COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

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Date: April 20, 2022

Subject: Request for a Rulemaking Hearing concerning New Rule, 6 CCR 1009-12, Community Disaster Behavioral Health Program

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Please find copies of the following documents: Statement of Basis and Purpose and Specific Statutory Authority, Regulatory Analysis, Stakeholder Engagement, and Proposed New Rule, 6 CCR 1009-12, Community Disaster Behavioral Health Program.

The Department is requesting that the State Board of Health set a hearing to establish new rules for the Community Disaster Behavioral Health Program (Program). The need for these rules is described below.

New legislation in the form of HB21-1281 Community Disaster Behavioral Health Program was signed into law on July 27, 2021. The legislation aimed to ensure the integration of behavioral health in disaster preparedness and response efforts statewide by formalizing and better resourcing existing initiatives for disaster behavioral health in Colorado. The Department, through the Division of Disease Control and Public Health Response's Office of Emergency Preparedness and Response (OEPR), is well-positioned to lead the implementation of the Community Disaster Behavioral Health Program (Program) as the home of Colorado's disaster behavioral health preparedness and response efforts.

The state disaster behavioral health team has facilitated statewide capacity-building and coordination efforts with community behavioral health partners and other emergency response systems for over 20 years. The state team moved to the Office of Emergency Preparedness and Response in 2010 and has developed disaster behavioral health planning and capacity in OEPR's public health emergency preparedness and hospital preparedness programs, as well as across local Emergency Support Function #8 – public health, medical services, and behavioral health coordination and Colorado's 9 regional Healthcare Coalitions through community mental health center response teams. The Department believes these efforts to integrate disaster behavioral health capacity in emergency systems reduce stress,

promote adaptive functioning, and improve outcomes for both survivors and responders, benefitting both the community and emergency systems.

The proposed rule will help the Department effectively disburse the Community Behavioral Health Disaster Preparedness and Response Cash Fund. House Bill 21-1281 appropriated funds to use in support of the overarching emergency system integration and for community behavioral health. The proposed rule language is intended to structure organizational criteria, allowable activities, and other program oversight for those programs seeking to use these funds. This rule will enable the Program to assess the fit of organizations interested in participating in the Program, and allow the Department to coordinate and capacitize community behavioral health organizations for community disaster response.

The Department has contacted a wide variety of stakeholders to solicit input on the proposed rule. A summary of the feedback received and, if the Department incorporated this feedback, is detailed in the Stakeholder Engagement section.

Thus, in response to legislative directives and stakeholder recommendations, the Department is requesting the State Board of Health set a hearing to consider the proposed rule to establish the Colorado Disaster Behavioral Health Program.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY for
New Rule, 6 CCR 1009-12,
Community Disaster Behavioral Health Program

Basis and Purpose.

On July 27, 2021, HB21-1281 Community Disaster Behavioral Health Program was signed into law to formalize and better resource existing disaster behavioral health (DBH) preparedness and response efforts. The Department, through the Division of Disease Control and Public Health Response's (DCPHR) Office of Emergency Preparedness and Response (OEPR), is well-positioned to lead this program as the home of Colorado's disaster behavioral health preparedness and response efforts. The state disaster behavioral health team's ongoing work has facilitated statewide capacity building and coordination with community behavioral health partners, public health and hospital preparedness programs, and other emergency response systems for over 20 years. Disaster behavioral health practice has evolved in response to diverse disaster incidents and community contexts here in Colorado. The existence and passage of this bill represent the accumulated learning and efforts of many state and local partners, as well as the recognized value of people-focused, psychosocial support and interventions during some of Colorado's hardest - and most resilient - days.

The Department is requesting that the State Board of Health set a hearing to establish a new rule for the Community Disaster Behavioral Health Program (Program). The basis and purpose for this rule are described below.

What is Disaster Behavioral Health?
The purpose of disaster behavioral health is to support adaptive functioning in the face of disaster disruptions. People experience stress and fear as automatic, survival reactions to threats around them. These are expected, normal reactions to abnormal events, and they are best supported as situational struggles rather than as persisting mental health conditions to be diagnosed or pathologized. Disaster behavioral health assumes a resilience trajectory for a majority of disaster survivors, while simultaneously recognizing the value of supportive interventions to the community's collective distress and adaptation challenges. Disaster behavioral health response intervenes at the community level with a public health approach.

Disaster behavioral health response encompasses various psychosocial activities which serve to support individuals, groups, and communities as they deal with cognitive, emotional, and spiritual impacts that disasters cause. Interventions like psychological first aid, community outreach and referral, basic stress education/training, and consultation to impacted groups and leaders, take place in many disaster settings, including (but not limited to):

- Disaster assistance centers
- Community or town meetings
- Shelters
- Schools
- Family assistance centers
- Victim information centers
- Hotlines and information lines
- Emergency Operation Centers (EOCs)

- Damage assessment teams
- Community re-entry programs
- Joint information centers/systems (JIC/JIS)
- Community clinics/Points of Dispensing (POD)
- Community trials

A fundamental disaster behavioral health goal is to help to restore the social fabric of the community: to connect or reconnect people with existing support networks that can address disaster consequences or basic needs that were interrupted. This includes the needs of people who already use mental health services to stay connected or be reconnected with their support or care where the disaster has disrupted them.

For the purposes of this Program and the proposed rule guiding its creation, it is important to delineate the practices and assumptions of disaster behavioral health, crisis services, and other traditional mental health treatment:

- Traditional mental health and substance use treatment services treat and support people facing ongoing mental health conditions or longer-term issues. They tend to be delivered by clinicians in office or facility settings, and often involve diagnosis and longer-term therapeutic relationships with record keeping (case files, charts, etc.).
- Disaster behavioral health response, in contrast, reaches disaster-impacted community members with and without mental health service history, often in-home or community-based settings. Disaster behavioral health response can be delivered at trained paraprofessional and first aid levels. Disaster behavioral health responders validate common disaster reactions and experiences, offer psychoeducation, connection, and linkage to resources for disaster-related issues, and identify relevant strengths and coping skills for those issues.
- Crisis services refer to interventions and treatments aimed at an individual who is experiencing a psychological crisis, often due to an ongoing mental illness. These interventions are focused on creating safety and connecting to wrap-around services to support the individual's return to health. Crisis services may be needed for some individuals in both disaster and non-disaster contexts but should not be assumed to be needed for all disaster survivors or for all kinds of disaster distress.

While these behavioral health services and capabilities differ, it is valuable for disaster behavioral health response to know how to link people with more acute or ongoing needs to other levels of care in behavioral health systems.

Overall, integrating disaster behavioral health in emergency response reduces stress and improves the functioning and outcomes of both survivors and responders, benefitting both the community and emergency systems. Disaster behavioral health considerations make emergency systems more understanding and effective in supporting community behavior and help to maintain and care for critical disaster workforces and resources involved in a whole community response.

