DEPARTMENT OF HUMAN SERVICES
FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA
SERVICES FOR PEOPLE WITH DISABILITIES AND OFFICE OF BEHAVIORAL HEALTH

Thursday, December 14, 2017
1:30 pm – 5:00 pm

SERVICES FOR PEOPLE WITH DISABILITIES

1:30-1:40 INTRODUCTIONS AND OPENING COMMENTS

- Reggie Bicha, Executive Director
- Mark Wester, Director, Office of Community Access and Independence
- Sarah Wager, Director, Office of Administrative Solutions
- Sarah Sills, Director, Division of Budget and Policy

1:40-1:50 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM POLICY

1 Please describe, in detail, the vision and direction for the IDD system in the State of Colorado. (For example, what should this system look, how should it be structured, and how should it function?). Given the changes that have occurred, and are underway, what next steps should be taken to ensure that the system adequately and appropriately serves people with intellectual and developmental disabilities within the context of this vision?

Section 27-10.5-301, C.R.S., directs the Department to operate regional center services for people with developmental disabilities (IDD) in Grand Junction, Pueblo and Wheat Ridge. The Department's vision for regional center operations is to provide an intensive therapeutic environment designed to address the significant support needs presented by individuals referred for regional center services. This targeted therapeutic treatment approach is focused on restoring the individual's ability to succeed in a community-based setting.

Over multiple decades, community IDD services have become more sophisticated, comprehensive, and available. As a result, the need for regional center services has declined. CDHS anticipates this trend to continue. Even so, the regional centers currently fulfill an important role in the larger IDD continuum of services. Regional centers provide intensive supports in order to address the needs of individuals with the most acute conditions. The Department will continue to operate the regional centers until their services are no longer needed.

The intent is for the regional centers to stabilize these individuals so that they can return to their community of choice. Referrals to the regional centers generally fit into three broad categories of presenting needs in addition to their diagnosis of IDD, as described below:

- **Complex medical needs**—individuals with severe, complex medical problems who are high risk for deteriorating into life-threatening acute situations. These individuals may also require long-term health monitoring. This category represents residents admitted prior to 2013.

- **Severe behavioral/psychiatric crisis**—are individuals who exhibit severe and complex behaviors and psychiatric distress, such as self-injurious, physically aggressive and extreme property destruction behaviors. Such individuals often have co-occurring mental illness, may require an intensive level of supervision and often have a history of unsuccessful placements with private providers.

- **Problematic sexual behavior, or danger to other**s—individuals in this category pose a significant community safety risk. They require treatment in an intensive therapeutic setting, requiring immediate, restrictive, and/or emergency interventions. Wheat Ridge Regional Center maintains a highly therapeutic setting for people in this category, separate from other regional center residents.

Regional centers currently serve approximately 265 adults with complex medical and severe behavioral/psychiatric needs. Services provided 24-hours/day include residential, medical, and behavioral supports. Residential services are provided in small group homes, some licensed as Home and Community Based Services (HCBS) and others licensed as Intermediate Care Facilities for the Intellectually and Developmentally Disabled (ICF-IDD).

Table 1, below shows the number of referrals and admissions the regional centers have received from the community over the 12 months.

Table 1: Regional Center Referrals for Admission and Admissions by CCB from October 2016 through October 2017

CCB	Referrals	Admits
DDRC	3	2
Developmental Pathways	10	7
Envision	2	0
Foothills Gateway	1	1
Imagine	1	1
Inspiration Field	1	1

Table 1: Regional Center Referrals for Admission and Admissions by CCB from October 2016 through October 2017		
CCB	**Referrals**	**Admits**
MDS	5	4
North Metro	6	4
Rocky Mountain Human Services	9	5
Southeastern	1	1
The Resource Exchange	7	8
Total	46	34
Source: CDHS C-Stat Data		

2 Through what process does the department analyze the initiatives included in, but not limited to those identified in Appendix E of the briefing document, to determine the impact of each one on any other initiative and on the IDD system as a whole? Are the changes resulting from these initiatives leading to the achievement of the vision described above, or are they impeding the process? Are there additional unfunded federal mandates that should be included in the department's analyses of initiatives? Does the Department have enough resources (staff and time) to perform the necessary analysis?

Table 2 is a summary of the components of system change from Appendix E that has affected CDHS over the last several years. The Department does analyze initiatives from the frame of services implementation.

Transfer of IDD to HCPF

Since the transfer of the Division for Intellectual and Developmental Disabilities to HCPF, CDHS no longer providers oversight of CCBs, except as it relates to early interventions, or the larger IDD service delivery system.

The Department functions as a public service provider in the IDD services system. As a service provider, the Department analyzes initiatives from the frame of service implementation. From that end, CDHS is impacted by several of the initiatives included in Appendix E of the HCPF briefing document, as any other service provider is impacted. Of the greatest impact are the following:

Table 2: Significant Policy Changes to the IDD System which impact the Department of Human Services as of 2017		
Topic	**Date**	**Impact on Department of Human Services**
Olmstead ruling - U.S. Supreme Court decision based on the Americans with Disabilities Act	1999	CDHS works to ensure individuals in regional center services are in the least restrictive setting by providing choice of residential setting to all individuals. In addition, individuals in the regional center system who were admitted after 1986 require a court ordered Imposition of Legal Disability (ILD). The ILD ensures court oversight of the continued need for regional center services every 6 months. CDHS also supports community services in an effort to maintain current supports for individuals outside the regional center system.
Transfer of IDD Programs/System to HCPF - H.B. 13-1314	March 1, 2014	CDHS functions as a public service provider, and no longer providers oversight to CCBs or the larger IDD service delivery system, except as it relates to early intervention. . CDHS provides direct IDD services in the regional center system.
Settings Rule - Federal Rule	March 17, 2014 (effective State Fiscal Year 2019-20)	CDHS will need to comply with the Settings Rule in HCBS services and maintain those changes. CDHS is working with CDPHE to identify areas of focus. These changes take staff time to implement.
Person-centered planning - Part of Federal Settings rule	March 17, 2014 (effective State Fiscal Year 2019-20)	CDHS is is implementing person centered practices throughout the regional center system. The Department identified the need for a dedicated staff to spearhead not only the formal training, but the application of person-centered planning.
Regional Center Task Force - H.B. 14-1368	July 1, 2014	CDHS participates in the RCTF Sponsors Group as well as the Implementation Group which works to move forward the recommendations of the RCTF. While the Department has completed the RCTF recommendation to enhance the transition process, continued work with HCPF and CCBs is necessary for effective transition planning and support for individuals leaving the regional center system. This effort takes staff resource to maintain.

Table 2: Significant Policy Changes to the IDD System which impact the Department of Human Services as of 2017		
Topic	**Date**	**Impact on Department of Human Services**
Grand Junction Regional Center campus relocation - S.B.16-178	July 1, 2016	CDHS is implementing SB 16-178. This process takes significant resources to accomplish. The dedicated cash fund has been used to procure the facilitator for the Advisory Group. Grand Junction Regional Center staff with Division and Office staff participate in the activities necessary to plan to move residents as well as all other operations from the GJRC campus in the allotted timeframe.
Mandatory Reporting -H.B. 15-109	July 1, 2016	CDHS adheres to the requirements outlined for mandatory reporting of potential mistreatment, abuse, neglect and exploitation of adults with IDD. This process necessitated a change in procedure for many critical incidents and includes new coordination with law enforcement.
Minimum wage increase - State Constitutional Amendment	January 2017 January 2020	DRCO completed a salary enhancement in November 2016. With the increase of the minimum wage the salary difference between regional center direct care staff and private sector positions will impact market which is used in the State's Total Compensation Plan.
Intensive Case Management - HCPF budget request	July 1, 2017	CDHS will work directly with the case management agency as they implement this extended service should it be funded.
Source: Department of Health Care Policy and Financing Staff Budget Briefing FY 2018-19: Appendix E; with updates from DHS		

The Department has identified the need for additional resources to implement the initiatives identified, as well as the vision of the regional center system. In order to execute the initiatives, as well as the vision, the Department is re-organizing Division for Regional Center Operations (DRCO) to allow for a broader bandwidth from which to support the regional centers. This re-organization, utilizing existing resources will include staff dedicated to: formal implementation of Person Centered practices, cutting-edge behavioral support, extensive transition planning, and Settings Rule implementation. With the addition of DRCO staff, the Department anticipates having the resources to analyze as well as implement the initiatives facing the IDD system.

1:50-2:00 REGIONAL CENTERS

3 Please provide an update on the Pueblo Regional Center Corrective Action Plan progress. What progress has been made toward lifting the placement restriction at this institution?

Please refer to HCPF question #25 in the HCPF agenda.

The Department has worked diligently to address the issues identified in the CMS report to HCPF from August 2016. Concerning the moratorium, the report states "based on CMS observations and interviews with PRC staff, the current staffing for PRC is not adequate to serve additional clients. PRC must not accept any new admissions until PRC decreases the annual staff turnover rate to 20% eliminates the use of double shifts on a routine basis and implements the relevant components of the state's CAP fully as verified by an independent monitor."

Issues identified by CMS:

1. The staff turnover rate for PRC was 39.89%
2. PRC staff reported to CMS that they frequently have to complete two eight hour shifts back-to-back to fill in for missing staff.
3. PRC staff reported being burned out and exhausted and expressed serious concerns about their ability to provide appropriate care to the individuals they serve.
4. PRC staff reported a lack of adequate supervision, as their supervisors were no longer in the homes providing daily training and support to the staff.
5. PRC staff reported concerns about other staff and/or administration retaliating against them for reporting incidents.
6. Based on CMS review of training materials for staff, PRC re-training of staff largely consists of re-reviewing and signing written policies and procedures rather than providing on-site training, or supervision and verbal coaching and feedback. Given the number of repeat incidents, this method appeared to be ineffective.

The Department has shown compliance through:

1. Staff turnover rate at PRC is 18.25% for the timeframe November 2016 - May 2017. Currently all necessary direct care positions are filled. Current vacancy rate at PRC is 3%.
2. PRC has greatly reduced the number of staff needing to work back-to-back or overstay their shifts. In August and September of 2017, only 1.2% of staff had to overstay their shifts.
3. Working back to back or overstaying shifts was the primary cause of staff reporting feeling burned out and exhausted. In a staff engagement survey completed April 2017, 80% of direct care staff rated their job satisfaction as a 4 or 5 out of 5, 96% stated they enjoyed working with the individuals served and 86% of direct care staff stated that they liked the team they worked with.

4. PRC has hired a manager for each group home and that manager is based at the group home.
5. There have been no reports of retaliation of staff for reporting incidents. PRC management, including house managers, meet each weekday to review incident reports. This provides significant on the job training and support for staff. In addition, this process has shown the "report, review and respond" approach to incident management. Staff understand the importance of reporting incidents, which directly results in better supports for residents through trending and tracking of incidents. HCPF's independent monitor has visited PRC twice since July 2017. He has not reported any concerns resulting from those visits.
6. With the addition of a house manager at each home, managers provide on-site face-to-face re-training, coaching and support for staff. CDHS also developed a pilot, staff mentorship program that is in progress at the Wheat Ridge Regional Center to enhance training. Target date to implement staff mentorship program at PRC is March 2018.

4 Please describe, in detail, the vision for day programming at the Grand Junction Regional Center? How can they be expanded in order to integrate other service opportunities, such as long term services and supports?

Senate Bill 16-178 mandates vacating the Grand Junction Regional Center (GJRC) campus. Currently, 22 residents live and participate in day programming on the campus. The program is licensed as an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD). Of the 22 ICF residents, three receive day programming in their residential setting (i.e., the GJRC campus), rather than at a central day program location. They will continue to receive services in that manner (i.e., in their new group homes). In order to facilitate the move off the campus, day programming for the other 19 residents will be provided at the Developmental Center (DC), which GJRC uses to provide day programming for residents in GJRC's Home and Community Based Services (HCBS) program. The DC is a 13,671 square foot building currently supporting day programming for 45 GJRC residents. Many of these individuals utilize the DC as a location to meet in the morning before leaving to participate in community-based work crews. The Department's analysis concluded that there is enough room at the DC to add program space to provide day programming for the individuals currently residing on the campus. Staff offices will be converted to day programming space, and those staff will relocate to a new leased administration building. In addition to day programming for Regional Center residents, the DC contains office space for program staff, nurses, therapists and the physician's exam room. As a result, this location operates as a "hub" for services and supports for residents of GJRC and will include additional opportunities for socialization and integration for residents currently living on the GJRC campus. Moving day programming is part of the larger migration of direct support services off the campus. Currently, medical supports for residents of the ICF license are already provided at the DC.

ICF residents typically receive the following day programming supports determined by individual need:

- gross motor
- fine motor
- sensory
- physical therapy
- occupation therapy
- recreation and leisure
- work skills training

Day programming options currently used by ICF individuals on the campus will continue to be available at the DC.

5 Please discuss the Department's proposal and community concerns regarding the size and number of group homes to be built for the Grand Junction Regional Center.

The Department submitted a proposal as part of the Governor's November 1 budget request to build four, 6-person group homes for the Grand Junction Regional Center. This proposal provides 24 new Intermediate Care Facility (ICF) beds to accommodate the 22 residents that currently reside on the Grand Junction Regional Center campus.

In formulating this proposal, the Department considered using the existing 29 Road home, which is currently offline. Using the 29 Road home would have allowed the Department to scale back its proposal to only building three new homes to serve the 22 current ICF residents. Community members, including the Grand Junction Advisory Group, a county commissioner, the Mesa County Sheriff, and a local legislator, expressed safety concerns about using the 29 Road home. The area around the 29 Road home has become more commercialized and experiences heavier traffic, which makes it a less inviting community-like setting. As a result, the Department concluded that selling the 29 Road home and building a fourth new home was the more prudent option.

The Department also considered whether the new homes should be 4-person or 6-person homes. Currently, all of the Regional Centers' group homes are licensed for eight individuals each, but typically have six or seven individuals living there. The Department believes that there are benefits to having 6-person homes over 4-person homes. Specifically cost efficiencies in staffing ratios and employee management are realized more so in a 6-person home than in a 4-person home, without sacrificing quality.

