health system. Ensuring that this system is well-connected, coordinated, and easy to navigate will allow individuals to move smoothly across levels of care—minimizing service gaps and reducing the risk of anyone falling through the cracks (see Goal 3).



Importantly, while this section focuses on efforts to expand higher-acuity behavioral health services, these should be accompanied by a continued focus on strengthening upstream supports, such as peer support, early intervention, and community-based services, to help prevent crises and reduce demand on more intensive levels of care.

Recommendations

A multi-faceted and iterative strategy will help to address current gaps in the behavioral health continuum of care over time.

Action Item 4.1: Assess and Build Up Alternatives to Inpatient Care

The closure of the inpatient psychiatric hospital in Grand Junction has significantly reduced access to inpatient psychiatric care for Pitkin County residents. In response, the focus should shift toward expanding services that offer intensive, structured support within the community. The goal is to help individuals stabilize and manage complex mental health needs without requiring hospitalization – or to support them in stepping down from inpatient care when appropriate. These community-based services should be designed to promote recovery in less restrictive, more supportive environments whenever possible.

Bolster ISP and Launch IOP. In the immediate-term, there are efforts underway to offer more intensive and structured community options. The Aspen Hope Center already operates an **Intensive Stabilization Program (ISP)** as an alternative to inpatient hospitalization for individuals in acute crisis and deemed to be high risk for suicide. The program allows individuals to remain at home with support from loved ones while receiving daily, wraparound care from local clinicians, peers, and partner agencies. ISP clients are seen by multiple professionals each day until they stabilize and transition to regular weekly therapy.

The Aspen Hope Center currently has one clinician providing ISP therapy, and in 2024, the program served 11 individuals. The organization is actively working to redesign and refresh its ISP model to better align with community needs. Efforts are underway to train and add up to three additional ISP therapists, who would also serve as crisis clinicians, to increase capacity and enhance service delivery.

In addition, the Hope Center is launching a new **Intensive Outpatient Program (IOP)** to address a critical gap in care. IOPs offer a higher level of support than traditional outpatient therapy while allowing individuals to live at home and maintain daily responsibilities. These programs typically include multiple sessions per week (often three to five days) that combine group therapy, individual counseling, and psychiatric services. Designed for those needing more intensive support than weekly therapy provides but not requiring 24/7 supervision, IOPs can also be tailored for adolescents, incorporating school coordination, family therapy, and developmentally-appropriate groups.

The Aspen Hope Center team has developed two separate curricula spanning 8-12 weeks, clinically appropriate for adults and adolescents, for the new IOP. This program offers approximately nine hours of intensive and structured outpatient group support each week. The program additionally provides care coordination, family support, individual therapy, and medication management when necessary.

As these more intensive community-based programs continue to develop, the Clinical Leadership & Systems Design Workgroup should develop a process to assess their utilization, outcomes, and accessibility to understand how well they are meeting local needs. Tracking enrollment numbers, client progress, referral sources, and barriers to participation will help identify who is benefiting from these services, and who may still be falling through the cracks. These data can inform strategic decisions around resource allocation, potential partnerships, and future program expansion.

Note:

Recommendations related to identifying and launching new services require more in-depth analysis of indicators of need, clinical acuity, system strain, and operational feasibility, as well as input from stakeholders and providers. Although outside the scope of this behavioral health strategic plan, once Pitkin has identified options to pursue, there are independent behavioral health consultants, consulting firms, academic/research institutions, and other entities that can provide targeted expertise in program design and implementation.

Action Item 4.2: **Evaluate the need and opportunity to reserve a specific number of beds at the new Vail Health inpatient behavioral health facility for Pitkin County adults and/or youth.**

Around the same time that the inpatient psychiatric hospital closed in Grand Junction, the Vail Health Precourt Healing Center opened (in May 2025). The Center is a 50,000-square-foot inpatient behavioral health facility located in Eagle County offering 28 private rooms – 14 for adolescents and 14 for adults – and providing 24/7 care

for individuals experiencing acute mental health crises. The center delivers a range of therapies, including individual and group counseling, as well as art, music, yoga, and movement therapy, all aimed at crisis stabilization and short-term treatment.

Even with expanded local alternatives to inpatient care, it may be valuable to explore a contract for a reserved bed(s) at the Center. This arrangement would ensure timely access to acute behavioral health services for Pitkin County residents experiencing a crisis. Under such a contract, the county would pay a fixed daily rate to secure a dedicated bed—regardless of daily occupancy—guaranteeing availability when needed. If deemed appropriate, this strategy could help reduce delays in care and minimize unnecessary use of emergency rooms or jail facilities.

Action Item 4.3: Leverage Telepsychiatry Consultation Programs to Support PCPs

Given ongoing gaps, the county should explore leveraging existing telepsychiatry consultation programs. These programs enhance access to psychiatric expertise by enabling primary care providers (PCPs) to consult with psychiatrists either in real-time (synchronous) or through delayed communication (asynchronous). In synchronous models, PCPs and psychiatrists engage in live video consultations to discuss patient cases. Asynchronous models allow PCPs to send patient information to psychiatrists, who then review the data and provide recommendations at a later time. These approaches support PCPs in managing behavioral health conditions and can reduce the need for in-person specialist visits.

For example, the University of Colorado School of Medicine offers free telepsychiatry programs targeting three different populations:

- **EASY** (Enabling Access to Specialty Care for You) supports PCPs caring for adult and geriatric patients with mental health and substance use concerns. The program also provides educational resources and training sessions to enhance providers' skills in managing mental health conditions.
- **CoPPCAP** (Colorado Pediatric Psychiatry Consultation & Access Program) is designed to assist pediatric PCPs in assessing and treating behavioral and mental health conditions in children and adolescents.
- **PROSPER** (Perinatal Resource Offering Support and Psychiatric Education and Referral) focuses on supporting PCPs who care for patients during the perinatal period.

In the short-term, to begin leveraging such existing resources, the Clinical Leadership & Systems Design Workgroup should:

- Promote awareness of existing telepsychiatry consultation programs among local primary care providers; and
- Encourage enrollment of local PCPs in these programs.

PCPs would then need to integrate telepsychiatry into care workflows and ensure they are equipped with private telehealth rooms to increase equitable access. Valley Health Alliance would be a valuable partner in these efforts.

Action Item 4.4: Reimagine Recovery-Oriented Facilities Through a Local-Regional Service Framework

In response to evolving state regulations that prohibit standalone detox facilities, Pitkin County and regional partners should re-envision recovery-oriented services using a strategic local-regional framework. This approach distinguishes between lower-intensity services that should be embedded locally and higher-intensity services that are best delivered regionally, based on frequency of use, staffing requirements, and resource intensity. Pitkin County should approach this period of transition as an opportunity to better align services with a more sustainable and intentional recovery services model.

Lower-Intensity, Higher-Frequency Services (Local)

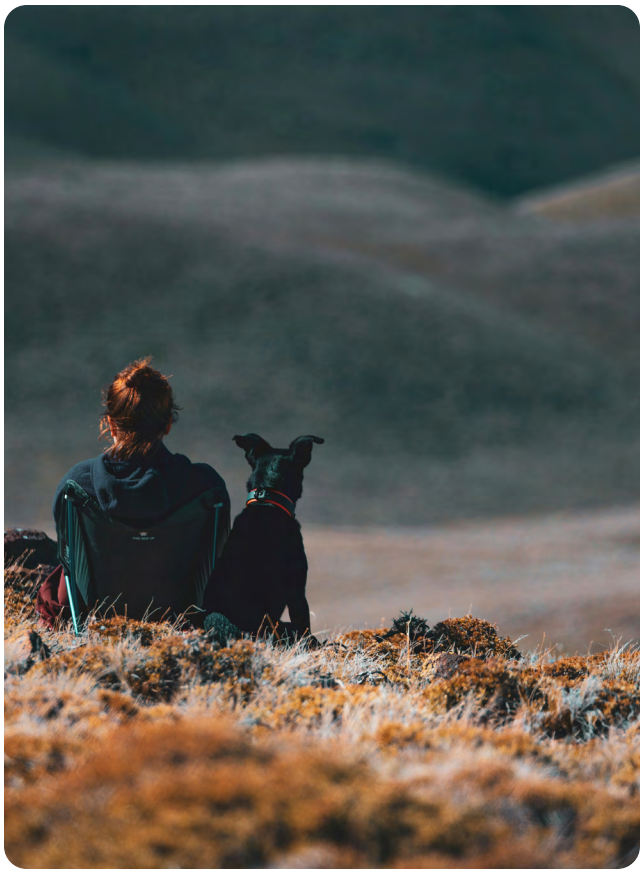
Outpatient and community-based services – including peer recovery support, harm reduction, MAT, therapy, case management, and recovery hubs – are used more regularly over extended periods and are most effective when delivered locally. These services foster strong relationships, promote sustained recovery, and enable integration with housing, employment, and other social supports. Providing these services locally is essential not only for convenience and continuity, but also to help individuals remain connected to their families, social networks, and communities (all key factors that support long-term recovery).