<u>Colorado's disaster behavioral health beginnings</u>
Colorado's efforts to improve behavioral health response to community crises and natural disasters began following the 1997 Fort Collins flood, the 1999 shooting at Columbine High School, and the 2002 Colorado wildfire season.

Around this same time, the National Response Framework (NRF), a single, comprehensive approach to disaster incident management in the United States was in development. The Emergency Support Functions (ESFs) are coordinating structures in the NRF that organize government agencies, community-based organizations, and private assets to address 14 functional areas of disaster response. The State of Colorado and many county emergency management offices have adopted this ESF structure, and the Department serves as the state Emergency Support Function #8 - Public Health, Medical Services, and Behavioral Health (ESF #8) coordinator and primary agency in Colorado's Emergency Operations Plan.

In 2004, the Department and Colorado Department of Human Services (CDHS), as the state department lead for ESF #8 and the state mental health authority respectively, entered an interagency agreement and began a formal, state-led effort to develop and integrate behavioral health in the holistic disaster health response. The state disaster behavioral health team and their programming moved from CDHS Office of Behavioral Health to the Department's Office of Emergency Preparedness and Response in 2010 to deepen this integration.

Early efforts focused on convening Community Mental Health Centers (CMHC) and developing their disaster response knowledge, team capacity, plans, and networks to leverage disaster lessons learned. The core agencies of Colorado's public behavioral health system, CMHCs' public missions, and county and municipal service areas also aligned for coordination with public health and emergency management agencies, whose disaster planning is organized within similar jurisdictions. Consistent relationships for preparedness planning, training, and exercise are critical to the integration, implementation, and improvement of disaster response.

In these same years, the state disaster behavioral health team also launched a two-year project to create a statewide partnership and structure for disaster behavioral health response. This project resulted in the partnership known as the Colorado Crisis Education and Response Network (CoCERN) and the first edition of the CoCERN Protocols and Guidelines. Parties involved in the development of the first CoCERN protocols included community mental health centers, state government programs, professional psychological organizations, voluntary organizations active in disaster with psychosocial support missions, crisis support teams, and public health systems. While each party to CoCERN's development and ongoing partnership is a separate and independent organization and complete adherence is not required, the document lays out an idea to increase the level of effectiveness, efficiency, and professionalism within cross-disciplinary and jurisdictional disaster behavioral health planning and response. A second edition of the CoCERN protocols and guidelines was published in 2018 and continues to guide behavioral health response coordination, resource management and deployment, communication, and credentialing within this statewide network.

These early efforts and networks in Colorado coincided with a shift and expansion of disaster and trauma literature about what psychosocial support and interventions communities need following a major crisis. CoCERN incorporated these learnings in their guidelines. Interventions now widely supported include Psychological First Aid, developed by the National Child Traumatic Stress Network and the National Council on PTSD, and the Crisis Counseling Assistance and Training Program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Federal Emergency Management Administration (FEMA) under federal disaster relief programs, both of which informed the development of a standard training curriculum for DBH teams across CoCERN organizations in Colorado.

Learning from disaster incidents: the cost of disaster behavioral health

While state coordination staff and activities have been funded through the Public Health Emergency Preparedness Program (PHEP) and the Hospital Preparedness Program (HPP), most disaster work completed locally by Community Mental Health Center (CMHC) teams has been voluntary in nature. Each CMHC has identified a disaster coordinator in their organization, but in most cases, this role and further team development is an add-on to other duties and positions. CMHCs have engaged DBH activities without adequate funding or reimbursement, limiting the extent to which these efforts can grow and serve all Colorado communities. In 2011, the Department began to provide small program support funds to better incentivize sustained disaster behavioral health preparedness. Awards between $7,500 and $13,000 a year defrayed only partial costs related to staff time and operational expenses of annual preparedness activities.

Meanwhile, local CMHCs responded to a host of events including the Holly and Windsor Tornadoes, multiple years of front range wildfires, the 2012 Aurora theater shooting, and the 2013 floods. Their disaster behavioral health response teams supported diverse community missions, from offering psychological first aid and walk-about support at shelters and disaster assistance centers to accompanying people during re-entry to neighborhoods where homes had burned to providing psychoeducation and support at community vigils and trial events following mass shootings.

Like preparedness work, disaster behavioral health response was not funded or reimbursed, with the exception of federal disaster relief programs like the Crisis Counseling Program, which would only become available under a federal disaster declaration. State and local responses could directly cost each responding CMHC hundreds of thousands of dollars.

The recognition that, with few exceptions, disaster response activities are not reimbursed by insurance and other typical funding mechanisms for behavioral health services became a critical limit and lesson learned for the disaster behavioral health system.

HB21-1281: state support for sustaining disaster behavioral health systems

In recognition of the benefits and costs of local disaster behavioral health work, the Colorado Behavioral Healthcare Council (CBHC) developed a policy statement in 2016 in support of ongoing DBH preparedness and response coordination and in order to communicate the need for further state investment. CBHC articulated policy priorities for:

- Formalizing the role of behavioral health providers in emergency preparedness and response.
- Enhancing emergency preparedness and response initiatives and ensuring sustainable funding.

In the summer of 2020, the Governor's Office launched the Behavioral Health Taskforce COVID-19 subcommittee reviewing the impact of the pandemic on mental health in Colorado. Like the CBHC statement before it, one of the many recommendations elevated by that subcommittee was to increase disaster behavioral health programming in Colorado. Their concluding recommendations in this domain were to:

- Formalize the role of Colorado's community behavioral health organizations in the disaster preparedness and response continuum.

- Create effective and adequate reimbursement for behavioral health disaster preparedness and response initiatives.
- Invest in community resilience initiatives and activities by the behavioral health system.
- Adequately support state and local infrastructure to respond to behavioral health needs following community-level crises.

House Bill 21-1281 Community Disaster Behavioral Health Program was introduced with bipartisan sponsorship to the 2021 legislative session. The bill reflects the recommendations of this subcommittee, the need identified in the CBHC policy statement, as well as more than 20 years of field and program lessons from voluntary and grant-supported disaster behavioral health preparedness and response work. The Department's DBH staff, in collaboration with the Colorado Behavioral Healthcare Council, presented DBH history and informational sessions with various government and behavioral health constituent associations. In the shadow of the COVID-19 pandemic and the shootings at the Table Mesa King Soopers, this bill was passed quickly and with strong support.

Content and Organization of the Proposed Rule

Thus, the Department possesses unique history, expertise, and system integration through which to solicit engagement, manage, and set rules for the Community Disaster Behavioral Health Program.