6 Please provide the following data for each regional center for the past five fiscal years:

a. Total number of beds by type

b. Number of occupied beds (census) by type

c. Total number of staff by job classification

d. Salary of staff

Table 3 shows the number of licensed beds and average census for each regional center over the past five fiscal years, as well as the current census as of October 2017.

Table 3: Number of Licensed Beds and Census by Type for Previous Five Fiscal Years											
	FY: 2012-13		FY: 2013-14		FY 2014-15		FY 2015-16		FY 2016-17		Oct 2017
	Licensed Beds	Avg. Census	Licensed Beds	Avg. Census	Licensed Beds	Avg. Census	Licensed Beds	Avg. Census	Licensed Beds	Avg. Census	Current Census
Grand Junction ICF	46	40	46	35	46	25	46	27	46	24	22
Grand Junction HCBS	80	61	80	55	80	55	80	55	80	56	64
Pueblo HCBS	88	74	88	69	88	63	88	58	88	53	47
Wheat Ridge ICF	142	127	142	126	142	122	142	120	142	127	130
Total	356	302	356	285	356	265	356	260	356	260	263
Source: Division for Regional Center Operations Census Data											

Table 4 includes data on the number of FTE and average salaries for Regional Center staff by job classification and Regional Center.

Table 4: Number of Positions and Average Salary by Job Classification and Regional Center, As of December 4, 2017								
	Grand Junction Regional Center		Pueblo Regional Center		Wheat Ridge Regional Center		All Regional Centers	
Row Labels	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Total Count of FTE**	**Total Average of Monthly Salary**
ADMIN ASSISTANT II	1	$3,085			3	$2,787	4	**$2,862**
ADMIN ASSISTANT III	1	$4,316	4	$3,484	4	$3,632	9	**$3,642**
ADMINISTRATOR II					1	$4,463	1	**$4,463**

Table 4: Number of Positions and Average Salary by Job Classification and Regional Center,
As of December 4, 2017

	Grand Junction Regional Center		Pueblo Regional Center		Wheat Ridge Regional Center		All Regional Centers	
Row Labels	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Total Count of FTE**	**Total Average of Monthly Salary**
ADMINISTRATOR III					1	$5,514	1	**$5,514**
ANALYST III					1	$4,354	1	**$4,354**
ANALYST VI					1	$7,029	1	**$7,029**
CLIENT CARE AIDE I			3	$2,449	3	$2,575	6	**$2,512**
CLIENT CARE AIDE II			24	$2,557	91	$2,657	115	**$2,636**
CLIN BEHAV SPEC II	3	$4,551			3	$4,685	6	**$4,618**
CLIN BEHAV SPEC III	1	Vacant					1	**Vacant**
COMP INSURANCE SPEC II	1	$5,767					1	**$5,767**
CORR/YTH/CLIN SEC OFF I					13	$4,295	13	**$4,295**
DENTAL CARE IV	1	$4,571			1	$6,017	2	**$5,294**
DENTIST I	1	$12,090			1	$13,196	2	**$12,643**
DIETITIAN I			1	$3,790			1	**$3,790**
DIETITIAN II					1	$4,073	1	**$4,073**
DIETITIAN III	1	$5,948			1	$4,425	2	**$5,187**
DINING SERVICES III	3	$2,639					3	**$2,639**
DINING SERVICES IV	1	$3,008					1	**$3,008**
GENERAL LABOR I	1	Vacant					1	**Vacant**
HCS TRAINEE I	24	$2,593	21	$2,624	78	$2,578	123	**$2,591**
HCS TRAINEE II	10	$2,607					10	**$2,607**
HEALTH CARE TECH I	133	$3,507	62	$3,485	46	$3,541	241	**$3,508**
HEALTH CARE TECH II			7	$3,819	1	$3,706	8	**$3,800**
HEALTH CARE TECH III	15	$4,070	11	$4,000	56	$4,026	82	**$4,030**
HEALTH CARE TECH IV	17	$4,402	14	$4,351	15	$4,426	46	**$4,396**
HEALTH PROFESSIONAL I					4	$4,220	4	**$4,220**
HEALTH PROFESSIONAL II	4	$4,386	3	$5,132	8	$4,433	15	**$4,526**
HEALTH PROFESSIONAL III	2	$5,356	4	$5,505	7	$5,521	13	**$5,490**

Table 4: Number of Positions and Average Salary by Job Classification and Regional Center,
As of December 4, 2017

	Grand Junction Regional Center		Pueblo Regional Center		Wheat Ridge Regional Center		All Regional Centers	
Row Labels	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Total Count of FTE**	**Total Average of Monthly Salary**
HEALTH PROFESSIONAL IV	1	$4,706	7	$5,401	1	$5,459	9	**$5,295**
HEALTH PROFESSIONAL V	5	$5,529	2	$5,793	14	$5,842	21	**$5,759**
HEALTH PROFESSIONAL VI			1	Vacant	3	$7,397	4	**$7,397**
HEALTH PROFESSIONAL VII	2	$8,336	1	Vacant	3	$8,490	6	**$8,452**
LABORATORY TECHNOLOGY I					1	$3,721	1	**$3,721**
LIAISON III			1	$5,767			1	**$5,767**
MANAGEMENT					1	$9,254	1	**$9,254**
MEDICAL RECORDS TECH I	1	$2,888					1	**$2,888**
MEDICAL RECORDS TECH II	1	$3,903			2	$3,848	3	**$3,866**
MENTAL HLTH CLINICIAN I			2	$3,051			2	**$3,051**
MID-LEVEL PROVIDER	1	$9,183	1	$8,704	3	$9,031	5	**$8,996**
NURSE I			11	$6,321	3	$6,279	14	**$6,314**
NURSE II	15	$6,879	3	$6,976	11	$6,754	29	**$6,842**
NURSE III	1	$7,953	1	$7,874	3	$7,755	5	**$7,818**
NURSE V	1	$8,642	1	Vacant			2	**$8,642**
NURSE VI					1	$7,575	1	**$7,575**
PHARMACY I					1	$7,582	1	**$7,582**
PHARMACY II	1	$8,660					1	**$8,660**
PHARMACY TECHNICIAN II	1	$2,876			2	Vacant	3	**$2,876**
PHYSICIAN II	2	$20,188			1	$16,604	3	**$18,396**
PROGRAM ASSISTANT I	2	$4,328	1	$3,867	4	$3,934	7	**$4,037**
PROGRAM ASSISTANT II	1	$4,972	5	$4,611	4	$4,350	10	**$4,513**
PSYCHOLOGIST I					1	$5,943	1	**$5,943**
PSYCHOLOGIST II					1	$6,700	1	**$6,700**
SAFETY SPECIALIST III					1	$4,530	1	**$4,530**

Table 4: Number of Positions and Average Salary by Job Classification and Regional Center, As of December 4, 2017								
	Grand Junction Regional Center		Pueblo Regional Center		Wheat Ridge Regional Center		All Regional Centers	
Row Labels	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Count of FTE**	**Average of Monthly Salary**	**Total Count of FTE**	**Total Average of Monthly Salary**
SOCIAL WORK/COUNSELOR I	1	$4,754					1	**$4,754**
STATE TEACHER AIDE					5	$3,059	5	**$3,059**
STRUCTURAL TRADES II					2	$4,137	2	**$4,137**
TEMPORARY AIDE			1	$9,040			1	**$9,040**
THERAPIST II	1	$5,229					1	**$5,229**
THERAPIST III	3	$7,272			5	$5,502	8	**$6,387**
THERAPIST IV	1	$7,725			1	$7,422	2	**$7,574**
THERAPY ASSISTANT II	17	$4,166	4	$4,179	6	$4,168	27	**$4,169**
THERAPY ASSISTANT III	2	$4,485			3	$4,428	5	**$4,451**
TRAINING SPECIALIST II			1	$3,572			1	**$3,572**
TRAINING SPECIALIST IV			1	$5,115			1	**$5,115**
Grand Total	**280**	**$4,065**	**198**	**$3,800**	**423**	**$3,883**	**901**	**$3,923**

Source: Department analysis of data in CPPS. Data includes filled and vacant positions. Average salary calculated on filled positions only.

2:00-2:10 REGIONAL CENTER TASK FORCE

7 Please provide additional detail concerning the information provided in the Implementation Summary Table (page 54 of the JBC staff briefing document for HCPF). Specifically, please explain how both the Scope and the Resources are reported as "Good" while the status of some deliverables are "On Hold" or "Not Started" and while the status of other deliverables is "In Progress" but not on schedule. Please provide additional information about each project milestone, and indicate by which date the Department expects to complete each recommendation identified in the table.

Please see Table 5.

Table 5: Regional Center Task Force Implementation Table	
Recommendation	**Comments**
Transitions Planning Process	The process for enhancing transitions from the regional center system was completed in 2015. Enhancements include the implementation of a person-specific transition checklist that identifies all the services and supports the individual needs, whom will provide them, and that training has been completed. Once the individual transitions, staff from the regional center provide ongoing support to the individual and the new support team for a minimum of 90 days. This support is intended to provide consistency through the individual's continuum of care.
ICF Bed Consolidation	The regional centers continue to operate as directed in C.R.S. 27-10.5-301. Pending legislative approval, there will be a reduction of ICF beds in Grand Junction associated with the move off the campus. Grand Junction ICF capacity will go from 46 beds to 24 beds. CDHS recommends building four 6-bed group homes to meet census needs. There will be a net reduction of 22 ICF beds in the regional center system.
Source: RCTF Implementation and Final Report: 2015	

8 What source and level of funding has been made available to the Department for implementation of the Regional Center Task Force recommendations? Is the level of funding adequate?

The Department did not request or receive funding to implement the Regional Center Task Force recommendations directed to it. Those recommendations have been implemented, so the Department will not need or request funding related to the task force going forward.

2:10-2:25 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM TRANSFER

9 Please provide data reflecting the total number of IDD children in out of home placement receiving services through the CHRP waiver for the past five fiscal years. Of these children, how many children are placed as a result of a dependency and neglect finding and how many are placed because of a Petition for Review of Need for Placement?

Please see Tables 6 and 7:

Table 6: CHRP Involved Children/Youth by Fiscal Year		
	CHRP Enrollment During Year	**Total # of CHRP Clients**
FY 2012-13	91	91 unduplicated
FY 2013-14	69	82 unduplicated
FY 2014-15	36	71 unduplicated
FY 2015-16	44	Not completed to date
FY 2016-17	39	Not completed to date

Table 7: Distribution of the type of petition utilized by county departments to obtain custody of the child/youth in CY 2017[1]		
Petition Type	**#**	**%**
Traditional Dependency and Neglect Petition	43	88%
Petition for Review of Need for Placement	6	12%

10 If the requested legislation were to become law, through what process will parents need to go in order to have their child(ren) returned home after an out of home placement that resulted from a Petition for Review of Need for Placement?

A parent may sign a voluntary placement agreement (VPA) with a county department of human/social services (county department). A VPA is valid for up to 90 calendar days. If the child/youth does not return home to the parent before the 90th calendar day, then the county department must file a dependency and neglect (D&N) petition or a petition in need of placement (PRNP) with the court in order to maintain custody and placement authority of the child/youth. Neither a VPA, nor D&N, nor PRNP require a parent to relinquish their parental rights. While a child/youth is in the custody of a county department, the parents' rights remain intact. Only if one or more of the criteria established in Section 19-3-604, C.R.S. is found through convincing evidence, are a parent's rights terminated.

When a county department of human/social services has custody of a child/youth, the county department is mandated to provide services to children, youth, and their families in an effort to reunify the child/youth with their parent/s. If reunification is not possible, other permanency options are explored, including, but not limited to guardianship and adoption to ensure the child/youth does not leave the child welfare system without achieving permanency.

[1] Information in this table reflects calendar, not fiscal year; therefore, the numbers are not equal. To obtain case-specific information for four more years will require additional time. The percentage in CY 2017 is reflective of the same trend in prior years.

11 Is the under-utilization of Medicaid by county child welfare agencies related to the provision of services to children with IDD under the CHRP waiver? Please explain. How will the passage of this legislation affect the county child welfare, Medicaid utilization rate?

The CHRP Waiver allowed the State to have 122 participants in FY 2014-15 and increased yearly to 190 participants in FY 2018-19. There were only 39 participants in FY 2016-17. The Department's Office of Performance & Strategic Outcomes (OPSO) completed the Children's Habilitation Residential Program Audit in October 2017. The goal of this audit was to understand the reason for underutilization of the CHRP Waiver. The audit found county departments' underutilization of the CHRP Waiver were due to the following:

- Otherwise Ineligible;
    - This category encompasses youth whose behaviors were scored as too functional to need CHRP (5), who were not on SSI (2), whose claims were denied by Medicaid (2), whose behaviors were too severe or unsafe to allow for housing outside of an institution (3), and one youth whose child welfare case was dismissed (1). The category also includes situations where county departments focused on enrollment in the adult Developmental Disability (DD) system because the youth was close to his/her 18th birthday (7).
- Ineligibility due to Youth Living with Biological or Adopted Family or Kin Provider not CHRP Approved;
- CHRP Rate Insufficient;
- Disruptions in Placement;
- Accepting the Child as a CHRP Placement Would Have Resulted in the Facility Being Over Capacity, With Too Many Youth in the Facility; and/or
- Provider not CHRP approved.

In addition to the areas listed above, county departments expressed concerns with the repetition and time burden related to CHRP Waiver enrollment and renewal processes. The audit also recommended consideration of removing identified barriers to CHRP Waiver enrollment, such as the requirements that a youth be in out-of-home care, enrollment be tied to specific provider, and whether placing limits on the number of children that may be cared for in a home with a CHRP Waiver child is unduly limiting placement options.

12 Under current law, what are the legal, professional, and personal implications to parents of having to relinquish their custodial rights in order to receive services for their IDD child(ren)?

Title 19 of the Colorado Revised Statutes provides the following definitions.

Section 19-1-103 (73) (a) C.R.S. (2017)

Legal custody" means the right to the care, custody, and control of a child and the duty to provide food, clothing, shelter, ordinary medical care, education, and discipline for a child and, in an emergency, to authorize surgery or other extraordinary care. "Legal custody" may be taken from a parent only by court action.

