SUMMARY OF STAKEHOLDER ENGAGEMENT

INTRODUCTION

In summer and fall 2025, Larimer County Behavioral Health Services (BHS) and Corona Insights staff engaged with the behavioral health community in Larimer County to help shape the design of a multi-year funding framework. This engagement process was built upon a foundation of research that had already been done with the broader Larimer County to community identify behavioral health needs (e.g., the Community Master Plan for Behavioral Health 2.0, the Community Health Improvement Plan for Larimer County, and the Mental Health and Substance Use Alliance Strategic Plan). The scope of this work was developing solutions to address those needs; thus, we engaged with behavioral health system stakeholders. This process was designed to build upon the findings from the previous plans and research; to provide synchronous and asynchronous opportunities for participation; and to provide opportunities for the behavioral health system stakeholders to share input on what multi-year investment options would have the greatest system-wide impact on behavioral health in Larimer County.

SMALL CONSULTATION GROUP

There are different forms of community engagement, from basic outreach and collaboration to empowering stakeholders and co-creating strategies with decisionmakers.[1] Because one of the goals of this engagement process was to further strengthen the partnership among behavioral health professionals and BHS, the department convened a Small Consultation Group to provide guidance and input. Specifically, BHS invited individuals to the consultation group who have a more system-level view of behavioral health in Larimer County.

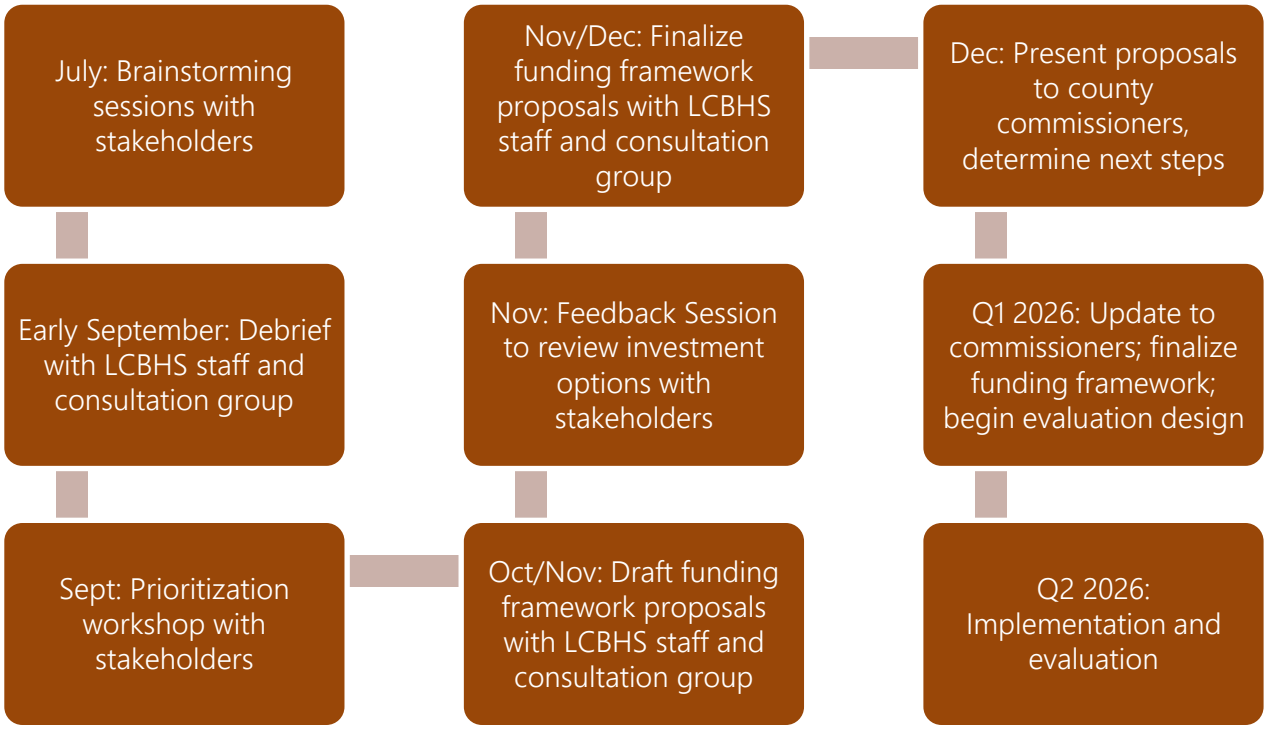
SMALL CONSULATION GROUP MEMBERS

- Heather O'Hayre, Larimer County Department of Human Services
- Tom Gonzales, Larimer County Department of Public Health and Environment
- Alyson Williams, Health District of Northern Larimer County
- Jennifer Guthals, Thompson School District
- Kim Moeller, Alliance for Suicide Prevention of Larimer County
- MJ Jorgensen, North Colorado Health Alliance
- Andrea Strayer, SummitStone Health Partners
- Misty Gulley, Larimer County Community Corrections

[1] International Association for Public Participation

PROCESS OVERVIEW

The stakeholder engagement process consisted of the following:



- **Phase 1: Brainstorming.** In this phase of work, our goal was to invite members of the behavioral health community to brainstorm ideas for how best to support behavioral health in the county. To gather this input, we assembled a stakeholder map identifying those most closely, moderately, and less impacted by any funding decisions but who might have a helpful perspective. The invitation list included but wasn't limited to representatives from the County's safety-net provider, hospital systems, nonprofits, Behavioral Health Services advisory groups (includes consumer, technical-professional and elected official perspectives), past and current BHS Impact Fund Grant recipients, law enforcement and emergency services agencies, private-practice providers, regional acute behavioral health care facilities, and more. We assembled a list including just over 200 stakeholders and invited those community members to participate throughout this process. In our brainstorming phase we held two in-person facilitated sessions and one online facilitated session, and emailed an online questionnaire to more than 700 people on BHS' mailing list to gather input asynchronously from those who could not attend one of these meetings. The input was gathered in July and synthesized in August.
    - Level of Engagement: Fifty-five total behavioral health stakeholders across three brainstorming sessions and the online questionnaire. The online questionnaire was available in English and Spanish.
    - Interpretation and Integration: Once we synthesized the input, we convened our first facilitated meeting with the Small Consultation Group. At the meeting, Corona presented the results of the brainstorming sessions and questionnaire, and the consultation group helped design the September prioritization activity used to engage the broader behavioral health community
    - Learn More: Appendix A_CI LCBHS Brainstorming Interim Report 2025 09 03.
- **Phase 2: Prioritization**. Based on the initial analysis and input from the Small Consultation Group, we synthesized over 100 ideas into 10 potential solution areas to fund. With help from the consultation group and BHS staff, we also identified 12 criteria to assess during a prioritization activity. We invited the behavioral

health community to prioritize the potential solution areas, either online in a questionnaire or in-person at a facilitated session.

- Level of Engagement: Twenty-six total behavioral health stakeholders engaged during the in-person, facilitated Prioritization Session or via the online questionnaire. The online questionnaire was available in English and Spanish.
- Interpretation and Integration: We shared the results of the prioritization with the consultation group. During a facilitated meeting, the Small Consultation Group provided feedback and then proposed funding ideas for each of the top three solution areas: behavioral health workforce, cross-organizational incentives, and system navigation.
- Learn More: Appendix B_CI LCBHS Memo Prioritization Session Summary 2025 10 07.

> **Phase 3: Feedback.** We presented fuller descriptions of the top ideas identified by the Small Consultation Group during an in-person, facilitated Feedback Session with behavioral health stakeholders in November 2025. Corona gathered feedback on the ideas that helped further refine them.

- Level of Engagement: Twenty-eight total behavioral health community members engaged during the Feedback Session.
- Interpretation and Integration: Based on the feedback, BHS staff narrowed the list down to three potential investment options and started to flesh out how each funding idea might be structured, who might be involved, how it aligns with other work, etc. We shared more in-depth descriptions of the three possible investment options with the Small Consultation Group to gather additional feedback and thoughts
- Learn More: Appendix C_CI LCBHS Ideas to Fund Handout 2025 11 01, Appendix D_CI LCBHS Feedback Session 2025 11 03

INDIVIDUALS/ORGANIZATIONS WHO PARTICIPATED

- A Little Help
- Abundance Foundation Inc.
- Alianza NORCO
- Alliance for Suicide Prevention of Larimer County
- Arula Grant Writers and Fundraising
- Banner Health
- Behavioral Health Services Consumer Advisory Council
- Boys & Girls Clubs of Larimer County
- CASA of Larimer County
- Centennial Area Health Education Center
- ChildSafe Colorado
- Colorado Artists in Recovery
- Colorado State University (multiple colleges/programs)
- Cor Defense
- Crossroads Ministry of Estes Park
- CSU Extension of Larimer County
- Every Child Pediatrics - Health & Wellness Centers
- Estes Valley Investment in Childhood Success (EVICS) Family Resource Center
- Family Care Center - Outpatient Behavioral Health
- Family Housing Network
- Fort Collins Museum of Discovery
- Fort Collins Rescue Mission
- Gardens on Spring Creek
- Harvest Farm
- Health District of Northern Larimer County and Mental Health and Substance Use Alliance
- Hearts & Horses
- Housing Catalyst
- La Cocina
- Larimer County Community Justice Alternatives - Community Corrections
- Larimer County - Human and Economic Health
- Larimer County Commissioner and Chair of the Behavioral Health Policy Council
- Larimer County Office of Performance, Budget & Strategy
- Larimer County Sheriff's Office Mental Health Co-Responder Unit
- Larimer County Sheriff's Office Youth Crisis Response Team with Thompson School District
- Larimer Medicaid Advisory Council

- Lighthouse
- Milestone Community Wellness
- Mindset Reps
- Motivated Minds
- New Eyes Village Church
- North Range Behavioral Health
- Outreach Fort Collins
- Peak View Behavioral Health
- PFLAG Fort Collins
- Poudre School District
- Queens Legacy Foundation
- Recovered Humans
- SAVA Center
- Signal Behavioral Health
- Signal Behavioral Health Council
- Specialized Alternatives for Families and Youth (SAFY)
- SummitStone Health Partners
- Teaching Tree Early Childhood Learning Center
- The Center For Family Outreach
- The Crawford Child Advocacy Center
- The Family Center/La Familia
- The Jacob Center
- The Matthews House United Neighbors/ Vecinos Unidos
- The Town of Estes Park
- The Town of Johnstown
- The Willow Collective
- The Yarrow Collective
- Turning Point Center For Youth & Family Development
- UCHealth
- UCHealth's Family Medicine Center Residency

CORONA INSIGHTS

PHASE 1

BRAINSTORMING SESSION SUMMARY

LARIMER COUNTY
BEHAVIORAL HEALTH SERVICES

Process Overview

During the summer of 2025, Corona Insights facilitated three sessions with the behavioral health community, on behalf of Larimer County Behavioral Health Services (LCBHS), to help brainstorm solutions to systemic issues and identify which ones could be best supported by a multi-year funding framework in Larimer County. These sessions were also intended to inform the community about the county's new forthcoming funding model and to encourage collaboration.