Higher-Intensity, Lower-Frequency Services (Regional)

Services such as medically supervised withdrawal (detox), residential substance use treatment (e.g., ASAM 3.5/3.7), crisis stabilization units, and partial hospitalization programs are resource-intensive and require 24/7 staffing, specialized medical providers, and higher infrastructure costs. Due to their infrequent use by most individuals and high operating costs, these services are most efficient and sustainable when delivered regionally to serve a broader geographic area.

Action Steps:

- Partner with regional stakeholders to collaboratively plan for the future of detox and residential treatment services, ensuring alignment with updated state regulations.
- Create a recovery-oriented service map that clarifies the distinction between regional and local providers and identifies gaps across both levels.
- Strengthen local recovery infrastructure by expanding access to community-based services such as peer support, MAT, recovery hubs, and wellness-focused programming.
- Engage in ongoing regional coordination to maintain access to high-acuity services, ensure appropriate resource allocation, and support seamless transitions between levels of care for Pitkin County residents.



By shifting to this local-regional model, communities can ensure that high-acuity services remain accessible when needed, while also building a robust local foundation for long-term recovery and wellness.

Action Item 4.5: Strengthen Integration & Oversight in the Crisis Response System

The **co-responder (PACT) program** and **mobile crisis services** are widely regarded in Pitkin County as essential, trusted components of the local behavioral health crisis system. Together, they provide rapid, compassionate, and community-based responses to individuals experiencing mental health crises, helping to divert people from emergency departments and the justice system. The PACT program contracts a clinician through the local Community Mental Health Center, now known as Health Solutions West. Mobile crisis services are provided separately by Aspen Hope Center, offering on-call, field-based crisis intervention across the region.

While both programs are deeply valued by community partners and stakeholders, opportunities to enhance alignment between services, reinforce clinical oversight across roles, and improve care continuity should be a focus. Streamlining communication, clarifying roles, and reducing potential duplication of efforts can help ensure that community members receive high-quality care regardless of the responding agency. As Pitkin County prepares for the next RFP cycle, there is an opportunity to strengthen integration, reinforce accountability, clarify roles within programs, and build on the strong foundation already in place to ensure seamless, high-quality care for individuals in crisis

Action Item 4.6: Assess and Redirect Funding to Strengthen the Behavioral Health Safety Net

The Behavioral Health Administrative Service Organization (BHASO), launched on July 1, 2025, is tasked with expanding the provider network, thereby increasing options for behavioral health partners and services. Pitkin County should actively collaborate with its designated BHASO—Rocky Mountain Health Plans—to identify and engage providers that can help ensure the delivery of essential and comprehensive behavioral health safety net services. As part of this effort, the county may also consider partnering with emerging providers, such as Vail Health, in coordination with the BHASO.

In the Future:

Identify new service types or levels of care to explore that are aligned with community needs.

In future years, Pitkin County should continue to explore other services or programs that could benefit the community. Some examples are provided in Appendix F.

Governance & Key Players

Clinical Leadership & Systems Design Workgroup

This cross-sector workgroup will focus on assessing and strengthening the behavioral health continuum of care in Pitkin County. Charged with identifying service gaps and opportunities, this group will pull together experts from healthcare, behavioral health, public health, human services, and criminal justice. It will be essential to include personnel who are providing the day-to-day delivery of services. The practical insight and frontline experience of direct service providers will help uncover real-time challenges, service fragmentation, and inefficiencies, as well as to identify creative solutions grounded in actual practice. Such insights will be critical to fine tuning current services and ensuring that any new service models are both realistic and responsive to community needs.

Recommended membership includes (but is not limited to) representatives from the following partners:

- A Way Out
- Aspen Hope Center
- Aspen Police Department
- Aspen Valley Hospital
- Department of Human Services
- Department of Public Health
- Health Solutions West
- MidValley Family Practice
- Mountain Family Health Centers
- PACT
- Rocky Mountain Health Plans
- Recovery Resources
- Valley Health Alliance

The Workgroup will also need to find ways to center community voice and lived experience to help ensure that the county's behavioral health system is comprehensive, sustainable, and equipped to serve residents across the full spectrum of need.

Resources Required

The resources required and funding source considerations are dependent on the options and services the County decides to pursue. However, in the short-term, this work would benefit from investments in planning and strategic capacity. For example:

- Technical assistance and consulting for service model design, clinical integration, or community needs assessment
- Policy and regulatory expertise to align with state requirements and funding opportunities
- Facilitation and convening support to engage cross-sector partners in collaborative planning
- Community engagement and tools to incorporate voices of people across the County

GOAL 5:
INCREASING AND IMPROVING ACCESS TO SERVICES

Background and Need

A 2022 Pitkin County survey of local mental health providers found that 55% did not accept insurance of any kind, although 75% reported offering a sliding scale for services. Many providers cited the administrative burden of dealing with insurance companies and inadequate reimbursement rates as key reasons for opting out of the insurance system.

Despite having a higher ratio of behavioral health providers to residents compared to the state average, Pitkin County still struggles with access. On average, mental health providers in the county see 244 individuals (i.e., patients) per year—a 5.79% decrease from the previous year's average of 259. However, according to survey responses, the providers who are practicing are often fully booked, creating significant barriers to care.

The 2023 Community Mental Health Assessment echoed these concerns. While both English and Spanish-speaking respondents reported feeling fairly or very comfortable seeking mental health support, cost was identified as the top barrier across both groups. Additionally, respondents noted the difficulty in finding therapists who accept insurance. A lack of local mental health professionals was widely recognized by community members, providers, and stakeholders as a major factor impacting access. This shortage has resulted in long wait times, extensive waitlists, and provider burnout.

Pitkin County has relatively few residents enrolled in public insurance programs—approximately 1,073 Medicaid members and 3,410 Medicare members, according to Human Services. Yet, due to low reimbursement rates and administrative challenges, most providers do not accept Medicaid or commercial insurance. As a result, access to mental health care is often limited to those who can afford to pay out of pocket, leaving lower-income residents with few viable options.

Recommendations

Action Item 5.1: Further maximize the impact of the Mental Health Fund managed by HeadQuarters

The Mental Health Fund served over 150 individuals in 2024, and demand has continued to increase.

- The Fund offers vital financial assistance to individuals and families facing mental health challenges who are unable to afford necessary services. It provides an important resource for those who are uninsured, underinsured, or unable to pay out of pocket. Priority populations identified by behavioral health partners in Pitkin County include marginalized groups, children, youth and families, older adults, and individuals transitioning from the criminal justice system.
- To ensure the Mental Health Fund effectively reaches these groups, it may be beneficial to review and potentially update eligibility criteria. This should be followed by a targeted communications plan to raise awareness about how to access the Fund among these priority populations.
- Given provider interest in accepting the Mental Health Fund, exploring ways to simplify the application process could help boost participation. Additionally, promoting the Fund to new providers just starting their practice could support them in gaining experience and building a patient base.

Action Item 5.2: Continue to Explore Incentives for Providers to Accept Commercial Insurance

A 2022 survey conducted by HeadQuarters found that nearly 60% of responding providers expressed willingness to accept insurance if key barriers were addressed. Additionally, 56% indicated they could serve a more diverse range of individuals —particularly those with varying insurance plans—if they were able to accept insurance. Notably, nearly 95% of respondents reported having turned away a person due to not accepting their insurance. While the sample size was relatively small (n=19), the findings suggest interest among providers in learning more about how to navigate the insurance system.