Section 19-4-102 C.R.S. (2017)
"Parent and child relationship" means the legal relationship existing between a child and his natural or adoptive parents incident to which the law confers or imposes rights, privileges, duties, and obligations. "Parent and child relationship" includes the mother and child relationship and the father and child relationship.

As defined in the Colorado Home and Community-Based Services (HCBS) Waivers, Children's Waiver Chart, the CHRP Waiver currently, only services children who are in the custody of the County Department of Human/Social Services, residing in an out-of-home CHRP approved placement and have a developmental disability (developmental delay age 0-4). Therefore, under current law, a parent *may* relinquish their legal "custodial" rights for up to 90 days through a VPA, as defined above in question 3, to access the CHRP Waiver.

Due to the current CHRP Waiver requirement of county department involvement to access the CHRP Waiver, the county department obtains legal custody and placement authority of the children/youth through a VPA, D&N, or a PNRP. During this time, the parental rights, or parent and child relationship, remains intact. The termination or relinquishment of parental rights may only occur through court action as defined in Title 19, Article 3, Part 6 C.R.S. (Termination of the Parent-Child Legal Relationship) and Title 19, Article 5, Part 1 C.R.S. (Relinquishment).

The Children's Waivers chart also provides information on a number of other waivers that may be available to a parent that maintains the child/youth in their own homes and do not require county department involvement. However, some children/youth's needs are so severe and challenging to provide services safely in the home, a parent chooses to relinquish their legal custody in order to access out of home placement and the services offered via the CHRP Waiver.

If a VPA or PNRP were utilized as part of this process, this would not have a negative, professional, impact to the family. If a D&N is required due to child abuse and/or neglect, then the finding of abuse and/or neglect may potentially affect the family professionally based on their employer's background check requirements. However, in the case of both a PNRP and a D&N, when a child/youth is in out-of-home placement and public moneys are expended, there may be a financial impact to the family. A court may obligate the parent of the child to pay a fee, based on the parent's ability to pay, to cover the costs of the guardian ad litem and cost of care for the child.

2:25-2:30 VETERANS COMMUNITY LIVING CENTERS

13 Please provide details on each funding source for Veterans Community Living Centers, including where the funding originates. What is the balance in cash funds from which spending authority is granted to the centers? How are these funds used?

Table 8 shows revenues, by funding source, for the Veterans Community Living Centers (VCLCs) for Fiscal Year 2016-17.

Table 8: Revenues by Funding Source Fiscal Year 2016-17					
Revenue Source	Fitzsimons	Florence	Homelake	Rifle	Total
Federal Funds					
Veterans Administration	$14,378,037	$4,698,829	$2,812,104	$3,138,633	$25,027,603
Cash Funds					
Medicaid	$6,677,946	$5,007,650	$2,437,476	$3,942,855	$18,065,927
Medicare	$696,759	$355,551	$464,166	$405,475	$1,921,951
Private Health Insurance	$965,471	$507,716	$0	$104,221	$1,577,408
Private Pay	$1,012,444	$1,145,014	$1,399,222	$1,374,230	$4,930,910
Others	$55,315	$68,451	$99,990	($62)	$223,694
General Fund	$367,114	$178,909	$301,430	$138,677	$986,130
Total Revenues	$24,153,086	$11,962,120	$7,514,388	$9,104,029	$52,733,623
Source: Colorado Operating Resource Engine (CORE)					

The VCLC Enterprise Fund has the following cash balances as of the end of FY 2016-17, by funding source, as shown in Table 9:

Table 9: Veterans Community Living Center Enterprise Cash Balance by Fund Type at Fiscal Year End 2016-17					
Revenue Source	**Fitzsimons**	**Florence**	**Homelake**	**Rifle**	**Total**
Federal Funds	$5,688,143	$2,610,058	$1,688,470	($737,674)	$9,248,997
Cash Funds	$5,250,559	$4,258,518	$2,754,839	($1,806,042)	$10,457,874
General Funds	$0	$0	$0	$0	$0
Total	$10,938,702	$6,868,576	$4,443,309	($2,543,716)	$19,706,871
Source: Department analysis of financial information contained in the Colorado Operating Resource Engine (CORE).					

The VCLC Enterprise Fund is used to operate the Veterans Community Living Centers at Fitzsimons, Florence, Homelake, and Rifle. Expenses covered by the Fund include:

- **Personal service costs -** Including administrative, direct care, kitchen, medical, and maintenance staff.

- **Operating Costs -** Including food, utilities, medical supplies and equipment, office supplies, pharmaceutical supplies, facility maintenance and cleaning supplies, etc.
- **Bond Payments -** Bonds were used to finance construction of the Fitzsimons VCLC. The final bond payment was made on December 1, 2017.
- **Cash-Funded Capital Construction/Capital Renewal -** The VCLCs periodically use the Enterprise Fund for capital construction projects. For example, the VCLCs are making investments from the Enterprise Fund in FY 2017-18 at the Homelake, McCandless, Fitzsimons and Rifle VCLCs to address necessary upgrades to those facilities.

In addition, the balance in the Enterprise Fund provides a "rainy day" fund should operational revenues not keep pace with expenses (e.g., temporary decline in census or unexpected damage to a facility). The current Enterprise Fund balance (about $19.7 million) represents about four and one-half months of the VCLC's current operating expenses.

14 Please provide additional information about the Department's R21 budget request to reduce the spending authority and FTE to align with actual expenditures. Why were the positions at the centers not filled and subsequently the eliminated? Does the reduction in FTE correspond with best practices in caseload per FTE in nursing homes?

The Department has reevaluated staffing needs at the VCLCs and determined that 19 currently vacant and unnecessary FTE can be eliminated without layoffs or affecting the quality of care. Resident acuity drives direct care staffing at the VCLCs. Over the past year, the VCLCs have refined the methodology used to determine resident acuity so that this determination relies more heavily on quantitative resident assessment data using a nationally recognized tool. As a result of this effort, the VCLCs found that they were slightly overstaffed relative to their current average resident acuity. The 19.0 FTE to be eliminated include 2.0 FTE at Fitzsimons, 5.4 FTE at Florence, 6.6 FTE at Homelake, and 5.0 FTE at Rifle. All but 4.6 of the FTE are in direct care positions. However, the reductions in direct care FTE are not expected to prevent the VCLCs from meeting required staffing ratios to provide quality care that is safe and meets the needs of the residents.

2:30-2:45 Compensation Adjustments for Direct Care Positions

15 Has the Department experienced improvement in employee and recruitment at the Colorado Mental Health Institute at Pueblo and the three regional centers since salary increases were implemented for nurses and direct care staff, respectively?

Since implementing the regional center pay increases in November 2016, vacancy and turnover rates for direct care staff at the regional centers have decreased significantly. Table 10 shows the

vacancy rate for each regional center on September 12, 2016 and on November 20, 2017, as well as the cumulative turnover rates for the periods March 2016 to October 2016 and November 2016 to May 2017.

Table 10: Comparison of Vacancy and Turnover Rates for Direct Care Staff at the Regional Centers Prior to and Post Pay Increases				
Regional Center	**Sept. 12, 2016 Vacancy Rate**	**November 20, 2017 Vacancy Rate**	**Cumulative Turnover Rate March 2016 to October 2016**	**Cumulative Turnover Rate November 2016 to May 2017**
Grand Junction	16%	6%	11%	7%
Pueblo	29%	4%	35%	17%
Wheat Ridge	15%	11%	33%	19%
Source: Department analysis of CPPS data.				

Based on these data, the Department concludes that the pay raises have been effective in attracting and improving the retention of staff for vacant direct care positions at the regional centers. The Department's current budget request is proposing the same initiative in its remaining 24/7 care facilities to improve recruitment and retention of positions that are key to ensuring the availability of care for some of the State's most vulnerable populations, including veterans, youth, and individuals with mental illness.

For the Colorado Mental Health Institute at Pueblo, the pay increases went into effect November 1, 2017. As such, there has not been sufficient data to conduct an analysis of the impact of the pay increases. Initial indications are that the pay increases will help resolve staffing issues at CMHIP. Specifically, September 18th through December 1st, CMHIP hired 15 nurses, 4 of whom were former CMHIP employees who decided to return to work at CMHIP after implementation of the pay increases. In addition, two part-time nurses elected to become full time.

16 How do state salaries for each job type identified in the Department's request, including positions at the regionals center and the Colorado Mental Health Institute (whose salaries have already been increased) compare with salaries for like positions in private provider organizations (CPAs, RCCFs, CCBs, PASAs) with whom the state or counties contract to deliver services? In addition, how are regionals issues factored into the determination of these salaries?

Salaries:

The compensation initiative moves direct care staff employed by the Department's 24/7 care facilities to the midpoint of the DPA job classification pay ranges. According to DPA, the

midpoint of the pay range represents the prevailing market wage for similar positions in the State's public and private-sector employment market. The prevailing wage is identified by DPA through a salary survey conducted each year by a consultant hired by DPA. The salary survey data collects wage and benefit data from private and public sector employers. The midpoint of the range is identified by comparing compensation for positions with similar duties to those in the State.

As a result, moving the Department's direct care staff to the midpoint of the pay range places direct care staff salaries in-line with the average salaries of other positions in the job market. As such, the Department is better able to compensate employees similarly to hospital providers, nursing homes, doctor's offices and clinics for direct care, nursing types of positions.

The Department does not have specific salary information or job duty information from private providers of Child Protection Agencies (CPAs), Residential Child Care Facilities (RCCFs), Community Centered Boards (CCBs), or Program Approved Service Agencies (PASAs). However, the regional center pay increases have been in place for more than a year. As a result, the CCB providers may be able to provide data on how those increases have affected CCB provider turnover and vacancy rates over the past year, as well as provide current salary information for comparable job titles.

Regional Differences:

The Pay Plan published by DPA dictates the salary ranges for State employees. The Pay Plan does not specifically delineate different salaries for job classifications based on cost of living in various regions of the State, nor do Personnel Rules indicate that state agencies should specifically compensate employees working in higher-cost regions at higher rates than employees working in lower cost regions.

17 For the past ten fiscal years, please provide data on the number of direct care positions by type in:

a. The State of Colorado (include division), and

b. Private provider organizations (include organization type, i.e. CCB, RCCF, CPA, PASA, etc.).

Table 11 provides data on the number of direct care positions, by Department and job classification as of June 2017.

Table 11: June 2017 Number of Direct Care Positions, by Department and Job Classification

Row Labels	Corrections	% of total	Education	% of total	Human Services	% of total	Grand Total
CLIENT CARE AIDE I		0%		0%	76	100%	76
CLIENT CARE AIDE II	13	3%		0%	405	97%	418

Table 11: June 2017 Number of Direct Care Positions, by Department and Job Classification							
Row Labels	**Corrections**	**% of total**	**Education**	**% of total**	**Human Services**	**% of total**	**Grand Total**
CORR/YTH/CLIN SEC OFF I	2443	81%		0%	566	19%	3009
CORR/YTH/CLIN SEC OFF II	755	87%		0%	109	13%	864
HCS TRAINEE I	0	0%		0%	105	100%	105
HCS TRAINEE II	19	36%		0%	34	64%	53
HCS TRAINEE III	13	46%		0%	15	54%	28
HEALTH CARE TECH I	38	10%	22	6%	321	84%	381
HEALTH CARE TECH II		0%	12	8%	130	92%	142
HEALTH CARE TECH III		0%	2	2%	102	98%	104
HEALTH CARE TECH IV		0%	3	6%	46	94%	49
MENTAL HLTH CLINICIAN I		0%		0%	132	100%	132
MENTAL HLTH CLINICIAN II		0%		0%	33	100%	33
MENTAL HLTH CLINICIAN III	0	0%		0%	4	100%	4
MID-LEVEL PROVIDER	42	47%		0%	47	53%	89
NURSE I	188	37%	3	1%	313	62%	504
NURSE II	5	4%		0%	129	96%	134
NURSE III	32	30%	1	1%	74	69%	107
SOCIAL WORK/COUNSELOR I		0%		0%	9	100%	9
SOCIAL WORK/ COUNSELOR II		0%		0%	37	100%	37
SOCIAL WORK/ COUNSELOR III	90	65%		0%	49	35%	139
THERAPY ASSISTANT I		0%		0%	14	100%	14
THERAPY ASSISTANT II		0%		0%	38	100%	38
THERAPY ASSISTANT III		0%	1	5%	18	95%	19
Grand Total	**3638**	**56%**	**44**	**1%**	**2806**	**43%**	**6488**

As shown in Table 11, with the exception of the number of Correctional/Youth Security Officer positions, the Department of Human Services is the largest employer of direct care staff among all executive branch agencies.

Attachment A provides data on the number of direct care positions for the past 5 fiscal years, by Department for all State agencies employing direct care positions. Data is shown by Department because Division-level data is unavailable from DPA for other state agencies. We provided five years of data because we requested that data from DPA as part of our compensation analysis and budget request. Obtaining 10 years of data was not possible within the timeframe between the budget briefing and hearing.

18 **Given the recent data indicating that increased salaries for direct care positions have improved recruitment and retention rates at the state's regional centers, and that such improvements are intended to further result in improved care of and outcomes for individuals served, please discuss options for reducing the negative impact of work force competition with nongovernmental provider agencies (including but not limited to Child Placement Agencies, Residential Child Care Facilities, Community Centered Boards, Program Approved Service Agencies) so that they do not experience increasing turnover and negative outcomes for clients.**

At this time, the Department has no data to support the assertion that there are actual negative impacts to private provider agencies resulting from the Department's compensation initiatives. The Department is only one employer in Colorado's job market and merely aligned its wages with the prevailing wage offered by job market for similar positions to address staffing crises within its 24-hour care facilities. Salaries for private provider staff are likely part of the private sector salary survey considered in determining the midpoint of the job classification pay range.

The Department has been cited with multiple deficiencies related to staffing, including one at Pueblo Regional Center resulting in a moratorium on admissions, and another immediate jeopardy citation at the Colorado Mental Health Institute at CMHIP for failing to adequately staff the facility. An immediate jeopardy citation can result in discontinuance of Medicaid payments to the facility and even closure. As a result of these deficiencies, it was necessary for the Department to increase direct care staff wages to the prevailing market wage to address the existing staffing shortages.