The Department has contacted a wide variety of stakeholders to develop and solicit input on the proposed rules. These stakeholders included community behavioral health organizations with long-standing disaster behavioral health engagement and teams, other community behavioral health organizations exploring their fit and capacity to engage the program, non-behavioral health entities whose emergency preparedness and response roles would interact with disaster behavioral health efforts, as well as those representatives and organizations who had participated as stakeholders for the HB21-1281 bill.

The proposed rule sets parameters for the Community Disaster Behavioral Health Program, and specifically includes criteria for

- Allowable Activities
- Eligibility Criteria for Participating Providers, Preparedness Capabilities Measures, and Award Determination
- Other Program Management and Oversight

Below is an explanation of each set of criteria.

Allowable Activities

This section catalogs allowable activities for which the Community Behavioral Health Disaster Preparedness and Response Cash Fund (Cash Fund) may be used in disaster preparedness, response, and recovery. The rule describes the annual preparedness grants and as-needed response and recovery applications by which the Cash Fund will be allocated. Because the Cash Fund is allocated to both annual activities for sustainable preparedness, and to event-based response and recovery activities, the rule clarifies that the program will prioritize funding to DBH activities that are not funded by another emergency management process or conditional disaster behavioral health program.

Eligibility Criteria for Participating Providers, Preparedness Capabilities and Measures, and Award Determination

The Community Disaster Behavioral Health Program aims to encourage geographic and socioeconomic diversity of disaster behavioral health providers. To identify community behavioral health providers with good fit and capacity to sustain disaster behavioral health activities, this section specifies the capabilities that organizations wishing to participate in the program must demonstrate or pledge to enact regarding service capacity, planning, response strike team availability, training, and culturally and linguistically appropriate services.

These capabilities use CoCERN training standards and reflect disaster lessons about what a disaster behavioral health provider needs to develop or maintain in their organization's readiness and team capacity, in maintained relationships and coordination across their service area, in behavioral health knowledge as subject matter experts for other emergency partners, and in awareness and responsiveness to the diverse cultural groups who make up the general public in the area that they serve. By meeting or agreeing to these criteria, the rule allows eligible providers to seek funding for both annual preparedness grant activities and for as-needed response and recovery activities (see Allowable Activities section).

This section also delineates the Community Disaster Behavioral Health Program from other non-disaster behavioral health services and from other statute or program-mandated disaster behavioral health duties. The rules specify that award determination from the Community Behavioral Health Disaster Preparedness and Response Cash Fund must not only align with allowable activities but will prioritize activities that are not covered by other conditional disaster behavioral health programs or funding. The rule also allows the Department to prioritize awards that promote the geographic and socioeconomic diversity of providers. This section begins to identify preparedness measures for participating organizations and allows the department to request additional data elements for reporting on the outcomes of utilized funding.

Other Program Management and Oversight

This section outlines greater specifics for program structures and management regarding annual program cycles, response funding allocation, and program reporting. The rule lays out annual activities and timelines by which Program information will be disseminated and through which providers will maintain their participation. These details are critical because the rule also clarifies that providers must participate in the annual preparedness grants in order to apply for Cash Fund support to as-needed response and recovery activities. The rule also issues expectations for how as-needed response and recovery applications involving multiple providers for one disaster incident can be submitted and administered.

In conclusion, the proposed rule has been informed by legislative directives and stakeholder recommendations. The proposed rule will standardize organizational criteria to widen and coordinate engagement by community behavioral health organizations with emergency management systems. Distribution of the Community Behavioral Health Disaster Preparedness and Response Cash Fund for allowable activities will improve the coverage of disaster behavioral health costs to participating organizations. And in total, the proposed rule and creation of the Community Disaster Behavioral Health Program will formalize and better sustain disaster behavioral health capacity across Colorado communities. Thus the

Department is requesting the State Board of Health set a hearing to consider the proposed rule to establish the Colorado Disaster Behavioral Health Program.

Specific Statutory Authority.
Statutes that require or authorize rulemaking: Section 25-20.5-1302 (3), C.R.S.

Is this rulemaking due to a change in state statute?
__X___ Yes, the bill number is _HB21-1281_____. Rules are _XX__ authorized ___ required.
_____ No

Does this rulemaking include proposed rule language that incorporate materials by reference?
_____ Yes ___ URL
__XX__ No

Does this rulemaking include proposed rule language to create or modify fines or fees?
_____ Yes
_XX___ No

Does the proposed rule language create (or increase) a state mandate on local government?
__XX__No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed,
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

___ Yes.

This rule includes a new state mandate or increases the level of service required to comply with an existing state mandate, and local government will not be reimbursed for the costs associated with the new mandate or increase in service. The state mandate is categorized as:
___ Necessitated by federal law, state law, or a court order
___ Caused by the State's participation in an optional federal program
___ Imposed by the sole discretion of a Department

Has an elected official or other representatives of local governments disagreed with this categorization of the mandate? ___Yes ___No. If "yes," please explain why there is disagreement in the categorization.

Please elaborate as to why a rule that contains a state mandate on local government is necessary.

REGULATORY ANALYSIS for
New Rule, 6 CCR 1009-12,
Community Disaster Behavioral Health Program

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
Community behavioral health organizations who would potentially meet the eligibility criteria to participate in the Community Disaster Behavioral Health Program (Program), such as current CMHC Disaster Coordinators, Community Behavioral Health Organizations who can determine eligibility for Community Disaster Behavioral Health Program	>600	C/S/B
Partners/organizations within emergency management systems who would plan and interact with DBH teams created by the Program, such as Local Public Health Emergency Preparedness and Response (EPR) staff, Healthcare Coalition Coordinators, Emergency Managers, CoCERN organizations, other jurisdictional planners, and leaders who coordinate preparedness and response with DBH response teams	>400	S/B
General Public		B

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by, or be at risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

<u>Economic outcomes</u>

Summarize the financial costs and benefits, include a description of costs that must be incurred, costs that may be incurred, any Department measures taken to reduce or eliminate these costs, any financial benefits.

C: A disaster behavioral health provider's cost of compliance with the proposed rules will vary but is not expected to be onerous. Providers interested in participating in the program will submit and update annually an organizational profile demonstrating that they satisfy organizational eligibility criteria and confirm their intent to participate in yearly preparedness activities. Most of what is included in the proposed rule and thus in the organizational profile reflects standards that already exist across the behavioral health and emergency preparedness communities.

B: The general public may benefit from this rule if, during an emergency or disaster event, they receive services made available through this funding, and these services reduce their need to access other physical, mental, or behavioral health care through the traditional health system and otherwise support their adaptation to the disaster event through linkage to additional resources.

Non-economic outcomes
Summarize the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and, if known, the likelihood of the outcomes for each affected class of persons by the relationship category.

Favorable non-economic outcomes:

C: These rules essentially set quality management requirements or expectations of providers of disaster behavioral health services, requiring documentation of capacity and capabilities, thereby creating defensible information in the event their services are questioned.