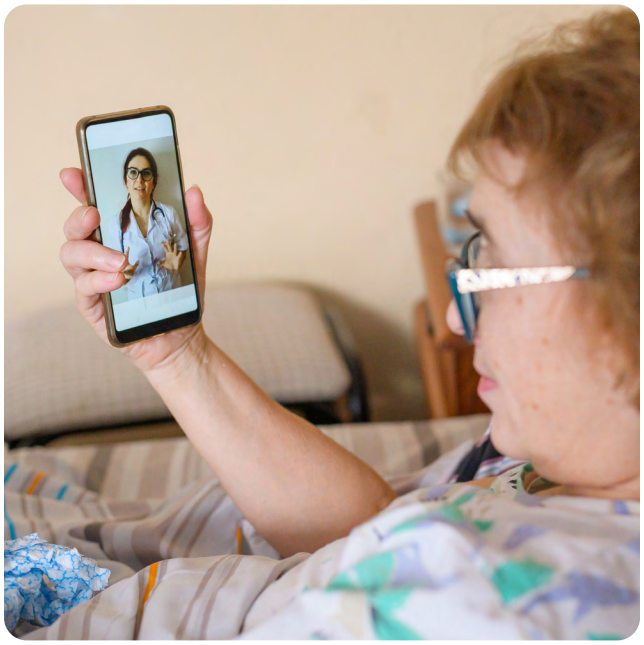
When HeadQuarters identifies providers who are open to accepting commercial insurance, they often refer them to Headway—a platform that simplifies the billing process by offering competitive reimbursement rates with many private insurers and Medicaid. Headway handles all administrative paperwork and offers a user-friendly interface, making it easier for providers to join insurance networks. It is a valuable resource, and there may be additional tools or platforms worth exploring to support providers in this transition.

Action Item 5.3: Consider the Counseling Compact

The Counseling Compact is a legislative agreement among participating states which allows counselors to practice across state lines either in person or via telehealth. It is a mutual recognition model, or a contract among states, allowing professional counselors licensed and residing in a compact member state to practice in other compact member states without need for multiple licenses. Colorado passed Senate Bill 22-077 "Interstate Licensed Professional Counselor Compact" in 2022, which allows licensed professional counselors in any state that has joined the compact to provide a variety of services. Forty states have enacted similar legislation, and four additional states are going through the process to pass legislation to participate.

This is a new initiative that is expected to start accepting applications from behavioral health professionals in the fall of 2025. The Compact will help people receiving services by improving continuity of care when they or their counselors travel or relocate – such as seasonal workers. The Compact will help protect the public by ensuring that member states rapidly share investigative and disciplinary information and cooperate in investigations of misconduct by practitioners, when necessary.

When it begins its operations, the Compact could help connect people in need of services – especially specialty areas – in a more timely manner than if they wait to see a professional in Pitkin County. As Pitkin County – and the State – continue to address the behavioral health workforce shortage, the Compact can serve as both a bridge and a long-term support for specific populations.



Action Item 5.4: Leverage CYMHTA

The Children and Youth Mental Health Treatment Act (CYMHTA) provides funding to help families access mental health treatment for their child or youth without requiring involvement from the child welfare system, when a dependency and neglect case is not appropriate.

To qualify for CYMHTA, the child or youth must:

- Have a diagnosed mental health condition
- Be at risk of out-of-home placement
- Not be eligible for Medicaid
- Be under the age of 18 at the time of application
- Not have a current or pending dependency and neglect action with child welfare

Participation in CYMHTA is voluntary and must be initiated by a parent or legal guardian. To begin the process, the guardian must contact the CYMHTA Liaison at the Behavioral Health Administrative Service Organization (BHASO) for Pitkin County's region, which is Rocky Mountain Health Plans. The liaison will then coordinate an assessment with the family.

Given the relatively low number of Medicaid-eligible residents in Pitkin County, CYMHTA may be a useful option for families whose commercial insurance has denied coverage for needed behavioral health services. However, for the program to be effective locally, providers in Pitkin County must be willing and able to serve CYMHTA-eligible youth. This may require additional outreach to local providers via the BHASO or the Behavioral Health Administration (BHA).

Governance & Key Players

Workforce Development Workgroup

Because expanding access to behavioral health care largely depends on increasing exposure to available providers, this work should be housed within the Workforce Development Workgroup.

The Workgroup should engage both professionals from larger organizations and independent or private practice providers to ensure a well-rounded perspective. Additionally, involving individuals with lived experience will offer valuable insight into community preferences—such as the comfort level with virtual sessions or working with out-of-state professionals—which can inform more effective service delivery strategies.

Recommended membership includes (but is not limited to) representatives from the following partners:

- Aspen Hope Center
- Behavioral Health Leadership Group
- Colorado Mountain College
- Department of Human Services
- Department of Public Health
- HeadQuarters
- Health Solutions West
- MidValley Family Practice
- Mountain Family Health Centers
- Rocky Mountain Health Plans

Resources Required

Until further research is conducted – such as identifying which incentives might encourage providers to accept Medicaid and/or commercial insurance – it remains difficult to determine the full scope of resources needed for implementation. In the short term, dedicated staffing from the Behavioral Health Champion will be essential to engage providers in conversations about potential incentives, share updates on the implementation of the Counseling Compact, and initiate coordination with the BHASO and Behavioral Health Administration (BHA).

GOAL 6:
ENSURING PITKIN COUNTY HAS A DIVERSE, SKILLED, AND COMMUNITY-ROOTED BEHAVIORAL HEALTH WORKFORCE

Background and Need

Since the onset of the COVID-19 pandemic, the behavioral health workforce in the United States has faced escalating challenges—and Colorado is no exception. By the end of 2026, the state is projected to face a shortage of approximately 4,400 behavioral health professionals. This gap is felt most acutely in rural, mountain, and frontier regions. The 2023 Colorado Health Access Survey found that the most common reason individuals were unable to access needed mental health care was the lack of available appointments.

For many behavioral health graduates—including adolescent counselors, child and family therapists, and addiction specialists—the path to licensure is difficult to navigate. Key barriers include limited access to supervised clinical hours and the high cost of licensing exams and preparation materials. In Colorado, candidates at the master's level must often complete 2,000 clinical hours and more than 100 hours of supervision over the course of two years. One study found that 57% of master's-level graduates in mental health fields do not complete licensure, often due to financial strain, burnout, or challenges with transferring licensure across state lines.