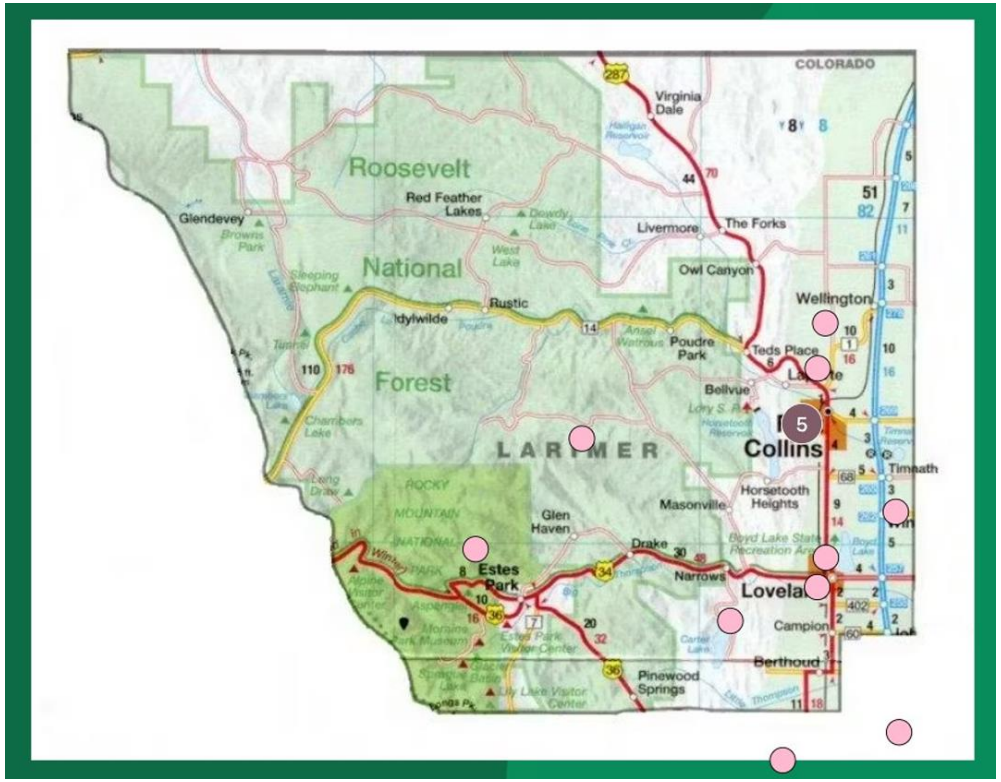
Methodology

- Three brainstorming sessions (two in-person and one virtual) were held during the summer of 2025.
  - A total of 55 people participated, representing a variety of organizations (e.g., peer-support/nonclinical spaces, hospitals, etc.).
- Additionally, an online questionnaire was circulated so that more members of the behavioral health system could provide input. The questionnaire was available in English and Spanish.
  - A total of 41 questionnaires (34 completes and 7 partials) were analyzed.

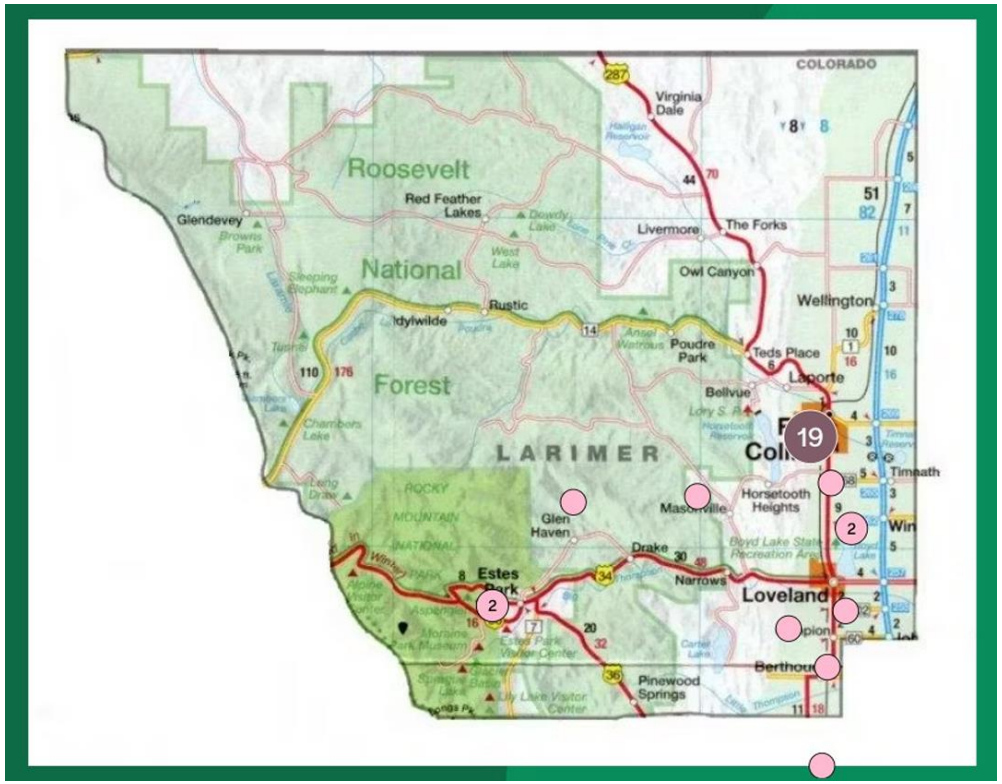
Participation by Geography

CORONAINSIGHTS

Session 1 (In person at the Longview Campus, July 7th)



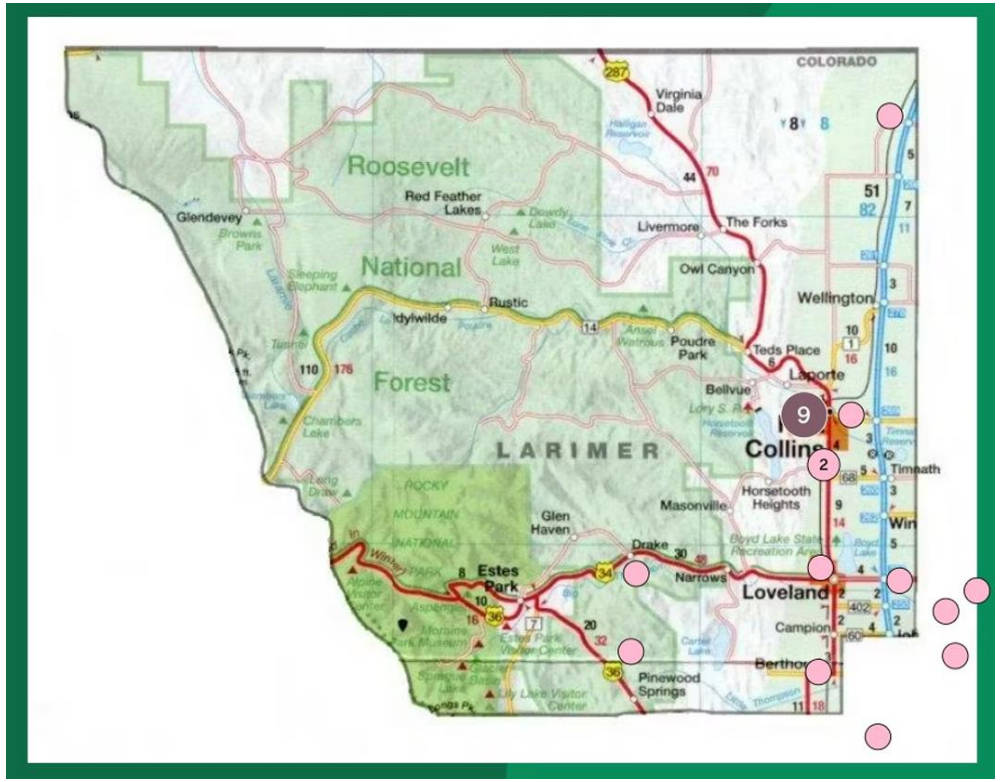
Session 2 (In person at the Old Town Library, July 23rd)



Participation by Geography

CORONAINSIGHTS

Session 3 (Virtual, July 31st)



