NORTHWEST COLORADO COUNCIL OF GOVERNMENTS

Behavioral Health Landscape Assessment

A Stakeholder Assessment and Action Guide

Prepared by GPS | 2026

Northwest Colorado Council of Governments (NWCCOG) of Eagle, Garfield, Grand, Jackson, Lake, Routt, Summit Counties

Table of Contents

Executive Summary

Purpose. This report presents what twenty-four community leaders across nine northwest Colorado communities said about the behavioral health systems they are building, maintaining, and in some cases watching erode. It was commissioned by the Northwest Colorado Council of Governments (NWCCOG), whose six member counties (Routt, Jackson, Grand, Summit, Eagle, and Pitkin) make up the institutional center of the work, and extends into three adjacent communities (Lake, Garfield, Moffat) whose behavioral health systems are operationally linked to NWCCOG counties through shared workforce, judicial districts, federally qualified health centers, and crisis response infrastructure.

Behavioral health services across the NWCCOG region have developed rapidly and independently, with diverse models, leaders, structures, and funding sources. This report is designed to answer key questions: How these services are meeting local challenges, and how sustainable are they? What variables explain relationships, commonalities and differences? Are some models replicable or extensible beyond the region? What should leaders better understand about these local systems that would prevent erosion of services and actually lead to thriving local solutions?

Process. Conversations were conducted between January and April 2026 under an understanding of anonymity, with participants identified throughout this report by role, organization, and county rather than by name. Voices represented include law enforcement, public health, hospitals and federally qualified health centers, community foundations, nonprofit prevention organizations, county leadership, schools, and the office of an elected district attorney. Quantitative data is drawn from public sources (Colorado Department of Public Health and Environment, Colorado Health Institute, Colorado State Demography Office, Healthy Kids Colorado, US Census Bureau) and from organization-reported program statistics with attribution.

The table below maps the key insights surfaced through this report to the primary recommendations that respond to them, with section references for follow-up reading.

Topic	Key Insight	Primary Recommendation	Section
Funding	Federal and state behavioral health funding is contracting simultaneously across multiple streams; communities cannot rebalance the way past cycles allowed.	Build local dedicated revenue mechanisms; pursue collaborative cross-county grant writing; redirect existing tax revenues (marijuana, nicotine) toward behavioral health.	3.2 · 4.4
Workforce	Universal provider shortage, with acute bilingual gaps in communities with significant Hispanic and immigrant populations.	Build training pipelines that grow providers from within the community; invest in regional credentialing and billing-service infrastructure; advocate for commercial insurance parity.	3.2 · 4.1 · 4.4
Contracted CMHC	Inconsistent service delivery from the contracted community mental health center, particularly in Jackson, Moffat, and parts of Grand.	Convene a regional CDPHE/BHA forum on contracted CMHC accountability; document patterns; develop a coordinated regional advocacy ask.	3.2 · 4.6

Topic	Key Insight	Primary Recommendation	Section
Crisis Response	Co-responder model has emerged as regional consensus; success depends on direct employment of clinicians and case-management follow-up, not the idea alone.	Support co-response models with advocacy and funding; convene a co-responder learning cohort across communities at different stages of development.	3.2 · 3.4 · 4.1 · 4.6
Stigma & Reach	Stigma reduction is real but uneven; specific populations (older agricultural workers, Spanish-speaking immigrants, young white men aged 35–45) require targeted approaches.	Support data collection efforts in communities without existing data infrastructure; build engagement through trusted entry points for under-reached populations.	3.2 · 4.5 · 4.6
Champions & Operations	Local champions matter, and the operational staff behind them — clinicians, case managers, peer specialists — is what makes systems durable through leadership transitions.	Invest in the operational layer alongside visible champions; build succession plans; identify and invest in emerging champions before they become system-defining figures.	3.2 · 4.3
Agricultural Engagement	Agricultural communities across Routt, Moffat, Lake, Jackson, and parts of Grand are underserved by formal behavioral health systems.	Partner with the Colorado Farm Bureau to promote the CAAMHP program (six free anonymous sessions with agriculturally competent providers); NWCCOG facilitate event with partners; leverage Farm Bureau and 4-H train-the-trainer models.	4.5

What follows. What follows is organized in four passes: a description of observed operating models, six emergent patterns across communities, a developmental framework for thinking about where each community is investing right now, and a set of innovations and exemplary programs that are worth attention from peers across the region.

1. Introduction and Purpose

Behavioral health systems across northwest Colorado are under simultaneous pressure on several fronts: federal grants contracting in real terms over the past eighteen months, state funding under continuing uncertainty, the contracted community mental health center delivering inconsistently across much of the region, and provider workforces too thin and too expensive to grow on conventional recruitment timelines. Rural counties, where the cost of inaction manifests in jail bookings, emergency room visits, and quiet losses among neighbors, are doing siloed work with limited resources and capacities.

They are also doing the work well in places, and the variety of what's working matters as much as the volume. A sheriff-led co-responder team in one county, built from a community stakeholder group rather than top-down and operating with directly employed clinicians instead of contracted vendors, has cut its county suicide rate by more than half in the six years since launch. In another county, a community foundation has converted memorial gifts following suicide and overdose losses into a managed investment vehicle that now grants seven figures back into local care each year, with the principal still growing. A school district has taken over school-based therapy from a dissolving nonprofit and is heading into a fall ballot vote to sustain it. A federally qualified health center has been running a youth resiliency curriculum inside middle and high school health classes for fifteen years, embedded in regular instruction rather than offered as something separate that students have to opt into.

- ◊ Crisis co-response has reduced a county suicide rate by more than 50% over 6 years
- ◊ Youth resiliency curriculum embedded in regular instruction in middle and high school health classes ensures participation and reach

This report is a synthesis of what twenty-four community leaders said about that mix between January and April 2026. The interview set spans the sectors most active in regional behavioral health: sheriffs and chiefs of police, public health directors, hospital and federally qualified health center executives, community foundation leaders, nonprofit prevention directors, county commissioners and administrators, an elected district attorney with her deputy, school district leaders, and early childhood council staff.

For Your Consideration

As you read through the report, consider the following questions:

- What catalyzed the mental and behavioral health investment in your community, and how does that history shape what exists today?
- What comprises your community's primary mental and behavioral health infrastructure (e.g., key leaders, funding, providers, etc.)?
- How do the sectors most involved in behavioral and mental health like law enforcement and first responders, schools, health care, public health, and nonprofit organizations actually work together in your community, and where do the connections break down?
- Where does your community's behavioral and mental health system end and a neighboring community's begin? Does that boundary reflect how people actually seek and receive care?

1.1 Scope and Boundaries

This report sits at three concentric scopes, and the institutional boundary between them matters for how the recommendations should be read.

Commissioned by NWCCOG (six member counties): The Northwest Colorado Council of Governments commissioned this report, and NWCCOG represents six counties: Routt, Jackson, Grand, Summit, Eagle, and Pitkin. Recommendations directed at NWCCOG as an institution apply to what it can do on behalf of these six member counties, with cross-county convening potential extending naturally to adjacent communities.

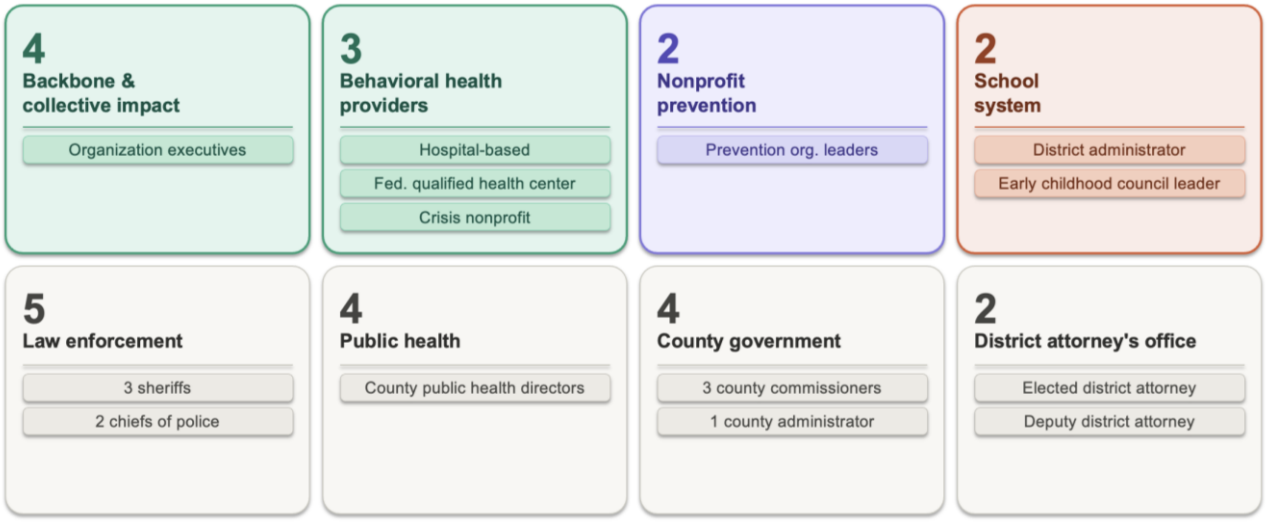
Studied northwest Colorado (nine communities total): Behavioral health systems do not stop at county lines. Workforce, judicial districts, federally qualified health centers, and crisis response infrastructure spill across NWCCOG boundaries in ways that enrich analysis and perspective. Three counties of note appear in the interview set because their behavioral health systems are operationally linked to NWCCOG counties, even though they are not NWCCOG members:

- **Moffat** shares a federally qualified health center and an evolving crisis response model with Routt County, and mining-industry decline has driven a distinct economic and behavioral health profile in the past decade.
- **Lake** shares 5th Judicial District boundaries with Eagle and Summit; bilingual immigrant family services in Leadville anchor much of the county's behavioral health infrastructure; and Aspen Hope Center provides regional crisis response coverage.
- **Garfield (Glenwood Springs):** Glenwood Springs anchors public safety response for what the city's public safety chief described as the highest concentration of unhoused individuals with behavioral health needs on the Western Slope. Aspen Hope Center serves Garfield as part of its three-county operating model.

Referenced for additional context out-of-region examples: References to practices, models, or data from outside the northwest Colorado region are flagged as “out-of-region” and include philanthropic partner work in other parts of Colorado, agricultural community engagement frameworks from the state Farm Bureau, and rural-state examples.

1.2 What This Report Is Based On

Two interviewers conducted twenty-four interviews between January and April 2026, structured around a common question set so that comparison across communities was possible without losing the texture and flow of each conversation. Interviews were conducted under an understanding of anonymity, and throughout this report interviewees are identified by role, organization, and county rather than by name. In tight rural communities role-based attribution is sometimes effectively identifying to insiders, an unavoidable consequence of small populations where there is only one sheriff, one public health director, or one elected commissioner in a given position at a given time. The interview set spans eight distinct sectors, illustrated below:



This report is exploratory and descriptive by design, not an epidemiological study. Quantitative data, including county demographics, suicide rates, and program outcomes, are drawn either from public sources (Colorado Department of Public Health and Environment, Colorado Health Institute, Colorado State Demography Office, Healthy Kids Colorado, organizational annual reports) or from interview-reported statistics. Any decision that requires precise epidemiological analysis should be supplemented with regional public health data work beyond what is in this synthesis.

1.3 Key Questions This Report Explores

Five questions structured the interview set, asked of every participant to allow comparison across communities:

- What are the key funding priorities related to behavioral health — short-term versus long-term, marijuana tax revenues, state and local investment, return on investment?
- What is needed to promote shared services or collaborative models of care, particularly in areas with limited services, providers, or resources?
- Who are the key community leaders for behavioral health — hospitals, public health, nonprofits, law enforcement, schools?
- What do community leaders need to know, or what type of information would benefit regional collaboration?
- How is community awareness and buy-in measured, including stigma reduction?

1.4 How to Use This Report

The report is built for working use over time, not for a single read. Three audiences are in mind: an elected official or county administrator who needs a systems-level picture of what's working and where to act; a program or service director looking for replicable models; and a funder trying to understand where dollars create durable change. Three design elements support that working use:

- **Pull quotes and callouts:** Pulled directly from the interview set and attributed by role, organization, and county. The point of the callouts is to preserve the voice and judgment of the people doing this work, rather than to summarize them into something neutral.
- **Questions for Your Community:** Three to five questions at the close of major sections, designed for use in council meetings, board retreats, or staff sessions. They are anchored in

the conditions of specific communities so that local leaders can adapt them to their own context rather than starting from a generic prompt.

- **Mini case studies:** Three programs profiled at depth: Summit County's SMART Team, Grand Foundation's HOPE Fund, and Eagle County Schools' takeover of school-based therapy. Each are presented with the conditions that make the model work and the caveats that govern replication.

A note on what to read in what order. Section 2 orients the reader to the region and to the specific community context behind each finding. Section 3 is the cross-cutting analysis: read it if you want to know what's true across communities and what's distinctive to yours. Section 4 organizes recommendations around what public leaders can actually do, with discussion questions positioned for working use.

2. Northwest Colorado Communities

This report focuses primarily on nine communities in Northwest Colorado, organized into four geographic clusters with some level of shared workforce, judicial districts, federally qualified health centers, behavioral health facilities, hospitals, first responders or other crisis response infrastructure. It is important to consider the demographic and economic structure, history of behavioral health system development, and specific organizations and unmet needs for each community before appreciating the regional landscape.

This section opens with an at-a-glance regional comparison and then moves through community profiles grouped by geographic cluster: Yampa Valley, Middle Park and North Park, the I-70 Mountain Corridor, and Roaring Fork and Upper Arkansas. Each profile carries a demographic snapshot, a description of the community's behavioral health ecosystem, strengths and challenges in the community's own terms, and a set of discussion questions for local leaders. This section also includes a regional timeline (Section 2.3) and a goal summary by community (Section 2.4).