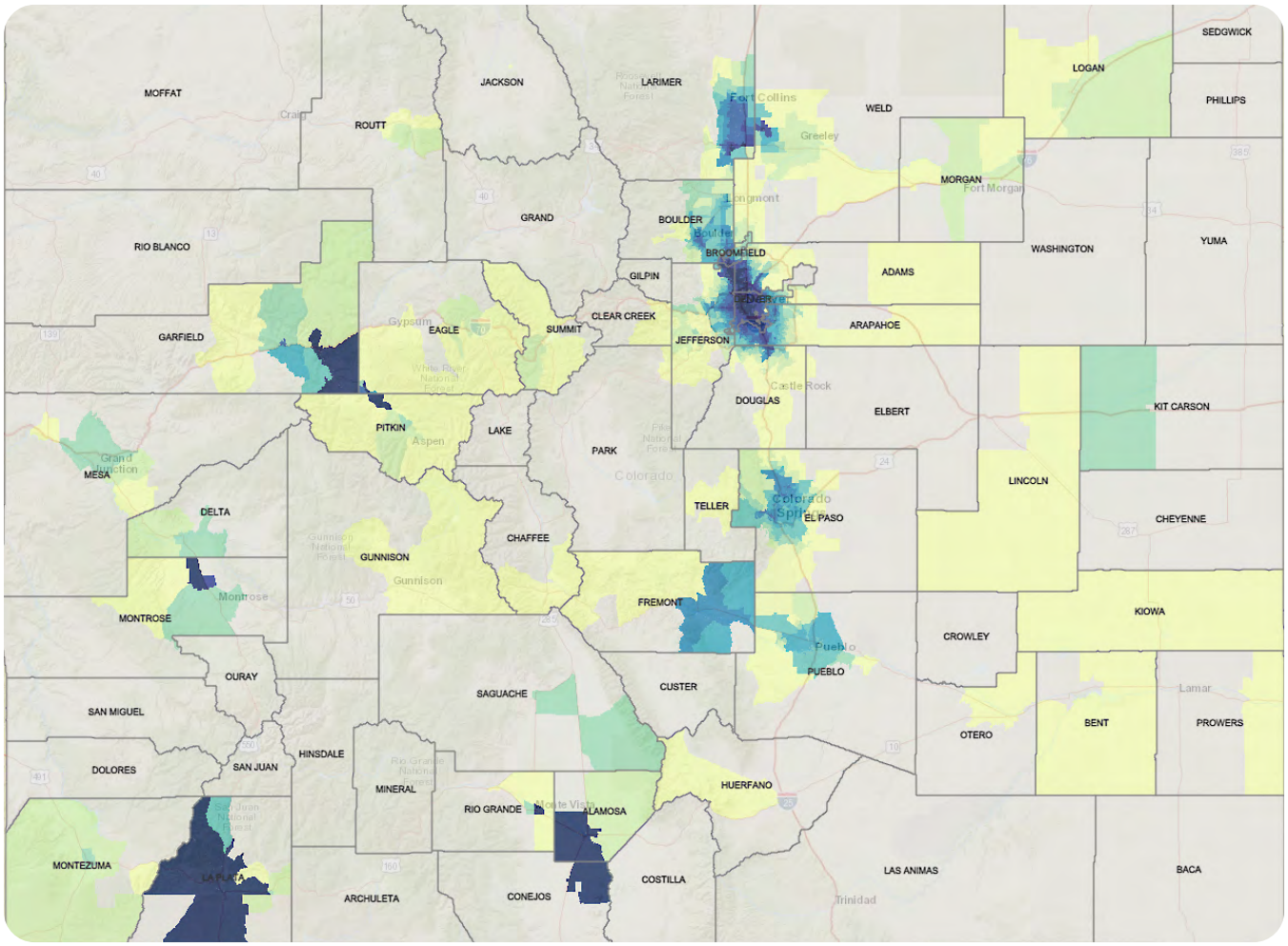
> *"People for whom English is a second language want to tell their story themselves – and not through an interpreter. Thus, more bilingual behavioral health counselors are needed."*
>
> – Interviewee

To monitor these shortages, the Colorado Department of Public Health & Environment conducts a statewide assessment every three years to identify Health Professional Shortage Areas (HPSAs). These designations highlight areas where access to providers is especially limited, particularly for populations that are low-income, uninsured, or face language barriers. Pitkin County has been designated as a Behavioral Health HPSA, emphasizing the urgent need to strengthen the local behavioral health workforce and improve access to care.

Professionals practicing in designated Health Professional Shortage Areas (HPSAs) have traditionally been eligible for several federal incentives, including:

- A 10% bonus on Medicare reimbursements for services provided in mental health HPSAs
- Eligibility for federal student loan forgiveness programs

However, the future of these benefits remains uncertain under the current federal administration.



Estimated Accessible Behavioral Health (BH) Encounters Per Person Age 15+ (In Deciles)

Score (Ratio)

Decile 1 (Lowest Need) Decile 2 Decile 3 Decile 4 Decile 5

Decile 6 Decile 7 Decile 8 Decile 9 Decile 10 (Highest Need)

Statewide Initiatives to Address Workforce Shortages

Colorado is making significant investments to strengthen and diversify its behavioral health workforce. Key initiatives include:

Senate Bill 25-292 – Workforce Capacity Center (WCC):

This legislation directs the Department of Health Care Policy and Financing, in collaboration with the Behavioral Health Administration, to establish a Workforce Capacity Center dedicated to supporting providers who serve children and youth with complex behavioral health needs. The WCC will:

- Develop and deliver training in evidence-based practices
- Cover the cost of training for participating providers
- Offer ongoing technical assistance to ensure high-quality implementation

University of Denver – Behavioral Health Scholarship Program:

The University of Denver's Graduate School of Social Work received grant funding to provide full-tuition scholarships to low-income students pursuing a Master of Social Work (MSW) with a focus on behavioral health. The program prioritizes applicants from rural communities and historically underrepresented groups.

P-TECH Behavioral Health Pilot Program:

Launched in several Aurora high schools, this pilot program enables students to earn a no-cost associate degree in behavioral health through the Community College of Aurora. Students gain hands-on experience in healthcare settings, earn stackable credentials, and receive paid work opportunities—all while completing their studies.

$4.2 Million Behavioral Health Workforce Accelerator:

In partnership with the National Council for Mental Wellbeing, Metropolitan State University of Denver is leading a workforce accelerator to expedite licensure for mental health graduate students. The initiative includes:

- Clinical placement support
- Supervised clinical hours
- Financial stipends (funded by Kaiser Permanente)
- Study materials and a structured peer cohort

The program also includes evaluation measures to assess its effectiveness in expanding and sustaining the behavioral health workforce.

Local Workforce Development Efforts in Pitkin County

Colorado Mountain College (CMC):

CMC offers a Bachelor's in Human Services with approximately 350 students enrolled—many of whom are well positioned to pursue master's degrees in Clinical or Mental Health Counseling. CMC also offers:

- Certified Addiction Technician (CAT) courses in the fall
- Certified Addiction Specialist (CAS) courses in the spring
- Both CAT and CAS programs include field experience and access to financial aid
- Paid internships can be offered to support nontraditional students who are working and interning
- Dual credit options are available in partnership with local high schools

Aspen School District:

The district is expanding its career and technical education offerings and aligning programs with CMC's trade degrees and industry-recognized credentials to create more accessible education pathways.

Mountain Voices Project (MVP):

MVP is pursuing funding to develop a behavioral health career pipeline, specifically targeting students and community members interested in exploring peer specialist roles and other entry points into the field.

Recommendations

A comprehensive, multi-faceted strategy is essential to address both immediate and long-term behavioral health workforce shortages. Key approaches include:

- Offering incentives to attract and retain both current and future behavioral health professionals
- Promoting behavioral health career pathways to a wide and diverse range of audiences
- Leveraging digital platforms to connect providers and streamline access to services
- Exploring opportunities to grow and formalize peer support networks for greater reach and sustainability

Action Item 6.1: Incentivize future and current behavioral health professionals

Expanding the behavioral health workforce in Pitkin County must go hand-in-hand with efforts to retain current professionals and prevent burnout. A holistic approach should focus not only on recruitment, but also on strengthening the pipeline, improving workplace satisfaction, and recognizing provider contributions.

- Establish a **scholarship and stipend fund** through the funders' collaborative to support paid internships and provide compensation to clinical supervisors. Additionally, explore virtual supervision to ease the burden on local providers.
- Develop a **step-by-step internship implementation toolkit**, drawing from successful local models. Create a complementary **recorded webinar** to walk through the toolkit and promote it to providers in both physical and behavioral health settings.
- Explore offering **incentives or stipends** for early-career providers—across healthcare and behavioral health—to gain weekly hands-on experience in clinics, enhancing both service delivery and clinical exposure.

In addition to acknowledging and celebrating behavioral health professionals, the nomination application could require information such as whether the professional has used OwnPath (the State's Learning Management System for behavioral health), participates in the Mental Health Fund, or accepts Medicaid or commercial insurance. Giving each of these categories points as part of the application could encourage more professionals to improve their services locally.

- Launch an annual recognition initiative to honor local behavioral health professionals. Collaborate with the local newspaper and other partners to:
  - Issue a public call for nominations
  - Develop a fair and transparent selection process
  - Highlight finalists and the winner through media coverage, "Connecting with Kathleen" local TV show, and other local channels
- Partner with organizations or platforms that have secured enhanced reimbursement rates for Medicaid and commercial insurance. Encourage providers to align with these partners to ease billing burdens and improve financial viability.
- Maintain active communication with **Colorado's Department of Health Care Policy & Financing (HCPF)** as it develops the **Workforce Capacity Center (WCC)**, expected to offer training, coaching, technical assistance, fidelity monitoring, and quality improvement support to build a system of care.
- Monitor updates from **CDPHE** regarding Health Professional Shortage Area (HPSA) designations and continued availability of **loan forgiveness programs**, should those incentives remain under federal policy.