Paying wages that are competitive with the market is necessary to ensure that the Department can recruit and retain qualified staff to serve some of the most vulnerable individuals in the state with the most acute care needs. As an alternative to this compensation request, the Department considered additional closure of units in the mental health hospitals and regional centers to

address deficiency citations related to staffing that placed these 24-hour care facilities at risk for sanctions.

19 If the Department's budget request is approved, how will the increased salaries of direct care positions at DYS impact the rate setting methodology process required by H.B. 17-1292?

H.B. 17-1292 mandates the Department to contract with an independent vendor to perform a salary survey related to the delivery of child welfare services. The Division of Youth Services (DYS) does not deliver child welfare services; therefore, the Department does not anticipate the increased salaries of direct care positions at DYS to have an impact on the rate setting methodology process required by H.B. 17-1292.

2:45-3:00 BREAK

Attachment A: Number of Direct Care Positions, by Department and Job Classification, Prior 5 Years, As of June				
JUNE 2013 - POSITIONS				
Job Classification	**Corrections**	**Education**	**Human Services**	**Public Health & Environment**
CLIENT CARE AIDE I			93	
CLIENT CARE AIDE II	13		341	
CORR/YTH/CLIN SEC OFF I	2313		444	
CORR/YTH/CLIN SEC OFF II	737		86	
HCS TRAINEE I	4		34	
HCS TRAINEE II	9		79	
HCS TRAINEE III	17		33	
HEALTH CARE TECH I	52	12	379	1
HEALTH CARE TECH II		21	85	0
HEALTH CARE TECH III		3	94	
HEALTH CARE TECH IV		3	62	
MENTAL HLTH CLINICIAN I			144	
MENTAL HLTH CLINICIAN II			79	
MENTAL HLTH CLINICIAN III	7		14	
MID-LEVEL PROVIDER	44		61	5
NURSE I	171	1	241	
NURSE II	9		103	
NURSE III	34	3	57	
SOCIAL WORK/COUNSELOR I			24	
SOCIAL WORK/COUNSELOR II			15	
OCIAL WORK/COUNSELOR III	62		50	
THERAPY ASSISTANT I			28	
THERAPY ASSISTANT II			87	
THERAPY ASSISTANT III		4	27	
Grand Total	**3472**	**47**	**2660**	**6**

Attachment A: Number of Direct Care Positions, by Department and Job Classification, Prior 5 Years, As of June				
JUNE 2014 POSITIONS				
Job Classification	**Corrections**	**Education**	**Human Services**	**Public Health & Environment**
CLIENT CARE AIDE I			76	
CLIENT CARE AIDE II	13		426	
CORR/YTH/CLIN SEC OFF I	2333		492	
CORR/YTH/CLIN SEC OFF II	745		91	
HCS TRAINEE I	5		34	
HCS TRAINEE II	11		14	
HCS TRAINEE III	14		16	
HEALTH CARE TECH I	50	20	438	0
HEALTH CARE TECH II		14	104	1
HEALTH CARE TECH III		2	103	
HEALTH CARE TECH IV		3	52	
MENTAL HLTH CLINICIAN I			97	
MENTAL HLTH CLINICIAN II			33	
MENTAL HLTH CLINICIAN III	0		4	
MID-LEVEL PROVIDER	43		47	1
NURSE I	175	3	309	
NURSE II	7		128	
NURSE III	33	1	63	
SOCIAL WORK/COUNSELOR I			10	
SOCIAL WORK/COUNSELOR II			32	
OCIAL WORK/COUNSELOR III	70		53	
THERAPY ASSISTANT I			18	
THERAPY ASSISTANT II			44	
THERAPY ASSISTANT III		1	20	
Grand Total	**3499**	**44**	**2704**	**2**

Attachment A: Number of Direct Care Positions, by Department and Job Classification, Prior 5 Years, As of June				
JUNE 2015 POSITIONS				
Job Classification	**Corrections**	**Education**	**Human Services**	**Public Health & Environment**
CLIENT CARE AIDE I			66	
CLIENT CARE AIDE II	13		432	
CORR/YTH/CLIN SEC OFF I	2351		557	
CORR/YTH/CLIN SEC OFF II	746		98	
HCS TRAINEE I	5		50	
HCS TRAINEE II	11		7	
HCS TRAINEE III	15		16	
HEALTH CARE TECH I	46	21	404	0
HEALTH CARE TECH II		13	126	0
HEALTH CARE TECH III		2	98	
HEALTH CARE TECH IV		3	48	
MENTAL HLTH CLINICIAN I			109	
MENTAL HLTH CLINICIAN II			32	
MENTAL HLTH CLINICIAN III	0		4	
MID-LEVEL PROVIDER	42		46	1
NURSE I	184	3	331	
NURSE II	5		130	
NURSE III	32	1	69	
SOCIAL WORK/COUNSELOR I			11	
SOCIAL WORK/COUNSELOR II			33	
OCIAL WORK/COUNSELOR III	79		52	
THERAPY ASSISTANT I			17	
THERAPY ASSISTANT II			43	
THERAPY ASSISTANT III		1	20	
Grand Total	**3529**	**44**	**2799**	**1**

Attachment A: Number of Direct Care Positions, by Department and Job Classification, Prior 5 Years, As of June				
JUNE 2016 POSITIONS				
Job Classification	**Corrections**	**Education**	**Human Services**	**Public Health & Environment**
CLIENT CARE AIDE I			76	
CLIENT CARE AIDE II	13		405	
CORR/YTH/CLIN SEC OFF I	2390		566	
CORR/YTH/CLIN SEC OFF II	755		109	
HCS TRAINEE I	3		105	
HCS TRAINEE II	16		34	
HCS TRAINEE III	15		15	
HEALTH CARE TECH I	42	22	321	0
HEALTH CARE TECH II		12	130	0
HEALTH CARE TECH III		2	102	
HEALTH CARE TECH IV		3	46	
MENTAL HLTH CLINICIAN I			132	
MENTAL HLTH CLINICIAN II			33	
MENTAL HLTH CLINICIAN III	0		4	
MID-LEVEL PROVIDER	42		47	0
NURSE I	185	3	313	
NURSE II	5		129	
NURSE III	33	1	74	
SOCIAL WORK/COUNSELOR I			9	
SOCIAL WORK/COUNSELOR II			37	
OCIAL WORK/COUNSELOR III	86		49	
THERAPY ASSISTANT I			14	
THERAPY ASSISTANT II			38	
THERAPY ASSISTANT III		1	18	
Grand Total	**3585**	**44**	**2806**	**0**

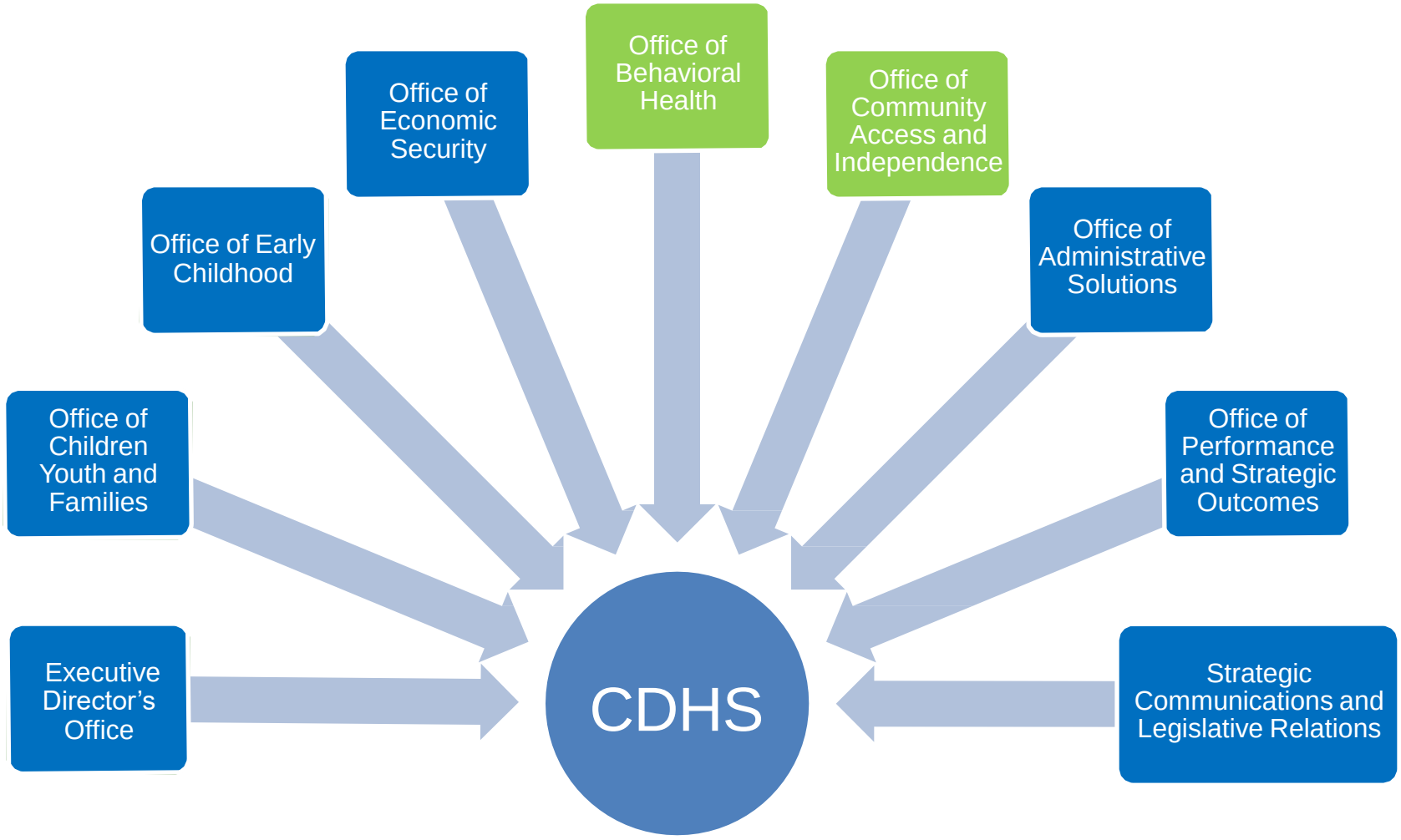
Attachment A: Number of Direct Care Positions, by Department and Job Classification, Prior 5 Years, As of June				
JUNE 2017 POSITIONS				
Job Classification	**Corrections**	**Education**	**Human Services**	**Public Health & Environment**
CLIENT CARE AIDE I			53	
CLIENT CARE AIDE II	13		406	
CORR/YTH/CLIN SEC OFF I	2443		662	
CORR/YTH/CLIN SEC OFF II	755		144	
HCS TRAINEE I	0		125	
HCS TRAINEE II	19		38	
HCS TRAINEE III	13		13	
HEALTH CARE TECH I	38	22	288	0
HEALTH CARE TECH II		12	67	0
HEALTH CARE TECH III		1	148	
HEALTH CARE TECH IV		3	48	
MENTAL HLTH CLINICIAN I			136	
MENTAL HLTH CLINICIAN II			39	
MENTAL HLTH CLINICIAN III	0		4	
MID-LEVEL PROVIDER	42		46	0
NURSE I	188	4	293	
NURSE II	5		121	
NURSE III	32	1	71	
SOCIAL WORK/COUNSELOR I			15	
SOCIAL WORK/COUNSELOR II			28	
OCIAL WORK/COUNSELOR III	90		52	
THERAPY ASSISTANT I			13	
THERAPY ASSISTANT II			33	
THERAPY ASSISTANT III		1	16	
Grand Total	**3638**	**44**	**2859**	**0**

COLORADO
Department of Human Services

FY 2017-18 Joint Budget Committee Hearing

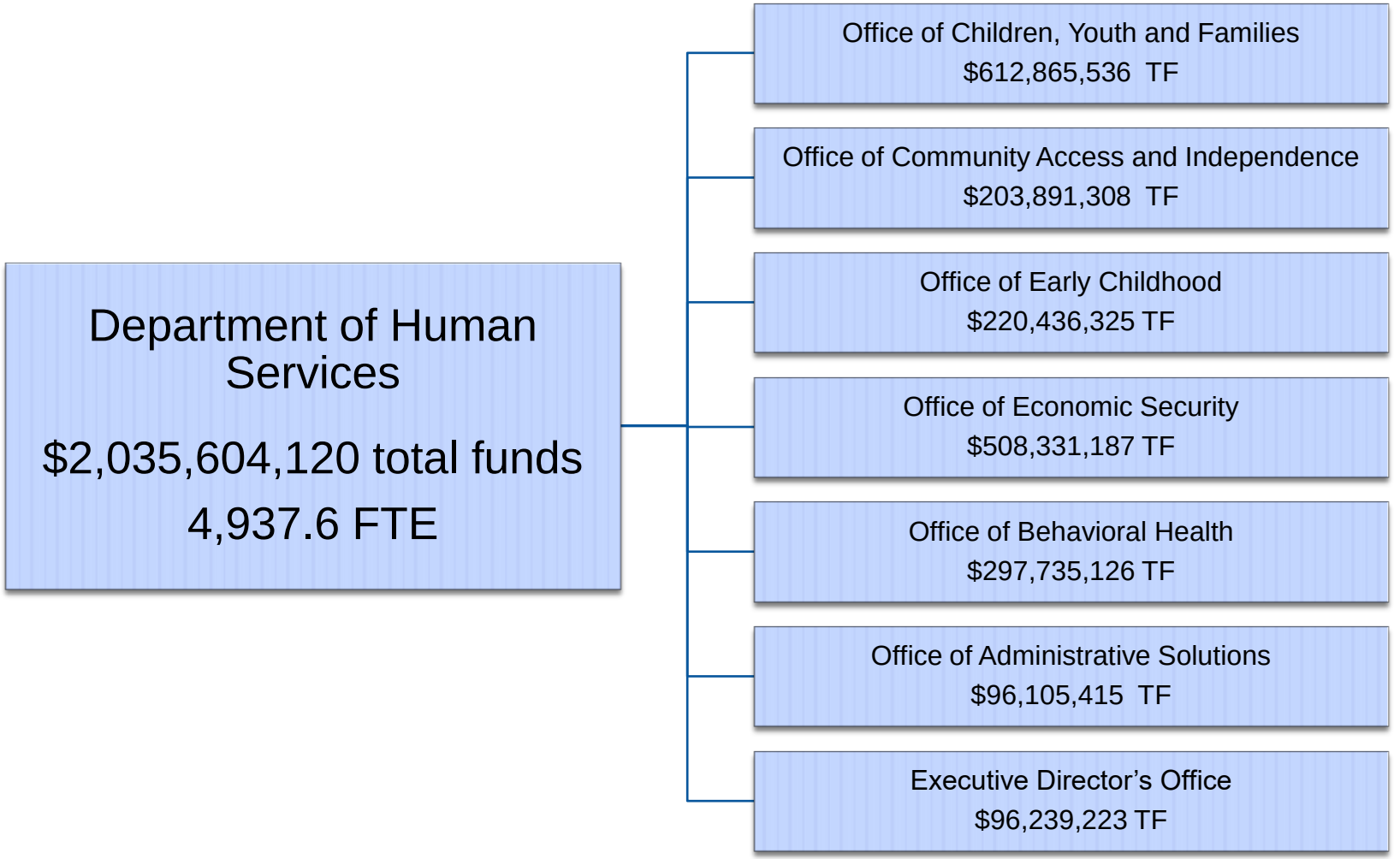
Department of Human Services: Services for People with Disabilities and Office of Behavioral Health