S: Those engaged in planning and preparedness for emergency or disaster events will benefit from these rules as they will set expectations for the types of activities that these funds can be used to support, as well as standardize expectations for the capacity and capabilities of the agencies or organizations providing Disaster Behavioral Health support services.

B: The general public, local public health professionals, and planners and leaders who coordinate preparedness and response with disaster behavioral health response teams will have increased confidence in the quality, funding, and availability of response activities, and access to supports that foster their own and others' adaptive functioning in disasters or emergencies.

Unfavorable non-economic outcomes: N/A

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

A. Anticipated Department personal services, operating costs or other expenditures:

Type of Expenditure	Year 1	Year 2

Personal Services	$131,602	$143,566
Operating Expenses	$2,700	$2,700
Capital Outlay Costs	$12,400	$0
Travel & Reimbursement	$8,099	$8,099
Payments to Behavioral Health Organizations	$375,000	$375,000
Centrally Appropriated Costs	$29,907	$32,990
Total	$559,708	$562,355

Anticipated CDPHE Revenues: NA

B. Anticipated personal services, operating costs or other expenditures by another state agency: NA

Anticipated Revenues for another state agency: NA

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Along with the costs and benefits discussed above, the proposed revisions:

___ Comply with a statutory mandate to promulgate rules.
___ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
___ Maintain alignment with other states or national standards.
___ Implement a Regulatory Efficiency Review (rule review) result
XX_ Improve public and environmental health practice.
XX_ Implement stakeholder feedback.

Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023.

___ Contributes to the blueprint for pollution reduction
___ Reduces carbon dioxide from transportation
___ Reduces methane emissions from oil and gas industry
___ Reduces carbon dioxide emissions from electricity sector

2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023.

___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry.
___ Supports local agencies and COGCC in oil and gas regulations.
___ Reduces VOC and NOx emissions from non-oil and gas contributors

3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023. ___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes. ___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation. ___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.
4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023. ___ Ensures access to breastfeeding-friendly environments.
5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Performs targeted programming to increase immunization rates. ___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).
6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023. ___ Creates a roadmap to address suicide in Colorado. ___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate. ___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries. ___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.
7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020. ___ Conducts a gap assessment. _X__ Updates existing plans to address identified gaps. ___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023.

___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

___ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

There are potential opportunity costs to inaction for the failure to promulgate rules. These costs may include not having the coordination and "standardized" development of disaster behavioral health capacity enacted through the Program. In addition, there may be an increased danger for teams entering the field if not fully trained or coordinated with the larger system as well as missed opportunities to provide and be compensated for beneficial services to an impacted community

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. For this rule, both apply. As there is no or minimal anticipated cost of compliance with the proposed rule, there is no less costly method to achieving the purpose of the rule. Furthermore, the specific proposals in this rulemaking were developed in conjunction with stakeholders.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

Few alternative methods for achieving the purpose of the proposed rules were considered because the statute refers to rulemaking and this rule was developed in collaboration with stakeholders.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

The following data and references informed the Department's proposed rulemaking:

- Community Behavioral Health Disaster Response Coordinator Job Description (in HB21-1281 folder)
- Colorado Crisis Education and Response Network (CoCERN) Protocols and Guidelines
- Colorado Disaster Behavioral Health Response Plan in ESF-8 annex to the State Emergency Operations Plan
- Gunderson, J., Crepeau-Hobson, F., Drennen, C. (2012) "Research to Practice: A Disaster Behavioral Health Framework" *Disaster Prevention and Management*
- SAMHSA DTAC Resources…(https://www.samhsa.gov/dtac)
- Promising Practices in Disaster Behavioral Health Planning: Building Effective Partnerships (features Colorado's programming) - Promising Practices in Disaster Behavioral Health Planning: Building Effective Partnerships
- SAMHSA Crisis Counseling Assistance and Training Program Concepts and Curriculum
- Disaster response reports from 7 Community Crisis Counseling Programs to the following disasters: 2002 Colorado Wildfires; 2005 Gulf Coast Evacuees; 2008 Windsor Tornado, 2012 Waldo Canyon and High Park Fire; 2012 Aurora Theater shooting; 2013 Colorado Floods; 2013 Black Forest Fire
- The Colorado Field Response Training
- The Colorado Psychological First Aid Training
- Derived from NCTSN & NCPTSD Psychological First Aid Field Operations Manual
- Stevan E. Hobfoll, Patricia Watson, Carl C. Bell, Richard A. Bryant, Melissa J. Brymer, Matthew J. Friedman, Merle Friedman, Berthold P.R. Gersons, Joop T.V.M de Jong, Christopher M. Layne, Shira Maguen, Yuval Neria, Ann E. Norwood, Robert S. Pynoos, Dori Reissman, Josef I. Ruzek, Arieh Y. Shalev, Zahava Solomon, Alan M. Steinberg & Robert J. Ursano (2007) Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention: Empirical Evidence, Psychiatry, 70:4, 283-315, DOI: 10.1521/psyc.2007.70.4.283
- McGonigal, K. (2016). The Upside of Stress: Why Stress Is Good for You, and How to Get Good at It.
- Bonanno, G. (2021) The End of Trauma: How the New Science of Resilience is Changing How We Think about PTSD.

STAKEHOLDER ENGAGEMENT
for New Rule, 6 CCR 1009-12,
Community Disaster Behavioral Health Program

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

Organization	Representative Name and Title (if known)
Community Mental Health Centers	Disaster Coordinators, Directors, Office of Behavioral Health grant contacts
Colorado Crisis Education and Response Network Member Organizations (comprises CO Organization for Victims Assistance and local victim advocate contacts; Colorado Society for School Psychologists; Colorado Crisis Support Network; Voluntary Organizations Active in Disaster (VOAD) and behavioral health non-profits; Rocky Mountain Crisis Partners; contacts from CDHS-OBH, CSEAP, CDPHE, CDA, CDE, CDPS-Colorado School Safety Resource Center, CMHCs, Colorado Mental Health Institutes, CO Institutions of Higher Learning, local public health agencies, offices of emergency management)	
Mental Health and Substance Use Treatment Providers contracted by Office of Behavioral Health	
Behavioral Health subcommittee of North Central Region Healthcare Coalition	
Local Public Health Agencies	Directors, EPR Staff, Regional Staff
Healthcare Coalition Coordinators	
Governor's Expert Emergency Epidemic Response Committee (GEEERC)	
Colorado Behavioral Healthcare Council	Doyle Forrestal, Frank Cornelia, Betsy Molgano
Colorado Legislators	Rep. Lisa Cutter, Rep. Perry Will, Sen. Brittany Pettersen
Colorado Behavioral Health Partnership (includes Mental Health Colorado, NAMI Colorado, Colorado Psychiatric Association, Colorado Crisis Services, Colorado Provider Association, Colorado Mental Wellness Network, Frontline Public Affairs, UC Denver, NASW CO chapter, Colorado Counseling Association, Advocates for Recovery	Moe Keller, Vincent Atchity, Adeline Hodge, Anna Weaver-Hayes, Anne Barkis Bev Marquez, Breeah Consuella, Carly Larson, Don Eberle, Hope Hyatt, Dr. Erin Baurle, Jennifer Miles, Jennifer Place, Lauren Snyder, Leanne Rupp,