There is a significant need in Pitkin County for more providers trained to address the **mental health needs of children ages 0–5**, particularly those impacted by trauma, family instability, or involvement in the child welfare system. Despite the critical importance of early intervention, the county lacks clinicians with the specialized training required to support this age group. Opportunities like the upcoming Child-Parent Psychotherapy (CPP) Learning Collaborative in Colorado (offered free of charge to Medicaid-accepting providers) represent a valuable chance to build local capacity.

Action Item 6.5: To better support provider participation in such programs, there should be a more coordinated way to share these training opportunities across systems and networks. Additionally, local partners should consider strategies to incentivize participation, such as offering stipends, continuing education credits, or protected time for providers to engage in advanced training that enhances the early childhood mental health workforce.

Action Item 6.2: Promote behavioral health educational pathways and careers to broad audiences.

A 2024 study commissioned by teletherapy provider VocoVision found that "behavioral health professional" does not rank among the top ten dream jobs for first graders. Increasing early exposure to the field could help broaden awareness of behavioral health career paths.

- Partner with local schools to integrate behavioral health professions into career exploration activities. Encourage teachers to actively include behavioral health professionals in career days and job fairs, and ensure guidance counselors promote these careers to students.
- Support Colorado Mountain College (CMC) in raising awareness of its behavioral health programs. Leverage opportunities to feature CMC programs in Department of Human Services mass mailings, county newsletters, social media, and other community communications.

Action Item 6.3: Leverage online platforms

In early 2025, the Center for Improving Value in Health Care (CIVHC) released the sixth update to its Telehealth Services Utilization Analysis, covering data from 2019 through 2023. The analysis shows a continued increase in telehealth visits for mental health across all provider types, rising from 47% of all visits in 2020 to 58% in 2023. Telehealth remains a critical tool for expanding access to mental health care by addressing barriers such as provider shortages, travel constraints, and stigma.

- In light of the rapid growth of telehealth platforms, Pitkin County should consider adopting and promoting a platform tailored for its residents. Some platforms exclusively use Colorado-based professionals or are open to piloting programs that prioritize local providers, offering an opportunity to enhance access to culturally and geographically relevant care.

Action Item 6.4: **Explore opportunities to expand and strengthen more formalized peer support networks.**

Evidence Based: SAMHSA recognizes peer support as an evidence-based practice.

Peers are crucial in behavioral health. They offer a unique perspective based on lived experience, promoting understanding, empathy, and empowerment. They help individuals navigate complex systems, develop recovery goals, and build supportive relationships.

- The newly established Behavioral Health Administrative Service Organizations (BHASOs) will provide support for peer services; however, the specifics of how this will be implemented remain unclear. Once these details are clarified, Pitkin County should develop a defined pathway to increase the number of peer specialists. This process should include researching peer credentialing programs offered by the Colorado Providers Association and the Colorado Mental Wellness Network.
- Historically, Medicaid reimburses peer services when the peer supports an individual with a covered diagnosis. Claims for these services are submitted under the name of the licensed clinician responsible for overseeing the Medicaid member's clinical care.

Governance & Key Players

Assigned Workgroup: Workforce Development Workgroup

This workgroup will serve as a collaborative planning team dedicated to recruiting and retaining the behavioral health workforce in Pitkin County. It should prioritize including partners who are currently implementing innovative workforce strategies, as well as organizations committed to creative solutions for addressing workforce shortages.

The workgroup will guide and, where appropriate, actively implement workforce recommendations. It will lead the initial planning and design phases, after which a designated central entity will take on primary responsibility for the system's implementation, coordination, and long-term sustainability.

Recommended membership includes (but is not limited to) representatives from the following partners:

- Aspen Family Connections
- Aspen Hope Center
- Aspen School District
- Behavioral Health Leadership Group
- Colorado Mountain College
- HeadQuarters
- Health Care Policy & Financing
- MidValley Family Practice
- Mountain Voices Project
- Pitkin County Communications Team
- SkiCo
- University of Denver Graduate School of Social Work

Resources Required

The resources needed for these recommendations primarily build on existing assets:

- The Internship Toolkit, the Counseling Compact, and the Workforce Capacity Center all leverage prior work and require minimal additional resources.
- Engaging the Aspen School District to promote behavioral health during Career Days is a resource-free opportunity.

Several established entities already have strong reimbursement arrangements with commercial insurers and Medicaid. Pitkin County can partner with these organizations rather than attempting to develop such systems independently, saving considerable time and effort.

However, resources will be necessary to create a scholarship fund and provide incentives or stipends for new practitioners. The workgroup can develop guidelines for these awards. Securing an initial $20,000 from donors or corporations could support a pilot program to assess future funding strategies.

Launching an annual recognition initiative for behavioral health professionals will mainly require staff time rather than large budgets. A staff member would need to manage nomination forms, promote the call for nominations, coordinate a selection committee, and handle media outreach.

If the County conducts mass mailings, including information about Colorado Mountain College (CMC) behavioral health programs offers a valuable promotional opportunity, with printing costs as the primary expense assuming use of a fulfillment center. If mass mailings are not feasible, CMC course overviews could be incorporated into electronic newsletters.

A thorough review will be needed to identify opportunities to further leverage the Mental Health Fund. While it successfully supported individuals in 2025, ongoing focus on sustainability and flexibility will be crucial to expanding its reach and impact.

Finally, the County should initiate discussions with telehealth platform providers to estimate costs. Some companies may be interested in piloting services tailored to mountain communities, potentially minimizing resource needs.

CONCLUSION

This strategic plan represents a shared commitment to advancing behavioral health in Pitkin County. It is rooted in collaboration, informed by community insight, and designed for action. It charts a path forward that is both ambitious and grounded, pairing long-term vision with practical steps that can drive meaningful, measurable progress.

While the work ahead will require adaptability, creativity, and continued partnership, Pitkin County is well-positioned to deliver on its vision: a behavioral health system that is equitable, responsive, and built to serve the whole community – today and into the future.

SUGGESTED INCREMENTAL IMPLEMENTATION OF THE PITKIN COUNTY BEHAVIORAL HEALTH STRATEGIC PLAN

Goal	Action Item	Description	2025		2026				2027				2028			
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic Plan Implementation	1.4	Launch a centralized Behavioral Health Landing Page														
Resource Navigation	3.2	Leverage ongoing efforts to build a resource directory														
Coordinated Funding	2.1	Convene VMHS in Q2 and all behavioral health funders in Q4 annually, at a minimum														
Strategic Plan Implementation	1.1	Pitkin County Public Health hires a Behavioral Health Champion to convene behavioral health partners and begin to establish the governance structure. The responsibilities of this position will be split between the governance and supporting coordinated funding.														
Strategic Plan Implementation	1.2	Initiate the full governance structure														
Strengthening the Continuum	4.2	Evaluate the need and opportunity to reserve beds at Vail Health														
Strengthening the Continuum	4.3	Leverage telepsychiatry consultation programs to support PCPs														
Strategic Plan Implementation	1.3	Convene quarterly partner meetings														
Access to Services	5.2	Continue exploration of incentives for providers to accept commercial insurance														
Access to Services	5.4	Leverage CYMHTA														
Strengthening the Continuum	4.4	Reimagine recovery-oriented facilities through a local-regional service framework														
Strategic Plan Implementation	1.5	Ensure workgroup co-chairs and Advisory Group members receive regular support and training as appropriate														
Resource Navigation	3.1	Create a Community Access and Navigation Workgroup to begin to explore how to strengthen coordination														
Access to Services	5.3	Consider the Counseling Compact														
Workforce	6.3	Leverage online platforms														
Resource Navigation	3.3	Create a dedicated collaboration hub for navigators to come together														
Coordinated Funding	2.2	Continue conversations around aligning grant application and reporting requirements														
Resource Navigation	3.4	Develop a shared communication channel														
Workforce	6.1	Explore how to incentivize future and current behavioral health professionals														
Strengthening the Continuum	4.5	Strengthen Integration & Oversight in the Crisis Response System														
Workforce	6.2	Promote behavioral health educational pathways and careers to broad audiences.														
Access to Services	5.1	Further maximize the impact of the Mental Health Fund managed by HeadQuarters														
Strengthening the Continuum	4.6	Assess and potentially redirect funding to strengthen the behavioral health safety net														
Coordinated Funding	2.3	Appoint a small group of funders to develop recommendations on the data to be used to guide this work														
Workforce	6.5	Identify a more coordinated way to share these training opportunities across systems and networks														
Workforce	6.4	Explore opportunities to expand and strengthen more formalized peer support networks.														
Coordinated Funding	2.4	Consider establishing a formal funders collaborative														
Strengthening the Continuum	4.1	Assess and build up alternatives to inpatient care														

Action Items reflect what is recommended in the strategic plan, and are an abridged version of the full description. See the strategic plan for additional context and details.