2.1 Regional At-a-Glance

The population figures in the table below rely on U.S. Census Bureau Population Estimates Program, July 1, 2024 (vintage V2024), while the additional demographic and median income data comes from the American Community Survey 5-Year Estimates, 2020–2024. Income is expressed in 2024 inflation-adjusted dollars.

Community	Primary BH Anchor(s)	Pop. (2024)	Hispanic	Med. Income	NWCCOG
Routt	NW CO Health (FQHC); Health Partnership; Routt Sheriff co-responder	25,243	9.8%	$106,489	Member
Moffat	NW CO Health; Memorial Regional Hospital	13,142	17.6%	$73,849	Adjacent
Jackson	Jackson PH; Middle Park Health; GCRHN subcontract	1,273	13.9%	$47,677	Member
Grand	GCRHN; Grand Foundation HOPE Fund; Middle Park Health	16,154	10.7%	$88,612	Member
Summit	Building Hope Summit; SMART Team; St. Anthony Summit	30,882	17.8%	$109,773	Member
Eagle	Vail Health BH / Hope Center; Speak Up Reach Out; Eagle Schools	54,330	30.9%	$104,096	Member
Pitkin	Aspen Hope Center (also serves Eagle/Garfield)	16,643	11.9%	$102,645	Member
Garfield	Aspen Hope Center; Valley View Hospital; Speak Up Reach Out	63,167	33.7%	$91,131	Adjacent
Lake	Full Circle Youth & Family Services; Elevated Community Health (FQHC)	7,369	34.5%	$96,575	Adjacent

Behavioral health system maturity does not track population size. For instance, the two communities with the most developed systems (Summit and Eagle) are mid-sized, while the largest community in the region (Garfield, at over 60,000 residents) faces some of the highest concentrations of unhoused behavioral health need. Demographic structure shapes which constraints hit hardest and present challenges with solving through general workforce expansion alone. For example, the communities with the highest Hispanic and Latino populations — Garfield at 33%, Eagle at roughly 30%, Lake at roughly 40% — face provider workforce challenges around bilingual capacity that do not exist at the same scale in less linguistically diverse counties.

2.2 Community Profiles

Each profile below carries a demographic snapshot, a narrative description of the community's behavioral health ecosystem, key strengths and challenges in the community's own terms, and a set of discussion questions.

Yampa Valley

Routt and Moffat counties share behavioral health workforce, the region's primary federally qualified health center (Northwest Colorado Health), the Yampa Valley Resource directory, and an evolving co-responder model. Routt and Moffat counties are meaningfully different and should not be treated as one. Routt has a robust nonprofit ecosystem, more mature philanthropic infrastructure, and a politically progressive county environment, Moffat is rural, conservative, and has been reshaped over the past decade by coal mine closures and the slower decline of extractive industries that supported families across both counties for generations.

Routt County [NWCCOG member]

Population (2024)	25,243
Area / setting	2,362 sq mi; resort and ranching economy anchored in Steamboat Springs
Hispanic/Latino	9.8%
Median Income	$106,489
Key economic features	Steamboat Resort tourism; ranching and agricultural base; growing wealth migration
Primary BH anchors	Northwest Colorado Health (FQHC, also serves Moffat); The Health Partnership; Routt County Sheriff Co-Responder Program; Routt County Crisis Support and Routt County Community Crisis Support; Building Better Tomorrow (umbrella)
Distinctive need	Stigma persists among older agricultural workers; recent suicide losses have galvanized local appetite for prevention

Routt has built one of the more functionally networked behavioral health systems in the region without a county-level mill levy, anchored by a federally qualified health center founded over two decades ago that provides safety-net primary, dental, and behavioral health services across both Routt and Moffat counties. The Health Partnership convenes the behavioral health provider community on a monthly cadence, has expanded Medicaid-accepting providers in the valley by ten

in recent years through a billing-support program, and maintains Yampa Valley Resource, a localized 211-equivalent directory that multiple interviewees in other counties referenced as the model for what a regional resource database could look like.

The county's co-responder program went live in September 2025 after roughly three years of design work. A clinician employed by UC Health is paired with a county deputy and a case manager. The clinician position is funded through a Behavioral Health Administration grant that is acknowledged as fragile in the medium term, while the county directly funds the deputy. The case management follow-up function, including supporting individuals after the immediate crisis with appointments, transportation, food assistance enrollment, and root-cause work, is what the Sheriff's Office described as the difference between stabilization and durable change. Caseload is reported at 40 to 50 clients during the October-to-March window, when seasonal demand peaks.

Routt also runs a layered peer support infrastructure that is unusual in the region: a peer support program available to first responders across all county departments (sheriff, police, fire, EMS) with approximately twenty trained peers in rotation, a Routt County Crisis Support function that responds to critical incidents and escalates from peers to licensed clinical social worker (LCSWs) and clinicians as needed, and a parallel Routt County Community Crisis Support that mobilizes for community members affected by incidents. A locally-staffed crisis line called the HOPE Initiative is currently being stood up to supplement 988, which Routt-area leaders described as initially serving callers with non-local operators and inaccurate region-specific information, a problem that seems to be improving nationally but motivated the local-staffing alternative regardless.

Strengths:

- Strong FQHC safety-net infrastructure spanning Routt and Moffat counties
- Active co-responder model with wraparound follow-up built in as a core function rather than an add-on
- Yampa Valley Resource directory in place and operational
- Multi-layered peer support across all first responder agencies
- Established health and human services coalition with 40+ partners

Challenges:

- Co-responder funding fragility: the BHA clinician grant is at risk in the medium term, with no obvious replacement source identified
- Mill levy effort for home health and hospice rejected by commissioners: the FQHC has launched a parallel $3M campaign that will raise approximately three years of operating runway while continuing to pursue the public funding path
- Onerous application process at the human resources coalition relative to the small amounts available for nonprofit funding
- Stigma persistent among older agricultural and ranching populations, requiring different engagement approaches than what works in town

Questions for Your Community

• What would it take to lock in sustainable, non-grant funding for the co-responder model if state funding through the Behavioral Health Administration tightens further?

- The Yampa Valley Resource is held up as a regional model. What would it look like for our community to either contribute to it or build an equivalent?
- The peer support infrastructure across all first responder agencies is unusual. What are the conditions that made it possible, and which of those conditions exist in our community?

Moffat County [Adjacent — non-member]

Population (2024)	13,142
Area / setting	4,743 sq mi; the most geographically isolated community in the region; ranching and extractive economy
Hispanic/Latino	17.6%
Median Income	$73,849
Key economic features	Coal mine closures driving economic and behavioral health distress; ranching and agricultural workforce; oil and gas presence; conservative political and cultural environment
Primary BH anchors	Northwest Colorado Health (FQHC shared with Routt); Memorial Regional Hospital; Moffat County Sheriff
Distinctive need	Documented economic and behavioral health distress from mine closures; deep stigma among older agricultural workforce; limited bilingual capacity in available services

Moffat is the cluster's outlier and one of the more challenging communities in the region to deliver behavioral health services for, partly because the demographic and geographical dispersion make service delivery less efficient and partly because the cultural environment requires different approaches than what works in Steamboat Springs. The economic foundation has been actively reshaped over the past decade by the closure of regional coal mines, which removed well-paid local employment that had supported families across both Routt and Moffat for generations. The politics tilt distinctly more conservative, and substance use and behavioral health framings that are effective in Steamboat often do not land as well in Craig.

Routt-area interviewees were emphatic that Moffat requires different strategies rather than adapted versions of Routt programs. A backbone organization executive in Routt described some shift in substance-use stigma over recent years, while a separate interviewee acknowledged that funded suicide prevention work in the region has not extended dedicated staff into Moffat county. The program covers Routt and a bit of Moffat but lacks the resources for sustained Moffat-specific presence. Religious and ranching community entry points have been identified as more promising than direct behavioral health framing for engagement work in the county, though the operational details of how to use those entry points well are still being worked out.

A Moffat County public health leader framed the central problem as discontinuity of follow-on care, where a resident may be seen once and then wait 30 to 60 days before the next appointment, a gap driven by insurance, timing, and program availability. Provider recruitment and retention are constrained by the cost and scarcity of housing. Substance use treatment and recovery support were also described as major needs along with “spokes” beyond the medication assisted treatment currently available such as groups, check-ins, and accountability structures. Dedicated behavioral

health attention to youth, older adults, and justice-involved residents is an area to explore, with the caveat that telehealth is not the preferred access point. One proposed alternative is to incentivize providers to visit the county for a set number of days each month to increase access to in-person services.

Strengths:

- Cultural cohesion that, once trust is established, supports community-led prevention work
- Shared FQHC infrastructure with Routt; Memorial Regional Hospital as the local anchor
- Porchlight provides MAT and uses a confidentiality-conscious design by providing private, walled parking, effective for lowering the visibility barrier to substance-use treatment
- EAP coverage across the county's largest employers (the county itself, the mining companies, and Memorial Regional Health)
- Supportive public officials who are receptive to creative approaches to improve behavioral and mental health

Challenges:

- Geographic isolation; longest crisis-transport distances in the region for any individual requiring inpatient stabilization
- Economic distress from extractive industry decline that shows up downstream as behavioral health and substance use need
- Substance use stigma reductions emerging in some pockets, but BH stigma remains high overall and is higher among older agricultural workers
- Region-wide BH grants and staffing often do not reach Moffat in practice, even when the funded program technically covers it
- Discontinuity of follow-on care: long gaps between an initial visit and the next,
- Provider recruitment and retention constrained by housing cost and scarcity and the primary Medicaid-serving agency carries a waitlist
- Gaps in health navigation and health literacy and the current navigation tool (Credible Mind) needs sustained funding
- Sustainability risk: when grant funding ends, programs stop and community trust erodes, prompting a shift toward non-federal funding sources

Questions for Your Community

• What are the trusted community entry points in Moffat that could support the people there with behavioral health services?

• Which Routt-based programs serve Moffat in name but not in practice, and what would it take to extend them meaningfully?

• If economic distress is driving behavioral health crisis, where do behavioral health investments need to coordinate with workforce and economic development investments?

Middle Park / North Park Region

Grand and Jackson counties are connected operationally and they are profoundly different in scale and resource. Middle Park Health serves both counties as a critical access hospital network, the Grand County Rural Health Network now subcontracts behavioral health prevention work into Jackson, and the behavioral health workforce moves between both counties. Grand has active

philanthropic infrastructure, an emerging co-responder model with multi-municipal match funding, and a community behavioral health strategic plan now in its third iteration. Jackson has approximately 1,400 residents, talented but capacity-limited public health leadership, and a community mental health center contract that has been delivering well below expectations.

Grand County [NWCCOG member]

Population (2024)	16,154
Area / setting	1,869 sq mi; mountain valleys; resort and ranching economy
Hispanic/Latino	10.7%
Median Income	$88,612
Key economic features	Winter Park Resort; ranching and ag base; second-home market; workforce-housing stress connecting to behavioral health caseload
Primary BH anchors	Grand Foundation HOPE Fund / Building Hope Grand; Grand County Rural Health Network (backbone collective impact organization); Middle Park Health (critical access; Kremmling navigator); Grand County Public Health
Distinctive need	Sudden community-wide events, including the East Troublesome Fire of 2020, COVID isolation, and accidental and suicide losses, have repeatedly stressed BH infrastructure; the relationship between workforce, housing, and mental health drives chronic caseload

Grand County has been actively developing its behavioral health systems, and the catalysts are well-documented. A confluence of events in 2020, including the East Troublesome Fire, COVID-related isolation, and a clustering of suicide and overdose deaths, forced a community-level question about what was happening to people in the county. The Grand Foundation's HOPE Fund emerged from that period, and its design is what makes it distinctive enough to feature as one of the case studies later in this report: a community-philanthropy vehicle that aggregates donations (including memorial gifts following suicide and overdose deaths), invests the principal, and uses investment income plus ongoing donations to fund a voucher program, pay for three provider office spaces, and now seed an emerging co-responder model with a county contribution matched by the towns of Winter Park, Granby, and Fraser. Further, the community is currently implementing the third iteration of a five-year behavioral health strategic plan with thirty strategies built off a community health assessment

Grand County Rural Health Network serves as the collective-impact backbone for Grand County and increasingly for Jackson as well. The organization runs several primary service lines including community health programs, a healthcare voucher program ($93K granted last year, ninety percent of it directed to behavioral health), healthcare enrollment assistance through Connect for Health Colorado, and patient navigation across specialties, alongside peer recovery coordination, high-fidelity wraparound for families with youth in acute behavioral need and convening of a 40-partner Health and Human Resources Coalition.

Grand County Public Health runs the steering committee that produces the BH strategic plan and convenes public health, the Rural Health Network, East and West Grand school districts, and the contracted community mental health center on a quarterly cadence. Core public health funding has

been cut by approximately twenty-five percent in the past twelve to eighteen months, and other federal streams that support workforce development, reproductive health, emergency preparedness have been reduced or eliminated. At the same time, application volume for remaining grants is reportedly two to three times historical averages. The public health department is currently funded at fifty-six to sixty percent from grant funds, down from a seventy-five percent target.

Local law enforcement described the local behavioral health environment as transformed by two structural shifts: the move from informal personal relationships with the community mental health center to formalized and less responsive ones, and the dramatic growth in significant mental illness cases in the past decade. The relationship with Winter Park Resort is a bright spot: the resort proactively engages its EAP and reaches out to local law enforcement for support on employee crises.

Strengths:

- The HOPE Fund mechanism as a replicable model for community philanthropy in service of behavioral health
- Active co-responder development with multi-municipal funding match across the county and three towns
- Backbone organization that provides direct service support along with collective impact convening and connection
- Strong resort employer engagement on workforce behavioral health
- Successful housing-BH integration via Winter Park Housing Assistance Fund and Grand County Assistance Fund

Challenges:

- Public health funding contraction (25% core cut; reproductive health funding eliminated; application competition tripling)
- Behavioral health coalition coordination has been difficult, with competing interests reportedly delaying productive work
- West Grand school district has fewer BH resources than East Grand and is more geographically isolated
- Workforce-housing pressure intersects with behavioral health caseload in ways the system has not yet addressed structurally

Questions for Your Community

• The HOPE Fund is positioned for replication. What philanthropic conditions and community memorial culture made it possible in Grand, and which of those exist in our community?