December 14, 2017



COLORADO
Department of Human Services

FY 2017-18 Department Appropriation



Colorado Department of Human Services FY 2018-19 Budget Requests

Office of Community Access and Independence

- ***Restore Regional Center Funding***
- ***Colorado Traumatic Brain Injury Program Spending Authority***
- ***Reduce VCLC Spending Authority***
- ***New Homes to Relocate Grand Junction Regional Center Intermediate Care Facility***
- ***Veterans Community Living Center – Homelake/McCandless Fall Prevention/Fire controls/Video Surveillance***
- ***DRCO Depreciation Fund Capital Improvements Continuation Project***
- Respite Care Task Force
- Funding for Area Agencies on Aging
- Spending Authority for Crimes Against At-Risk Persons

Office of Administrative Solutions

- ***Phase I of II Compensation Adjustments for Direct Care Positions at DHS Facilities***
- HIPAA Security Remediation
- Interoperability Phase 4 of 5

Colorado Department of Human Services FY 2018-19 Budget Requests

Office of Behavioral Health

- **Compression Adjustment for Nurses at Colorado Mental Health Institute Pueblo**
- **Jail-Based Bed Space**
- **Community Based Intensive Residential Treatment Program**
- **Court Ordered Reports FTE Caseload**
- **Purchased Bed Capacity**
- **Outpatient Competency Restoration**
- **Children's Mental Health Treatment Act**
- **Medication Consistency and Health Information Exchange**
- Colorado Mental Health Institute at Fort Logan Window Replacement
- CMHIP Capital Renewal, Phase 1 of 3
- CMHIFL Capital Renewal, Phase 1 of 3
- Institute Facility Modernization Phase IIa

Office of Community Access and Independence

COLORADO
Department of Human Services

Office of Community Access & Independence FY 2018-19 Decision Items

- ***Operating Requests***
  - Restore Regional Center Funding: $6.7 million
  - Reduce VCLC Spending Authority: ($620,000)

- ***Capital Requests***
  - New Homes to Relocate Grand Junction Regional Center Intermediate Care Facility: $6.7 million
  - Veterans Community Living Center – Homelake/McCandless Fall Prevention/Fire controls/Video Surveillance: $782,000
  - DRCO Depreciation Fund Capital Improvements Continuation Project: $730,000

COLORADO
Department of Human Services

Office of Community Access and Independence

Intellectual and Developmental Disabilities System Policy

COLORADO
Department of Human Services

Office of Community Access and Independence

Regional Centers

Regional Centers

Grand Junction

HCBS Beds: 80

HCBS Census: 64
HCBS Group Homes: 10

(1 offline home)

ICF Beds:46

ICF Census: 22

ICF Campus: 4 Dorms

Services: Residential and Day Habilitation

Pueblo

HCBS Beds: 88

HCBS Census - HCBS: 47
HCBS Group Homes: 11

(3 offline homes)

Services: Residential and Day Habilitation

Wheat Ridge

ICF Beds: 142

ICF Census: 130
ICF Group Homes: 19
(0 offline homes)

Services: Residential and Day Habilitation

Regional Centers: Licensed Beds and Census

	FY 2012-13		FY 2013-14		FY 2014-15		FY 2015-16		FY 2016-17		Oct 2017
	Licensed Beds	Av. Census	Licensed Beds	Av. Census	Licensed Beds	Av. Census	Licensed Beds	Av. Census	Licensed Beds	Av. Census	Current Census
Grand Junction ICF	46	40	46	35	46	25	46	27	46	24	22
Grand Junction HCBS	80	61	80	55	80	55	80	55	80	56	64
Pueblo HCBS	88	74	88	69	88	63	88	58	88	53	47
Wheat Ridge ICF	142	127	142	126	142	122	142	120	142	127	130
Total	356	**302**	356	**285**	356	**265**	356	**260**	356	**260**	**263**

Source: Division for Regional Center Operations Census Data

Regional Centers Referrals and Admissions by CCB

Regional Center Referrals for Admission and Admissions by CCB October 2016 through October 2017		
CCB	Referrals	Admissions
DDRC	3	2
Developmental Pathways	10	7
Envision	2	0
Foothills Gateway	1	1
Imagine	1	1
Inspiration Field	1	1
Mesa Developmental Services	5	4
North Metro	6	4
Rocky Mountain Human Services	9	5
Southeastern	1	1
The Resource Exchange	7	8
TOTAL	**46**	**34**
Source: CDHS C-Stat Data		

DRCO Transitions
Short-Term Treatment and Stabilization Model

Current Cumulative Denominator *(All Models)* = 299

95 Individuals in the Short-Term Treatment & Stabilization Model that have achieved recommended progress and/or transitioned since July 2012

81 Individuals (85%) Have Successfully Transitioned to a Community Provider

14 Individuals (15%) Remain in the RCs

- **1 Individuals (7%)**– Referral Packet Remaining to be Sent (1-WRRC)
- **2 Individuals (14%)** – Referral Packets Sent – RFP Pending (2-WRRC)
- **6 Individuals (43%)** – Awaiting Provider Interest (2-GJRC, 2-PRC, 2-WRRC)
- **5 Individuals (36%)** – Provider Available (3-GJRC 2-WRRC)
- **0 Individuals** – Facilitated by CO Choice Transitions Program

DRCO Transitions
Intensive Treatment Model

Current Cumulative Denominator *(All Models)* = 299

51 Individuals in the Intensive Treatment Model that have achieved recommended progress and/or transitioned since July 2012

47 Individuals (92%) Have Successfully Transitioned to a Community Provider

4 Individuals (8%) Remain in the RCs

- **0 Individuals** – Awaiting Guardian Engagement
- **0 Individuals**– Referral Packets Remaining to be Sent
- **3 Individuals (75%)** – Referral Packet Sent – RFP Pending
- **0 Individuals** – Awaiting Provider Interest
- **1 Individuals (25%)** – Provider Available
- **0 Individuals** – Facilitated by CO Choice Transitions Program

Reference Data

DRCO Transitions
Long-Term Habilitation Model

Current Cumulative Denominator *(All Models)* = 299

153 Individuals in the Long-Term Habilitation Model that have achieved recommended progress and/or transitioned since July 2012

48 Individuals (31%) Have Successfully Transitioned to a Community Provider (15-GJRC, 19-PRC, 14-WRRC)

105 Individuals (69%) Remain in the RCs

- **99 Individuals (94%)** – Awaiting Guardian Engagement (28-GJRC, 28-PRC, 43-WRRC)
- **0 Individuals** - Referral Packet Remaining to be Sent
- **3 Individuals (3%)** – Referral Packets Sent – RFP Pending (3-WRRC)
- **0 Individuals** – Awaiting Provider Interest
- **3 Individuals (3%)** – Provider Available (1-GJRC, 1-PRC, 1-WRRC)
- **0 Individual** – Facilitated by CO Choice Transitions Program

Reference Data

Pueblo Regional Center Corrective Action Plan

Issue Identified by CMS	Action taken by DHS
Staff turnover	Current vacancy rate at PRC is 3%.
Back-to-back shifts	Reduced the number of staff needing to work back-to-back or overstay their shifts to 1.2% in August and September 2017
Staff burnout and exhaustion	April 2017 staff stay survey/interviews • 80% of direct care staff rated job satisfaction as a 4 or 5 out of 5 • 96% stated they enjoyed working with the individuals served • 86% of direct care staff stated that they liked the team they worked with.
Lack of adequate staff supervision	Hired a manager for each group home and that manager is based at the group home.
Concerns about retaliation	There have been no reports of retaliation of staff for reporting incidents.
Re-training of staff policies and procedures rather than providing on-site training, or supervision and verbal coaching and feedback	• Managers provide on-site face-to-face re-training, coaching and support for staff. • Developed a pilot staff mentorship program that is in progress at the Wheat Ridge Regional Center to enhance training.

Grand Junction Regional Center
Senate Bill 16-178

- Requires CDHS to vacate the campus by July 1, 2018 or as soon as all current residents are transitioned to settings that support their well-being and respect their individual choices.
  - An independent, third-party facilitator engaged the GJRC's 23 residents and their parents and guardians in a service selection process.
  - 22 residents indicated their desire to continue receiving services in the Grand Junction area, in an Intermediate Care Facility (ICF) operated by the Grand Junction Regional Center. One resident transferred to Wheat Ridge Regional Center.
- Requires the State to sell the campus
- Directs CDHS to convene an Advisory Group to help develop a plan to vacate the campus.
- Created the GJRC Transition Cash Fund.

SB16-178 Progress to Date

July 2016	• Advisory Group formed.
Aug. & Sept. 2016	• Service selection process completed: 22 residents decided to remain in Grand Junction.
December 2016	• Initial plan submitted to the JBC and CDC. CDHS was directed to develop additional recommendations.
March 2017	• Advisory Group reconvened to develop additional transition plan options.
May 2017	• CDHS received final transition recommendations from the Advisory Group.
Summer 2017	• CDHS completed a cost analysis of the Advisory Group Recommendations.
October 2017	• JBC approved 1331 supplemental to move admin off of the campus and continue funding the Advisory Group.

1331 Supplemental Approved Funding

Move Admin and Day Services Off Campus

Moving fees for Admin: $17,750

Obtain Admin, Support, and Day Program leased space: $300,000

Day Program will be moved, and Laundry, Warehouse, and Garage will be closed by June 30, 2018

Transition Existing Programs and Services

Decommission unused campus administrative and support facilities: $37,500

Transition storage from GJRC warehouse to other facilities: $100,000

Lease of administrative space completed by January 2018

Advisory Group Facilitation

Continued funding to facilitate Advisory Group: $150,000

Procurement in process. To be complete by January 2018

Request: Grand Junction Regional Center

- Total capacity of 24 beds of ICF service in Grand Junction

ACTIONS NEEDED:

- Authorize and appropriate funding to build four, 6-bed ICF homes
- Authorize the sale of 29 Road Group Home

Grand Junction Regional Center Move	
Component	Cost
Land Acquisition	$300,000
Construction	$3,863,070
Infrastructure: services/utilities	$233,000
Infrastructure: site improvements	$220,000
Build four 6-person homes (18,600 total sq. ft.)	$3,255,000
[redacted]gram	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Professional Services	$997,375
Equipment and Furnishings	$644,800
Miscellaneous	$75,881
Contingency (5%)	$316,556
Total	$6,197,682

COLORADO
Department of Human Services

Office of Community Access and Independence

Regional Center Task Force

Regional Center Task Force

Recommendation	Comments
Transition Planning Process	Process for enhancing transitions from the regional center system was completed in 2015, including implementation of a person-specific transition checklist. Once the individual transitions, staff from the regional center provide ongoing support to the individual and the new support team for a minimum of 90 days to provide consistency through the individual's continuum of care.
ICF Bed Consolidation	Regional centers continue to operate as directed in C.R.S. 27-10.5-301. Pending legislative approval, there will be a reduction of ICF beds in Grand Junction associated with the move off the campus (from 46 beds to 24 beds).
Source: RCTF Implementation and Final Report 2015	

COLORADO
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Office of Community Access and Independence

Veterans Community Living Centers

Veterans Community Living Centers

Veterans Community Living Center Enterprise Cash Balance by Fund Type FY 2016-17					
Revenue Source	**Fitzsimons**	**Florence**	**Homelake**	**Rifle**	**Total**
Federal Funds	$5,688,143	$2,610,058	$1,688,470	($737,674)	$9,248,997
Cash Funds	$5,250,559	$4,258,518	$2,754,839	($1,806,042)	$10,457,874
General Funds	$0	$0	$0	$0	$0
Total	**$10,938,702**	**$6,868,576**	**$4,443,309**	**($2,543,716)**	**$19,706,871**

Source: Department analysis of financial information contained in the Colorado Operating Resource Engine (CORE).

COLORADO
Department of Human Services

Office of Children, Youth, and Families

Children's Habilitation Residential Program Transfer

Children's Habilitation Residential Program Utilization

CHRP Involved Children/Youth by Fiscal Year		
	CHRP Enrollment During Year	Total # of CHRP Clients
FY 2012-13	91	91 unduplicated
FY 2013-14	69	82 unduplicated
FY 2014-15	36	71 unduplicated
FY 2015-16	44	Not completed to date
FY 2016-17	39	Not completed to date

Distribution of the type of petition utilized by county departments to obtain custody of the child/youth in 2017		
Petition Type	#	%
Traditional Dependency and Neglect Petition	43	88%
Petition for Review of Need for Placement	6	12%

Office of Administrative Solutions

COLORADO
Department of Human Services

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Department of Human Services

Office of Administrative Solutions

Compensation Adjustments for Direct Care Positions

Employment Market Challenges

State unemployment rate of 2.4%

State Unemployment rate for health care of 2.0%

State wages are not competitive

Benefits are not competitive or highly valued by entry-level staff

Vacancy Rates ranging from 4-33% (August 2017)

High acuity of patients and residents

Lack of regular performance or cost of living increase

Findings by CMS related to staffing at CMHIP and Pueblo Regional Centers

What have we done administratively to solve hire and retain qualified staff?