APPENDIX A: METHODOLOGY

Pitkin County engaged SHG Advisors to lead the development of its Behavioral Health Strategic Plan. A mixed-methods approach was used to ensure the planning process was both comprehensive and inclusive.

Document Review & Best Practices Scan

- Conducted a thorough review of existing plans, reports, and data relevant to behavioral health in Pitkin County and the surrounding region. The goal was to build on existing knowledge, avoid duplication, and identify opportunities or gaps for integration.
- Conducted an ongoing scan of behavioral health best practices to inform recommendations. This included reviewing national models and evidence-based approaches across the behavioral health continuum.

Stakeholder Engagement

- Held 2 in-person and 7 virtual partner meetings to share updates, present emerging findings, and actively gather input. On average, between 25 - 35 participants attended each session, representing behavioral health providers, social service agencies, schools, law enforcement, community-based organizations, funders, and county departments. Sessions incorporated a mix of presentations, discussion prompts, and interactive activities, including:
  - Visioning exercise to identify key themes and priority issue areas
  - Care coordination deep dive, featuring a BHASO update and collaborative brainstorming of additional solutions
  - Workforce development discussion focused on behavioral health staffing needs, trends, and current initiatives
  - After-action review of previously implemented approaches, including lessons learned and strategies for sustaining or improving them
  - Continuum of care reflection, exploring strengths and gaps across the current system in Pitkin County
  - Governance structure review, weighing the pros and cons of different models
  - User story activity to generate ideas for improving access to services and resources
- Conducted 24 structured interviews with behavioral health providers, partners, and funders to gain deeper insights into current challenges, successes, and opportunities for system improvement
- Facilitated 7 focus groups with targeted audiences, including behavioral health providers, youth-serving organizations, and private sector representatives. These sessions allowed for more focused discussions tailored to the unique perspectives of each group (See Appendix B for a summary of themes resulting from the focus groups.)
- Participated in 5 meetings convened by behavioral health partners to stay informed and aligned with local and regional efforts

Ongoing Communication & Context Monitoring

- Launched a dedicated landing page for the Pitkin County behavioral health strategic planning process to keep partners and stakeholders informed. The page includes upcoming meeting details, and minutes, materials, and recordings from past sessions. It also announces opportunities to get involved – such as focus groups and a question/comment form – and provides links to relevant resources and sector updates.
- Engaged in weekly meetings with Pitkin County leadership to ensure the strategic plan remained responsive and aligned with broader behavioral health developments. These regular touchpoints fostered real-time collaboration and alignment.
- Actively monitored changes across the federal, state, and local behavioral health landscape. This included tracking legislative and policy reforms, funding opportunities, and structural changes – such as the evolving role of Behavioral Health Administrative Service Organizations (BHASOs), statewide workforce initiatives, and Medicaid behavioral health redesign efforts. These insights were used to ensure that the strategic planning process remained timely and relevant given systems-level initiatives.

APPENDIX B - FOCUS GROUPS

SHG Advisors facilitated 7 focus groups with targeted audiences, including behavioral health providers, youth-serving organizations, and private sector representatives. These sessions allowed for more focused discussions tailored to the unique perspectives of each group. The following themes emerged:

Communication and Collaboration Challenges

- Ongoing issues in coordination across behavioral health initiatives and nonprofits.
- Poor information sharing, especially around funding opportunities and service availability.
- Need for clearer, more consistent communication between agencies, schools, and law enforcement.

Service Access Barriers

- High-acuity youth and families face challenges connecting to needed services.
- Confusion over available services, detox access, referral requirements, and policy inconsistencies.
- Limited availability of in-home therapy and bilingual providers.
- Insurance and Medicaid barriers, especially for vulnerable populations.

Sustainability and Workforce Concerns

- School-based mental health services need continued funding and clinician training.
- Recruitment and retention of qualified providers is difficult due to the high cost of living.
- Emphasis on the need for skilled professionals and centralized leadership to reduce fragmentation.

Strategic Planning and Systems Integration

- Support for a behavioral health strategic plan that balances county leadership with clinical expertise.
- Calls for better care coordination and integration, including through telehealth and co-location of services.

Data, Oversight, and Accountability

- Demand for an independent entity to oversee collaboration and planning efforts.
- The importance of tracking outcomes, aligning funding decisions with community needs, and reducing service duplication.

Equity and Community Engagement

- Need to better serve marginalized groups, including Spanish-speaking and bicultural populations and those involved in the justice system.
- Calls for more effective and culturally responsive outreach and resource navigation.

Program Gaps and Promising Practices

- Gaps in adolescent mental health and detox services.
- Need for expanded emergency shelter and inpatient treatment options.
- Positive attention to and long-term funding for community initiatives like PACT and school-police collaborations.

Resource Management and Outreach

- Challenges in promoting services (e.g., wellness calendars, community events) due to limited staff and tools.
- Suggestions to shift funds from awareness events to direct services.

APPENDIX C – BEHAVIORAL HEALTH CHAMPION DRAFT POSITION DESCRIPTION

Job Responsibilities:

Background:

The Pitkin County Public Health Department – in partnership with the County Manager's office and Human Services – is the lead entity responsible for advancing behavioral health initiatives. This position in the Public Health Department will oversee the following groups:

- **Behavioral Health Strategic Plan Advisory Group** - Responsible for (1) considering recommendations from workgroups, (2) reviewing progress of strategic plan implementation and discussing course corrections, and (3) re-prioritizing actions as a result of emerging needs
- **Ad hoc Workgroups** - Responsible for (1) doing day-to-day work for their organizations, (2) completing assigned tasks in the strategic plan and work plans, (3) reporting on progress made, and (4) discussing obstacles and brainstorming solutions

This position will also serve as the liaison between funders and the Advisory Group, ensuring that there is two-way communication between what the Advisory Group is prioritizing and doing, as well as what funders are supporting and investing.

Strategic Leadership & Coordination:

- Act as the central liaison for behavioral health matters, promoting collaboration among county departments, community organizations, and funding bodies.
- Oversee the execution of the Behavioral Health Strategic Plan, ensuring alignment with county objectives and responsiveness to emerging community needs.

Governance & Advisory Oversight:

- Facilitate quarterly meetings with behavioral health partners to share information and best practices.
- Define and implement membership structures for Advisory and Workgroups, including roles, responsibilities, and governance protocols.
- Lead the recruitment, onboarding, and training processes for Advisory and Workgroup members.
- Maintain regular meeting schedules to monitor progress and address challenges in strategic plan implementation.
- Update public dashboards and dedicated web pages to reflect ongoing initiatives and outcomes.

Funding Coordination:

- Convene annual meetings with behavioral health funders to discuss current investments, identify alignment opportunities, and address emerging trends.
- Manage contracts related to Vital Mental Health Services, including the review and approval of invoices and deliverables.
- Cultivate relationships with existing and prospective funders, providing recommendations to enhance funding strategies and explore the feasibility of a formal Funders Collaborative.