• What governance structure would help the local behavioral health coalition address competing interests and funding environments to productive collaboration?

• If 56–60% grant-funded is the new normal for rural public health, what is the local funding mechanism that closes the gap?

Jackson County [NWCCOG member]

Population (2024)	1,273 — the smallest county in the region

Area / setting	1,621 sq mi; high alpine basin; ranching and oil/gas economy
Hispanic/Latino	13.9%
Median income	$47,677
Key economic features	Ranching, agriculture, hunting and outfitting; some oil and gas activity; shrinking population; very limited housing market
Primary BH anchors	Jackson County Public Health (one deputy director, 75% time, also serving as a school district nurse); Middle Park Health BH clinic (one day per week, 14 slots, waitlisted); GCRHN SAMHSA youth prevention subcontract; contracted CMHC (Health Solutions West, formerly Mind Springs)
Distinctive need	Smallest county in the region; one staff member effectively holding the public health and partial behavioral health coordination function; technology gaps limiting telehealth viability for older populations

Jackson is an under-resourced community, and its system runs on extremely thin. The county's deputy public health director carries seventy-five percent of public health responsibilities and serves as a school district nurse the remaining twenty-five percent. The community mental health center contract was described in nearly identical terms by local leaders: promises made, promises not consistently kept, no reliable office presence, and kiosk-based telehealth that often fails technically. The CMHC's most recent year-end utilization showed twenty-three people served in Jackson against hundreds served in other counties, a ratio that supports the under delivery characterization.

Middle Park Health, a critical access hospital system, runs a one-day-per-week behavioral health clinic in Walden with capacity for fourteen slots that is consistently waitlisted. The hospital is considering expanding to two days per week if the numbers continue to support it. The Grand County Rural Health Network has subcontracted into Jackson on a Substance Abuse and Mental Health Services Administration (SAMHSA) youth substance use prevention grant (currently in year two of five), and the public health director has facilitated this connection actively. School-district behavioral health capacity is constrained: the school nurse covers a four-hundred-student rural school district by herself, and the licensed psychologist the school district contracted through the community mental health center recently left, and the search for a replacement has been difficult.

Jackson has working partnerships, a five-year SAMHSA-funded prevention program, school district programming, and public health leadership described by the county administrator as the biggest advocate for community behavioral health. What it lacks is depth in any one role. The system runs on one person's capacity and one organization's weekly clinic. The loss of either would create a system gap that cannot be filled internally on any reasonable timeline.

Strengths:

- Sustained five-year SAMHSA youth substance use prevention work delivered through the GCRHN subcontract
- Middle Park Health's weekly behavioral health clinic providing licensed care inside the county
- Public health leadership widely respected by county administration and partners across the cluster
- Trust-based, small-community service model in which coordination is informal but effective

Challenges:

- Single-source-of-trust dynamic creates real system fragility and one person carries an outsized share of the system function
- Contracted CMHC delivering inconsistently; opioid abatement funds reportedly under-targeted to Jackson relative to other counties
- Telehealth and tech adoption is limited for the older population that makes up much of the county's demographic
- No co-responder model; sheriff's office cannot hold individuals in crisis overnight; crisis referrals route to Steamboat, Granby, or Laramie
- Workforce retention is structurally difficult given housing and amenities

Questions for Your Community

• What is the redundancy plan if sole behavioral health resources become unavailable for an extended period?

• If the contracted community mental health center is unable to provide the level of services needed, what is the path to improving the contract?

• Where would Jackson see the most impact from regional shared services: workforce, crisis response, or prevention?

I-70 Mountain Corridor Region

Summit and Eagle counties anchor the I-70 mountain corridor and host the region's two most developed behavioral health ecosystems. Summit built its system through a county-level mill levy, a community-foundation intermediary, and a sheriff-led co-responder team that has now become one of the most studied rural co-responder models in the state (if not the nation). Eagle built its system around a resource-rich hospital, a substantial school district commitment that recently transitioned in scope, and a mature prevention nonprofit that operates across three counties. Communities elsewhere in the region are now explicitly studying both for adaptation.

Summit County [NWCCOG member]

Population (2024)	30,882
Area / setting	619 sq mi; resort economy anchored by Breckenridge, Keystone, Copper Mountain, and Arapahoe Basin
Hispanic/Latino	17.8%
Median income	$109,773
Key economic features	Year-round resort economy; substantial seasonal workforce; meaningful second-home market; strong philanthropic culture rooted in long-tenured community foundations
Primary BH anchors	Building Hope Summit (backbone, mill-levy funded); Summit County Sheriff's Office SMART Team; St. Anthony Summit Medical Center; Family & Intercultural Resource Center (FIRC)

Distinctive need	Specialty gaps in eating disorders and pediatric inpatient care; young adult white male population aged 35–45 emerging as an overlooked at-risk group based on 2025 county suicide data

Summit has built one of the most intentionally designed behavioral health systems in rural Colorado, and the origin story matters because it shaped the design choices that have made the system durable. In 2013, the year Summit lost thirteen community members to suicide, the Summit County Foundation began a behavioral-health special initiative seeded by memorial gifts following the suicide loss of a Foundation trustee whose family then committed to building a community-level response. The initiative formalized as Building Hope Summit. By 2018, the Foundation, county leadership, and a community stakeholder coalition had built the political and substantive case for a public funding mechanism, and the Strong Future Mill Levy was approved by voters with three combined purposes: childcare, behavioral health, and wildfire mitigation. Strong Future funds approximately seventy percent of Building Hope Summit's current budget and reaches nineteen programs across eleven community organizations. Notably, reauthorization is on the ballot in 2028.

Summit County SMART Team 2025

- ◊ 58% reduction in the county suicide rate since the team's inception
- ◊ 682 crisis calls
- ◊ 764 referrals to community partners
- ◊ 1,390 individuals receiving case-manager follow-up
- ◊ 450 mental health assessments completed
- ◊ 89% of contacts stabilized in place
- ◊ 8% involuntarily placed
- ◊ 3% transported to higher level of care
- ◊ 510 hours returned to first responders

Building Hope Summit operates as a system convener rather than as a direct service provider, which is a structural choice. The organization supports the provider community through training, billing service subsidies for new clinicians, credentialing assistance, and continuing education with a mini-grant program. Building Hope Summit also runs a scholarship program covering twelve free therapy sessions where finance is a barrier, aggressively markets behavioral health services and resources, and administers the biennial community and provider survey to provide data-informed perspective on both progress and regression. The organization has staffed up from three full-time positions to seven plus part-time contractors over recent years, a growth pattern its executive director described as the recognition that the operational layer behind programming is what makes the programming durable.

On the law enforcement side, the Summit County Sheriff's Office stood up the SMART Team co-responder model in late 2019, with structural choices that have met the challenges head on: three teams of three, each composed of clinician, deputy, and case manager. The team of three utilize plain clothes and unmarked vehicles to reduce perceived threat in the field, and the behavioral health clinicians are directly employed by the sheriff's office rather than contracted through a vendor. The SMART Team model was built from a community stakeholder group rather than imposed from the top, and case-manager follow-up function is built in as a core component, not an add-on. Reported 2025 outcomes include a 58% reduction in the county suicide rate since the team's inception, 682 crisis calls, 764 referrals to community partners, 1,390 individuals receiving case-manager follow-up, 450 mental health assessments completed, 89% of contacts stabilized in place, 8% involuntarily placed, 3% transported to higher level of care, and 510 hours returned to first responders by relieving them of behavioral-health-related call burden. A separate SMART-

style team operates inside the county jail with reported zero in-custody suicides and substantially reduced assaults since launch, alongside a falling recidivism rate that the sheriff has framed as evidence that the model works inside the jail and in the field.

The Summit County commissioner who also serves on the State Board of Human Services brings a state-policy lens to this cluster. Her perspective is that the Colorado Behavioral Health Administration is likely to evolve in the near future to respond to significant funding pressures. Additionally, the commissioner's substantive critique of rural-relevant regulations is concrete: walk-in crisis center rules are stringent and costly in terms of compliance, creating challenges for rural communities to try innovative models. Mental Health First Aid for elected officials was offered as a low-cost, high-impact entry point for engaging leaders unfamiliar with the field, and she surfaced an inventive rural delivery idea: county staff who already do other small-population inspection work (elevator inspectors, for example) could be cross-trained to deliver MHFA in communities where dedicated trainers are not economically viable.

Strengths:

- Strong Future Mill Levy provides durable, voter-approved local behavioral health funding
- SMART Team statistics are publishable and demonstrate clear return on investment over six years
- Jail-based SMART team is a quietly significant innovation reducing in-custody crisis and recidivism
- State Board of Human Services representation enables strong policy advocacy

Challenges:

- 2028 mill levy reauthorization requires sustained voter education and political will, particularly under any economic downturn
- Specialty gaps persist in eating disorders and pediatric inpatient care
- SMART Team operating at reduced capacity (three teams of three, down from five) due to grant funding instability
- Young adult white male population aged 35–45 emerging as an overlooked at-risk demographic in 2025 county suicide data, with current programming not reaching it

Questions for Your Community

• The SMART Team's outcomes are notable. What are the benefits, for our community, to commit a first responder and a county to a directly-employed clinician model rather than a vendor contract?

• Measure 1A (2018) Strong Future passed in 2018 with a multi-purpose framing: childcare plus behavioral health plus wildfire mitigation. What is our community's equivalent natural coalition for a local BH funding measure?

• If the 2025 county-level suicide data revealed a demographic group that current programming does not reach, would we know? What would change?

Eagle County [NWCCOG member]

Population (2024)	54,330

Area / setting	1,694 sq mi; resort economy anchored by Vail and Beaver Creek; significant year-round residential and workforce populations down-valley in Eagle, Gypsum, and Avon
Hispanic/Latino	30.9%
Median income	$104,096
Key economic features	Vail Resorts; substantial year-round workforce; Latino workforce population concentrated in down-valley communities; strong philanthropic infrastructure via Vail Health Foundation
Primary BH anchors	Vail Health Behavioral Health (integrated outpatient, crisis, and school via Hope Center absorption); Speak Up Reach Out (prevention nonprofit, Eagle/Garfield/Pitkin); Eagle County Public Schools (13 school therapists, district-employed since March 2025); Aspen Hope Center (Pitkin/Eagle/Garfield)
Distinctive need	Largest Hispanic and Latino workforce population in NWCCOG; bilingual provider recruitment and retention is a persistent system constraint that workforce expansion alone has not solved

Eagle's behavioral health system is the region's most developed in terms of clinical depth, philanthropic infrastructure, and school-system integration. Vail Health Behavioral Health, anchored by a hospital health system that has committed a ten-year, approximately $100 million philanthropic investment in behavioral health and regional prevention leadership, operates the Hope Center crisis team (originally a standalone nonprofit, since absorbed into Vail Health), the Precourt Healing Center for complex substance use (modeled in part on Mesa County's approach), school-based therapy supports, and a provider training pipeline. A reported sixty-seven percent reduction in deaths by suicide is attributed to the crisis team's integrated work and the broader Vail Health Behavioral Health model, with thousands of community members accessing services through the system since its inception.

Eagle County Public Schools transitioned the school-based therapy program from the dissolving Eagle River Your Hope Center nonprofit to direct district employment in March 2025. The current configuration is thirteen school therapists and a supervisor at $1.5 million annual cost, with Medicaid and CHP+ reimbursement covering meaningful but partial revenue and foundation grants paying the gap. A fall ballot mill levy override combining teacher pay and school-based behavioral health is the sustainability path through 2028 and beyond. The transition was driven in part by a structural mismatch: when school therapists were employed by Vail Health, the hospital's billing requirements pushed services into private insurance billing that priced families out and limited utilization. District employment removed that barrier and made services genuinely accessible to families across the income spectrum.

Speak Up Reach Out, a regional prevention nonprofit serving Eagle, Garfield, and Pitkin, administers the Eagle HOPE (Helping Our People Elevate) Certification program, a workplace mental health certification that uses a cohort approach with coaching support. The model was built

around the recognition that one-time training does not change workplace mental health practice, whereas the cohort plus coaching structure produces durable change. Adoption barriers like cost and time commitment are real, but the program is built for expansion across municipalities and employers and is a candidate for regional NWCCOG-wide promotion.

Aspen Hope Center, headquartered in Pitkin, also serves Eagle and Garfield with a mobile crisis and fee-for-service model. The organization has built a notable training pipeline for behavioral health providers, nurses, social work students, and others already living in the community work through clinical hours with supervised support, with four of the current twelve to fifteen trainees already hired by the organization. It is one of the more creative answers to rural behavioral health workforce constraints in the region, and the model rests on a recognition that out-of-region recruitment is not the strategy for rural mountain communities, but growing providers from within is. Eagle's law enforcement co-responder model is older than the region's others. Work dating to 2014 through 2016 integrated law enforcement, EMS, and behavioral health into a community response framework that tracked emergency department diversions, avoided hospitalizations, and first responder trauma reduction. The town of Eagle's police chief described first responder behavioral health as 'an untended void' and the regional infrastructure as a strong but insufficient piece of the puzzle.

H.O.P.E Certification is a community-level initiative that brings together cities, counties, and medium to large businesses, nonprofits, associations, and coalitions to learn about and implement best practices for cultivating a caring culture focused on community well-being and leadership role modeling.

Since launching in Colorado, H.O.P.E. has engaged 74 organizations representing more than 40,000 employees through four regional Workplace Wellbeing Summits. Fourteen organizations went on to participate in regional implementation cohorts, and the model expanded further with the launch of a dedicated enterprise cohort for a large regional healthcare provider. To date, Eagle County has 3 organizations with 30 individuals on track for certification.