Open competitive recruitment for direct care positions	Increased recruitment efforts through multiple venues	Implementing hiring and new employee orientation on a weekly and/or bi-weekly basis
Implementing referral, signing and retention bonuses	Implementing new job classifications to provide for career advancement	Provide more flexible work schedules
Hiring a staff consultant to improve staff scheduling	Exploring options for tuition reimbursement, continuing education credits	Developing goal to increase percentage of staffing coverage with regular work hours to reduce need for overtime or extended shifts

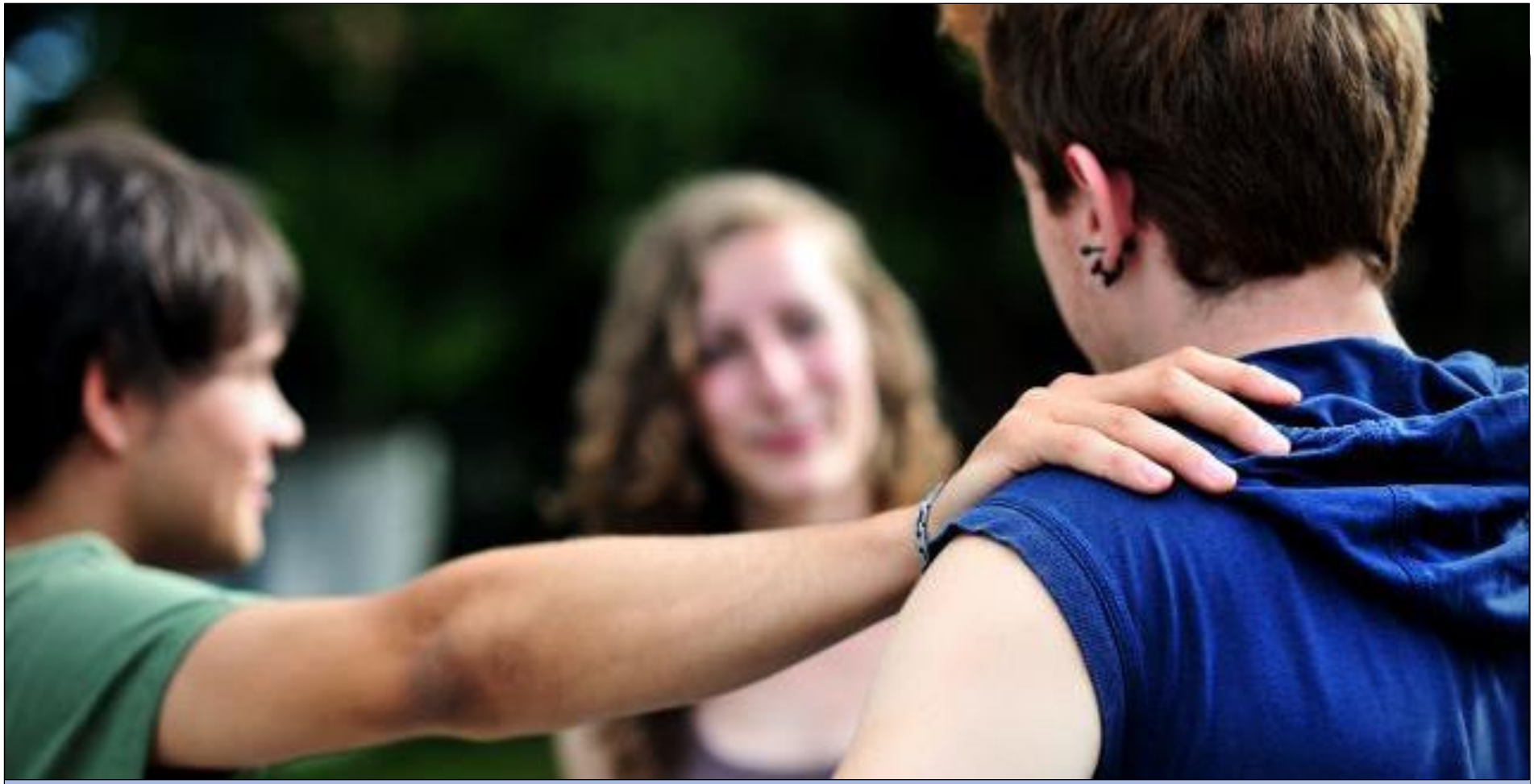
Office of Administrative Solutions FY 2018-19 Decision Items

- ***Phase I of II Compensation Adjustments for Direct Care Positions at DHS Facilities: $13.1 million total funds***
  - Colorado Mental Health Institutes, Veterans Community Living Centers, and the Division of Youth Services
  - Continued difficulty in recruiting and retaining highly qualified individuals to fill direct care positions throughout the 24/7 facilities

24/7 Direct Care Compensation Adjustments

Regional Center Comparison of Vacancy and Turnover Rates for Direct Care Staff at the Regional Centers Prior to and Post Pay Increases				
Regional Center	Sept 12, 2016 Vacancy Rate	November 20, 2017 Vacancy Rate	Cumulative Turnover Rate (March 2016-October 2016)	Cumulative Turnover Rate
Grand Junction	16%	6%	11%	7%
Pueblo	29%	4%	35%	17%
Wheat Ridge	15%	11%	33%	19%
Source: Department analysis of CPPS data				

- CMHIP pay adjustments effective November 1, 2017
  - Hired 15 nurses, 4 of whom were former CMHIP employees
  - Two part-time nurses elected to become full time



Office of Behavioral Health

COLORADO
Department of Human Services

Office of Behavioral Health
FY 2018-19 Decision Items

- ***Operating Requests***
  - **Compression Adjustment for Nurses at Colorado Mental Health Institute Pueblo: $8.9 million**
  - **Jail-Based Bed Space: $7.4 million and 3.3 FTE**
  - **Community Based Intensive Residential Treatment Program: Net zero transfer**
  - **Court Ordered Reports FTE Caseload: $1.1 million and 11 FTE**
  - **Purchased Bed Capacity: $3.4 million and 3.0 FTE**
  - **Outpatient Competency Restoration: $1.2 million and 3.0 FTE**
  - **Children's Mental Health Treatment Act: $650,000**
  - **Medication Consistency and Health Information Exchange: $590,000 and 0.9 FTE**

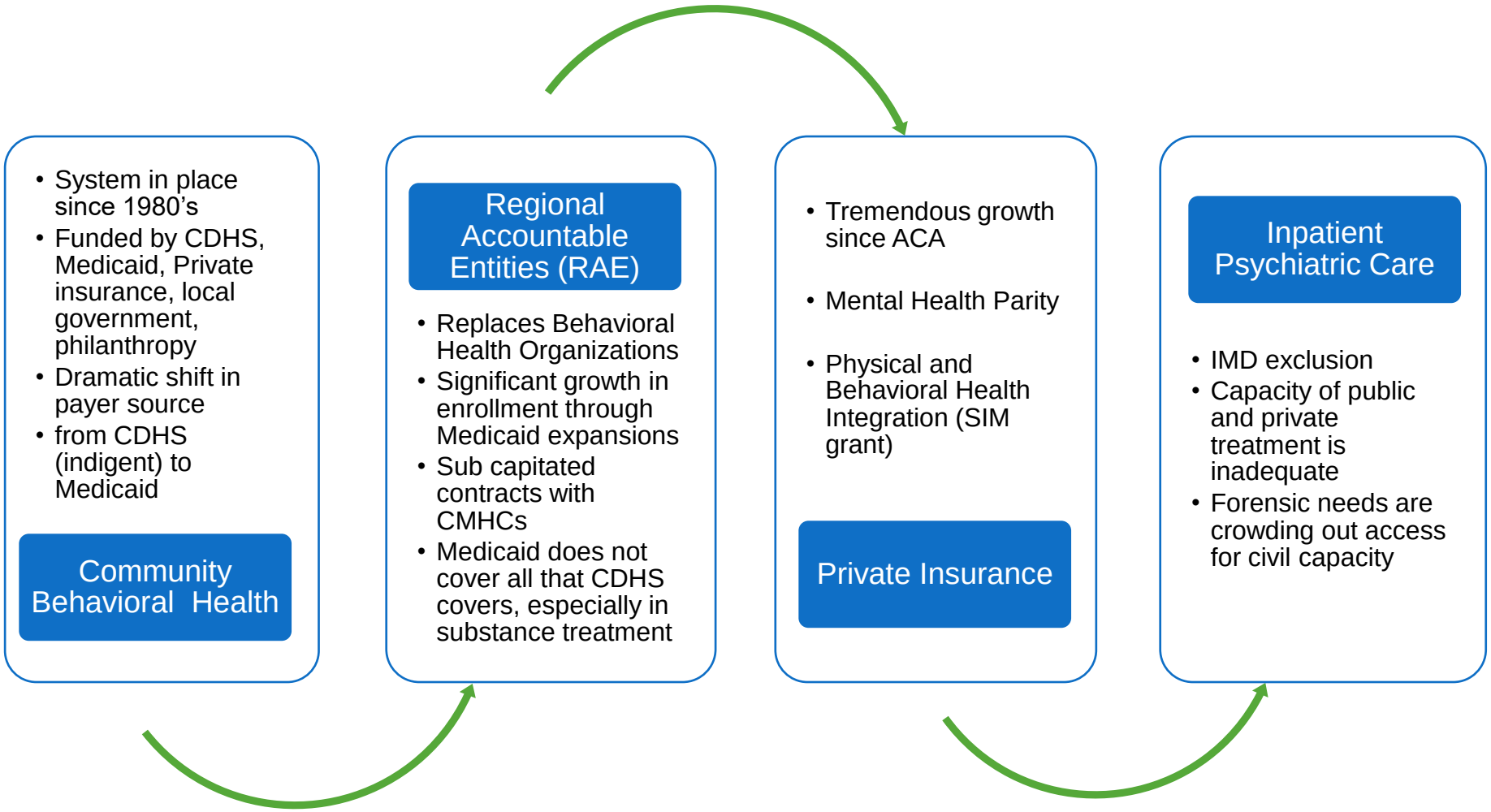
- ***Capital Requests***
  - Colorado Mental Health Institute at Fort Logan Window Replacement: $1.7 million
  - CMHIP Capital Renewal, Phase 1 of 3: $15.5 million
  - CMHIFL Capital Renewal, Phase 1 of 3: $8.9 million
  - Institute Facility Modernization Phase IIa: $11.8 million

COLORADO
Department of Human Services

Office of Behavioral Health

Behavioral Health Delivery System

Shifting Landscape of Behavioral Health

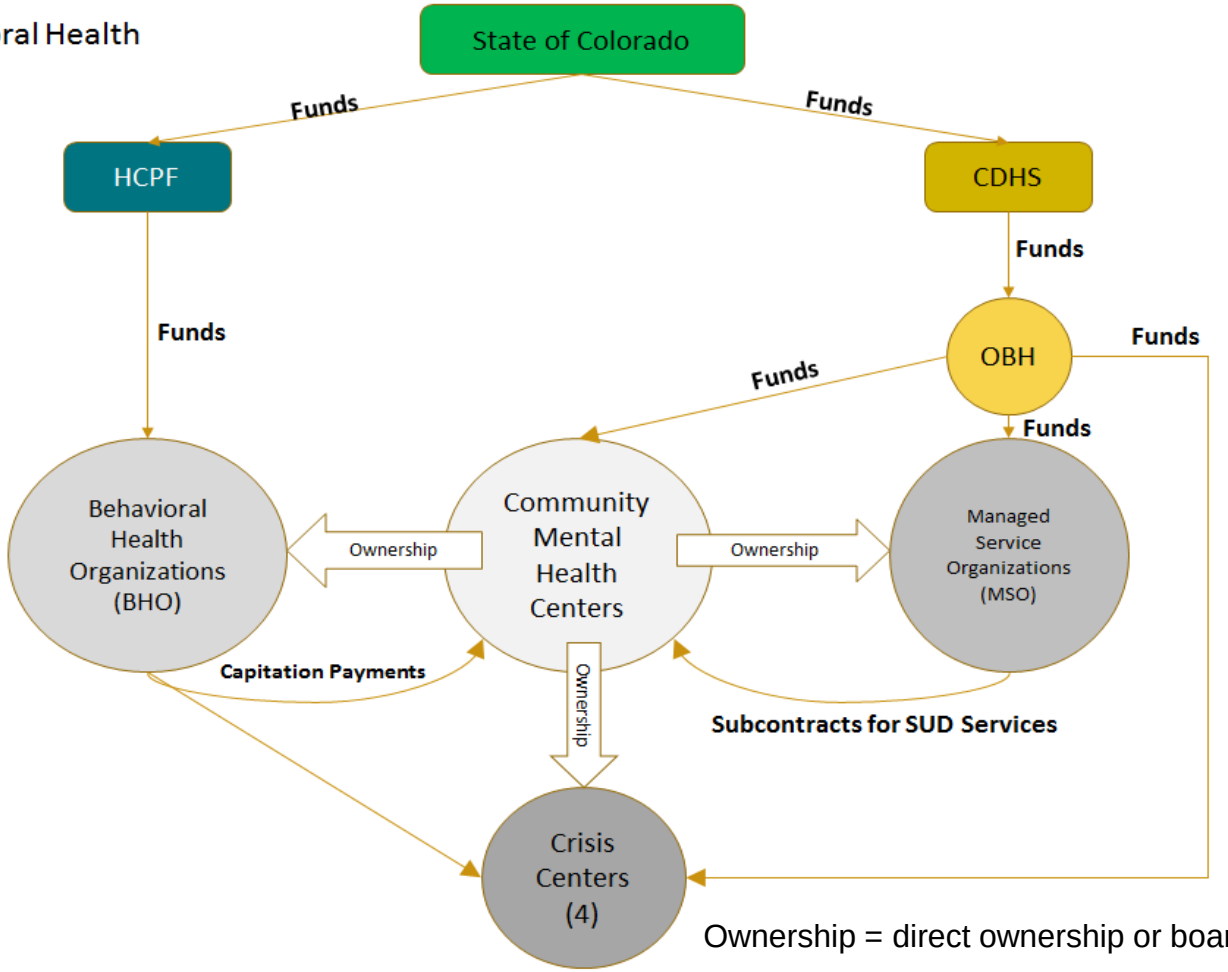


Behavioral Health Delivery System

Community Mental Health Center	Regional Accountable Entities (RAE)	Private Insurance	Managed Service Organization	State Mental Health Institutes
Indigent Individuals (Income less than 300% FPL, uninsured, or Medicare only, and not eligible for Medicaid)	Medicaid Recipients with an identified behavioral health need	Depends on enrolled members of private insurance companies	Uninsured individuals or individuals whose insurance does not include substance use disorder benefits and income does not exceed 300% FLP	Patients are court ordered or referred to by CMHCs, county departments of human services or the Department's Division of Youth Services