Community Engagement & System Improvement:

- Map existing behavioral health committees and workgroups to identify opportunities for consolidation and improved coordination.
- Present to various organizational boards to advocate for streamlined initiatives and increased effectiveness.
- Collaborate with the County Manager's Office to identify and implement process improvements within the behavioral health system.

Qualifications:

- Minimum of 3 years of experience in a supervisory or leadership role within a relevant department or function.
- Demonstrated ability to lead cross-sector collaborations, manage complex projects, and create successful new initiatives. .
- Strong communication skills and experience in stakeholder engagement.
- Proficiency in strategic planning and implementation within public health or behavioral health contexts.

APPENDIX D - SUGGESTED DATA/OUTCOME MEASURES, BY GOAL

Goal 1: Ensuring that the Strategic Plan is Implemented

Suggested Process Measures for Tracking Implementation of Goal 1:

- Development and use of formal governance documents (e.g., bylaws, charters, member guidelines) that define structure and decision-making processes
- Frequency and consistency of governance meetings
- Meeting attendance rates by members, and quorum achievement rate
- Number of leadership roles filled (e.g., Chairs, Vice Chairs)
- Number of applicants for workgroups and the Advisory Group
- Diversity of governance membership (e.g., across sectors, geographies, lived experience)
- Number of public-facing updates posted (e.g., meeting summaries, dashboard)
- Website traffic or engagement metrics on the landing page/dashboard
- Public attendance or engagement at open meetings or events

Suggested Outcome Measures for Tracking Impact of Goal 1:

- Retention rate of Advisory Group and Workgroup members over time
- Member satisfaction or confidence in the governance process (e.g., through annual surveys)
- Number of recommendations and the extent to which they are implemented (not just proposed) by the Advisory Group
- Policy or program changes resulting from governance input
- Funding secured to sustain governance functions

Goal 2: Coordinated Funding to Increase Impact

Suggested Process Measures for Tracking Implementation of Goal 2:

- Number of funders actively participating
- Frequency of funder collaborative meetings held
- Attendance rate at funder collaborative meetings
- Number of shared funding priorities established
- Development and use of shared funding application/reporting templates
- Number of funders aligning around shared impact measures or evaluation strategies
- Total dollars aligned, pooled, or distributed through the collaborative
- Number of grants awarded and projects funded
- Number of new partnerships or service/program integrations formed due to collaborative funding

Suggested Outcome Measures for Tracking Impact of Goal 2:

- Percentage of funder collaborative members satisfied with collaborative operations (via surveys)
- Percentage of funding reaching priority populations or underserved areas
- Degree of alignment across funders' investment strategies
- Number of duplicated investment efforts reduced or eliminated

Goal 3: Building a Coordinated Resource Navigation System

Suggested Process Measures for Tracking Implementation of Goal 3:

To measure progress in the design and planning phase, the focus should be on process and capacity-building indicators such as the following:

- Create a Community Access and Navigation Workgroup to begin to explore how to strengthen coordination
- Completion of a system-wide resource navigation assessment, by end of Year 2
- Number of system design workgroup meetings held and attendance rates
- Number of agencies participating in early coordination efforts (e.g., workgroups, shared directory project)
- Completion and usage rate of shared resource directory
- Number of front-line navigators engaged in shared learning or collaboration spaces
- Completion of a case management landscape assessment
- Adoption of a shared framework for tiered service levels (e.g., navigation, stabilization, intensive case management)

Goal 4: Strengthening the Behavioral Health Continuum by Addressing Gaps in Treatment and Recovery

Suggested Process Measures for Tracking Implementation of Goal 4:

- Utilization rates for new/expanded services (enrollments, encounters per month)
- Referral sources and patterns to alternatives (e.g., from ER, law enforcement, self-referral)
- Average wait time for access to each service
- Number of primary care clinics implementing a consultation or integration model
- Number of providers trained in models like CoCM, SBIRT, or MAT
- Volume of psychiatric or addiction consults provided (real-time and asynchronous)

Suggested Outcome Measures for Tracking Impact of Goal 4:

- Reduction in ED visits or psychiatric hospitalizations for behavioral health reasons
- Diversion rate from inpatient/crisis settings to alternative care
- Improved clinical outcomes from screening tools (e.g., decreased PHQ-9 scores over time)
- Increased early identification and treatment initiation for behavioral health conditions
- Reduced specialist wait times or psychiatric referral delays
- Improved provider confidence and satisfaction in managing behavioral health in primary care

Goal 5: Increasing and Improving Access to Services

Suggested Process Measures for Tracking Implementation of Goal 5:

- Number of providers contacted about accepting commercial insurance
- Number of meetings or info sessions held with providers
- Number of providers expressing interest in learning more about insurance participation
- Number of providers referred to support tools/platforms
- Number of providers offered technical assistance or incentives
- Number of providers informed about the Counseling Compact
- Number of providers applying for Compact privileges

Suggested Outcome Measures for Tracking Impact of Goal 5:

- Increase in the number of therapy sessions supported by the Mental Health Fund
- Increase in the number or percentage of local providers accepting commercial insurance
- Increase in the number of insured individuals served by local providers
- Decrease in the percentage of individuals turned away due to lack of accepted insurance
- Number of providers maintaining participation after 6 or 12 months
- People's satisfaction with ease of finding in-network providers
- Increase in the number of providers available to residents via telehealth
- Decrease in wait times for initial mental health appointments
- Percentage of people able to maintain continuity of care across moves or seasonal changes
- People-reported improvement in access to preferred providers or specialized services

Goal 6: Ensuring Pitkin County has a diverse, skilled, and community-rooted behavioral health workforce

Suggested Process Measures for Tracking Implementation of Goal 6:

- Number of paid internships and stipends awarded
- Participation rates in workforce development programs and trainings
- Number of partnerships established with educational institutions and training programs
- Number of outreach activities conducted to promote behavioral health careers (e.g., career days, school presentations)
- Utilization rate of credentialing or licensing support programs (e.g., Counseling Compact, Workforce Capacity Center)

Suggested Outcome Measures for Tracking Impact of Goal 6:

- Increase in the total number of behavioral health providers practicing locally
- Reduction in wait times for people seeking behavioral health services
- Increased diversity in the behavioral health workforce (e.g., by demographics, geographic location)
- Provider satisfaction and burnout levels (measured via surveys)
- Improvement in access metrics for priority populations (e.g., rural, marginalized groups)

APPENDIX E - TIERED CASE MANAGEMENT, EXISTING EFFORTS AND NEXT STEPS

The following existing and developing programs will provide some level of case management within specific Pitkin County populations. The opportunity in future years is to further explore and expand upon these strengths to build a more intentional, coordinated, and tiered system of case management that spans the full continuum of need.

Community Stabilization Program (CSP) at Aspen Hope Center will provide short-term, targeted support to high-risk individuals experiencing acute stressors, such as transitioning from crisis or hospitalization. This program will help fill the gap between brief resource navigation and more sustained case management by offering time-limited, relationship-based assistance focused on stabilization and preventing escalation. Unlike navigation, CSP involves active clinical follow-up and coordination. Compared to more intensive case management, CSP is shorter in duration and focused on resolving immediate barriers and serving as a critical bridge that helps individuals stabilize and transition to longer-term support if needed. The Aspen Hope Center CSP will be provided by licensed and licensed-eligible mental health providers with close clinical oversight and support.

In contrast to the Center's Intensive Stabilization Program (ISP), discussed in Goal 4, CSP is more flexible, mobile, and community-based, meeting people where they are. As Pitkin County considers expanding its case management continuum, the CSP model offers a promising template for scaling lower-intensity stabilization support across additional populations and settings.

Recovery Resources provides case management services specifically tailored to those who are unhoused in Pitkin County and/or have substance use disorders. Case managers coordinate the full continuum of care, from outreach and detox admission to post-detox stabilization and referrals to outpatient substance use treatment or medication-assisted treatment (MAT). With the changing rules to standalone withdrawal management, Recovery Resources is exploring leaning further into this model and prioritizing case management services for this population. Future opportunities include expanding eligibility, deepening coordination with housing and behavioral health partners, and identifying sustainable funding to support long-term service delivery.