Strengths:

- Resource-rich hospital health system anchor with sustained philanthropic commitment over a ten-year horizon
- Reported 67% reduction in suicide deaths attributed to the integrated Vail Health Behavioral Health model
- School district has assumed direct ownership of school-based therapy and committed to sustaining it
- Distinctive workforce-cohort certification (Eagle HOPE) and provider training pipeline (Aspen Hope Center)
- Long-running co-responder model dating to 2014–2016, the oldest in the region

Challenges:

- Foundation funding (ten-year, approximately $100M) acknowledged by Vail Health BH leadership as not sustainable beyond its horizon
- Bilingual provider recruitment chronically difficult given the substantial workforce population requiring Spanish-language services
- Commercial insurance does not reimburse case management, care coordination, or neuropsychological screening, all services central to the integrated model

- The fall mill levy override is required for sustainability beyond May 2028

Questions for Your Community

• Vail Health's philanthropic anchor is not replicable elsewhere in the region. What is the structural lesson (beyond the dollars) that other communities can use? How can its robust infrastructure support the region?

• Eagle County Schools took over the school-based therapy program because hospital billing requirements made the school model unviable. Where else in our community does an institutional billing structure prevent good service?

• Eagle HOPE Certification is built for cohort-based workforce mental health change. Which employers in our community would benefit, and what is the path to either bringing the program here or building a local equivalent?

Roaring Fork / Upper Arkansas Region

Pitkin, Garfield, and Lake counties share Aspen Hope Center as a multi-county service anchor, and they share the Roaring Fork Valley and Upper Arkansas Valley as connected geographies. However, their behavioral health profiles diverge substantially beyond that connective tissue. Pitkin is NWCCOG's wealthiest member county and home to Aspen Hope Center's headquarters. Garfield includes Glenwood Springs, the region's most concentrated unhoused population, with behavioral health needs, and is not a NWCCOG member. Lake county is rural and is this region's most under-resourced community with active immigrant family services, a recently lost co-responder program, and no county-funded suicide prevention services.

Pitkin County [NWCCOG member]

Population (2024)	16,643
Area / setting	975 sq mi; resort and second-home economy anchored by Aspen
Hispanic/Latino	11.9%
Median income	$102,645
Key economic features	Aspen Resort; substantial second-home and high-net-worth population; arts and culture economy; growing year-round workforce living in down-valley communities
Primary BH anchors	Aspen Hope Center (also serves Eagle, Garfield); Aspen Valley Hospital; Mind Springs / Health Solutions West contract presence
Distinctive need	Workforce population gap between the high-wealth resident base and the service workforce living in Roaring Fork down-valley communities, with associated commute and access constraints

In addition to the Pitkin County Behavioral Health and Mental Health Strategic Plan that serves as a planning anchor, Pitkin's behavioral health profile is elevated by the Aspen Hope Center, a diversified-revenue nonprofit that provides mobile crisis, school-based services, fee-for-service contracts with hospitals and law enforcement, and an in-house training pipeline. The revenue mix is notable for a rural behavioral health provider: approximately fifty percent from contracts (with hospitals, schools, law enforcement, and others), thirty percent from fundraising, twelve percent

from grants, five percent from outpatient therapy income, with a sliver from investment income. The model demonstrates what diversification looks like in a sector where foundation philanthropy alone has run out as the answer, and the contract-heavy mix means that institutions with budgets pay for the services they need rather than relying entirely on philanthropic subsidy.

The organization runs the same operating model across its three-county service area in Pitkin, Eagle, and Garfield but adjusts service based on local conditions. Western Garfield school districts, for example, have resisted school-based mental health programming, and Aspen Hope has responded by using other entry points (nicotine cessation, social-emotional curriculum embedded in health classes) to build trusted-adult relationships with students rather than insist on behavioral-health-framed access. Commercial insurance reimbursement is named as the missing piece of behavioral health sustainability, for Aspen Hope, for Vail Health, and across the region. Critical services (case management, care coordination, neuropsychological screening, community-based prevention) are not reimbursed by commercial carriers, and provider credentialing takes approximately six months for new clinicians. Both are structural barriers to scaling provider workforce.

Strengths:

- Diversified revenue model that does not depend on any single funder or stream
- Three-county operational reach with model consistency and local-delivery flexibility built into the design
- Workforce training pipeline pulling in nurses and social work students from within the community
- Direct working relationships with hospitals, schools, and law enforcement through contracted services

Challenges:

- Commercial insurance non-reimbursement of core services limits sustainability across the BH provider landscape
- Provider credentialing pipeline (six months) constrains rapid workforce expansion
- Western Garfield school board resistance limits service penetration in part of the service area
- Coverage gap between high-wealth Aspen and lower-income Roaring Fork down-valley communities

Questions for Your Community

• Aspen Hope Center's revenue mix is 50% contracts. Which institutions in our community could meaningfully contract for behavioral health services, and what would unlock that arrangement?

• Where commercial insurance does not reimburse, are there state-level advocacy partners we could join through the Colorado Division of Insurance or the legislature?

• If our schools resist behavioral health programming directly, what are the alternative doors we could use to build trusted-adult relationships with students?

Garfield County [Adjacent — non-member]

Population (2024)	63,167

Area / setting	2,956 sq mi; valley-floor economy anchored by Glenwood Springs and Rifle
Hispanic/Latino	33.7%
Median income	$91,131
Key economic features	Roaring Fork Valley workforce hub serving Aspen and Vail; energy and extractive economy in western part of county; high-traffic I-70 corridor connection
Primary BH anchors	Aspen Hope Center; Valley View Hospital; Speak Up Reach Out; Garfield County Public Health
Distinctive need	Highest concentration of unhoused individuals with behavioral health needs on the Western Slope, particularly in Glenwood Springs

Garfield County's behavioral health profile is complicated by the contrast between its eastern and western halves and by Glenwood Springs's role as a regional service magnet for unhoused populations. The city's public safety department, which combines police chief and fire chief responsibilities under a single department head, manages a population of complex unhoused individuals.

Two recent system losses have created notable gaps in the county's behavioral health response. The Mind Springs (now Health Solutions West) detox facility, into which the city had invested approximately $300,000, closed last year, removing the closest detox capacity for a population that needs it. A community-based fifteen-to-twenty-person wraparound group serving people released from custody disbanded following the retirement and subsequent illness of its organizer. The model had been working, and the city had contracted the organizer for $50,000, but the model depended on her presence, and there was no succession plan when she stepped back. Police department personnel contract for behavioral health support through Code 4 Counseling for officer and EMS peer support while the fire department contracts directly with Aspen Hope. Western Garfield school districts have resisted school-based mental health programming. The county's behavioral health response capacity is functional but stretched, and the public safety chief explicitly named an opportunity to explore the San Francisco Bay Area TRUST model, which pairs the national 988 crisis line with field clinician response, as the kind of approach Glenwood Springs would benefit from but has not been able to stand up.

Strengths:

- Aspen Hope Center provides regional crisis and mobile response coverage across the western Garfield service area
- Valley View Hospital provides emergency mental-health-hold capacity
- Marijuana tax revenues fund some BH investments in eastern Garfield
- Active public safety leadership engaged on co-responder model development conversation

Challenges:

- Loss of Mind Springs detox facility removed nearest detox capacity for a population that needed it
- Disbanded community wraparound group following organizer retirement; no succession plan was in place
- Concentrated unhoused population with severe BH needs

- Western Garfield school district resistance to school-based BH programming
- No formal co-responder model in place; first responders triage in real time without a dedicated clinician partner

Questions for Your Community

• Glenwood Springs needs a co-responder model. What is the realistic funding and staffing path given current public safety budget constraints?

• A community wraparound group disbanded when its organizer retired. What governance structure prevents that pattern across other community-based programs in our county?

• The county's eastern and western halves operate in different BH worlds. What would coordinated planning across that internal divide look like?

Lake County [Adjacent — non-member]

Population (2024)	7,369
Area / setting	377 sq mi; highest incorporated town in North America; mining heritage; high-altitude geography
Hispanic/Latino	34.5%
Median income	$96,575
Key economic features	Climax Mine; growing service economy; substantial Hispanic and Spanish-speaking population concentrated in Leadville; fear of immigration enforcement actively shaping community life in 2026
Primary BH anchors	Full Circle Youth and Family Services (backbone prevention nonprofit, 30+ years); Elevated Community Health (FQHC, new BH director recently hired); Lake County Public Health (6 FTE total); Solvista / Health Solutions West (largely telehealth presence)
Distinctive need	Spanish-speaking immigrant community with documented fear of ICE enforcement shaping help-seeking; recently lost co-responder grant (June 2025); no funded suicide prevention services; bilingual child behavioral health providers effectively unavailable

Lake County is this region’s most under-resourced community and the one carrying the highest population vulnerability concentration. Approximately forty percent of Leadville's population is Hispanic or Latino, much of it Spanish-speaking and immigrant, and in 2026 fear of immigration enforcement is actively shaping how services can and cannot be delivered. The community mental health center presence (Solvista / Health Solutions West) is largely telehealth without bilingual capacity, and bilingual child behavioral health providers are effectively unavailable to the families who need them most.

Full Circle Youth and Family Services has been the backbone organization in Leadville for over thirty years, running a family resource center (rental assistance, diapers, parenting programs, voucher work), a youth mentor program, a youth outdoor programming track, and most recently a new 'Greater Futures' collaborative funded by a $35,000 county Board of County Commissioners unmet-needs allocation in partnership with other local nonprofits. The organization's service approach goes beyond referral: the executive director's framing was that the work is to take the

connection “one step further” because for the population she serves, the gap between a phone number and an outcome is too wide to be bridged by a referral alone.

Local law enforcement trust is fragile, for reasons that are separate from immigration policy, given significant incidents over the prior several years. Full Circle, not the sheriff's office, is the trusted point of contact for immigrant families across the county. The county lost its co-responder grant in June 2025, and there is no replacement in sight. Lake County Public Health runs on six full-time positions total, described by its director as a bare minimum for everything from immunizations to environmental health complaints, and there is no funding for suicide prevention services even though a recent community health assessment placed behavioral health as the top community issue, with Spanish-speaking respondents reporting the lowest behavioral health ratings (an indicator of deep stigma rather than absence of need). Elevated Community Health, the FQHC, runs school programming and provides sliding-scale care.

Strengths:

- Full Circle's 30+-year backbone presence and trusted immigrant resource role
- Elevated Community Health (FQHC) provides safety-net BH services and school programming
- Community health assessment recently completed and baseline data exists for the first time in years
- Supportive Board of County Commissioners funding above-typical share (30–40%) of public health budget

Challenges:

- Co-responder grant lost in June 2025 with no replacement source identified
- No funded suicide prevention services (capacity constraint rather than absence of desire)
- Spanish-speaking child behavioral health providers effectively unavailable
- ICE fear actively suppressing help-seeking and limiting public gathering of the immigrant community
- Law enforcement trust fragile beyond immigration policy reasons, given documented past incidents
- Solvista/HSW telehealth without bilingual capacity limits utility for primary at-risk population

Questions for Your Community

• Lake County's behavioral health access for the Spanish-speaking community is constrained by trust, language, and fear simultaneously. Which of those is the leverage point we can act on most quickly?

• How can Lake County's workers more easily access BH services in neighboring communities where they are employed? What opportunities are available to extend services to Lake County?

• The co-responder grant ended without a replacement. What is the path to either restoring federal or state co-responder funding or building a community-funded alternative?

• Full Circle is the trusted backbone, but a thirty-year-old nonprofit cannot indefinitely substitute for missing public infrastructure. What is the right division of labor between Full Circle and County systems for the next decade?

2.3 Timeline of Behavioral Health System Development

Communities across northwest Colorado have built their behavioral health systems on different timelines, and the catalysts have rarely been linear planning. The table below illustrates key milestones over the past decade, whether it is a passed funding measure, a committed local champion, a community-wide tragedy that forced a reckoning, or other imperatives.

Year	Community	Milestone
2013	Summit	Building Hope Summit launches as a special initiative of the Summit County Foundation following a year of 13 community suicides; memorial gifts from one trustee family seed the fund.
2014–2016	Eagle	Marijuana tax passed; DOLA Peace Officer Mental Health grant; community paramedicine pilot; co-responder work begins at the Hope Center.
2018	Summit	Strong Future Mill Levy passes combining childcare, behavioral health, and wildfire mitigation; formally institutionalizes Building Hope Summit; SMART Team planning begins.
2019	Summit	SMART Team launches as a directly-employed, plain-clothes, three-person team (clinician + deputy + case manager) co-responder model.
2020	Grand	East Troublesome Fire and COVID-19 catalyze community-level behavioral health response; Grand Foundation initiates HOPE Fund concept following memorial gifts exceeding $500K.
2021	Eagle	Vail Health announces 10-year ~$100M commitment to behavioral health (figure attributed to regional prevention leadership); Hope Center crisis team formally absorbed into Vail Health Behavioral Health.
2022	Routt	Routt County Sheriff and partners begin co-responder model planning; The Health Partnership convenes BH provider network; HOPE Initiative crisis line concept emerges.
2023	Grand	Building Hope Grand launches; HOPE Fund begins granting (now $700K+ in cumulative grants); regional QPR training expands.
2025 (March)	Eagle Schools	Eagle County Public Schools assumes ownership of school-based therapy program from the dissolving Eagle River Your Hope Center nonprofit; 13 therapists employed, $1.5M annual cost, runway through May 2028.
2025 (Sept)	Routt	Co-responder program goes live with UC Health clinician; HOPE Initiative selects program director.
2025 (June)	Lake	Co-responder grant ends with no replacement; Full Circle loses key behavioral health funding stream; Elevated Community Health hires new BH director.
2025–26	Region-wide	Federal and state funding contraction accelerates; CDPHE grants reduced (Grand County reports 25% core cut, 56–60%

Year	Community	Milestone
		grant fund landing); opioid settlement funds become an increasingly important lever; community mental health center accountability issues escalate in Jackson, Moffat, and Grand.