	Margaret Elmer, Margie Grimsley Michelle Dawson, Sarah Mooney Ryan Burkhart, Tonya Wheeler
Colorado Counties Inc	Gini Pingenot
Denver Childrens' Home	Armann Heshmati

A series of five stakeholder meetings were held virtually between November 29, 2021, and February 28, 2022. The agenda for each meeting was established to allow close review of draft rules, stakeholder discussion, and to provide relevant historical or programmatic context. Efforts were made to feature local partner reflections and disaster experiences that demonstrated concepts or informed discussions from the proposed rule language. Stakeholder questions and considerations about anticipated rules sections were also solicited following the first meeting in a Google form to guide future meeting agendas and discussions. Additional feedback was collected outside the meeting series in a shared Google document and through email correspondence when Google applications presented a challenge.

Key discussion topics and feedback raised and addressed with stakeholders across the meeting series included

- The involvement of individual behavioral health providers. For reasons including responder safety, responder relief, and maintenance of system planning and relationships, disaster behavioral health response teams are best developed within organizations that can ensure continuity of regular services when staff persons are deployed, create team depth for buddy systems, and opportunities for respite, and consolidate coordination with other response agencies. While the integration of individual providers may continue to be investigated, the eligibility criteria addressing team capacity were accepted.
- Building and maintaining response team capacity was added to preparedness activities and demobilizing and addressing the disaster response team's recovery needs was added to recovery activities to supplement the activities identified in the bill language.
- Cash Fund depletion. Some stakeholders expressed concern that the Cash Fund would be expected to cover both preparedness and response/recovery activities. In years with multiple disasters, the Cash Fund could be swiftly depleted and all the more quickly depending on what proportion of the annual allocation would already be taken by annual preparedness activities. The point was conceded, though could not be changed. Instead, proposed rule language was added to the other program management and oversight section to address how the as-needed response & recovery dollars would be reserved and distributed across the fiscal year, and how reporting would document any programming or funding limits to demonstrate additional need or necessary adjustments as the program is initially implemented.

Program staff from the Department also attended standing meetings by invitation of interested stakeholder groups including the Colorado Behavioral Health Partnership, the Behavioral Health subcommittee of the North Central Region HCC, and Healthcare Coalition Coordinators.

Meeting notes, draft rule sections, meeting materials, agendas, and recordings were shared broadly among all those who were invited to participate in this stakeholder process. Contacts and opportunities for connecting with other aspects of Colorado's disaster behavioral health and wider emergency response systems were shared with stakeholders on several occasions.

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

_XX___ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

To date, no major factual or policy issues have been encountered. The Department is committed to continued communication with stakeholders throughout the rulemaking period.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

X	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.	X	Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.	X	Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

HOUSE BILL 21-1281

BY REPRESENTATIVE(S) Cutter and Will, Amabile, Bernett, Bird, Boesenecker, Caraveo, Duran, Esgar, Exum, Froelich, Gonzales-Gutierrez, Gray, Hooton, Jackson, Jodeh, Kipp, Lontine, McCluskie, McCormick, McLachlan, Michaelson Jenet, Ortiz, Ricks, Sirota, Sullivan, Titone, Valdez D., Young;
also SENATOR(S) Pettersen, Buckner, Danielson, Fenberg, Gonzales, Jaquez Lewis, Story, Winter, Zenzinger.

CONCERNING THE CREATION OF THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE PROGRAM IN THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT TO ENSURE BEHAVIORAL HEALTH IS ADEQUATELY REPRESENTED WITHIN DISASTER PREPAREDNESS AND RESPONSE EFFORTS ACROSS THE STATE, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Colorado has a rich history of disaster preparedness efforts

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

across sectors and industries throughout the state;

(b) Colorado has taken deliberate measures to ensure that disaster response is community-oriented and comprehensively accounts for communities' behavioral health needs;

(c) In May 2020, the governor asked the behavioral health task force to establish the COVID-19 special assignment committee to develop key recommendations for consideration in a future crisis;

(d) The committee determined that Colorado must maintain and enhance a coordinated behavioral health emergency disaster response and ensure the permanency of robust resources for preparedness and response;

(e) The COVID-19 pandemic has demonstrated the importance of behavioral health emergency preparedness and response as communities have worked to manage the short- and long-term impact on the behavioral health of Coloradans;

(f) Behavioral health is a critical component of any adequate emergency response plan, and preparedness efforts are enhanced by the inclusion of community mental health center (CMHC) partners;

(g) Community behavioral health organizations, including CMHCs, have:

(I) Actively responded to local, state, and national emergencies, critical incidents, and disasters for decades;

(II) Supported the recovery from these events, including natural disasters, violence, mass casualty events, and public health crises; and

(III) Been actively involved in community preparedness and response activities associated with local and statewide public health emergencies;

(h) There are costs associated with preparedness and planning activities in addition to the ongoing efforts of response and recovery that often do not have a definitive end date. Additionally, many types of community responses do not have a federal emergency management agency

funding stream attached or other ways to reimburse for staff training or time spent during the response or recovery.

(i) Colorado's CMHCs have been actively involved in community preparedness and response activities associated with public health and health-care coalitions for decades without proper or adequate reimbursement, limiting the extent to which efforts can grow and reach the entire Colorado population; and

(j) Disaster behavioral health response differs from traditional psychotherapeutic interventions. The goal is to support normal behavioral functioning and decrease stress, which allows for normal executive functioning of the brain, such as decision-making, problem solving, and cognitive processing. The community behavioral health disaster response coordinator is not a practicing therapist but is instead providing a range of basic services through a tiered response effort that is designed to support normal functioning during and after times of trauma and chaos. The intent of disaster response is to promote individual, family, and community resilience and it helps affected individuals return to a pre-event level of functioning as quickly as possible. Disaster response methods include triage, basic support, psychological first aid, and making appropriate professional referrals in the community. These services are provided both to survivors and first responders, and the actual methods used depend on the type of event, the number of people affected, and the availability of resources.

(2) Therefore, the general assembly declares that it is necessary to formalize the role of Colorado's community behavioral health organizations in the disaster preparedness and response continuum and create avenues for effective and adequate reimbursement for those related activities.

SECTION 2. In Colorado Revised Statutes, **add** part 13 to article 20.5 of title 25 as follows:

PART 13
COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE PROGRAM

25-20.5-1301. Definitions. AS USED IN THIS PART 13, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE PROGRAM" OR "PROGRAM" MEANS THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE PROGRAM CREATED IN SECTION 25-20.5-1302.