Pitkin Area Co-Responder Teams (PACT) is a collaborative community program that brings together law enforcement and mental health professionals. PACT pairs a mental health clinician with local law enforcement who respond jointly to calls for service where mental health or substance use challenges may exist in the community and/or other at-risk populations.

In addition to a clinician, PACT includes a case manager and peer support specialist to provide follow-up services. The program incorporates elements of both care coordination and case management. For example, the clinician manages referrals and works with partner agencies to ensure access to appropriate care and services - reflecting a care coordination role. Meanwhile, the case manager supports individuals with more hands-on, practical needs such as

completing Medicaid applications, job searches, or housing navigation, which are core functions of case management.

The case manager role is often cited as a valued and essential component of PACT, and some partners have noted that there is room to grow the role to better meet community needs. Expanding the capacity and scope of the PACT case manager role could potentially increase availability, strengthen follow-up protocols, and formalize connections to longer-term services.

Mental Health Access Program (MHAP). MHAP was developed as a result of Pitkin County's Community Health Assessment (2022) and Public Health Improvement Plan (2023-2027). The goal was to create a more coordinated and equitable approach to serving individuals with mental health needs across the full continuum of care. MHAP functions as a weekly case conferencing group that brings together frontline staff to discuss referred cases and collaboratively identify appropriate services and supports. The program aims to fill a coordination gap by providing a space for providers to share resources and troubleshoot barriers.

In practice, MHAP has increasingly focused on individuals with complex or high-acuity behavioral health needs. While the program reflects strong intent and cross-sector collaboration, outcomes have been mixed. Many referrals are individuals with high levels of need who are either unwilling to engage in services or have been denied or removed from programs due to behavioral or eligibility issues. These limitations highlight broader system gaps in long-term, trauma-informed care for the highest-need residents.

To strengthen MHAP's impact, there may be value in clarifying referral criteria and expectations across agencies, and aligning MHAP more closely with the broader navigation and case management strategies being developed county-wide.

In future years, some initial action steps to further assess case management capacity and opportunities include the following:

Conduct a case management landscape assessment

- Map all existing case management programs by population served, intensity of services (light-touch to intensive), funding sources, and staffing models.
- Identify where services overlap, where they are siloed, and where there are gaps along the continuum of need.

Analyze target populations not currently served and gaps in access

- Identify key populations who are not connected to case management
- Assess whether case management services are equitably available across geography, language, or cultural identity
- Assess the extent to which programs are consistently turning people away, maintaining waitlists, or limiting services due to staffing or funding constraints

Hold a case management convening or learning session

- Bring together providers like Aspen Hope Center, Recovery Resources, PACT, and others for a structured session to share models, pain points, and promising practices.
- Use this space to continue building relationships, clarify roles, and surface opportunities for alignment or shared protocols.
- Create a common language and framework for describing levels of case management (e.g., navigation, stabilization, intensive), to support coordination and resource matching. This can also help identify where new tiers or services are needed.

APPENDIX F – NEW SERVICE TYPES/LEVELS OF CARE TO EXPLORE IN THE FUTURE

In future years, Pitkin County should continue to explore other services or programs that could benefit the community.

Crisis In-Home Respite

Crisis in-home respite is a short-term, intensive service that provides immediate support to individuals experiencing a behavioral health crisis, while allowing them to remain safely in their home environment. The goal is to stabilize the situation, prevent hospitalization, and reduce stress for both the individual and their family or caregivers. Trained mental health professionals or paraprofessionals deliver care that may include safety planning, de-escalation, emotional support, and coordination with other services. This service type can be used for both adults and youth in crisis.

Treatment and Therapeutic Foster Homes

Treatment and therapeutic foster homes provide a structured, family-based setting for children and youth with significant behavioral health needs who are unable to safely remain with their families. These homes are staffed by specially trained foster parents who receive additional support and supervision from mental health professionals. As an alternative to residential treatment facilities, therapeutic foster homes offer a less restrictive, more nurturing environment that supports emotional healing and stability while still providing the intensive support needed for youth with complex needs.

> The Colorado Division of Child Welfare (DCW) is committed to recruiting and supporting more treatment and therapeutic foster homes as a key strategy in ensuring kids with more complex needs can remain in family-like settings. Colorado has increased the foster care maintenance rate for these foster parents and developed a coordinated training model at the state level to support counties and agencies looking to build this level of care.

Other Consultation and Integrated Care Models

To help address ongoing gaps in psychiatric and substance use disorder (SUD) treatment, with limited access to specialists, the county should further explore consultation models within primary care settings (in addition to the three University of Colorado programs discussed above). These models embed behavioral health expertise where individuals and families already seek medical care, improving access and early intervention.

Consultation can take various forms (e.g., real-time provider-to-provider consultations, telepsychiatry, or integrated care teams) and can strengthen the local continuum of care by extending the reach of scarce psychiatric and addiction expertise.

Some models to explore include the following:

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

SBIRT is an evidence-based approach used to identify, reduce, and prevent problematic use of alcohol, drugs, and other substances. It begins with universal screening to assess the level of risk in all individuals, often within primary care, emergency departments, or school-based health settings. For individuals identified as at-risk, there is a brief intervention involving a short, structured conversation to raise awareness, enhance motivation, and encourage behavior change. If a person screens at a high-risk level, they are provided with a referral to treatment for more intensive care. SBIRT is designed to catch substance use issues early and connect individuals to support before problems become more severe. Such proactive approaches help reduce the burden on crisis systems and inpatient care. Valley Health Alliance would be a valuable partner in exploring the use of SBIRT.

Colorado has demonstrated a commitment to promoting and investing in SBIRT:

- Colorado's Medicaid program, Health First Colorado, covers SBIRT services in primary care, hospital, and emergency room settings. All enrolled members aged 12 and older are eligible for these services, and eligible providers include physicians, psychologists, licensed clinical social workers, and other licensed professionals who have completed SBIRT training.
- Peer Assistance Services, Inc. offers no-cost, interactive two-hour SBIRT training for health and mental health professionals in Colorado.
- The SBIRT-SBHC Project is a collaborative effort between the Behavioral Health Administration (BHA) and the Colorado Department of Public Health and Environment (CDPHE). The project has allocated approximately $1.5 million annually from the Substance Abuse Prevention and Treatment Block Grant to support the implementation of SBIRT in school-based health centers (SBHCs) across Colorado.
- The SBIRT Advisory Council is a subcommittee of the Colorado Substance Abuse Trend and Response Task Force (SATF), which operates under the Colorado Office of the Attorney General. Established in January 2019, the Council focuses on expanding and strengthening the implementation of SBIRT across various settings in Colorado.

Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is an evidence-based approach to integrating behavioral health into primary care. It uses a team-based structure – typically a primary care provider, behavioral health care manager, and psychiatric consultant – to deliver coordinated, patient-centered care. The model emphasizes measurement-based care (e.g., PHQ-9), proactive follow-up via a patient registry, and improved outcomes for common conditions like depression and anxiety through consistent, data-driven management.

MidValley Family Practice, Mountain Family Health Centers, and Aspen Valley Health already embed behavioral health into primary care and lay a strong foundation for whole-person care. Adopting a structured model like CoCM could build on that foundation, offering added value through its defined roles and measurable outcomes. Exploring CoCM may also help further align and strengthen integrated care across the region and, again, Valley Health Alliance should be a key partner in such endeavors.

Contingency Management

Contingency management (CM) is a practical, scalable strategy that supports behavioral change and treatment engagement, and can help individuals progress through less intensive levels of care or avoid relapse. CM is an evidence-based behavioral intervention that uses tangible rewards to reinforce positive behaviors—most commonly abstinence from substance use, medication adherence, or treatment participation. Individuals earn incentives (such as vouchers, gift cards, or privileges) when they meet clearly defined goals, like providing a negative drug test or attending counseling sessions.

This approach works especially well for people struggling with stimulant use (e.g., methamphetamine or cocaine), where other treatment options are limited. It is often used in outpatient or intensive outpatient programs and can be part of a larger recovery plan. Contingency management can also be combined with other supports, like MAT or case management, and works best when used consistently alongside counseling.

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