Two patterns are visible across the timeline: The developmental arc is not linear, and community-wide tragedies have been more reliable catalysts for system investment than incremental planning has been. Additionally, regression is possible. Term-limited elected officials, retiring single-source-of-trust leaders, and grant cycles all create risk that operates independently of community capacity, which is why succession planning and durable funding mechanisms matter as much as the initial wins.

Community Innovation in Response to CMHC Underperformance

For more than a decade, widespread dissatisfaction with the nonprofit designated as the community mental health center (CMHC) for ten Western Slope counties, including all NWCCOG communities served as a catalyst for independent local investment in behavioral health. Community leaders across the region documented persistent gaps with Mind Springs Health including crisis response teams that regularly failed to dispatch, limited access to outpatient and bilingual services, high rates of psychiatric hospital readmissions, and a lack of transparency around how public dollars were being spent. A 2022 multi-agency investigation confirmed the depth of the problem, finding that nearly half of a sampled group of outpatient clients had received care categorized as posing a "severe, life-threatening impact" (Colorado News Collaborative/CPR, March 2022).

The failure to meet community needs emerged as a documented pattern and prompted some communities to act. Eagle County established Eagle Valley Behavioral Health in 2021, a Vail Health subsidiary and the first new CMHC created in Colorado in several decades, marking the first formal separation from an incumbent CMHC in the state system's 50-year history. Summit County, which had already passed a mill levy in 2018 to fund independent services and created Building Hope Summit, subsequently joined Eagle's new center. Across the region, communities developed co-responder programs pairing mental health clinicians with law enforcement, peer support networks, and locally funded counseling access, filling gaps the CMHC was not meeting.

In April 2025, Mind Springs was acquired by Health Solutions, a Pueblo-based nonprofit with more than six decades of experience and rebranded as Health Solutions West (HSW). That transition represents a meaningful inflection point for the region. Early indications vary by community: some areas have noted improved responsiveness and a renewed commitment to local engagement under new leadership, while the March 2025 closure of West Springs Hospital -- the only inpatient psychiatric facility on the Western Slope -- has increased access barriers regionwide regardless of organizational changes. The degree to which trust has been rebuilt, and the role HSW will play going forward, continues to unfold differently across its service area.

Sources: Colorado News Collaborative / Colorado Public Radio ("Life-threatening errors at mental health center went undisclosed to patients, public," March 2022); Colorado Sun ("Officials say mental health clinic is failing Colorado mountain towns," December 2021).

2.4 Community Behavioral Health Goals for 2026 and Beyond

Each community surfaced specific near-term goals during the interview process. The table below summarizes them by community; the details and context appear in the respective community profiles above.

Community	Noted BH Goals for 2026 and Beyond
Routt	Fully staff and sustain co-responder model; launch HOPE Initiative crisis line; pursue mill levy for home health and hospice (with parallel campaign raising 3 years of operating runway in the meantime); expand peer support across first-responder agencies
Moffat	Begin BH education and awareness work with county leaders; engage through trusted religious and ranching cultural touchpoints; explore substance use stigma reduction campaigns; extend Routt-based prevention staffing into dedicated Moffat coverage
Grand	Launch licensed co-responder model with multi-municipal match; expand Building Hope Grand; streamline HOPE Fund voucher administration; address West Grand school district behavioral health gaps, support implementation of community behavioral health strategic plan initiatives
Jackson	Improve contracted CMHC accountability; expand Middle Park Health BH clinic to 2 days per week; build redundancy into single-source-of-trust public health staffing; continue SAMHSA youth substance use prevention through GCRHN subcontract
Summit	Sustain and reauthorize Strong Future Mill Levy (2028 ballot); maintain SMART Team funding (currently 3 teams of 3); close specialty gaps in pediatric and eating disorder care; expand Katz-Amsterdam data tracking; address young adult white male demographic gap surfaced in 2025 county data
Eagle	Pass fall 2025 mill levy override for teacher pay and school-based BH; expand Vail Health provider training pipeline; develop regional inpatient capacity; continue embedding in judicial and school systems; advocate for commercial insurance parity
Pitkin	Sustain diversified-revenue Aspen Hope Center model; continue training pipeline (12–15 trainees, 4 already employed); advocate for commercial insurance reimbursement of case management and coordination services
Garfield (Glenwood Springs)	Stand up co-responder or TRUST-model response; address unhoused-with-severe-BH population with wraparound services; strengthen western Garfield school partnerships; replace lost Mind Springs detox capacity
Lake	Restore co-responder funding; develop bilingual BH capacity (especially child providers); strengthen community health assessment follow-through; support Full Circle's immigrant outreach; build local LE trust

Questions for Your Community

• Looking across the regional goals, which goals could two or more communities pursue jointly and benefit from collaboration rather than parallel solo effort?

• Which of these goals require state-level advocacy that NWCCOG could lead on behalf of multiple counties rather than each community separately?

• Which goals are at greatest risk if federal or state behavioral health funding contracts further over the next 18 months?

3. Findings: Patterns Across the Region

Section 2 looked at each community on its own terms, with its demographics, anchor organizations, and the specific people holding pieces of the system together. This section seeks to offer findings and insights across all communities organized in four passes: a description of the operating models we observed, six patterns that emerge across communities, a developmental framework for thinking about where each community is investing right now, and a set of innovations and exemplary programs that are worth attention from peers in the region.

3.1 Community Operating Models

Across northwest Colorado, behavioral health systems have not converged on a single design, rather ,communities have built around available assets. Five operating models recur across the region, each with structural conditions that have to be in place for it to function and structural strains that show up when those conditions weaken.

Hospital-Anchored (Eagle / Vail Health Behavioral Health)

In Eagle County, a resource-rich hospital system serves as the foundational infrastructure: providing clinical services, operating the crisis response function (Hope Center, absorbed into Vail Health Behavioral Health), staffing the co-responder partnership with law enforcement, contracting school-based therapy in its early years, and underwriting prevention work through the Vail Health Foundation. The reported 67% reduction in deaths by suicide is attributed to the crisis team's integrated work, and the model offers a degree of clinical depth including acute psych capacity, the Precourt Healing Center for complex substance use, and a training pipeline that no other community in the region can replicate without a similarly committed hospital partner.

What it requires:

- A hospital system that treats behavioral health as a mission-aligned priority, not a cost center.
- Philanthropic infrastructure capable of underwriting services that don't reimburse.
- Care coordination capacity that integrates the hospital with schools, law enforcement, and the broader community.

Where it strains:

- Foundation funding has a horizon (10 years in Vail Health's case), and the model isn't self-sustaining beyond.
- School-based therapy required transfer back to district ownership because hospital billing requirements priced families out, a structural mismatch the integrated model couldn't absorb.
- Commercial insurance does not reimburse case management, care coordination, or neuropsychological screening, services that are central to the integrated approach.

Sheriff-Led Co-Responder (Summit / SMART Team)

Summit County's SMART Team was built from a community stakeholder group in 2019, not handed down from the sheriff's office to its partners. The team operates with three units of three (clinician, deputy, case manager), in plain clothes and unmarked vehicles, with clinicians directly employed by the sheriff's office rather than contracted through a vendor. Reported 2025 outcomes include a 58% reduction in the county suicide rate since inception, 682 crisis calls, 764 community partner referrals, 1,390 individuals receiving case-manager follow-up, and 89% of contacts stabilized in place. What the SMART Team's leadership emphasized is that the model is freely replicable; the sheriff is on a weekly call helping other communities stand similar models up and has explicitly offered to share the design for free.

What it requires:

- A sheriff who is 100% committed: not tolerant, not supportive, but committed.
- A community stakeholder coalition that built the model from the ground up and owns it.
- Direct employment of clinicians (vendor contracts produce friction that the model can't absorb).
- Case management follow-up function as a core component and not crisis response alone.

Where it strains:

- Funding is grant-dependent in the absence of a local dedicated revenue stream; the Summit team has shrunk from five units of three to three due to grant volatility.
- Term limits and sheriff turnover are real risks, partially mitigated by strong community-coalition ownership.
- Federal and state grant landscapes increasingly favor new initiatives over sustaining proven programs, an inverse relationship between program success and funder interest.

FQHC / Safety-Net (NW Colorado Health, Elevated Community Health, Middle Park Health)

Federally Qualified Health Centers anchor the safety net across several communities with primary care, dental, and integrated behavioral health on a sliding scale for uninsured and Medicaid-enrolled residents. Northwest Colorado Health serves Routt and Moffat, has run a homegrown youth resiliency program in middle and high school health classes for fifteen years, and operates the region's only home health and hospice agency. Elevated Community Health (Lake / Eagle) is rebuilding around a newly hired BH director and continues to anchor school programming and sliding-scale clinical services. Middle Park Health, a critical access hospital, operates the one-day-per-week behavioral health clinic in Walden that is consistently waitlisted at 14 slots. The FQHC model carries genuine structural advantages: Medicaid billing eligibility, federal funding floors that are more stable than public health pass-through grants, and primary care integration that lets BH work happen in the context of an annual physical rather than as a separate help-seeking moment.

What it requires:

- Designation, Medicaid billing infrastructure, and federal floor funding.
- A primary care platform that BH can integrate into rather than sit alongside.
- Board willing to tolerate volatility: the FQHC space requires constant rebalancing of revenue sources.

Where it strains:

- Workforce shortages, especially bilingual clinicians for child behavioral health, limit capacity.

- Medicare doesn't come close to covering rural home health and hospice costs, requiring parallel campaigns to keep service lines viable.
- FQHCs cannot specialize in high-acuity BH (inpatient, residential, eating disorders).

Community Foundation / Backbone Organization (Building Hope Summit, Grand Foundation)

In Summit and Grand counties, the system convener is not the hospital, not the sheriff, and not the public health department. It is a community foundation or backbone organization that aggregates funding, runs voucher programs, supports provider training and credentialing, administers community surveys, and operates as a neutral intermediary between government, philanthropy, and providers. Building Hope Summit, funded largely by the Strong Future Mill Levy, reaches 19 programs across 11 organizations and runs the biennial survey that drives the system's accountability loop. Grand Foundation's HOPE Fund, a memorial-gift-to-managed-investment vehicle, has granted approximately $700,000 since 2023 and is now helping seed an emerging co-responder model with multi-municipal match funding. Both demonstrate what a well-governed intermediary can do when it has sustained funding and the right governance to support for-profit and nonprofit providers equally.

What it requires:

- Sustained funding base: voter-approved local revenue, memorial-gift culture, or both.
- Governance that allows the intermediary to be a neutral convener rather than a competitor with its own grantees.
- Operational staffing: Building Hope Summit's growth from 3 to 7 full-time positions reflects the operational layer that program work requires.

Where it strains:

- Dependence on sustained philanthropic or public commitment; a single failed reauthorization could unwind the model.
- Cannot bill Medicaid or commercial insurance, which constrains revenue diversification.
- Coordination complexity grows with program count; risk of duplication with other coordinating bodies.

Nonprofit Prevention / Grassroots (Speak Up Reach Out, Full Circle, GCRHN, Health Partnership)

Prevention-focused nonprofits operate as the connective tissue in communities where the clinical system does not reach, like providing upstream interventions, outreach to populations that distrust formal systems, peer support, and the navigation services that get someone from awareness to appointment. Speak Up Reach Out (Eagle / Garfield / Pitkin) runs suicide prevention work and operates the Eagle HOPE Certification workplace program. Full Circle Youth and Family Services (Lake) is the trusted backbone for an immigrant community whose relationship with formal institutions is fragile by design and by history. Grand County Rural Health Network and The Health Partnership (Routt) operate as collective-impact backbones with substantial direct-service portfolios. These organizations carry the deepest community trust in the system and the most consistent funding instability.

What it requires:

- Deep community trust built over years; this can't be created by a new entrant.

- Cultural and linguistic match to the populations served.
- Tolerance for funding fragility via grant cycles, philanthropic priorities, and federal funding shifts.

Where it strains:

- Without a pathway for clinical reimbursement, services have to be philanthropy or grant funded.
- Burnout among small staffs running programs that reach larger populations than the org size suggests.
- Grant cycles increasingly favor new programs, not sustaining work.

3.2 Recurring Patterns Across Communities

Six patterns consistently recur across communities in this study. They appear regardless of system maturity, anchor organization type, or political environment. Each is described below with the source-attributed evidence behind it, followed by a discussion question that local leaders can take into their own conversations.

1. Funding fragility and the federal/state retreat

Concern about funding fragility is universal across the region, and it has shifted in the past year and a half from background noise to active risk management. Federal and state dollars are contracting simultaneously: core CDPHE funding has been reduced by approximately 25% in the past twelve to eighteen months according to one Grand County public health director, who also reported that her organization is now landing at 56–60% grant-funded against a 75% target. COVID-era workforce development funds carry stop-work orders, reproductive health funding has been eliminated, and Federally Qualified Medicaid revenue is under federal threat. An Eagle/Garfield prevention leader offered the bluntest framing: every state mental health program is on the chopping block.

What makes this pattern more than a familiar austerity story is the compounding effect across funding streams. When one stream contracted in past cycles, communities could rebalance. The current contraction is happening across federal core funding, federal one-time funding (the COVID workforce stream), Medicaid policy uncertainty, state CDPHE pass-throughs, and philanthropic reallocations simultaneously — and it is hitting prevention work first because prevention metrics are hardest to show in short funding cycles.

Questions for Your Community

• If we are landing at 56-60% grant-funded against a 75% target, what are the other revenue mechanisms that close the gap?

• Which of our currently grant-dependent programs would we lose first if funding contracts another 25%?

• What is our two-year plan for a world in which Medicaid behavioral health revenue is unstable?