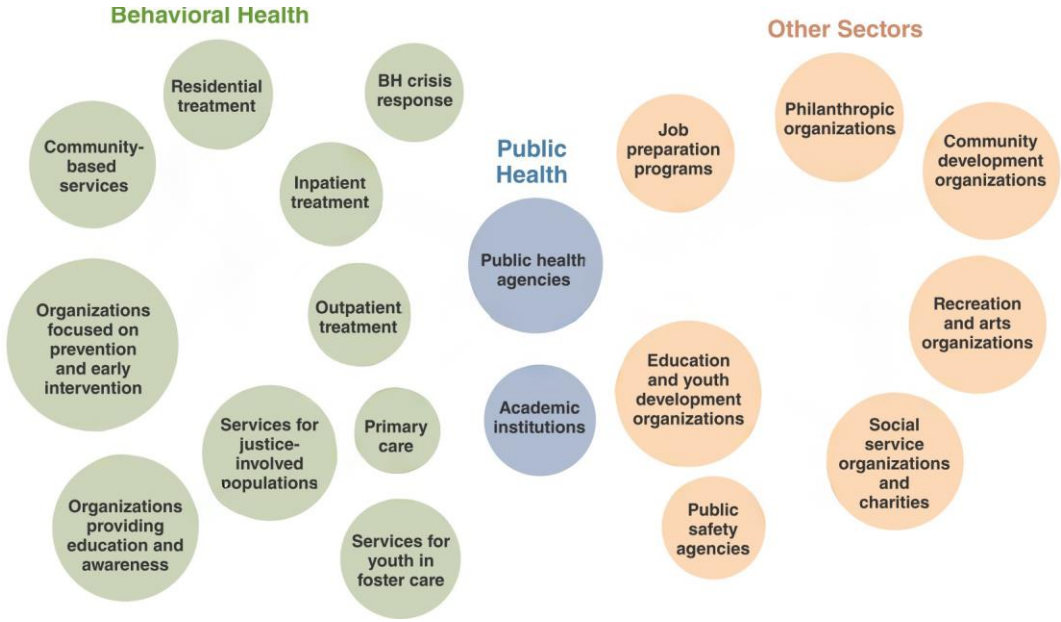
SESSION ACTIVITY

MAPPING THE BEHAVIORAL HEALTH SYSTEM

Mapping Exercise Overview

CORONAINSIGHTS

- During the sessions, participants were invited to review a map of the behavioral health system and to add anything that was missing from the map.
- Then participants were asked to identify where in the system there are already strong connections and where there are opportunities to strengthen a connection in the future.
- The following page identifies the common themes expressed across sessions, followed by detailed findings for specific maps in each session.



Map from RAND, Monitoring and Surveillance of Behavioral Health in the Context of Public Health Emergencies: A Toolkit for Public Health Officials

Mapping Exercise Common Themes

CORONAINSIGHTS

Commonly expressed **strengths** in the behavioral health system:

- Generally, behavioral health crisis response and services for justice-involved populations were linked by strong connections to other system actors; they appear to be strengths in the system.
- While many felt that public safety agencies had strong connections to behavioral health crisis response agencies, others wanted to see these agencies develop stronger connections to community-based services, education, and prevention/early intervention services.
- Community-based services and social service organizations and nonprofits were the two categories with the most connections, though less than half of these were strong. This suggests that while local nonprofits tend to be well-connected, these connections can always be stronger.

Opportunities for further strengthening:

- Many participants felt that philanthropic organizations, public safety agencies, and job preparation programs needed to take a bigger role in the behavioral health system and facilitate stronger connections.
- Links between crisis response, inpatient, outpatient, primary care, and community-based services were considered crucial and constitute one way of thinking about the care provision continuum for behavioral health. Generally, these links exist and were perceived to need strengthening. The crisis response to inpatient link was more often seen as strong; some inpatient->outpatient pathways are stronger than others; and the outpatient->primary care->community-based connections could be strengthened.
- Participants often felt there was a need for a central hub that cataloged organizations providing behavioral health services, communicated their capacity, and could help connect individuals seeking care to service providers and resources.
- Data sharing was identified as a particular barrier to coordination. There is a strong desire to increase data sharing while ensuring data privacy (e.g., schools not understanding where a student is; health not being able to communicate with the school; people needing to rehash their background to each and every provider).
- Participants often wanted to add actors/organizations to the system map. These included caregivers, transportation systems, senior care organizations, and individuals with lived experience.

Emergent context

- Impending funding cuts (especially to Medicaid) impact this. People will lose access to inpatient/outpatient/primary care without Medicaid; some may need to get a job to qualify (making job prep programs more important).

July 7th Session: Map 1

- This group identified strong connection and co-response between behavioral health crisis response and public safety agencies.
- While some participants identified strong existing connections between organizations focused on prevention/early intervention and social service organizations/charities, others wanted to see these bolstered with additional efforts and funding.
- Gaps were identified in immediate services, Medicaid providers, and housing.
- There was a desire for stronger connections between inpatient and outpatient treatment, in addition to outpatient treatment and organizations providing education and awareness.
- The group requested that “Services for youth in foster care” be recategorized as “general youth services.”

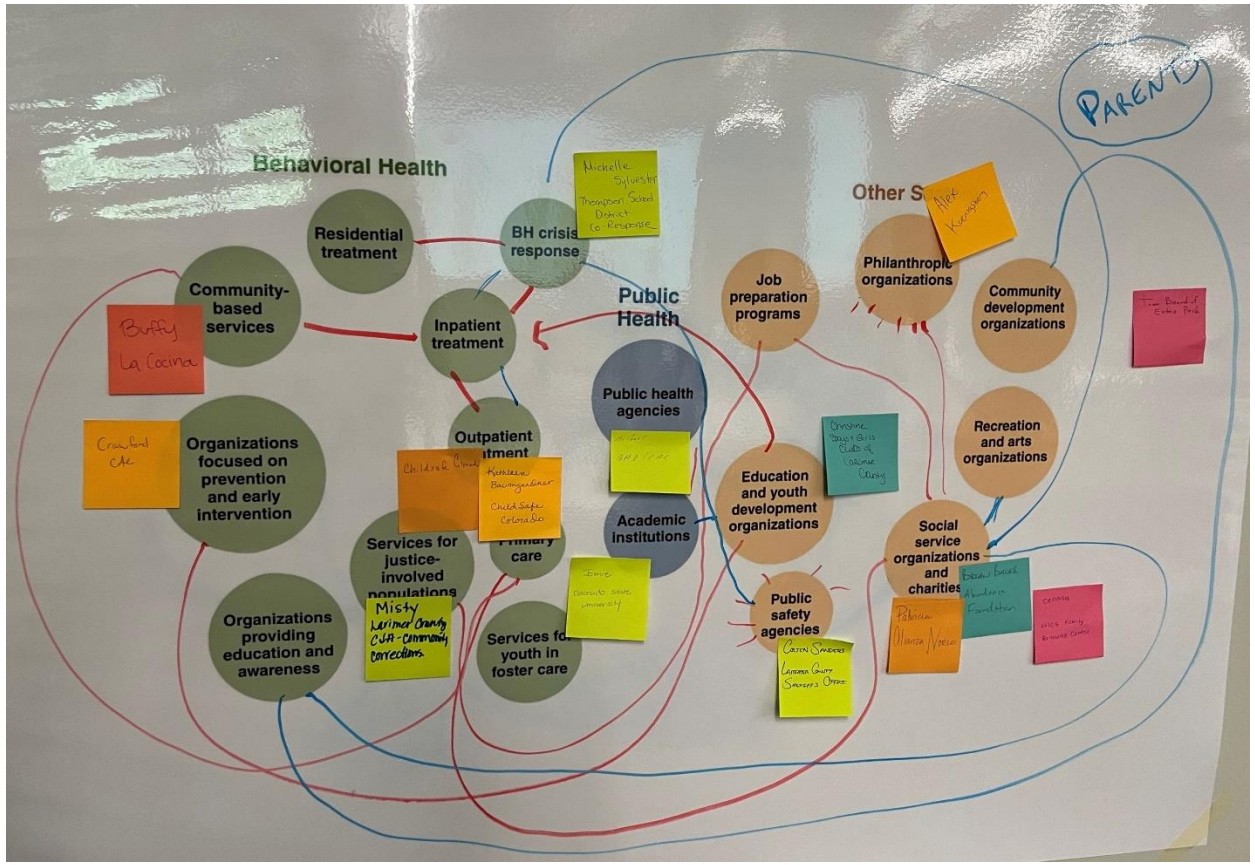
July 7th Session: Map 2

- This group recategorized "Behavioral Health" as "Direct Services" and "Other Sectors" as "All of Life".
- This group added important players to the map including public schools, senior services, city government, and others.
- This group identified the need for affordable and reliable transportation as a universal connection that needed to be made to improve every aspect of the system.
- A desire for more harm reduction approaches was presented, especially for justice-involved youth.
- This group identified strong existing connections between social services, food banks, and housing providers.
- While this group thought there were strong connections between public safety organizations and public schools, they noted that different regulations complicated collaboration between the latter and primary care.

July 23rd Session: Map 1

- This group identified strong connections emerging from recreation and arts organizations and education and youth development organizations.
- Participants in this group felt that local philanthropic organizations needed to be more involved in this system.
- This group desired a better hub for community-based services and wanted a resource to raise awareness, catalog services, and facilitate connections.
- This group thought there was a significant gap between crisis services and other community-based services. Participants felt community-based service had more to offer many other organizations/actors on the map.