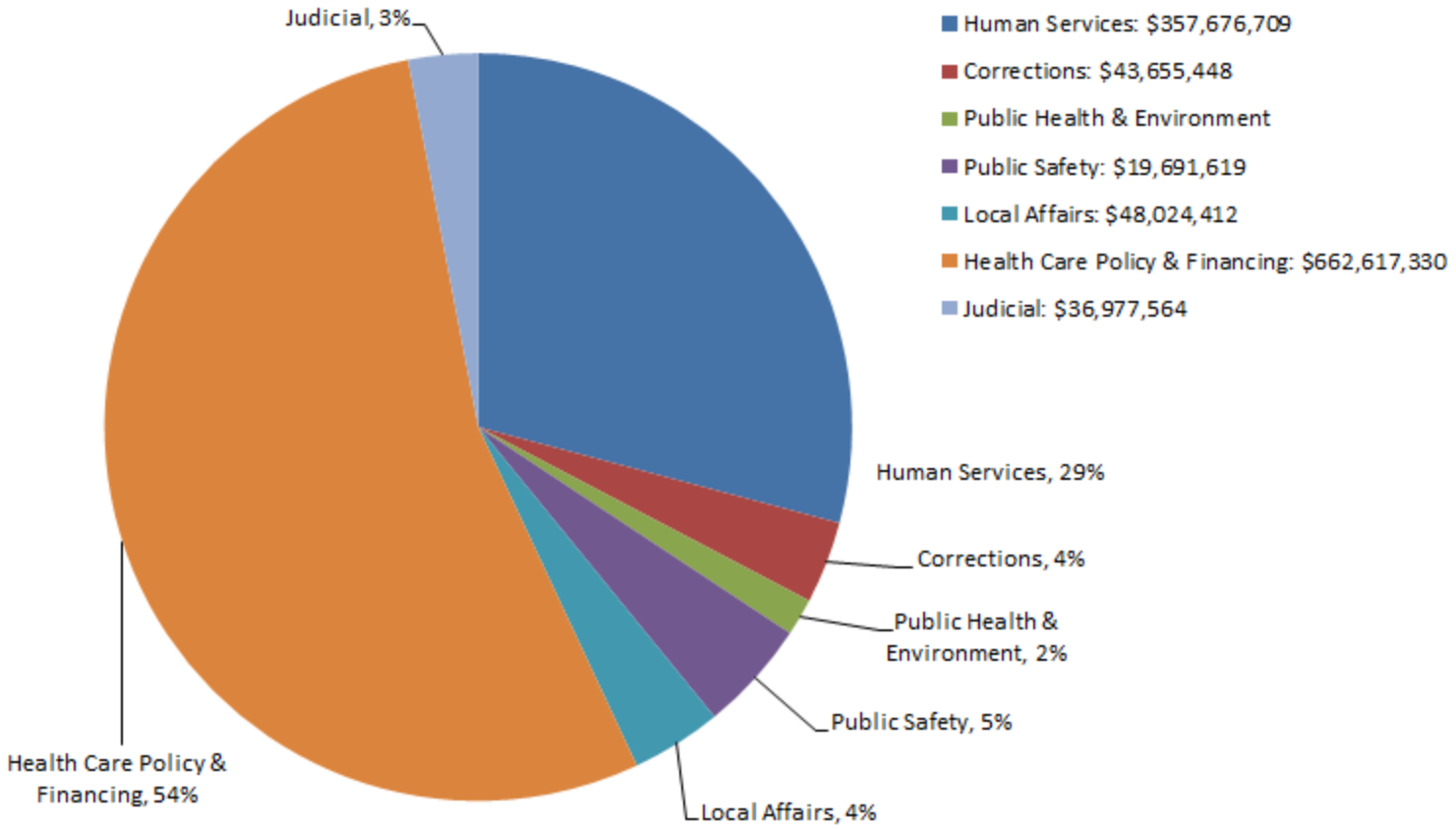
Behavioral Health Delivery System – Ownership Structures

Community Behavioral Health



Ownership = direct ownership or board representation

$1.2 Billion
Behavioral Health Funding



Adequacy of Resources

Existing Analyses

1. WICHE Needs Assessment
2. OSPB Study
3. CIRCLE Business Analysis
4. Colorado Health Institute Needs Assessment for the SAMHSA Opioid Crisis Grant

Legislative Options

1. Audit funding streams for CMHCs, MSOs, and Crisis System
2. Commission a study to evaluate quality, effectiveness, and efficiency of publically funded community behavioral health
3. Review existing methodology for distributing funding to be based on need

Adequacy of Resources: Inpatient Psychiatric Care FY 2016-17

Mental Health Institute	Bed Capacity	Patients Served	Forensic Patients	Civil Patients Served	Average Civil Length of Stay
Fort Logan	94	386	9	377	91.7
Pueblo	429	1,246	1,087	159	90.1
Other State Beds	1,525	N/A	N/A	N/A	N/A
Total	**2,048**	**1,632**	**1,047**	**545**	**N/A**

COLORADO
Department of Human Services

Office of Behavioral Health

Quality of Care and Potential System Improvements

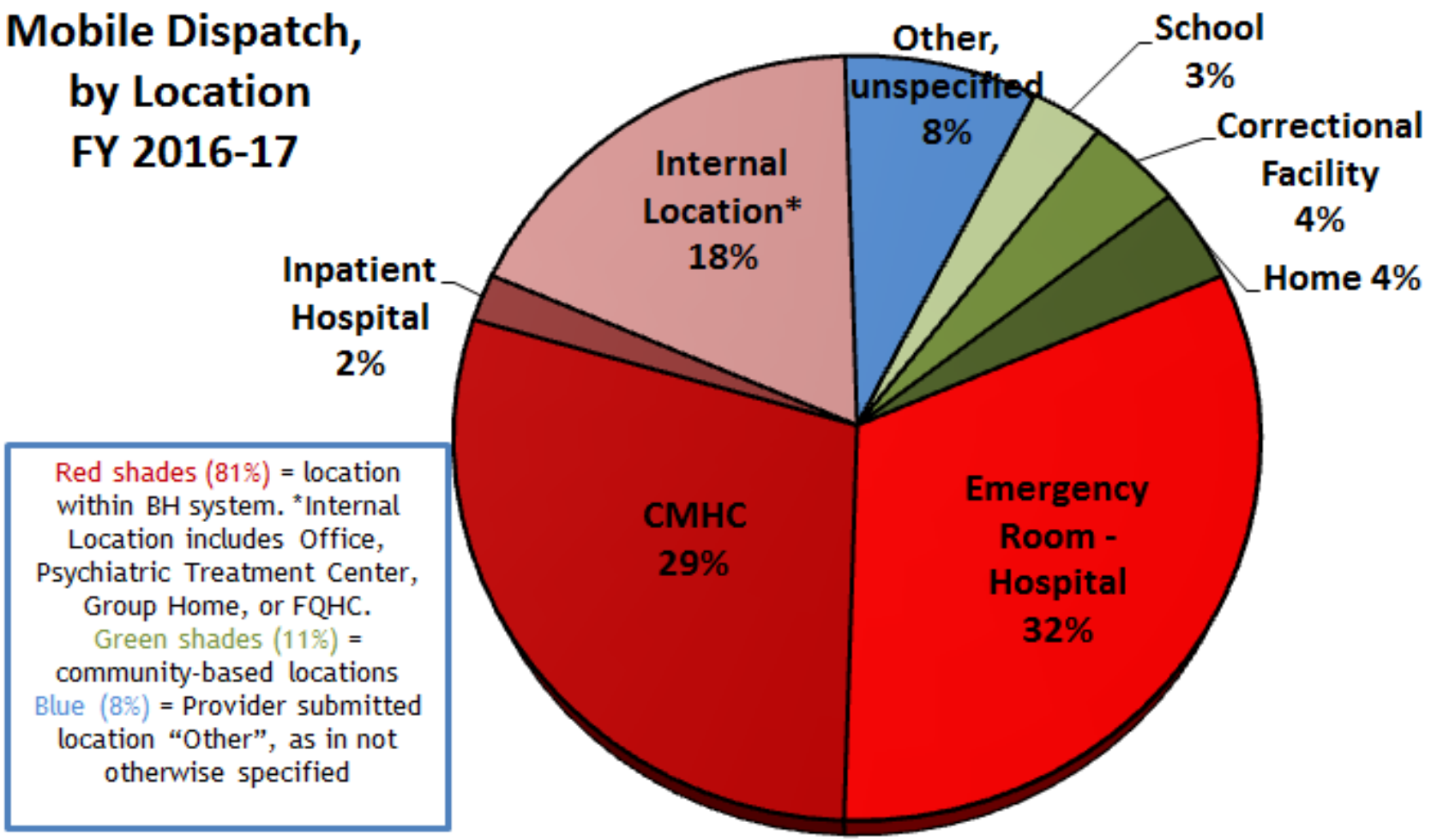
Community Behavioral Health Division

- Number of people with Opioid Use Disorder
- Percent of Persons Engaged in Substance Use Disorder Services
- Improved Living Situation for Homeless – Mental Health
- Crisis Services – Timeliness
- Crisis Services – Suicidality
- Timeliness of License Issuance

Mental Health Institute Division

- 24/7 Facility Staffing
- Patient to Staff Assaults
- Events of Medication Variance
- Percent of Civil Readmissions within 30 Days
- Percent of Civil Readmissions within 180 Days
- Percent of Current Civil Patients Ready for Discharge Except for Barriers

Mobile Crisis Response



Community Behavioral Health Forums

Strengths

- Assertive Community Treatment
- Peer Support Services
- Community Partnerships
- Integration
- Individuals Placement and Supports

Areas Needing Improvement

- Same-Day Access to Services and Network Expansion
- Medication-Assisted Treatment (MAT)
- Impatient Residential Services
- Substance Use Disorder Services for Pregnant Women and Adolescents
- Cost and Complexity
- Workforce and Transportation
- Prevention and Intervention Services
- Housing

COLORADO
Department of Human Services

Office of Behavioral Health

Court Orders Concerning Competency

Need for Inpatient Services

Competency Evaluation

- **Inpatient Evaluation only needed for:**
  - Individuals deemed to be a danger to self or others
  - Individuals who completed initial outpatient evaluation unsatisfactorily

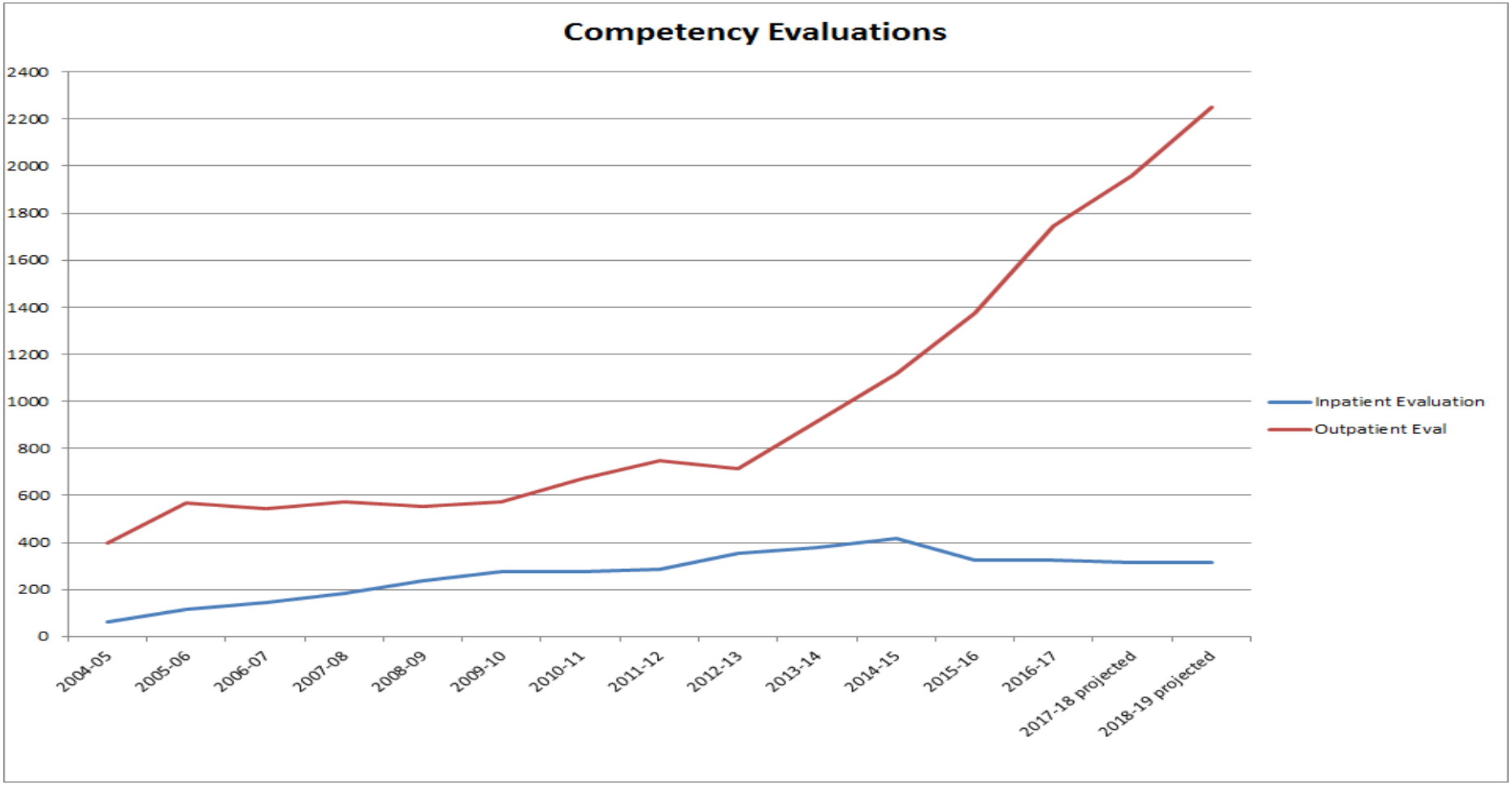
Restoration to Competency

- **Inpatient Restoration only needed for:**
  - Individuals deemed to be a danger to self or others
  - Individuals clinically determined to need inpatient services