State of Colorado: Behavioral Health Funding & Administrative Resources

Colorado state level behavioral health funding flows through several primary state-administered channels. The brief descriptions below identify four key agencies' roles along with links to current program and funding information.

Colorado Behavioral Health Administration (BHA)

Established in 2022 as the state's unified behavioral health authority, BHA coordinates policy, funding, and oversight of mental health and substance use services statewide. It administers Colorado Crisis Services, co-responder program grants, federal block grants, and a prevention-to-recovery service portfolio reaching all Colorado communities.

Learn more: Funding opportunities | Programs BHA funds

Colorado Department of Public Health and Environment (CDPHE)

CDPHE administers upstream prevention and early intervention programs aimed at reducing substance use and improving mental health before crisis occurs. The department funds community-level prevention grants (including the EPIC grant program), overdose prevention initiatives, and coordinates with BHA on population-level behavioral health strategy.

Learn more: Prevention funding | Overdose prevention grants

Department of Health Care Policy and Financing (HCPF) — Medicaid

HCPF administers Health First Colorado (Colorado's Medicaid program), the largest single payer of behavioral health services in the state. It funds community-based mental health and substance use services, crisis coverage, Intensive Behavioral Health Services (IBHS), and waiver programs for individuals with serious mental illness.

Learn more: Behavioral health services | Community-based programs

Colorado Attorney General's Office — Opioid Abatement Council

The AG's Office negotiated more than $912 million in opioid settlement funds from pharmaceutical manufacturers and distributors. Funds are distributed through the Colorado Opioid Abatement Council as competitive grants for treatment, recovery, prevention, and crisis infrastructure — with targeted priority for rural and underserved communities.

Learn more: Opioid Abatement Council | Funding opportunities

Current Budget & Funding Context

- **Federal funding loss (2025):** HHS and CDC terminated approximately $250 million in federal health funding to Colorado, primarily from American Rescue Plan Act grants. The BHA identified 60+ programs affected, including crisis resolution teams, peer recovery services, co-responder programs, and services for adults with serious mental illness. (Source: Colorado Public Radio, March 2025)
- **State budget shortfall:** Colorado lawmakers entered the 2025–2026 budget cycle managing a $1.2 billion shortfall, compounded by federal Medicaid uncertainty. The Department of Human

2. Provider workforce shortages: universal, persistent, and getting worse where bilingual capacity is needed

The workforce shortage shows up across every community, with the same pattern: waitlists, clinicians unwilling or unable to accept Medicaid, and challenging recruitment for bilingual (especially Spanish-speaking) providers. One regional prevention executive observed that 50 new therapists had been added in her catchment area without meaningfully changing capacity constraints. This points to the idea that demand is growing faster than supply, and recruitment from outside the region runs into the same housing-cost barriers that limit retention of all professional workforces in mountain communities. The most acute version of the constraint appears in Lake County, where bilingual child behavioral health providers are effectively unavailable to a Spanish-speaking immigrant population that, per a recent community health assessment, reported the lowest behavioral health ratings of any demographic group surveyed.

The structural response, where communities have built one, is the training pipeline. Aspen Hope Center's approach that supports nurses, social work students, and other residents already living in the community move through clinical hours with supervised support, has produced four hires out of twelve to fifteen trainees, and the model offers something that out-of-region recruitment cannot: people who already chose to live here. Building Hope Summit's parallel work on credentialing support and billing service subsidies addresses a different bottleneck with the six-month credentialing timeline and the administrative burden that prevents existing providers from scaling. Neither alone solves the workforce gap and both are necessary.

Questions for Your Community

- Where in our community could we grow our own providers rather than recruit from outside?
- If bilingual provider recruitment is the most acute constraint, what is the multi-year pipeline strategy for bilingual workforce development?
- What administrative burden could a regional credentialing and billing service remove for our existing private-practice providers?

3. Concerns about the contracted community mental health center

Several communities in this study raised serious and consistent concerns about the performance of the contracted community mental health center, currently operating as Health Solutions West following its rebrand from Mind Springs. The pattern, paraphrased from interviews across three counties, includes contracts signed without consistent service delivery, promised office presence that does not materialize, sunk investments in a detox facility, and opioid-abatement-funded programming that has reached only a small fraction of the intended population in at least one county. A Grand County police chief described workforce issues, including clinicians staffing the hotline from outside the county and unfamiliar with the community they were serving.

This is not a small operational complaint. The contracted CMHC is, by state design, the safety-net behavioral health provider of last resort for the broader region. Where it does not deliver, there is no other entity with a statutory mandate to fill the gap, and rural counties bear the consequences through law enforcement absorbing crisis response that should have a clinical partner, through residents driving hours to access services, through opioid abatement funds not flowing to the people they were intended to serve. A regional advocacy effort to CDPHE and the Behavioral

Health Administration for accountability mechanisms is one of the more concrete actions NWCCOG could lead on behalf of the affected counties.

Questions for Your Community

- In our county, what is the experience with the CMHC and what factors contribute??
- Are we tracking opioid abatement spending and service reach in a way that would help us identify areas for concrete actions?
- If we wrote a joint regional letter to CDPHE and BHA requesting accountability mechanisms, what would we ask for specifically?

4. Co-responder model as emerging consensus

The co-responder model (law enforcement paired with behavioral health clinicians for crisis response) is the single most frequently cited needed innovation across the interview set. Summit County's SMART Team is the regional exemplar. Routt County's program went live in September 2025 with a UC Health clinician. Grand County is in active development with multi-municipal match funding through the Grand Foundation's HOPE Fund. Eagle County's co-responder model dates to 2014–2016 and is the oldest in the region. The Sheriff, Memorial Regional Health hospital, and local nonprofits partner to provide crisis response in Moffat county. Glenwood Springs and Lake (which lost its grant-funded co-responder in June 2025) all cited the absence of a co-responder as a critical gap.

What multiple law enforcement leaders converged on, separately, was that the model's success is not about the idea alone. The decisive factors are 100% law enforcement or first responder leadership commitment, direct employment of clinicians rather than vendor contracts, plain-clothes and unmarked-vehicle operation to reduce perceived threat, and case management follow-up that turns crisis response into durable stabilization. A Routt County sheriff echoed the wraparound point: the post-crisis follow-up, whether that bringing someone to a Human Services office to fill out service paperwork, taking them to a pharmacy to pick up medication, or identifying the root cause of repeated crisis episodes, is what reduces repeat calls. Crisis stabilization alone, without that follow-up, produces another crisis call a few months later.

Questions for Your Community

- If we were going to stand up a co-responder model, who is the law enforcement or first responder leader who would commit to it fully? Who would be the community stakeholder coalition partners?
- What is the case-management follow-up function that already exists or could be built in our community to make co-response sustainable?
- How would we fund the clinician position in a way that survives uncertain state funding conditions?

5. Stigma is decreasing unevenly

Across communities with sustained prevention and awareness work, interviewees described real and measurable reductions in stigma particularly among younger people, in resort and hospitality workforce populations, and in communities that have lived through public losses that galvanized

response. A Jackson County administrator's phrasing was that what 'used to be weird' is now everyday language.

However, the unevenness in terms of where stigma is decreasing matters as much as the progress. Stigma remains deepest among older rural residents, agricultural workers, the Spanish-speaking immigrant community in Lake County, and in Moffat's more conservative cultural environment. Within Summit County, the 2025 county suicide data revealed a demographic group not typically on vulnerable-population lists: men aged 35 to 45 and predominantly white. In several communities, stigma surrounding substance use remains persistent, even as acceptance of mental health increases. Tailored approaches are needed for each of these groups and the assumption that general awareness work reaches them does not hold.

Questions for Your Community

- Do we have demographic-disaggregated data on stigma and help-seeking in our community?
- Which populations in our community are not reached by current prevention messaging and what are the trusted entry points for them?
- If our recent suicide data revealed an unexpected demographic concentration, would our current programs reach it?

6. Champions matter and so does the operational layer behind them

Without exception, the communities with the strongest behavioral health systems in this study have a visible, committed champion: a sheriff who is on a weekly call helping others build co-responder teams; a community foundation executive who turned memorial gifts into a managed fund; a public health director who effectively holds her county's system together; a hospital executive who got behavioral health onto the radio and into the institutional priority set.

While champions tend to emerge in response to specific losses, what is less obvious from the outside is that champions alone cannot sustain a system. The Summit County sheriff was explicit on this point: the model works because the community stakeholder group built it and owns it. The Building Hope Summit executive director described her organization's growth as the recognition that the operational layer behind champion-led programming is what makes the programming durable. Strategies that wait for organic champions to emerge will be slow. Strategies that identify and invest in emerging champions and in the operational staff who let champions do strategic work will be faster, and more resilient when champions move on, retire, or term out.

Questions for Your Community

- Who are the champions we already have in our community and what would it take to invest in the operational layer behind them?
- Who are the emerging champions we could invest in now, before they become the system-defining figures?
- What is our succession plan when a current champion retires, terms out, or moves on?

Champions alone cannot sustain a system. Strategies that identify and invest in emerging champions and in the operational staff who let champions do strategic work will be faster, and more resilient when champions move on, retire, or term out.

3.3 Where Communities Are Investing Right Now

Communities across northwest Colorado are at different points in their behavioral health system development, and a useful way to read across them is to ask where each is investing energy right now. The framework below sketches four broad investment stages, with examples drawn from the interview set. It is not linear as communities can advance and regress depending on funding cycles, leadership turnover, and external events.

Investment Focus	Characteristics	Examples	Where to Invest Next
Awareness & Foundation	Building shared understanding that BH is a system issue; identifying community champions; collecting baseline data; connecting to regional resources	Moffat County; sustained work building from constrained capacity in Jackson County	Champion identification, community-level education, connection to regional case studies and shared learning
System Foundations	Strategic plan or assessment underway; one or two anchor organizations stable; grant-funded prevention and crisis response in development; co-responder planning	Lake County; Grand County (in active transition)	Stable anchor org funding, backbone organizational support, peer learning networks, grant writing capacity
System Building	Multiple organizations collaborating; co-responder active; voucher and navigation programs in place; some local funding emerging	Routt County; Grand County (evolving from foundations into building)	Funding diversification, insurance reimbursement advocacy, workforce pipelines, data systems
Integration & Sustainment	Integrated care continuum across providers; local dedicated revenue mechanism; outcomes data demonstrating ROI; training pipeline; strong community buy-in	Summit County; Eagle County	Sustaining funding for what's been built, closing specialty gaps, regional leadership, policy advocacy, supporting replication

Jackson County warrants a specific note within this framework. Reading the framework alone risks reading the placement as a judgment about system quality, but the on-the-ground reality contradicts that read. The investment focus there is not 'awareness' in any meaningful sense. It is building durability into a system with current limitations.

Katz Amsterdam Foundation: Shared Measurement Framework

The Katz Amsterdam Foundation (KAF) has been a key convener and funder of behavioral health innovation across mountain resort communities in Colorado and beyond. Beginning in 2019, KAF brought together behavioral health leaders from Colorado communities -- including Eagle, Summit, Pitkin, and Grand counties -- alongside peers from resort and rural communities across Utah, Wyoming, Nevada, Idaho, Montana, and California. These communities share a distinct set of challenges: elevated rates of substance use and suicide, seasonal and transient workforces, high costs of living that strain both residents and providers, and persistent stigma around seeking help. Through annual convenings and ongoing peer learning, the network has developed joint programs including anti-stigma campaigns, volunteer peer training, and provider education series that have been implemented across multiple communities.

A central product of this collaboration is the Shared Measurement Framework (SMF) -- a common set of outcome areas and indicators developed by a working group from seven initial mountain communities to enable learning within and across the network. The SMF tracks progress across five domains: social dynamics and party culture, behavioral health knowledge and attitudes, provider capacity, access and affordability of care, and adverse behavioral health outcomes. Because much of the data needed to assess mountain community behavioral health systems did not exist in standard sources, the network developed its own community member and provider surveys. In 2022, KAF launched a shared Tableau dashboard to make this data accessible and comparable across communities -- a resource that supports local decision-making, informs funders, and helps communities identify where gaps remain and where progress is being made.

Learn more: katzamsterdam.org -- Supporting a Mental & Behavioral Health Network

3.4 Innovations and Exemplary Programs

The programs below are drawn from interviews across the region and represent practices that other communities have explicitly studied or expressed interest in adopting. Three appear as full mini case studies; the rest are described more briefly. Where a model has clear replication considerations, those are flagged.

MINI CASE STUDY | **Sheriff-Led Co-Responder Team (Summit County SMART Team)**

Built in 2019, the SMART Team operates with three units of three that include a clinician, a deputy, and a case manager who operate in plain clothes and unmarked vehicles. Clinicians are directly employed by the Summit County Sheriff's Office rather than contracted through a vendor. The model originated in a community stakeholder coalition that designed and continues to own it; the sheriff has framed the stakeholder-built origin as the single most important design choice.

Reported 2025 outcomes include a 58% reduction in the county suicide rate since the team's inception, 682 crisis calls, 764 referrals to community partners, 1,390 individuals receiving case-manager follow-up, 450 mental health assessments completed, 89% of contacts stabilized in place, 3% transported to higher level of care, 8% involuntarily placed, and 510 hours returned to first responders by relieving them of behavioral-health-related call burden. A separate SMART-style team

operates inside the county jail, with reported zero suicides and substantially reduced assaults since launch.

What makes it work: Direct employment of clinicians eliminates the vendor friction that other co-responder models have experienced. Plain clothes and unmarked vehicles reduce the perceived threat of the response. Case management is built in as a core function, not an add-on. The community stakeholder coalition that owns the model creates governance redundancy in case of sheriff turnover.

Replication caveats: Sheriff leadership commitment must be at 100%, not at 'tolerant.' Funding stability is the unresolved challenge and the Summit team has shrunk from five units of three to three due to grant volatility. Federal and state grant landscapes increasingly favor new initiatives over sustaining proven programs.