July 23rd Session: Map 2

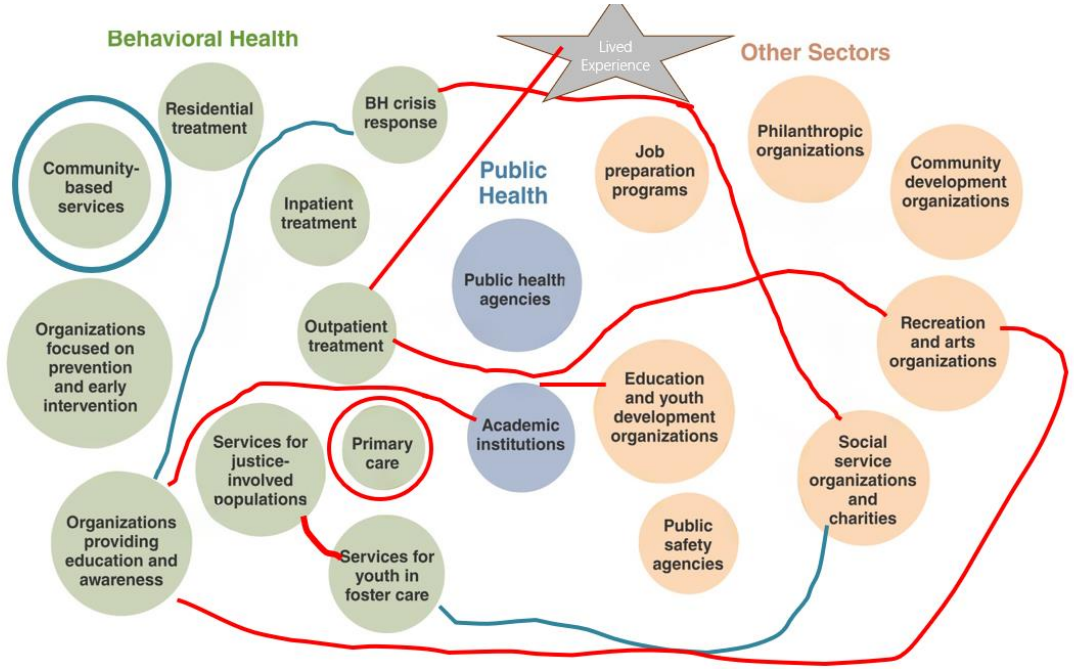


- This group identified parents/caregivers as an important missing actor from the behavioral health system.
- Participants in this group wanted stronger connections from primary care to social service organizations, organizations involved in prevention, and job preparation programs.
- This group believed philanthropic organizations could take a more active role in the system at large.
- While this group believed public safety agencies collaborated well with behavioral health crisis response, they also wanted to see more collaboration and connections from public safety agencies to many actors/organizations in the system.
- This group desired stronger connections from impatient treatment to outpatient treatment, community-based services, and crisis response.

July 31st Session: Map 1

CORONAINSIGHTS

MB

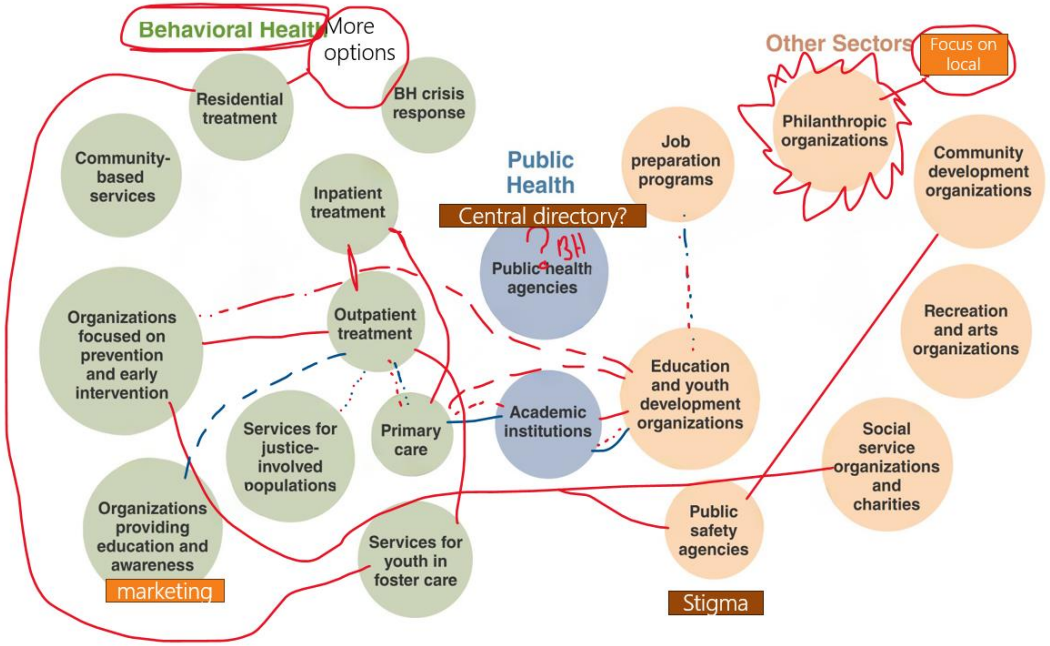


- This group believed it was important to include Larimer County residents with lived experience (those seeking care, caregivers, etc.) in our understanding of the system. They wanted stronger connections between these individuals and outpatient treatment.
- Participants in this group believed there was a strong need to connect primary care to other organizations/actors in the system.
- While this group believed there to be a strong connection between organizations providing education/awareness and behavioral health crisis response, they thought the latter could be better linked to social service organizations.
- This group felt community-based services were generally well connected.

July 31st Session: Map 2

CORONAINSIGHTS

JP

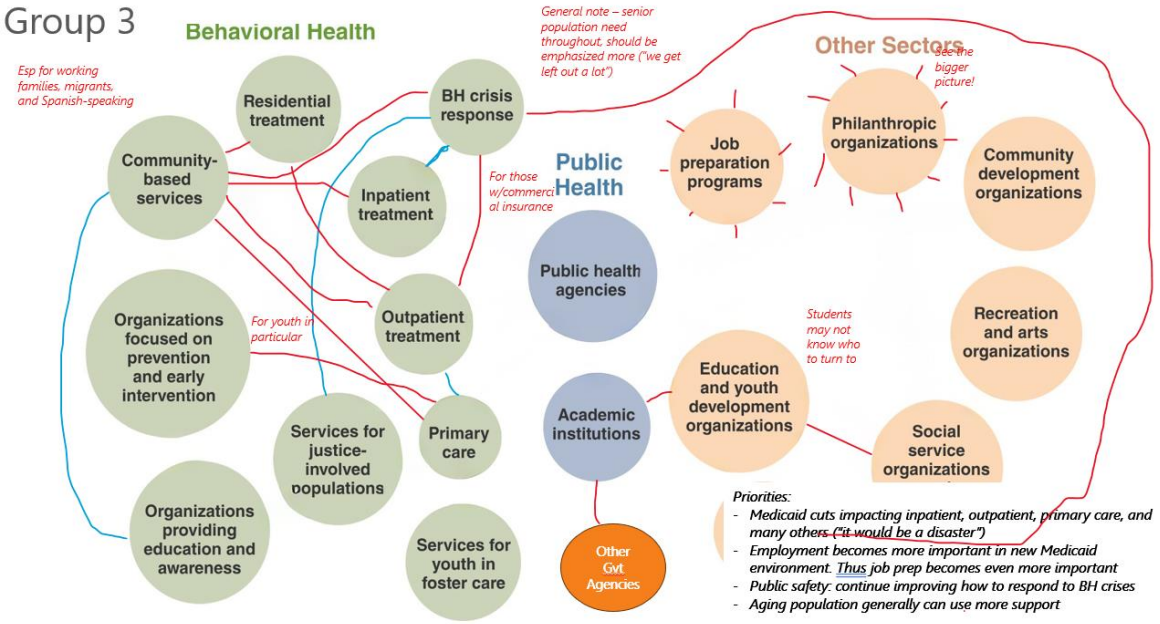


- This group believed philanthropic organizations were isolated from the system and desired a greater focus on collaboration between local philanthropists and behavioral health.
- Participants in this group desired a central directory of public health agencies that could help practitioners and those seeking care navigate the system better.
- This group believed there needed to be better connections between education and youth development organizations and primary care, prevention, and academic institutions.
- This group thought there needed to be more options for residential treatment, especially for youth.
- Participants in this group thought organizations providing education and awareness needed better marketing and promotion to share their message with audiences.