(2) "COMMUNITY BEHAVIORAL HEALTH DISASTER RESPONSE COORDINATOR" OR "RESPONSE COORDINATOR" MEANS AN INDIVIDUAL WHO IS DESIGNATED BY A COMMUNITY MENTAL HEALTH CENTER OR OTHER BEHAVIORAL HEALTH PROVIDER TO FULFILL THE DUTIES AND RESPONSIBILITIES OF THE RESPONSE COORDINATOR PURSUANT TO SECTION 25-20.5-1302.

(3) "DISASTER" HAS THE SAME MEANING AS SET FORTH IN SECTION 24-33.5-703.

25-20.5-1302. Community behavioral health disaster preparedness and response program - creation - department duties - rules. (1) SUBJECT TO AVAILABLE APPROPRIATIONS, THE DEPARTMENT SHALL IMPLEMENT THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE PROGRAM USING EXISTING INITIATIVES AND ACTIVITIES TO ENSURE THAT BEHAVIORAL HEALTH IS ADEQUATELY REPRESENTED WITHIN DISASTER PREPAREDNESS AND RESPONSE EFFORTS ACROSS THE STATE.

(2) THE PROGRAM IS INTENDED TO ENHANCE, SUPPORT, AND FORMALIZE BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE ACTIVITIES CONDUCTED BY COMMUNITY BEHAVIORAL HEALTH ORGANIZATIONS, INCLUDING COMMUNITY MENTAL HEALTH CENTERS AS DEFINED IN SECTION 27-66-101 (2); EXCEPT THAT THE ACTIVITIES MUST NOT REPLACE OR SUPERSEDE ANY DISASTER PLANS PREPARED OR MAINTAINED BY A LOCAL OR INTERJURISDICTIONAL EMERGENCY MANAGEMENT AGENCY, AS ESTABLISHED IN SECTION 24-33.5-707. THE ACTIVITIES MAY INCLUDE BUT ARE NOT LIMITED TO:

(a) PREPAREDNESS ACTIVITIES, SUCH AS:

(I) RISK ASSESSMENT, HAZARD VULNERABILITY ASSESSMENTS, AND DISASTER PLANNING;

(II) DEVELOPMENT OF POLICIES AND PROCEDURES FOR DISASTER

PREPAREDNESS AND RESPONSE PLANNING;

(III) IMPLEMENTING DISASTER COMMUNICATION PLANS;

(IV) TRAINING ON AND PRACTICING EXISTING DISASTER PREPAREDNESS AND RESPONSE PLANS; AND

(V) ENGAGING WITH LOCAL AND STATE PARTNERS FOR DISASTER PREPAREDNESS AND MEDICAL SURGE PLANNING;

(b) RESPONSE ACTIVITIES, SUCH AS:

(I) COORDINATION AND RESPONSE WITH LOCAL AND STATE PARTNERS;

(II) SUPPORTING EMERGENCY FUNCTIONS, SUCH AS HEALTH AND MEDICAL RESOURCE REQUESTS FOR BEHAVIORAL HEALTH SERVICES;

(III) TRIAGING PSYCHOLOGICAL OR PSYCHO-SOCIAL CARE FOR AFFECTED INDIVIDUALS;

(IV) PROVIDING IMMEDIATE AND ONGOING SUPPORT AND CARE FOR INDIVIDUALS IN CRISIS IMPACTED BY EMERGENCIES AND DISASTERS, INCLUDING PROFESSIONALS WHO RESPOND TO EMERGENCIES AND DISASTERS AND OTHERS ON THE SCENE OF SUCH INCIDENCES; AND

(V) PROVIDING ONGOING FOLLOW-UP, REFERRALS, AND SERVICES FOR AFFECTED INDIVIDUALS; AND

(c) RECOVERY ACTIVITIES, SUCH AS:

(I) PROVIDING ONGOING DEBRIEFING OPPORTUNITIES FOR AFFECTED INDIVIDUALS AND COMMUNITIES; AND

(II) MAINTAINING CONNECTIONS TO ONGOING CARE FOR AFFECTED INDIVIDUALS.

(3) THE DEPARTMENT SHALL:

(a) PROMULGATE RULES AS NECESSARY FOR THE OVERSIGHT AND

MANAGEMENT OF THE PROGRAM, INCLUDING ALLOWABLE USES FOR FUNDING ALLOCATED FROM THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE CASH FUND CREATED IN SECTION 25-20.5-1303. THE RULES PROMULGATED PURSUANT TO THIS SUBSECTION (3)(a) MUST ENCOURAGE GEOGRAPHIC AND SOCIOECONOMIC DIVERSITY OF PROVIDERS.

(b) WORK COLLABORATIVELY WITH COMMUNITY BEHAVIORAL HEALTH ORGANIZATIONS, INCLUDING COMMUNITY MENTAL HEALTH CENTERS, TO:

(I) DEVELOP AND MONITOR THE EXPECTED DUTIES AND RESPONSIBILITIES OF RESPONSE COORDINATORS;

(II) DEVELOP MEASURES FOR PREPAREDNESS CAPABILITIES AND A METHODOLOGY FOR REPORTING ON OUTCOMES OF UTILIZED FUNDING AND REPORT ON THE OUTCOMES OF UTILIZED FUNDING TO THE GENERAL ASSEMBLY, AS NECESSARY; AND

(III) DECIDE ON AND ANNUALLY REVIEW AND UPDATE, IF NECESSARY, ALLOWABLE USES FOR THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE CASH FUND CREATED IN SECTION 25-20.5-1303;

(c) CREATE, DEFINE, AND PUBLISH ELIGIBILITY CRITERIA FOR COMMUNITY BEHAVIORAL HEALTH ORGANIZATIONS TO PARTICIPATE IN THE PROGRAM, WHICH AT A MINIMUM MUST CONSIDER CAPABILITIES AND CAPACITY IN THE FOLLOWING PROGRAMMATIC ELEMENTS:

(I) SERVICE CAPACITY;

(II) PLANNING;

(III) RESPONSE STRIKE TEAM AVAILABILITY;

(IV) TRAINING; AND

(V) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES; AND

(d) PROVIDE FUNDING TO COMMUNITY BEHAVIORAL HEALTH

ORGANIZATIONS ON AN ANNUAL OR AS-NEEDED BASIS FOR THE ACTIVITIES OUTLINED IN SUBSECTION (2) OF THIS SECTION; EXCEPT THAT FUNDING MUST NOT BE PROVIDED TO REIMBURSE EXPENSES INCURRED PRIOR TO THE EFFECTIVE DATE OF THIS SECTION.