MINI CASE STUDY | Community Foundation Memorial Fund (Grand Foundation HOPE Fund)

The HOPE Fund was conceived in 2020, when the Grand Foundation observed that memorial gifts following local suicide and overdose deaths exceeded half a million dollars. The foundation built a managed-investment vehicle that aggregates ongoing donations (including memorial gifts), invests principal, and uses both investment income and new gifts to fund a voucher program, three paid provider office spaces, and an emerging licensed co-responder model that is now funded jointly by the county, the town of Winter Park, the town of Fraser, and the town of Granby with a Grand Foundation match.

Since 2023, the fund has granted approximately $700,000. An initial $750K corpus matched by city contributions brought the fund to $1M shortly after launch. The voucher program reaches behavioral health users who are underinsured or unable to pay and provider office spaces have helped attract and retain clinicians who would otherwise leave for higher-cost real estate elsewhere.

What makes it work: The memorial-gift mechanism converts community tragedy into sustained philanthropic investment and creates a virtuous cycle in which behavioral health becomes a visible community investment rather than an opaque government program. The foundation's neutral intermediary role allows it to support for-profit and nonprofit providers equally, navigating relationships that government funders sometimes cannot.

Replication caveats: Requires a meaningful philanthropic base. The model is replicable in communities with any philanthropic infrastructure but requires foundation governance that allows the fund to support service providers rather than pursue programmatic priorities of its own.

MINI CASE STUDY | School District Takeover of School-Based Therapy (Eagle County Public Schools)

In March 2025, Eagle County Public Schools assumed direct ownership of the school-based therapy program that had previously operated through the Eagle River Your Hope Center nonprofit, which had dissolved. The current configuration: 13 school therapists and a supervisor, $1.5 million annual cost, Medicaid and CHP+ reimbursement covering meaningful but partial revenue, and foundation grants paying the gap. A fall ballot mill levy override combining teacher pay and school-based behavioral health is the sustainability path through 2028 and beyond.

The transition was driven in part by a structural mismatch. When school therapists were employed by Vail Health, the hospital's billing requirements required private insurance billing that priced families out of services and limited utilization resulting in a school-based program operating inside a hospital billing infrastructure that wasn't designed for it. District employment removed that barrier and made services genuinely accessible to families across the income spectrum.

What makes it work: School districts have direct relationships with families and can deliver services where families already are. Medicaid and CHP+ provide a partial revenue floor that hospital-based delivery did not. The transition was enabled by a $1M inheritance from the dissolving nonprofit and a federal grant that supported credentialing and supervision for trainees moving toward licensure.

Replication caveats: The district has runway through May 2028 only, contingent on the fall mill levy override succeeding. Replicating the model elsewhere requires a district willing to absorb the program and a community willing to identify and approve new revenue to sustain it.

Eagle HOPE Certification (Speak Up Reach Out)

A workplace mental health certification program Helping Our People Emerge (HOPE) trains cohorts of municipal employees in mental health response and recovery-oriented workplace practice. The cohort model with coaching support is meaningfully more effective than one-time training. Priced at approximately $75,000 per cohort of 10 employees, the program produces the kind of durable behavioral change that single-session training typically does not. Adoption barriers like cost and time commitment are real, but the program is positioned for expansion across municipalities and employers and is a candidate for regional NWCCOG-wide promotion.

Building Hope Summit Provider Infrastructure

Distinct from Eagle HOPE Certification, Building Hope Summit operates a portfolio of provider-side supports: scholarships that pay for 12 free therapy sessions for clients where finance is a barrier; a billing service subsidized for new providers' first three months to lower the administrative entry barrier to private practice; credentialing support that addresses the six-month-plus delay between hiring a clinician and being able to bill insurance; and continuing education with a $2,000 mini-grant program for trainings providers identify as useful. One Grand County public health director suggested specifically that NWCCOG explore regionalizing some of this infrastructure across member counties as a workforce-support strategy.

Yampa Valley Resource Directory

A localized 211-equivalent directory maintained by The Health Partnership in Routt County. The directory keeps current contact information, service availability, and access criteria for behavioral health services across the Yampa Valley. Multiple interviewees referenced it as the model for what a regional NWCCOG-coordinated resource directory could look like. The strength of the model is that it is maintained by a backbone organization with direct provider relationships; the contact information stays accurate because providers update it as a condition of participating in convening work.

Routt County Peer Support Infrastructure

The peer support system is for first responders, with approximately twenty trained peers available across sheriff, police, fire, and EMS agencies in the county, plus a Routt County Crisis Support function that responds to critical incidents and escalates to LCSWs and clinicians as needed, plus

a separate Routt County Community Crisis Support that mobilizes for community members affected by incidents. The structured escalation pathway, from peer to LCSW to clinician, is a model for communities working to layer informal and clinical support around acute events.

Vail Health Provider Retention and Training

Two adjacent innovations from Vail Health Behavioral Health: a training pipeline that brings nurses, social work students, and others living in the community through clinical hours with supervised support; and Round River Ranch, an archery and outdoor program for behavioral health providers themselves that has emerged as a creative provider-retention strategy. Both reflect the recognition that out-of-region recruitment is not the answer to rural BH workforce gaps.

Northwest Colorado Health Parallel-Track Funding Campaign

When the Routt County commissioners declined to put a home health and hospice mill levy on the ballot, the federally qualified health center launched a parallel fundraising campaign while continuing to pursue the public funding path. The $3 million campaign is intended to raise approximately three years of operating runway for the at-risk service line; $500,000 was raised through direct asks to the city, county, hospitals, and providers before the main campaign launched. The model is instructive for communities where public funding is uncertain but the service can't wait: raise the private money to buy time for the public conversation.

Aspen Hope Center Diversified Revenue

Among regional BH providers, Aspen Hope Center demonstrates the most diversified revenue model: 50% from contracts (with hospitals, schools, law enforcement), 30% from fundraising, 12% from grants, 5% from outpatient therapy income, and a sliver from investment income. The contract-heavy mix means that institutions with budgets pay for the services they need rather than relying entirely on philanthropic or grant subsidy. For communities trying to move from grant-dependent to institutionally-anchored BH delivery, this is a model worth studying.

Early Childhood Workplace Mental Health (Routt Early Childhood Council)

Funded through an Attorney General's Office Youth Well-Being grant, the Routt Early Childhood Council has delivered a Conscious Discipline program for early childhood educators that combines in-person training with virtual coaching follow-up. The program leader's framing is that the program provides wellbeing support in addition to professional development. 62% of 120 surveyed teachers reported struggling with self-care, only 30% reported balancing work and life. The intervention works partly because it does not require teachers to seek wellbeing services on their own time; the support comes to them as part of their work.

Out-of-Region Reference: TRUST Model

A San Francisco Bay Area model that pairs 988 crisis line dispatch with clinician field response, named by Glenwood Springs's public safety chief as the kind of approach he would build in his community if he could. The TRUST model is out-of-region and operates in a substantially larger urban environment, but the structural idea of a clinical response routed through a non-police number is worth studying as an adjacent design to the law-enforcement-paired co-responder model.

Additional Programs

Eagle County paramedic-delivered mobile detox (in-region). Eagle County paramedics offer mobile detox, free transport to hospital and services, and provide Medication Assisted Treatment in the home for individuals who cannot or will not present to a clinical setting. This extends Eagle's existing community paramedicine work into a substance use modality that other counties in the region have asked about explicitly. It is one of the more concrete answers in the region to the question of how to deliver substance use care to populations who do not trust formal settings or cannot easily reach them.

Telluride voucher model and directory (out-of-region, San Miguel County, CO). Telluride's Behavioral Health Care Coalition operates a voucher program covering up to twelve therapy sessions, with the first six available regardless of income and the next six income-limited and reimburses providers at $125 per 45–60 minute session. The program is funded through a local mental health fund supported by property tax and is administered alongside a resource directory hosted on the Telluride website at roughly $100 per year that allows providers to maintain their own listings. The combination of a sustained voucher program funded by local property tax and a low-cost provider-maintained directory is a model that communities can study.

Gunnison County small-business EAP co-op (out-of-region, Gunnison, CO). Small local businesses in Gunnison County formed a cooperative to buy into an Employee Assistance Program providing six free therapy sessions and other resources for participating employees. In its third year of operation, the co-op reports utilization above ten percent, meaningful for a workforce that conventional EAP programs typically reach at one to three percent. The model addresses an opportunity across the northwest Colorado region where small employers (restaurants, retail, construction) cannot afford standalone EAPs but represent a significant share of regional employment.

Sources of Strength youth peer program (multi-state, with Colorado presence). An evidence-based youth peer support program associated with a reported 29% decrease in suicidal ideation, with Train-the-Trainer capacity available in Colorado and Hope Squads operating in several Colorado school districts. The model is particularly applicable to NWCCOG school districts already running Healthy Kids Colorado surveys, since the survey data provides a baseline against which Sources of Strength outcomes can be measured. Eagle County's prevention nonprofit and Summit's Building Hope work both have natural points of intersection with this model.

Wellness Warriors at Vail Resorts (in-region, Eagle County). Vail Resorts has trained staff members as Wellness Warriors who are peer connectors who help fellow employees navigate available resources and connect to services. The model fits inside a large resort employer's existing workforce structure rather than requiring external behavioral health staffing and offers a template that could be adapted by other resort, hospitality, and service-economy employers across the region.

4. Recommendations

The recommendations in this section are organized around what public leaders can actually do. Each subsection addresses a lever that town managers, county commissioners, mayors, school board members, and sheriff offices control or influence:

- which models are worth replicating in your community
- how to think about governance and where coordination should sit
- what champion variations look like across sectors
- how to diversify a behavioral health funding base
- where state and local advocacy is likely to produce traction
- and what can be accomplished in the next 12 to 18 months versus what requires a three to five year horizon.

Each subsection closes with discussion questions that local leaders can take into council meetings, board retreats, or staff sessions. Recommendations directed at NWCCOG as an institution apply to its six member counties (Routt, Jackson, Grand, Summit, Eagle, Pitkin) and include notes where the recommendation extends naturally to convening with adjacent communities.

4.1 Replicable Models

Five models stand out from the interview set as candidates for adaptation by communities at different stages of behavioral health system development. Below are the recommendation framings and the conditions that make each work (full case studies appear in Section 3.4).

Co-Responder Model (Highest-Priority Replication Opportunity)

The co-responder model is the single highest-priority replication opportunity in the region. Summit County's SMART Team is the regional exemplar; Routt County's recently-launched program and Grand County's in-development version are adaptation examples. The success factors that recur across interviews include: 100% commitment from the first responder leader; direct employment of clinicians rather than vendor contracts; plain clothes and unmarked vehicles to reduce perceived threat in the field; case management follow-up as a core program function rather than an add-on; and a community stakeholder group that builds the model from the ground up and continues to own it. Funding strategies should draw on Behavioral Health Administration co-responder grants, opioid abatement funds, DOLA grants, and local government contributions, but should actively plan for the grant-cycle volatility.

Community Philanthropy / Memorial Fund Model

The Grand Foundation's HOPE Fund that aggregates philanthropic dollars (including memorial gifts) into a managed fund that supports a voucher program, provider spaces, and system-building is replicable in any community with a philanthropic base. The decisive design element is the fund mechanism that promotes sustained investment, and the neutral intermediary role that allows the fund to support providers across the for-profit and nonprofit divide. Communities with smaller philanthropic bases may build hybrid versions that fit their local profiles.

Community Stakeholder Coalition Model

Building Hope Summit's approach, including a broad-based community stakeholder coalition, structured gap analysis at multi-year intervals, and investment of local tax dollars across multiple service organizations represents what coordinated behavioral health system governance can look

like. The specific Strong Future Mill Levy may not be replicable in every county, but the governance model, the data accountability loop, and the multi-stakeholder convening can be adapted. The key replication insight is that the stakeholder coalition precedes the service program: a coalition with shared values and shared data can choose to fund any number of program designs.

Training Pipeline Model

For communities that cannot recruit behavioral health providers from outside, there are several training opportunities worth exploring for adaptation. For example, the Aspen Hope Center's training model requires an anchor organization willing to invest in workforce development at the cost of immediate billing revenue, and pairs well with Building Hope Summit's parallel work on billing service subsidies and credentialing support. Another area to investigate are partnerships, licensure, and supervision models between local organizations and institutions of higher education. The clearest signal from interviewees was that growing local behavioral health workforce is more effective and sustainable than recruiting from the outside.

Parallel-Track Funding Campaign

Northwest Colorado Health's response to a failed mill levy effort is a useful adaptive strategy for communities where the political environment is not yet ready for a tax measure. The model assumes that public funding remains the long-term answer but accepts that private funding can buy the time required for that conversation to mature. It also requires being publicly candid about which services are at risk, a communications choice that creates short-term staff anxiety but builds long-term donor and voter confidence.

Questions for Your Community

- Of these five models, which one best fits the conditions in our community right now and which one would we be aspiring to in five years?
- What conditions would we need to put in place over the next 18 months to make our chosen model viable?
- Where could two or more communities in this region partner to replicate one of these models jointly rather than separately?

4.2 Governance: Centralized or Distributed?

The governance question that recurred across the interview set is where coordination and ownership of behavioral health work should sit, and the consistent answer is that neither full centralization nor decentralization works. NWCCOG's role, on this evidence, is to serve as a regional convener and shared learning hub. At the county level, each community has an identified backbone organization (public health department, nonprofit, community foundation, or similar) that maintains a strategic plan, coordinates funding applications, and convenes local stakeholders. Direct service delivery should sit with community-specific organizations that have the trust and capacity to do the work and the regional layer should not attempt to own or operate services.

Several interviewees were explicit about a related point: cross-county collaboration strengthens grant applications and builds the relationships that make the rest of regional work possible. One Speak Up Reach Out executive described an OGVP grant application as substantially stronger because Summit and Garfield applied jointly; The Health Partnership in Routt described EPIC

grant coordination as both winning the funding and surfacing the cross-county relationships that now support other work. Where possible, grant applications for regional initiatives should require cross-county collaboration. The secondary effect of that requirement is that the relationships outlast any particular grant cycle.