July 31st Session: Map 3

CORONAINSIGHTS

Group 3



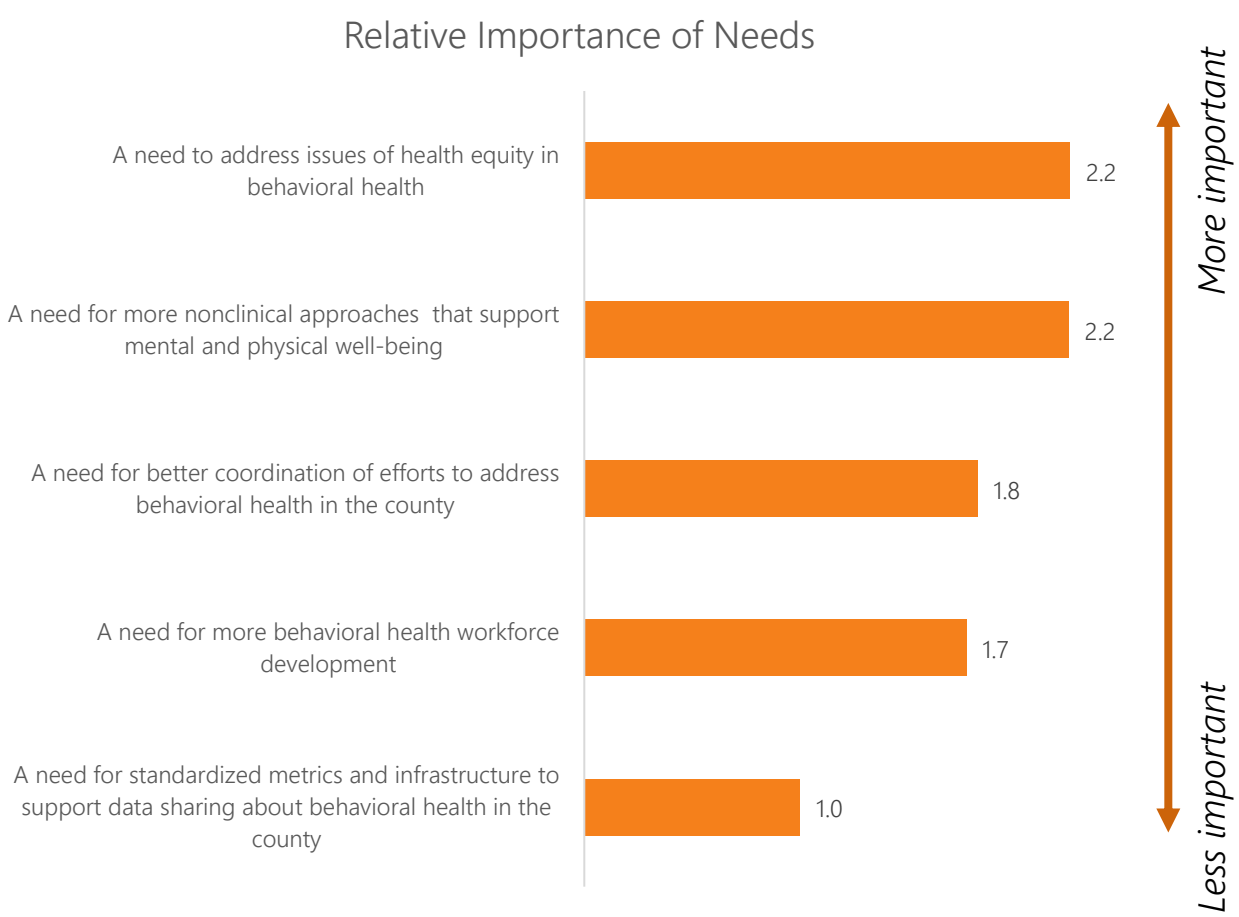
- This group believed philanthropic organizations and job preparation programs were isolated from the behavioral health system.
- Participants worried about impending Medicaid cuts' impact on care and the future role of employment requirements in the behavioral health system.
- While this group saw a strong connection between community-based services and organizations providing education/awareness, they wanted to see stronger connections between the former and many aspects of behavioral healthcare.

ONLINE QUESTIONNAIRE

RANKING COMMUNITY NEEDS

Health equity and nonclinical approaches were ranked as the most important needs within the community.

CORONAINSIGHTS



- In the online questionnaire, respondents were asked to rank the relative importance of already identified behavioral health needs in the community.
  - Addressing health equity and increasing nonclinical approaches were ranked the most important.
  - Coordination of efforts and developing the behavioral health workforce were the next most important.
- Respondents were also allowed to suggest other needs. Common suggested other needs included:
  - Funding
  - Cultural or anti-racism training
  - Those with lived experience shaping the solutions
  - More prevention
  - Including families in behavioral health
  - Addressing the unique needs of an aging population

BOTH SESSION ACTIVITY AND ONLINE QUESTIONNAIRE

SOLUTION GENERATION

Solutions Overview

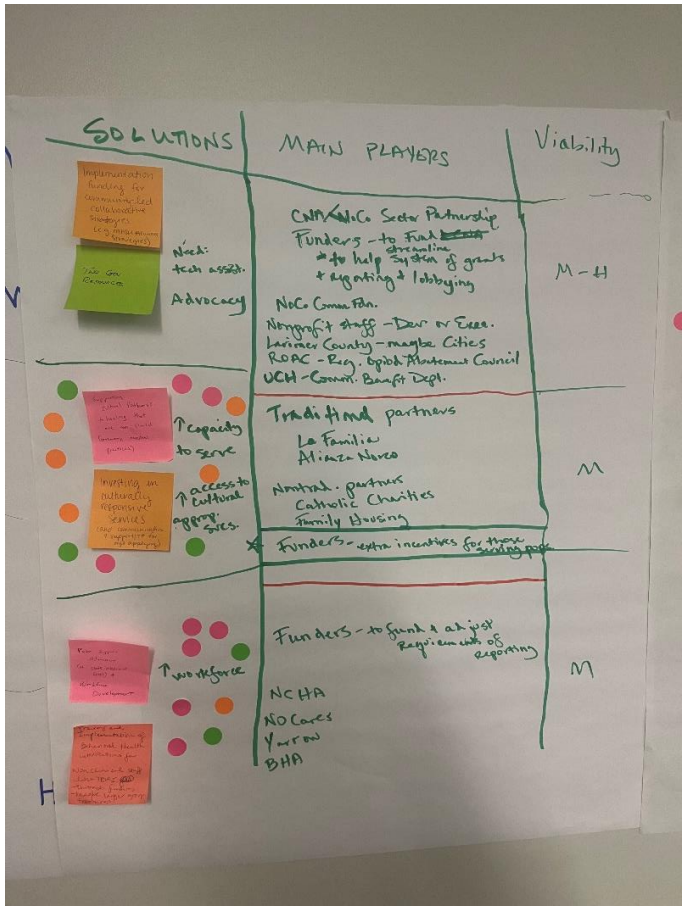
Participants in both the sessions and in the online questionnaire were asked to generate the top opportunities to strengthen the behavioral health system in Larimer County and to focus specifically on those that would benefit from multi-year funding.

For the session, participants did this in small groups and detailed what the opportunity would be and its viability.

For the online questionnaire, participants were asked to generate specific actions to address each identified community need. Then they were asked what specific actions to support the behavioral health system in Larimer County would most benefit from multi-year support and from a joint effort of multiple organizations.

While the activities were slightly different, there were common themes across both, presented on the following page. In the session, participants selected their preferred solutions. The solution areas on the following page are ordered from most to least popular. It is important to keep in mind that there were sometimes only minimal differences in popularity between solution areas and that popularity reflects only the session participants.

Note that solution themes may already be currently addressed by LCBHS funding/efforts or may fall outside of the current scope of LCBHS. However, this is still valuable information as it provides feedback that LCBHS could amplify communications efforts in this space, increase related efforts, and/or share with other departments and organizations that focus in these areas.



Example of the outcome of the session activity.

Solution Generation Themes

1. Non-clinical, culturally responsive services, communication, and care (e.g., funding for culturally-resonate healing spaces including plant fungi medicine; reimbursement fund for culturally-relevant services).
2. Better public technology resources to help individuals navigate to essential services (e.g., centralized map or website with all providers).
3. Better public human resources to help individuals navigate to essential services (e.g., behavioral health specific referral line, more resource navigators).
4. More funding and support for resource navigation professionals (e.g., establish a navigation program/credential/training; provide funding for more case managers; care coordination conference or working group).
5. Promote data sharing among healthcare systems and community resource programs (e.g., adopt universal health records or data-sharing protocols; incentive use of a consistent EMR; create a consistent referral system and platform for tracking and closing referrals).
6. Support BH workforce development and retention (e.g., support a BH job board; provide burnout prevention fund; fund cultural and disability competency training; fund efforts to create more trauma-informed workspaces; provide scholarships and support for culturally diverse therapists and peer supporters; loan repayment; hiring local).
7. Better support and resourcing for caregivers, peers, and nonclinical staff (e.g., promote and/or provide scholarships to peer certification programs, especially for diverse professionals).
8. Embedding peer support throughout the BH system (e.g., embedding peer supporters in healthcare offices or other settings).
9. Encourage respite care as an alternative to hospitalization for people in crisis. (e.g., provide funding for peer respite care; implement a 'living room model' for individuals to receive services prior to charges/incarceration).
10. Provide reliable and accessible transportation (e.g., Dial-A-Ride transportation services, volunteer-based transportation options, reimbursing Ubers).
11. Provide additional BH specific networking opportunities (e.g., facilitating regular cohorts and collaboratives; host a conference, like a BH/civic version of Startup Week).
12. Provide prevention-focused, wide-spread training for adults in contact with youth (e.g., who are service providers; recognizing BH challenges; understanding ACES).
13. Incentive co-location and collaboration (e.g., fund more co-location efforts or 'one-stop-shops'; provide incentives and funding for collaborative efforts).
14. Provide collaborative skill-building and training for providers (e.g.., Medicaid billing collaborative; additional training and support for navigating HIPAA compliance).
15. Reform grantmaking (e.g., promote consistent applications; encourage a shift in focus to sustainability rather than innovation; greater collaboration among philanthropy; provide more non-competitive funding).

ONLINE QUESTIONNAIRE

CONCERNS ABOUT MULTI-YEAR FUNDING

Concerns Overview

CORONAINSIGHTS

- In the online questionnaire, participants were asked to share any concerns or risks to keep in mind when developing the multi-year funding.
- These concerns will help shape the process to develop the funding framework and guide communications about the funding.

Concerns Summary

CORONAINSIGHTS

- A few participants noted instability in funding, perhaps due to federal changes or changes in the sustainability of this new funding.

"sustainability of programs after grants are over and with medicaid unknows."

"The biggest risks are that: 1. funding will decrease, and/or 2. Insufficient funding will be available for emergent issues in later years.."

- A few participants were concerned about whether this new funding would make it more difficult for smaller organizations or newer ones to participate.