25-20.5-1303. Community behavioral health disaster preparedness and response cash fund. (1) THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE CASH FUND, REFERRED TO IN THIS SECTION AS THE "FUND", IS CREATED IN THE STATE TREASURY. THE FUND CONSISTS OF GIFTS, GRANTS, AND DONATIONS AND ANY OTHER MONEY THAT THE GENERAL ASSEMBLY MAY APPROPRIATE OR TRANSFER TO THE FUND.

(2) THE STATE TREASURER SHALL CREDIT ALL INTEREST AND INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE FUND TO THE FUND.

(3) ANY UNEXPENDED AND UNENCUMBERED MONEY REMAINING IN THE FUND AT THE END OF ANY FISCAL YEAR REMAINS IN THE FUND AND MUST NOT BE TRANSFERRED TO THE GENERAL FUND OR ANY OTHER FUND.

(4) MONEY IN THE FUND IS CONTINUOUSLY APPROPRIATED TO THE DEPARTMENT FOR THE PURPOSES DESCRIBED IN SECTION 25-20.5-1302.

SECTION 3. In Colorado Revised Statutes, 24-75-402, **add** (5)(ss) as follows:

24-75-402. Cash funds - limit on uncommitted reserves - reduction in the amount of fees - exclusions - repeal. (5) Notwithstanding any provision of this section to the contrary, the following cash funds are excluded from the limitations specified in this section:

(ss) THE COMMUNITY BEHAVIORAL HEALTH DISASTER PREPAREDNESS AND RESPONSE CASH FUND CREATED IN SECTION 25-20.5-1303.

SECTION 4. Appropriation. For the 2021-22 state fiscal year, $529,801 is appropriated to the department of public health and environment for use by the office of emergency preparedness and response. This appropriation is from the general fund and is based on an assumption

that the office will require an additional 1.8 FTE. To implement this act, the office may use this appropriation for state directed emergency preparedness and response activities.

SECTION 5. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Leroy M. Garcia
PRESIDENT OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED June 28, 2021 at 11:40am
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Disease Control and Public Health Response Division

COMMUNITY DISASTER BEHAVIORAL HEALTH PROGRAM

6 CCR 1009-12

Section 1: Purpose and Authority

A. The Department shall implement the Community Disaster Behavioral Health Program (Program) using existing initiatives and activities to ensure that behavioral health is adequately represented within disaster preparedness and response efforts across the state.

B. Section 25-20.5-1302, C.R.S. directs the State Board of Health to promulgate rules as necessary for the oversight and management of the Program, including allowable uses for funding allocated from the Community Behavioral Health Disaster Preparedness and Response Cash Fund (Cash Fund) created in section 25-20.5-1303, C.R.S..

C. The Program is intended to enhance, support, and formalize behavioral health disaster preparedness and response activities conducted by community behavioral health organizations, including community mental health centers as defined in section 27-66-101(2), C.R.S.

1. Disaster behavioral health response differs from traditional psychotherapeutic interventions. The goal is to promote adaptive functioning and decrease stress in the shadow of a disaster, which helps to restore executive functioning of the brain, such as decision-making, problem-solving, and cognitive processing. A community disaster behavioral health responder is not a practicing therapist but is instead providing a range of basic services through a tiered response effort that is designed to promote individual, family, and community resilience and helps affected individuals return to a pre-event level of functioning as quickly as possible. Disaster response methods include triage, basic support, psychological first aid, and making appropriate professional referrals in the community. These services are provided to survivors as well as professionals and volunteers who respond to emergencies and disasters and others on the scene of such incidents. The actual methods used depend on the type of event, the number of people affected, and the availability of resources.

2. The activities must not replace or supersede any disaster plans prepared or maintained by a local or interjurisdictional emergency management agency, as established in section 24-33.5-707, C.R.S.

Section 2: Definitions

A. "Community Disaster Behavioral Health Program" or "Program" means the Community Disaster

Behavioral Health Program created in section 25-20.5-1302, C.R.S..

B. “Community Behavioral Health Disaster Preparedness and Response Cash Fund” or "Cash Fund" means the Community Behavioral Health Preparedness and Response Cash Fund created in section 25-20.5-1302, C.R.S..

C. “Community Behavioral Health Disaster Response Coordinator" or "Response Coordinator" means an individual who is designated by a community mental health center or another behavioral health provider to fulfill the duties and responsibilities of the response coordinator pursuant to section 25-20.5-1302, C.R.S..

D. “Disaster" has the same meaning as set forth in section 24-33.5-703, C.R.S. “Disaster” means the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to fire, flood, earthquake, wind, storm, wave action, hazardous substance incident, oil spill or other water contamination requiring emergency action to avert danger or damage, volcanic activity, epidemic, air pollution, blight, drought, infestation, explosion, civil disturbance, hostile military or paramilitary action, or a condition of riot, insurrection, or invasion existing in the state or in any county, city, town, or district in the state.

E. “Department” means the Colorado Department of Public Health and Environment.

Section 3: Allowable Activities

A. Allowable activities funded by the Program may include, but are not limited to:

1. Preparedness activities focused on the response to community needs, such as:

   a. Risk assessment, hazard vulnerability assessments, and disaster planning with jurisdictional emergency partners;

   b. Development of policies and procedures for disaster team preparedness and response planning with jurisdictional emergency partners;

   c. Building and maintaining response team capacity, including training requirements

   d. Implementing disaster communication plans;

   e. Training on and practicing existing disaster response plans; and

   f. Engaging with local and state partners for disaster preparedness and medical surge planning;

2. Response activities, such as:

a. Coordination and response with local and state partners;

b. Supporting emergency functions or operations, such as shelters or health and medical resource requests for disaster behavioral health services;

c. Triaging psychological or psycho-social care for disaster-affected individuals;

d. Providing immediate and ongoing support and care for individuals in crisis impacted by emergencies and disasters, both disaster survivors as well as volunteers and professionals who respond to emergencies and disasters and others on the scene of such incidents;

e. Outreach, psychoeducation, and consulting to response personnel and impacted community groups; and

f. Providing ongoing follow-up, referrals, and services for affected individuals;

3. Recovery activities, such as:

a. Providing ongoing support opportunities for affected individuals and communities;

b. Maintaining connections for referrals to ongoing care for affected individuals; and

c. Demobilization and addressing disaster response team's recovery needs;

4. Any additional activities as deemed appropriate and necessary by the Department.

B. The Cash Fund will be allocated to annual grants for preparedness activities and as-needed applications for response and recovery activities each fiscal year

1. Annual grants will be available to organizations who demonstrate eligibility [See Section 4.] and commit to yearly preparedness activities

2. As-needed applications may be submitted for allowable response and recovery activities following a disaster event

C. The Program will prioritize and fund activities that are not supported by other conditional disaster behavioral health programs and funding.