Cross-county collaboration strengthens grant applications and builds the relationships that make the rest of regional work possible.

Questions for Your Community

- What would we ask the backbone organization in our county to do that they aren't already doing?
- Where could our county join a cross-county grant application in the next 12 months that we wouldn't have considered on our own?
- What is the relationship between our local backbone organization and NWCCOG's regional convening role and where does that relationship need clarification?

4.3 Champion Variations

The champion role looks different depending on which sector leads in a given community, and each variation carries distinct advantages and challenges. The table below summarizes the variations observed across the interview set, with examples drawn anonymized by role and county.

Champion Type	Northwest Colorado Examples	Strengths and Challenges
Public Health Director	Grand County PH director; Jackson County deputy PH director; Lake County PH director	Statutory role with data access and prevention focus; community trust; close to upstream interventions. Limited clinical authority; small staffs; rarely 24/7 crisis-response capable.
Hospital / Health System Leader	Vail Health BH (Eagle); Middle Park Health (Grand / Jackson)	Clinical capacity; Medicaid billing infrastructure; sustainability through hospital balance sheet; training pipeline. Requires hospital institutional commitment to BH as mission; not universally available.
Community Foundation / Backbone Org Executive	Grand Foundation (Grand); Building Hope Summit (Summit)	Neutral convener; can fund multiple providers; philanthropic leverage. Not a service provider directly; dependent on sustained fundraising; governance complexity.
Law Enforcement	Summit County Sheriff's Office; Routt County Sheriff; Hayden Chief of Police	24/7 crisis response capacity; political credibility on safety questions; co-responder model leadership. Term limits; cultural stigma within law enforcement; not health-focused by training.
Nonprofit Org Executive	Speak Up Reach Out (Eagle/Garfield/Pitkin); Full	Deep community trust; upstream prevention focus; reach into populations clinical

Champion Type	Northwest Colorado Examples	Strengths and Challenges
	Circle (Lake); The Health Partnership (Routt), Grand County Rural Health Network (Grand)	systems don't serve. Chronic funding instability; no clinical reimbursement; burnout risk.
Operational Layer / Frontline Workforce	SMART Team clinicians and case managers; Building Hope Summit operational staff; peer support specialists; school-based therapists	Make champion-led programs durable; provide continuity through champion transitions; embedded relationships with the populations served. Often invisible in funding conversations; conflated with 'overhead' rather than essential infrastructure.

Recommendation: investment should reach beyond visible executive and elected champions to the operational layer, including clinicians, case managers, peer support specialists, and frontline workers. This operational layer makes champion-led programming durable through inevitable leadership transitions.

Questions for Your Community

- Looking across these six champion types, which exist in our community already and which would we need to develop?
- Where is our operational layer thinnest and what would it take to build it?
- When our current champion transitions out of role, who carries the work forward, and how is that succession being prepared?

4.4 Funding Strategies and Diversification

Given the contraction visible in federal and state funding, communities should pursue an intentionally diversified funding strategy. Six pillars emerged across the interview set, each with distinctive strengths and trade-offs.

Local Dedicated Revenue (Most Durable)

The Strong Future Mill Levy in Summit County is the clearest evidence in the region of what local dedicated revenue produces over time: stability, voter accountability, and the political legitimacy to do system-building work. Similar mechanisms could be pursued in other counties, with support for ballot language development, public education campaigns, and post-passage implementation drawing on Summit County's 2018 experience. Eagle County's existing marijuana tax allocation and the Eagle Schools mill levy override effort (covering teacher pay and the 13 school therapists) provide additional regional models. A toolkit for communities pursuing local behavioral health funding measures including template ballot language, ROI analysis frameworks, communications and stakeholder coalition building lessons is one of the more concrete deliverables to support behavioral health systems.

Opioid Settlement Funds (Time-Limited but Significant)

Opioid abatement funds are flowing to counties through state and national settlement agreements. These, like many marijuana funds, emerged as one-time, time-limited dollars, but they are substantial and can be directed to co-responder programs, peer support, and workforce development. Advocacy for flexible use of these funds is important, along with supporting communities in developing strong spending plans.

Commercial Insurance Reimbursement (Underutilized)

Multiple interviewees at Vail Health Behavioral Health and Aspen Hope Center in particular identified commercial insurance reimbursement as the missing piece of behavioral health sustainability across the region. Current commercial reimbursement does not cover critical services including case management, care coordination, and community-based prevention. Building Hope Summit's work on billing service subsidies and credentialing support for new providers addresses one side of the bottleneck. Collective advocacy with the Colorado Division of Insurance and the state legislature on parity issues could address the other. Convening regional providers could develop a joint advocacy agenda specific to mountain and rural communities.

Collaborative Grant Writing

Multiple interviewees described collaborative grant applications where multiple counties or organizations apply jointly as both more competitive and more relationship-building than single-applicant approaches. The OGVP grant (Summit-Garfield collaboration), The Health Partnership's coordination on the EPIC grant, and the SAMHSA youth prevention subcontract running through GCRHN into Jackson are all examples of cross-county collaboration that strengthened the grant and the relationships behind it. Valuable support includes convening co-applicants or communities to develop regional grant strategies and seeking and disseminating upcoming grant opportunities broadly.

Tax Revenue Redirection

Specific revenue-redirection asks emerged from interviewees in the schools and prevention sectors and warrant consideration. Marijuana tax revenue currently flows into general funds in some municipalities rather than to behavioral health. Nicotine tax revenue is currently captured into general funds in some communities rather than prevention. School resource officer positions could be funded out of prevention dollars rather than general public safety budgets, creating space in those budgets for non-officer behavioral health spending. Supporting coordinated advocacy across local communities for consistent county-level allocation of marijuana, nicotine, and other dedicated tax revenues to behavioral health and prevention purposes is a meaningful approach.

Workaround Funding Models

Several creative funding mechanisms emerged that can bridge gaps in the formal system: I-Matter, the state voucher for youth therapy, which several interviewees said should be more widely promoted and enrolled; Second Wind Fund, a private foundation that covers mental health costs for those who cannot afford care; Olivia's Fund and similar memorial funds that convert community tragedy into sustained philanthropic investment; pro-bono and reduced-fee provider networks like Building Hope Summit's scholarship model that pairs 12 free sessions with credentialing support for participating providers; and state indigent behavioral health programs that should be mapped and promoted more widely across the region.

Questions for Your Community

- If we were to pursue a local dedicated BH revenue measure in our county in the next four years, what is the coalition that builds the case for the ballot?
- Where are our marijuana and nicotine tax revenues currently going and what would it take to redirect a portion to behavioral health?
- What is our county's plan for the post-opioid-settlement funding cliff, and who is convening that conversation?

4.5 Policy and Advocacy Opportunities

NWCCOG has an opportunity to serve as a regional advocacy voice on behavioral health policy at both the state and local levels. The priorities below emerged explicitly from the interview set.

State-Level

- Sustainable BHA co-responder funding came up repeatedly: dedicated, ongoing state funding for co-responder programs rather than one-time grants, advocated through the Behavioral Health Administration. The Summit County sheriff made this request explicitly.
- Several interviewees raised concerns about the performance of the contracted community mental health center and a coordinated regional approach to CDPHE and BHA on performance accountability mechanisms including rural service delivery reporting, contract compliance, and service utilization by county is a concrete advocacy ask.
- Commercial insurance parity for case management, care coordination, and community-based prevention is the closest thing to a structural fix for the sustainability gap; legislative work and Colorado Division of Insurance engagement are both available paths.
- State regulations limiting flexibility in rural service models particularly walk-in crisis center regulations warrant advocacy for tiered regulatory frameworks that allow innovation in frontier and rural settings.

Local and Business Community

Resort and hospitality industry engagement is a natural extension of the workforce behavioral health conversation. The seasonal workforce in resort communities has documented high behavioral health needs and low access to consistent services. Building on the existing Vail Resorts model, NWCCOG could coordinate the development of a resort employer engagement framework covering EAP support, co-responder coordination, and workforce mental health investment, applicable to ski resorts but also to the broader hospitality and service economy.

Agricultural community engagement is the other under-developed sector. Routt and Moffat counties and parts of Lake, Jackson, and Grand have significant agricultural populations with high stigma and low access to behavioral health services, a combination that conventional behavioral health programming has not closed. One existing partner organization specifically designed for this population is worth surfacing as a regional resource: the Colorado Agricultural Addiction and Mental Health Program (CAAMHP), co-administered by the Colorado Farm Bureau and the Colorado AgrAbility Project at Colorado State University. CAAMHP provides six free, anonymous therapy sessions with an agriculturally competent licensed provider, accessible by telehealth which matters in a population whose most stressful seasons are also their busiest and whose ability to leave the operation is constrained. More than thirty clinicians have completed the agricultural-

competency training to date, with roughly ten to fifteen currently practicing under the program, and over two hundred medical professionals (physicians, nurses, EMTs, hospital administrators) plus several rural pastors have completed a shorter version of the training, meaning the program has built a regional referral network beyond its own clinician panel. NWCCOG could partner with the Colorado Farm Bureau on a Western Slope-targeted promotion of CAAMHP through Farm Bureau train-the-trainer activities, 4-H partnerships, and NWCCOG's existing Economic Day event, leveraging the trust the Farm Bureau already holds with ranching and agricultural communities to reach a population that the formal behavioral health system has consistently underserved. Program information is available at coloradofarmbureau.com/caamhp.

Elected official education is the simplest and possibly highest-leverage local advocacy investment. Multiple interviewees called for formal mental health education for elected officials including county commissioners, town council members, and school board members. Mental Health First Aid training is the most concrete starting point, and one Summit County commissioner suggested an inventive rural delivery strategy: cross-training the county staff who already do other small-population inspection functions (elevator inspectors and similar) to also deliver MHFA in communities where dedicated trainers are not economically viable.

Questions for Your Community

- Which of the state-level advocacy priorities is most relevant to our county, and where would we add our voice to a regional NWCCOG-led ask?
- What is our community's relationship with the local Farm Bureau or 4-H and could behavioral health content be welcomed into convenings they already host?
- When would we host a Mental Health First Aid or other behavioral health training for our elected officials, and who would attend?

4.6 Short-Term Wins (12–18 Months)

The following actions are achievable within twelve to eighteen months with the right partnerships and committed participants.

Action	Description
Regional BH Resource Database	Build on the Yampa Valley Resource model maintained by The Health Partnership in Routt to develop a regional version maintained by a backbone organization with direct provider relationships, distributed widely to law enforcement, schools, employers, and community members.
Mental Health First Aid for Elected Officials	Coordinate a series of mental health training sessions targeting county commissioners, town council members, and school board members across northwest Colorado. Partner with Building Hope Summit or Speak Up Reach Out for delivery. Consider the county-staff-as-trainers model raised in interviews to extend reach into smaller communities.
Co-Responder Learning Cohort	Convene communities at different stages of co-responder development — Summit as the model, Routt as the recent launch, Grand as the in-development version, others in early planning — for regular peer exchange. Document what's transferable and what's context-dependent.

Action	Description
Grant Opportunity Mapping	Develop a forward-looking calendar of grant opportunities relevant to behavioral health in rural Colorado (SAMHSA, DOLA, BHA, opioid settlement, AG office, private foundations). Share with member communities to enable coordination and avoid duplicative applications. Identify candidates for cross-county joint applications.
CMHC Service Delivery Forum	Convene a regional forum on contracted community mental health center service delivery concerns. Document patterns of concern from affected counties and develop a coordinated regional advocacy approach to CDPHE and BHA requesting accountability mechanisms.

4.7 Long-Term Marathon Opportunities (3–5 Years)

The following represent longer-horizon opportunities that require sustained investment, political will, and regional coordination.

Opportunity	Description
Regional Inpatient Capacity	Multiple interviewees noted that inpatient and residential BH capacity remains inadequate across the region. A regional approach, possibly anchored by Vail Health's existing acute psych facility, could serve communities that currently transport patients to Denver, Pueblo, or Grand Junction, all of which involve hours of law enforcement or family time and remove the patient from local support networks during the most stabilizing phase of recovery.
Workforce Pipeline Development	Build a regional behavioral health workforce pipeline modeled on Aspen Hope Center's training approach and Building Hope Summit's credentialing infrastructure. Recruit locally, provide supervised training hours, and offer loan repayment plus housing support to attract clinicians to mountain communities. Bilingual workforce development should be a distinct, funded line within the broader pipeline.
Dedicated Local Funding in More Counties	Support Grand, Lake, Garfield, and Moffat counties in developing local behavioral health funding mechanisms like mill levies, special districts, and earmarked marijuana revenues modeled on Summit County's Strong Future initiative with adaptations for each county's political and economic environment.
Regional Co-Responder Network	Develop a regional co-responder network with shared training, data systems, and cross-county coverage agreements, building on Summit County's SMART Team model and the NWCCOG convening role. Cross-county coverage matters especially in lower-population counties where standing up a fully independent team is not viable.
Insurance Advocacy and New Billing Models	Work with the Colorado Division of Insurance and the state legislature to expand reimbursable behavioral health services including case management, care coordination, community-based prevention and develop a regional billing and credentialing support service that enables more providers to accept insurance across the region.

Opportunity	Description
Cross-State Wyoming Collaboration	Multiple interviewees from Jackson and the Eagle/Garfield prevention sectors noted interest in collaboration with Wyoming communities that face similar rural behavioral health challenges. Piloting a cross-state learning exchange could reveal learning and collaborative opportunities, recognizing that the state-policy environments differ but the on-the-ground service realities overlap.

Questions for Your Community

- Of these short-term and long-term actions, which two or three would create the most visible value for our community in the next 18 months?
- What would it take for our county to be one of the early adopters of the regional BH resource database or the co-responder learning cohort?
- Where in the long-term list could our community contribute leadership rather than wait to receive?