"Equity in collaboration: Larger or more established organizations may unintentionally dominate collaborative funding efforts. LCBHS should ensure smaller grassroots and peer-led organizations have equal access, voice, and capacity support when partnerships are formed. "

"Risk/concerns would be impact to organizations left out of such initiatives, including that multi-year initiatives have a start and finish date that doesn't allow new organizations in, in the middle."

Concerns Summary

CORONAINSIGHTS

- Another concern was whether this funding would be flexible to evolving needs.

"Funding flexibility: Collaborative projects often evolve as trust and needs emerge. multi-year funding should allow some flexibility in implementation and timeline, especially in community-led or experimental models."

"A potential risk or concern could be that we may reduce our ability to adapt to changing needs and priorities."

- Some participants noted a concern about whether the community, including those with lived experience, would get to shape what gets funded.

"Include people with lived experience in planning and oversight. Programs are often designed without direct input from those they serve."

- A few were also concerned about organizational stability.

"Don't build a system that creates clients, build a community supported system to meet all people's wherever they are on their path."

"Organizational stability could be a factor. Therefore, some metric of stability should be considered."

ONLINE QUESTIONNAIRE

PARTICIPANT DEMOGRAPHICS

Demographics of Online Questionnaire Participants

CORONAINSIGHTS

	Count
Total Respondents	*34*
Average Number of years in Larimer County	22
Type of Org	
Nonprofit	20
Government Org	5
PK-12 Education	2
Higher Education	0
Funding Org	0
Private Business	3
Other	6
Not currently employed	2
Relationship with Behavioral Health	
Work in behavioral health	17
Volunteer in behavioral health	5
Have lived experience with behavioral health	18
Serve on behavioral health advisory group	5
Received a grant from LCBHS	16
Applied for a grant from LCBHS	5
None of the above	2
Prefer not to answer	

	Count
Total Respondents	*34*
Area of Behavior Health You Work In	
Promotion	5
Prevention/Education	11
Treatment	14
Recovery	8
Other	3
Audiences Served (Work or Volunteer)	
Children (0-14)	14
Youth (15-24)	18
Young Adults (25-34)	17
Adults (35-54)	14
Older adults (55+)	14
Families	13
Communities of Color	15
LGBTQIA+	17
Veterans	13
People living with disabilities	18
All of the above	8

PRIORITIZATION SESSION: KEY FINDINGS MEMO

INTRODUCTION

On September 23, 2025, Larimer County Behavioral Health Services (LCBHS) hosted, and Corona Insights facilitated, a meeting of local behavioral health stakeholders and leaders to discuss and prioritize ten behavioral health potential solutions that could be the focus of a future multi-year funding framework. The meeting was designed to also elicit feedback about how the funding framework might be structured and how it could operate.

Participants at the meeting represented various community organizations and perspectives. Meeting facilitators asked each participant to rank their top three of ten behavioral health and wellness solutions across a set of 12 criteria. (A detailed description of the prioritization activity and lists of solutions and the criteria definitions can be found in the Appendix.) LCBHS staff wanted the prioritization results to reflect the broader community, so they decided to attend the meeting and listen to the discussion, but they did not participate in the prioritization activity.

RESULTS FROM PRIORITIZATION ACTIVITY

Community stakeholders identified **three funding priorities** during the workshop:

1. **Behavioral Health Workforce** – Recruit, retain, and expand skills of behavioral health workforce (e.g., support a behavioral health job board; provide burnout prevention fund; fund cultural and disability competency training; fund efforts to create more trauma-informed workspaces; provide scholarships and support for culturally diverse therapists and peer supporters; loan repayment; hiring local).
   - This was ranked highest with 7 top scores, driven by continuity of care concerns and recognition that workforce stability is foundational to achieving all other goals.
2. **Cross-Organization Incentives** – Incentivize cross organizational and co-location of services (e.g., fund more co-location efforts or 'one-stop-shops'; provide incentives and funding for collaborative care efforts).
   - Discussion around this emphasized the importance of collaboration, shared resources, and proven co-location models like the Murphy Center and Free Recovery Community Denver.
3. **System Navigation** – Improve care coordination (e.g., establish a navigation program/credential/training; provide funding for more case managers; care coordination conference or working group, centralized map or website with all providers).
   - Discussion around this emphasized the need for centralized coordination and resource-sharing and supporting more dedicated system navigators. While this scored low on permanency ("every resource list is immediately outdated"), this wasn't considered a major problem.

	BH Workforce	Cross-org. Incentives	System Navigation
Breadth of Benefit	**37**	22	19
Depth of Benefit	14	20	20
Achievable	**31**	21	26
Complementary Solution	**27**	22	20
Public Support	25	**26**	22
Stakeholder Support	**36**	30	29
Permanency	**33**	22	17
Equity	19	19	12
Collaboration	12	**51**	33
Transformative	**32**	23	21
Data Availability	23	20	26
Return on Investment	**30**	21	26
Total Sum	319	297	271
Median Score	29	22	22
Maximum Score	37	51	33
Number of Top Scores	7	2	0

THEMES FROM POST-ACTIVITY GROUP DISCUSSION

Collaboration Over Competition: Participants consistently emphasized that effective solutions require organizations working together. Cross-org incentives was the solution most directly connected with collaboration, but discussions revealed that collaboration will be critical to implementing any efforts within the three top solution areas.

Behavioral Health Access and Cultural Responsiveness: Both BH Access and cultural responsiveness, although not ranked in the top 3, were considered to be critical. One way to resolve this is to integrate them into the evaluation criteria for proposals (e.g., does this solution increase access? Is it culturally responsive?). Stakeholders also envisioned ways where particular solutions within each of the top three areas might also explicitly support access and cultural responsiveness (e.g., having a co-located central hub could mitigate many access issues; investing in workforce development around culturally competent care could increase cultural responsiveness).

Ongoing stable funding for existing core services: Stakeholders reiterated that philanthropy's preference for "new, sexy programming" over core services creates inefficiency and instability. BH community members want mechanisms for funding some of the things they are already doing without having to constantly introduce new work. Furthermore, the lack of stability in the ecosystem in the current moment threatens any system-improvement effort (e.g., "my staff are leaving before their jobs get cut.").

IMPLEMENTATION IDEAS

In addition to the specific ideas already discussed in the brainstorming sessions, some more concrete solutions that arose through the prioritization discussion included:

- Facilitated wellness retreats for workforce, which do not ask overburdened staff to plan their own retreat (BH workforce)
- Funding a burnout prevention fund and distributing grants from this (BH workforce)
- QBHA scholarships for workforce development (BH workforce)
- Shared personnel agreements splitting costs between organizations, in particular for funding system navigators (System nav/cross-org incentives)
- Central resource hubs with satellite services for rural areas, similar to the Murphy center (System nav/cross-org incentives)
- Defining robust care coordination (e.g., tour guide > travel agent, a view inclusive of but broader than behavioral health), and mapping organizations already offering this level of coordination such as CO-SLAW (System nav)
- Providing more robust care coordination training, convening, and resource-sharing (System nav)
- Contributing to priorities already defined by the Health District's Coordination of Care Workgroup (System nav)

OTHER FINAL COMMENTS ABOUT PRIORITIZATION RESULTS:

- These results align with other regional strategic plans, and with known gaps in training and capacity landscape.
- Prevention was a challenging domain in this prioritization exercise and could have been defined more broadly.
- Participants recognized the need for both quick wins and long-term strategies for voter renewal.

FRAMEWORK FEATURES DISCUSSION SUMMARY

Session participants engaged in smaller group discussions about what a multi-year funding framework could look like, especially through the lens of the top 3 priority areas to fund. Below we describe initial reactions and preferences that were discussed.

Funding Structure: Initial conversations about funding structure suggested a preference among the BH community for grants over fee-for-structure contracts, though it was difficult to strongly assess this point without a more specific solution in mind. Opportunities may exist for reimbursement models (e.g., burnout prevention funds could be offered as either grants or reimbursements). In addition, LCBHS may want to encourage partnership development through the use of planning grants. Finally, LCBHS may want to consider the extent of prior collaborations between organizations and any existing MOUs or partnership agreements when considering applications.

Timeline: Stakeholders agreed that the minimum viable multi-year funding mechanism would provide 3–5 years of funding with renewable options. Some suggested a two-phase approach with an initial planning and resource-mapping phase (up to 12 months), followed by an implementation phase. Often participants mentioned that the first year of a collaborative project needs to focus on relationship-building and norming (especially if parties have not worked together closely in the past). Complex solutions like reforming system navigation and making it accessible to all may require a decade-long investments.

Support Beyond Funding: Discussion in this area emphasized that the county could provide a liaison/coordinator position to help grantees understand the landscape of other service providers. The county should also support networking and collaboration among grantees (regularly scheduled meetings, asynchronous communication platforms, etc.).

Measuring Success of Funded Projects: Participants emphasized that any efforts to evaluate the ultimate success of multi-year projects should include external/neutral perspectives. The evaluation approach will need to vary based on the project, with specialized expertise brought in as needed (esp. for co-location projects, need capital planning, facilities, business expertise). Participants also wanted evaluation to be based on metrics that show deeper/system-wide transformation over output indicators (e.g., number of clients served, number of hours of training provided), and hoped that evaluations could leverage both quantitative and qualitative data.