1. Requests for response and recovery funding from the Cash Fund must demonstrate that other resource requests and sources of funding have been explored, as appropriate to standard emergency management processes, the level of declaration, or the type of disaster hazard. These other resources include but are not limited to:

a. 213 Resource Requests to County Emergency Operation Centers (EOCs)

b. The Colorado Healing Fund

c. The SAMHSA/FEMA Crisis Counseling Program

d. The SAMHSA Emergency Response Grant (SERG) Program

e. Disaster specific funding opportunities or other collaborative grants, such as the Antiterrorism and Emergency Assistance Program grant from the federal Department of Justice

Section 4: Participating Providers Eligibility Criteria, Preparedness Capabilities Measures, and Award Determination

A. All providers who submit requests for participation in the Program must demonstrate capabilities and capacity, or emerging capabilities and capacity, in the following programmatic elements:

1. Service capacity

a. Be able to provide subject matter expertise for supporting people with mental health conditions in disaster incidents.

b. Have existing relationships with Colorado's behavioral health system and behavioral health services to refer individuals in need of higher-acuity or specific behavioral health services.

c. Designate a Disaster Behavioral Health Response Coordinator (Response Coordinator) and back-up Response Coordinator to maintain the responsibilities and duties of the role.

d. Serve the general public of the service area through disaster preparedness and response programming and coordinate response with other community disaster behavioral health program organizations that serve the same communities.

2. Planning

a. Must be in compliance with Centers for Medicare and Medicaid (CMS) preparedness standards within their organization

b. Will maintain relationships (e.g. regular meeting attendance, documented agreements, and plans) with their service area's local and regional emergency preparedness and response (EPR) partners and coalitions, to at least include

i. Local Public Health Agencies (LPHA)

ii. Healthcare Coalitions (HCCs)

iii. Colorado Crisis Education and Response Network (CoCERN)

3. Response Strike Team Availability

a. Can maintain organization continuity while fielding a team of 8+ fully trained Disaster Behavioral Health Responders available for public response in the service area

i. The provider will provide liability coverage for their team's disaster response activities

iI. Can provide a licensed behavioral health professional to support the team

iii. Can maintain team capacity over extended periods of time without a response

4. Training

a. Ensure Disaster Behavioral Health Responders are trained to CoCERN protocol credentialing standards

b. Have representation from the organization at 30 hours of training meetings per year

c. Connect strongly with Local Public Health Agency(ies) in the service area for Emergency Support Function (ESF) #8 planning, training, exercises, and response coordination.

5. Culturally and linguistically appropriate services

a. Provide culturally and linguistically appropriate services as guided by Culturally and Linguistically Appropriate Services (CLAS standards)

b. Maintain community-based relationships that inform, evaluate, and improve culturally and linguistically appropriate practices and capacity

B. The Department will utilize the following measures in assessing preparedness and capabilities of providers:

1. Number of responders with completed CoCERN Disaster Behavioral Health Responder training requirements

2. Designation of organization's Disaster Behavioral Health Response Coordinator and back

up coordinator

3. Ongoing participation in:

   a. Behavioral Health Disaster Coordinators' meetings

   b. CoCERN meetings

   c. Regional and local planning, training, exercise events with HCCs and LPHAs

C. Eligible providers may seek funding from the Department for annual preparedness activities and as-needed response and recovery activities outlined in Section 3 (Activities)

D. The Department will award funding based on need, alignment with the intent of the Program, and a determination of priority.

1. The Cash Fund will not be used in non-disaster programs and will not support other statute or program-mandated duties, such as

   a. Victim Advocate Activities

   b. Mental health or substance abuse treatment

   c. Required school-based services

   d. CMS preparedness requirements or continuity of operations planning

   e. Treatment for mental illness/substance abuse crisis interventions

   f. Mental health first aid training

2. The Program will prioritize and fund program activities that are not supported by other conditional disaster behavioral health programs and funding (e.g. Crisis Counseling Assistance and Training Program available under federal disaster declarations, activities funded by the Colorado Healing Fund)

E. The Department may prioritize awards in a way that promotes the geographic and socio-economic diversity of providers.

F. All requests for funding, and award decisions made by the Department, are publicly accessible and may be utilized in reporting the outcomes of the Program and allocated funds.

G. The Department may request specific data elements be collected by an awarded provider in accordance with the intent of the Program as necessary for reporting on the outcomes of utilized funding.

Section 5: Other Program Management and Oversight

A. Annual Program cycle

1. The Program will be administered through annual grants for preparedness activities each state fiscal year and through as-needed applications for response and recovery activities

    a. Providers interested in participating in the Program will submit and update annually an organizational profile demonstrating that they satisfy organizational eligibility criteria (see Section 3) and confirm their intent to participate in yearly preparedness activities.

    b. The Program will seek diverse geographic and socio-economic coverage by providers.

    c. Providers must participate in preparedness grants in order to apply for as-needed response and recovery funds.

2. The Department will make disaster behavioral health capabilities available for review before organizations submit their intent to participate

B. Response funding allocation

1. A proportion of the annual allocation to the Cash Fund will be reserved for as-needed response and recovery applications.

    a. The proportion reserved for response and recovery activities will be annually determined following the period in which providers submit their intent to participate.

    b. Allowable response and recovery activities will be supported on a first-come, first-served basis

        i. The funds reserved for response and recovery will be evenly spread across fiscal quarters. The Department will track the quarterly drawdown on the reserved funds and set a mechanism by which funding can be moved across quarters in response to need.

        ii. An initial application by a provider to the Cash Fund for response and recovery costs may be capped to expedite initial disbursement in alignment with State procurement protocols. Funding agreements may be supplemented if the additional need is demonstrated, if it aligns with allowable activities and if additional funds are available.

2. If more than one provider serves an impacted area and each wishes to submit an application for as-needed response and recovery activity funding, the providers must collaborate to identify working relationships or activity distinctions.

3. If a provider serves an impacted area and recognizes the need to involve other provider(s) to cover needs, the primary provider may involve the secondary provider(s) as a sub-recipient of the funds they receive.

C. Program Reporting

1. On an annual basis, the Department will report on the following aspects of the Program

a. Provider participation, including number, geographic coverage, and socio-economic reach;

b. Funding dispersed, to preparedness and response activities respectively;

c. Preparedness, response, and recovery activities conducted with Cash Fund support;

d. Any programmatic and funding limits identified, including changes to allowable uses of the Cash Fund;

e. Other measures and capability assessments of disaster behavioral health integration in disaster preparedness and response efforts including;

i. Number of fully trained team members;

ii. County plans with disaster behavioral health integration; and

iii. Number of responses or emergency exercises with disaster behavioral health participation

f. When available, narratives and feedback about disaster behavioral health efforts from key emergency partners, impacted communities, disaster behavioral health providers themselves;

2. The Department will gather information for the annual report through organizational profiles, annual preparedness statements of work, as-needed response, and recovery applications on a fiscal year basis.