FINAL PRIORITIZATION RANKING

	BH Workforce	Cross-org. Incentives	System Navigation	Peer Integration	Prevention & Resiliency	BH Access	Culturally Responsive	Data Infrastructure	Caregiver Support	Administrative Training
Breadth of Benefit	37	22	19	17	23	14	0	11	8	1
Depth of Benefit	14	20	20	23	6	27	27	1	15	3
Achievable	31	21	26	19	14	10	15	3	13	4
Complementary Solution	27	22	20	21	25	9	12	8	9	3
Public Support	25	26	22	17	18	21	6	6	12	3
Stakeholder Support	36	30	29	11	18	14	10	6	2	0
Permanency	33	22	17	17	32	7	6	14	6	2
Equity	19	19	12	17	1	29	55	3	0	1
Collaboration	12	51	33	12	7	1	8	25	0	7
Transformative	32	23	21	23	17	11	15	10	2	2
Data Availability	23	20	26	13	10	12	1	31	11	9
Return on Investment	30	21	26	22	21	10	3	9	14	0
Total Sum	319	297	271	212	192	165	158	127	92	35
Median Score	29	22	22	17	18	12	9	9	9	3
Maximum Score	37	51	33	23	32	29	55	31	15	9
Number of Top Scores	7	2	0	0	0	1	2	1	0	0

APPENDIX

METHODOLOGY

After receiving instructions, each participant logged into an online survey and anonymously ranked the top three solutions they personally thought should be prioritized based on each of the individual criterion alone. For example, participants ranked the top three solutions if the only criterion was "permanency," then they identified their top three solutions if the only criterion was "data availability," and so on.

Each solution was then scored on a three-point scale; solutions ranked #1 for a criterion received three points, solutions ranked #2 received two points, and solutions ranked #3 received 1 point. All other solutions received zero points. Scores were calculated by summing each issue by each criterion and for each issue across all criteria. Because the highest ranked issues were assigned a larger number (3) than the second—highest ranked issue (2), and so on, the highest sums represented the issues that ranked high across many dimensions for many participants.

After the prioritization activity, the results were quickly tabulated and shared with participants to observe and discuss.

SOLUTIONS PRESENTED FOR PRIORITIZATION

1. **Data Infrastructure:** Create infrastructure to support data sharing among healthcare systems and community resource programs (e.g., adopt universal health records or data-sharing protocols; incentivize use of a consistent EMR; create a consistent referral system and platform for tracking and closing referrals).

2. **Peer Integration:** Embed peer support throughout the behavioral health system (e.g., embedding peer supporters in healthcare offices or other settings, peer respite care as an alternative to hospitalization, etc.).

3. **System Navigation:** Improve care coordination (e.g., establish a navigation program/credential/training; provide funding for more case managers; care coordination conference or working group, centralized map or website with all providers).

4. **Cross-org Incentives:** Incentivize cross organizational and co-location of services (e.g., fund more co-location efforts or 'one-stop-shops'; provide incentives and funding for collaborative care efforts).

5. **Prevention & Resiliency:** Increase prevention and early intervention training for the community (e.g., teach how to recognize behavioral health challenges; teach adults working with youth how to use ACES, promote and/or provide scholarships to certification programs).

6. **Behavioral Health Access:** Make behavioral health service easily accessible and mitigate transportation issues (e.g., Dial-A-Ride transportation services, volunteer-based transportation options, reimbursing Ubers).

7. **Culturally Responsive:** Provide culturally responsive services, communication, and non-clinical care (e.g., funding for culturally-resonate healing spaces, including alternative medicine; reimbursement fund for culturally-relevant services).

8. **Administrative Training.** Provide non-clinical skill-building and training for providers (e.g., Medicaid billing collaborative; additional training and support for navigating HIPAA compliance).

9. **Behavioral Health Workforce:** Recruit, retain, and expand skills of behavioral health workforce (e.g., support a behavioral health job board; provide burnout prevention fund; fund cultural and disability competency training; fund efforts to create more trauma-informed workspaces; provide scholarships and support for culturally diverse therapists and peer supporters; loan repayment; hiring local).

10. **Caregiver Support:** Support caregivers (e.g., respite care, caregiver services and training).

CRITERIA USED FOR PRIORITIZATION

1. **Breadth of Benefit** – This solution will directly or indirectly benefit a lot of people.
2. **Depth of Benefit** – This will make a large difference in the lives of people who need it.
3. **Achievable** – This can be accomplished.
4. **Complementary Solution** – This will prevent, mitigate, or solve other issues.
5. **Public Support** – Larimer County residents, including those with lived experience, would be on board.
6. **Stakeholder Support** – Elected officials, community leaders, and practitioners would be on board.
7. **Permanency** – This will have a long-lasting impact.
8. **Equity** – This will ensure **all** individuals have fair and just access to high-quality, culturally responsive mental health services, resulting in equitable outcomes.
9. **Collaboration** – This solution will require multiple organizations to work in collaborative partnership and create shared goals
10. **Transformative** – This solution has the potential to significantly improve or reshape behavioral health systems or outcomes.
11. **Data Availability** – This initiative's effectiveness could be measured efficiently (public data or low cost evaluation).
12. **Return On Investment** – Funding this initiative would deliver a high return on dollars invested.

DEMOGRAPHICS OF PARTICIPANTS

	Count
Total Respondents	*26*
Type of Org	
Nonprofit	14
Government Org	7
PK-12 Education	2
Higher Education	1
Funding Org	0
Private Business	1
Other (volunteer, caregiver)	2
Relationship with Behavioral Health	
Work in behavioral health	12
Volunteer in behavioral health	3
Have lived experience with behavioral health	15
Serve on behavioral health advisory group	2
Received a grant from LCBHS	15
Applied for a grant from LCBHS	4
Something else	4
Prefer not to answer	2

BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT

1. Develop an incentivized **early-career pipeline** in partnership with local training and education programs to strengthen recruitment and development across all behavioral health roles—from peers to licensed clinicians—and support community organizations by creating a vetted, well-supported pool of candidates for internships and employment.
2. To prevent burnout and strengthen the current workforce, **fund initiatives that build supportive workplace cultures** — including leadership training, policy development, wellness stipends, and other employee trainings, workshops, and/or specific events to promote wellness and resilience.

CROSS-ORGANIZATION INCENTIVES

3. Fund a **dedicated convener** to facilitate collaborative efforts between organizations/individuals working in the same area to coordinate services, reduce duplication, and maximize resource sharing. These could take the form of project-specific convening groups. This funding would support an FTE to plan, facilitate, and coordinate efforts and actions. This funding may also compensate time for participants, and support asynchronous communication platforms and/or technology to support collaboration (e.g., Slack).
4. Fund **personnel that provide professional services across organizations**. In addition to providing key services that address capacity gaps (e.g., a part-time psychiatrist who works at more than one organization, Medicaid billing consultants, nonprofit accountants, etc.), the personnel would also help connect organizations to each other through knowledge sharing. This could take the form of paying for a shared staff person's benefits (while each host organization is still responsible for pay) or fund a contract to provide similar services to multiple organizations. A lead organization would coordinate and manage the personnel, facilitating across other providers. (Also addresses workforce development)
5. Fund **co-located behavioral health services**—collaborative projects that bring behavioral health services into existing community settings (e.g., schools, permanent supportive housing, primary care offices, etc.) to make care more accessible and coordinated.

SYSTEM NAVIGATION

6. Repurpose and **expand the Hub and Spoke model** to support opioid use disorder treatment sites, so that it supports behavioral health broadly—this could be through new collaborative agreements and multi-org partnerships.
7. Further develop a **county-wide care coordination portal** that practitioners or people seeking care can access through phone or web where people would be able to find information about care across the whole county and make referrals (currently similar systems are being developed at SummitStone, the Health District, and PSD). This could take the form of…
    a. Expanding care navigation resources, by building a county-wide technology tool (e.g., Health Info Source, 211 Colorado, etc.) that helps both providers and residents connect to behavioral health services across payer sources. To ensure the success and adoption of the tool, fund adequate staff to maintain and train on the tool.
    b. Advancing the Larimer Integrated Network of Care (LINC)—Originally launched through an Impact Fund grant, this initiative develops a shared care coordination database to support people who frequently use behavioral health and criminal justice systems. LINC would enable real-time care record sharing, provider connections, and more effective diversion and care access efforts. (Also addresses cross-org incentives as well)

FEEDBACK SESSION

Instructions

CORONAINSIGHTS

The eight potential ideas are posted around the room. Spend the next 30-40 minutes examining some of these ideas in detail.

- Start at the idea you are most excited about (we will rotate at least once)
- Use post it notes to answer the questions on the flipcharts about each potential idea:
  - If this project idea is funded, what work do you think would happen over the next 5 years?
  - If it is successful, what would be the main outcomes for the behavioral health system?
  - What organizations could collaborate on this project?
  - What would ensure success of this project idea?
- Also share any other questions, concerns, or ideas you have related to the project

After contributing to at least two ideas…

- Take a few minutes to explore some of the feedback that your peers have provided
- What strikes you about the feedback? What themes do you notice?

Idea 1: Early Career Pipeline

CORONAINSIGHTS

Develop an incentivized **early-career pipeline** in partnership with local training and education programs to strengthen recruitment and development across all behavioral health roles—from peers to licensed clinicians—and support community organizations by creating a vetted, well-supported pool of candidates for internships and employment.

Collaborators

- Poudre School District (existing workforce dev project)
- Local leadership coaches
- Area health education centers
- FRCC or CSU to provide bilingual courses in clinical studies
- Medical organizations and large group practices
- Peer support organizations

Activities

- Provide leadership training + mentorship
- Support internship -> fellowship -> clinical training -> job process
- Paid internships with 3rd party feedback and oversight
- Provide paid therapy opportunities
- Develop curriculum, standards, and public awareness

Enablers

- Resolve privacy issues
- Continuous education paid via stipends
- Stronger benefits

Outcomes

- Reduced provider burnout from other alternatives to make $
- Enhance employee retention
- Less turnover
- Healthier, stronger workforce
- Higher-quality candidates
- Long-term retention, especially of counselors

Questions, ideas, and comments

- Need a developmental approach to workforce development, from early to late career
- Need fully paid internships
- Could incentivize established providers (who are facing burnout) to train/support new providers + help them learn the field
- Could fund grants/scholarships for QBHA training

Idea 2: Supportive Workplaces

CORONAINSIGHTS

To prevent burnout and strengthen the current workforce, **fund initiatives that build supportive workplace cultures** — including leadership training, policy development, wellness stipends, and other employee trainings, workshops, and/or specific events to promote wellness and resilience.

Collaborators

- Colorado Health Foundation – they do a lot of wellness initiatives that are culturally relevant
- Larimer County + State of CO
- NCHA
- Private businesses who can provide training and services
- Community colleges
- Larimer + Weld workforce centers
- Association for Suicide Prevention
- Large private donors

Activities

- Wellness funds / stipends for workforce
- Menu of options for wellness that are proven effective
- Draft policies and incentives
- Attention and effort to monitoring work/life balance

Enablers

- Shared infrastructure
- Fund rotations so ppl entering the field get exposed to different orgs
- Follow through with policy ideas
- Flexibility but also specific criteria for wellness funds
- Payment during time off / reduced hours due to burnout
- Organizing entities that are agnostic, trusted, and informed
- Low barriers to participation

Outcomes

- Improvement in retention and staff morale (ppl stay in workforce)
- Regional culture of development, support, and wellness (okay for ppl to leave one workplace, but want them to stay in the field)
- Longevity of careers
- More supportive workplace policies

Questions, ideas, and comments

- What does wellness stipend mean? Who would qualify?
- Pay is a main driver of turnover… this idea does not address pay
- What can we do to make health insurance more accessible and promote access to non-western forms of healing/wellness?
- We do a reimbursement model where staff submit receipts for what they spent it on (massage, acupuncture, hot springs trip, etc.) and we reimburse (Yarrow)
- CHF does a wellness stipend that requires no reporting. Our staff voted on how they wanted to use it, and they wanted it as $

Idea 3: Dedicated Convener

CORONAINSIGHTS

Fund a **dedicated convener** to facilitate collaborative efforts between organizations/individuals working in the same area to coordinate services, reduce duplication, and maximize resource sharing. These could take the form of project-specific convening groups. This funding would support an FTE to plan, facilitate, and coordinate efforts and actions. This funding may also compensate time for participants, and support asynchronous communication platforms and/or technology to support collaboration.

Collaborators

- LCDHE / CHIP
- Health District / MHSLC alliance
- NCHA / NoCoCares
- LCHBS
- Youth MH task force
- Schools (TSD, PSD, Estes)

Activities

- 1-3 day event, gathering nonprofits, gov. official, funders, etc. to work directly on a plan and eliminate months of bureaucracy
- Masterplans + strategic plans regionally

Enablers

- Ongoing committed funding to build trust among participants
- Trusted partner(s) in community

Outcomes

- Streamlined plan & priorities
- Increased knowledge of systems / services
- Increased trust and resource sharing
- Move from coordination -> collaboration -> integration
- Reduce duplication
- Increase access

Questions, ideas, and comments

- Can this be a shared staff model? Seen this work successfully.
- There are so many conveners, and I think someone is already convening the conveners.
- How can we leverage existing collaborative infrastructure?
- Why only 1? What happens when there's a waitlist? What if the culture/values don't work for some clients? There are already many orgs that do this type of work, and have waitlists. Fund them.

Idea 4: Shared Professionals / Services

CORONAINSIGHTS

Fund **personnel that provide professional services across organizations**. In addition to providing key services that address capacity gaps (e.g., a part-time psychiatrist who works at more than one organization, Medicaid billing consultants, nonprofit accountants, etc.), the personnel would also help connect organizations to each other through knowledge sharing.

Collaborators

- Care coordinators / case managers
- SummitStone
- Orgs who need to gain access to psychiatrists
- All nonprofits
- All school districts
- Arula is in early stages of convening this group and designing this model

Activities

- Fund 2-3 orgs that could work together to reach a goal
- Case mgmt. for orgs who hand off clients (i.e., CAC, CASA, Childsafe)
- Aligning work between school districts
- Survey community to understand needs
- Medicaid billing consultant
- Effective use of unique providers across whole community
- Quickly connect people to support (less confusion / run-around)

Enablers

- System of evaluation of shared providers as well as ongoing support
- Availability and buy-in from professionals
- Must function better or cost less than individual services

Outcomes

- Lower cost of care
- Saving $ not paying for FT staff in each org
- Providers with broader knowledge
- Makes it easier for nonprofits to contract with providers
- Integrates knowledge of BH in non-BH settings
- More resource sharing
- Efficiencies with school districts working together

Questions, ideas, and comments

- Pair service personnel to groups in same industry?
- A cross-organization person doesn't work in practice. Organizational culture is important; who hires, fires, reviews performance, provides benefits? (Health District has learnings here)
- Obstacles/problems paying for shared staff – those who need it most might not be able to afford
- How are we tracking outcomes across organizations?
- Are we missing opportunities for prevention?

Idea 5: Co-located Behavioral Health Services

CORONAINSIGHTS

Fund **co-located behavioral health services**—collaborative projects that bring behavioral health services into existing community settings (e.g., schools, permanent supportive housing, primary care offices, etc.) to make care more accessible and coordinated.

Collaborators

- NCHA
- Nonprofits (inc. child and family serving orgs)
- Healthy steps
- Larger systems

Activities

- Identify services with high demand or with most access barriers, and determine ideal location for the highest need population
- Some buildings (schools, housing facilities) already in place become more of a central hub for clients
- Shared space for offices and community events, not something that exists already
- Orgs have shared values, provide direct services, warm hand offs
- Connection between elderly and youth

Enablers

- Direct access to services where people spend time
- Shared vision for space
- Contractual agreements
- Third party + willingness of organizations to identify duplication
- Incentives or funding for additional staff to participate in co-location (as of now, we are struggling to staff our existing location and are spread too thin)

Outcomes

- Better continuum of care; more seamless
- Less time-consuming referral process resulting in fewer people falling through the cracks
- Mitigating travel
- Receiving care earlier, earlier outcomes leading to less need for services later
- Shorter duration of services

Questions, ideas, and comments

- Need maintenance of third spaces… As school enrollment declines, is there space in those buildings?
- Where is the best location? Some locations privilege the child, others the adults in the family. Students may experience stigma if receiving services in schools where their friends could see.
- Would there be space for whole programs to move there?
- If we had the physical spaces that held our hub of services, couldn't that house the personnel to run the hub+spoke model, the portal of care, and the providers that serve across orgs?

Idea 6: Hub-and-Spoke Model

CORONAINSIGHTS

Repurpose and **expand the Hub and Spoke model** to support opioid use disorder treatment sites, so that it supports behavioral health broadly—this could be through new collaborative agreements and multi-org partnerships.

Collaborators

- COSLAW
- NCHA
- Schools (TSD, PSD, Estes)
- Yarrow collective
- Willow collective
- Nonprofits
- Private practitioners
- Philanthropic groups
- EMS
-

Activities

- Have a care coordinator with a thorough understanding of agencies they are referring to
- Navigation into care
- Person-centered planning
- Build community understanding to enhance collaboration
- Support for unhoused folks
- Mobile Integrated Health (MIH) system implementation

Enablers

- Increase in qualified behavioral health assistant access
- Hub remains agnostic – is not a provider of clinical services
- Staff are co-located… happening currently with COSLAW model – clinics, hospitals, schools, etc.
- Well-supported hub workers (compensated fairly, addressing burnout)

Outcomes

- Expands an already-successful model
- Patient gets most appropriate treatment
- Reduction in duplication
- Fewer 'hoops' for the individual
- Holistic support dome efficiently and more safely
- Less likely that unspoken needs go untreated
- Cost reduction

Questions, ideas, and comments

- This is the only bullet point on the sheet that doesn't have a great explanation of the goal/vision.
- What is the difference between this and 7B? (advancing the LINC)
- Works alongside idea #7 (care coordination portal)
- Can this be opened to other types of inpatient need (e.g., teens, substance use, justice system)

Idea 7: Care Coordination Portal

CORONAINSIGHTS

Further develop a **county-wide care coordination portal** that practitioners or people seeking care can access through phone or web where people would be able to find information about care across the whole county and make referrals (currently similar systems are being developed at SummitStone, the Health District, and PSD).

Collaborators

- All mental health agencies
- Criminal justice partners
- County BH services
- Social services
- Training programs
- Healthcare providers (inc. EMS, large group practices, outpatient agencies)
- Schools (TSD, PSD, CSU)
- "All nonprofits"
- "All community providers"

Activities

- Development of software platform (subject matter experts assisting in creation)
- Directory of who does what connecting with ALL organizations (housing, employment, food access, criminal justice)
- Must be easy to navigate and continuously updated
- Community chat feature asking for referrals
- Need to allow ppl to opt out of sharing info w/ law enforcement

Enablers

- Keeping provider info up-to-date
- Buy-in + collaboration from clients, agencies, and private providers
- Open access to all groups/families
- Tech support
- Full-time care coordinators

Outcomes

- More families access care more efficiently (prevents crises)
- Clients get connected to all relevant programs
- Individuals needing support don't slip through the cracks
- Providers share info and take into account work w/ other providers
- Easier referral processes reduces staff burnout
- Providers offer more resources
- Better health outcomes
- Reduce duplication in services

Questions, ideas, and comments

- Data privacy – some ppl will want to share data with certain orgs not others
- Needs to not be siloed in BH (include transportation, housing)
- Need to make sure smaller orgs are represented on the portal
- Could be duplicative of state shared health info exchange
- Client reviews / testimonies?
- Present to commissioners in December

1401 Lawrence Street
Suite 1600
Denver, CO 80202
303.894.8246
CoronaInsights.com