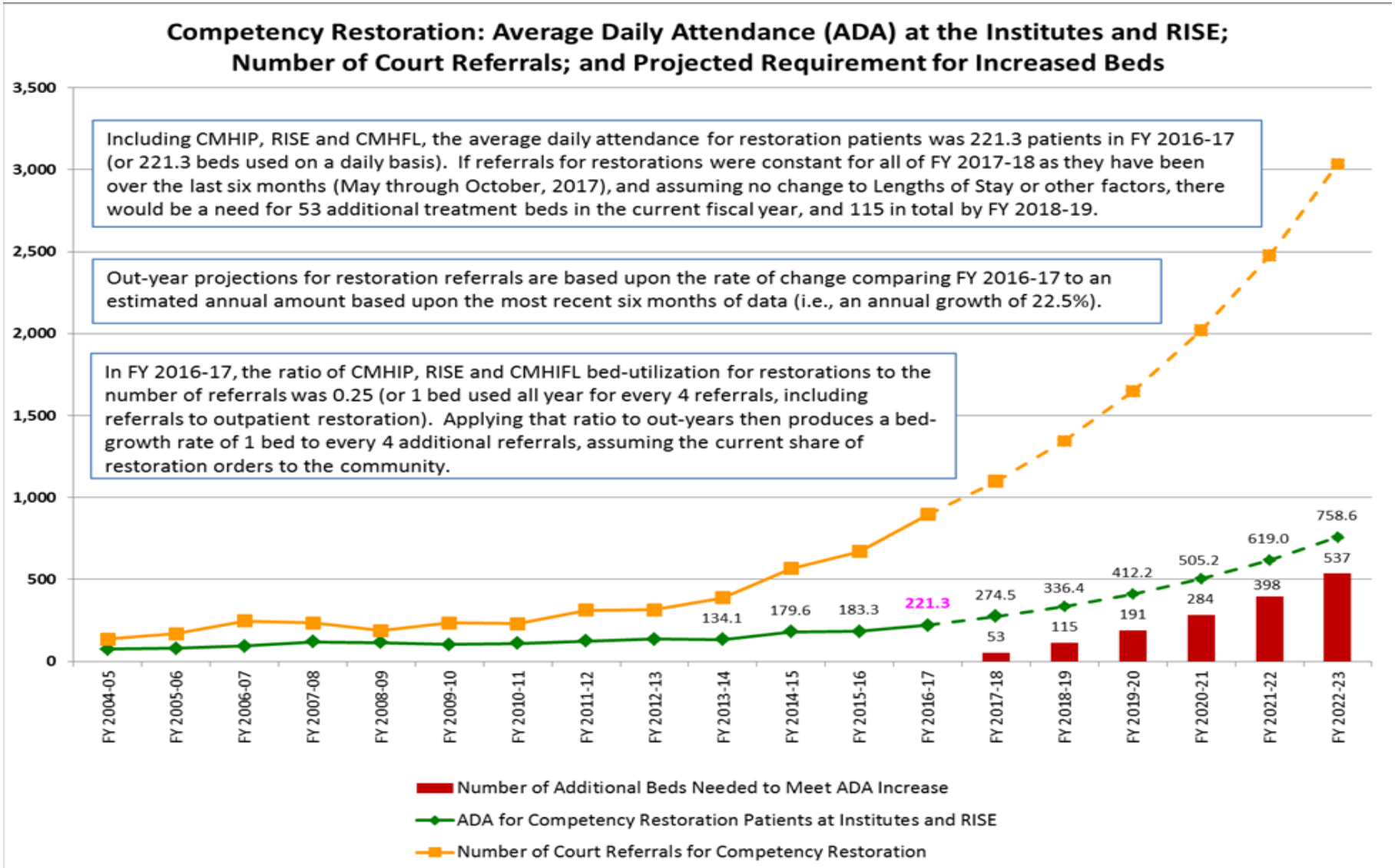
Cost of Competency Services by Inpatient Setting

		Competency Evaluation	Restoration to Competency
CMHIP	Cost per day	$676/day	$676/day
	Average Length of Stay	38.9 days	141.2 days
Jail-based (RISE)	Cost per day	$310.50/day	$310.50/day
	Average Length of Stay	38.8 days	83.1 days
Community and Jail Settings	Cost per day	$29.68/day	$29.68/day
	Average Length of Stay		212.8 days

Court Ordered Referrals for Competency Evaluations



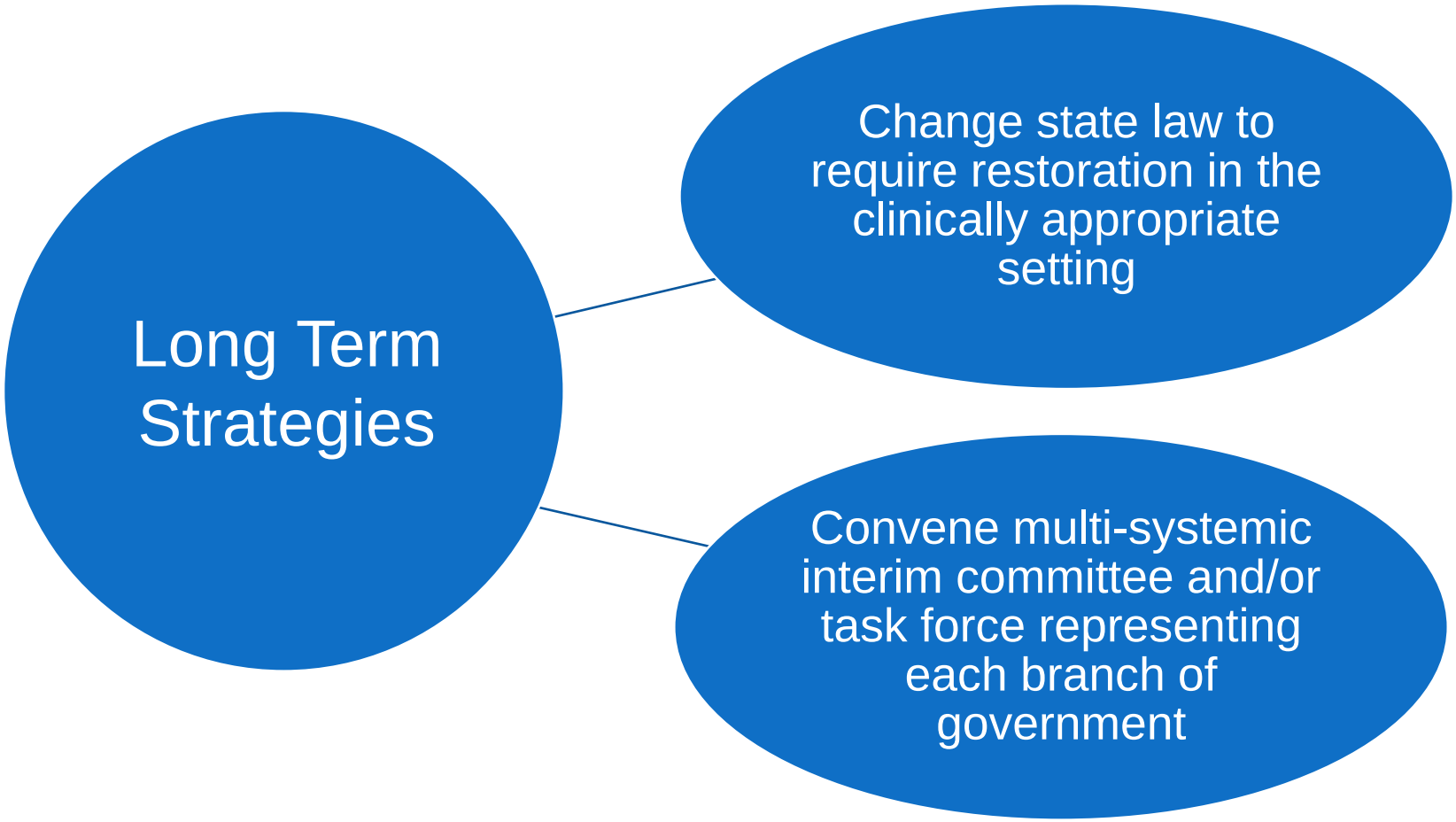
Competency Restoration



Centers for Legal Advocacy V. Bicha Compliance Efforts

- FY 2018-19 Requests
  - Jail-Based Bed Space: $7.4 million and 3.3 FTE
  - Court Ordered Reports FTE Caseload: $1.1 million and 11.0 FTE
  - Purchased Bed Capacity: $3.4 million and 3.0 FTE
  - Outpatient Competency Restoration: $1.2 million and 3.0 FTE
  - Medication Consistency and Health Information Exchange: $590,000 and 0.9 FTE

Addressing the Settlement Agreement



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Office of Behavioral Health

Colorado Mental Health Institute at Pueblo

CIRCLE Program - Community Based Intensive Residential Treatment Program

- Program provides comprehensive residential treatment to individuals with co-occurring substance use and mental health disorders.
- Eligibility: Referrals from the criminal justice system and CMHIP
- CIRCLE Business Analysis – September 2016
- Funding: Maximize funding sources including Medicaid

Adolescent Unit at the CMHIP

- Referrals
  - Court for competency evaluations or restoration services
  - Civil mental health hold
  - Division of Youth Services transfer

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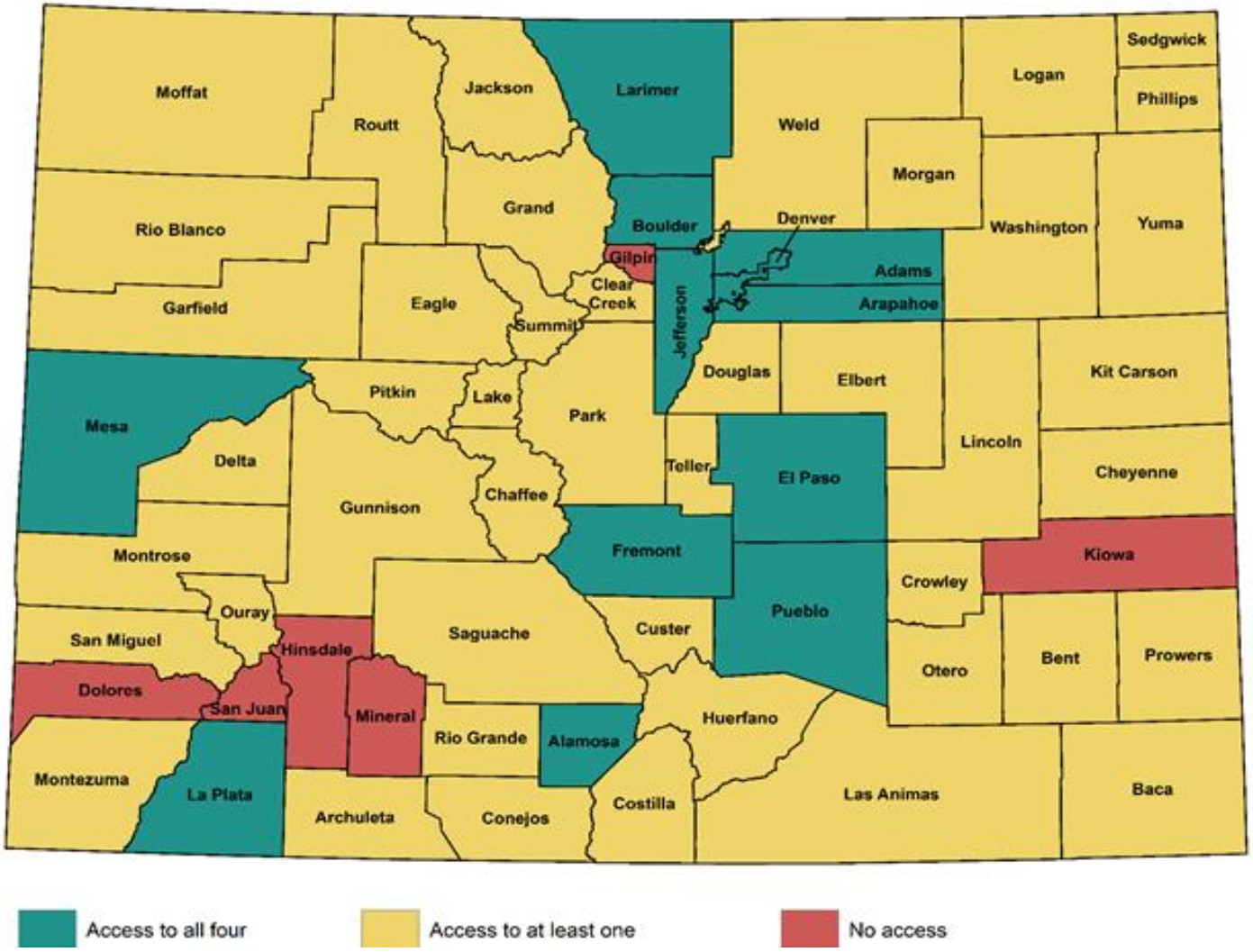
Department of Human Services

Office of Behavioral Health

Substance Use Disorder and SB 16-202

Adequacy of Detoxification Services



COLORADO
Department of Human Services

Reggie Bicha

Executive Director

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303-866-3475

DEPARTMENT OF HUMAN SERVICES
FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA
SERVICES FOR PEOPLE WITH DISABILITIES AND OFFICE OF BEHAVIORAL HEALTH

Thursday, December 14, 2017
1:30 pm – 5:00 pm

SERVICES FOR PEOPLE WITH DISABILITIES

1:30-1:40 INTRODUCTIONS AND OPENING COMMENTS

1:40-1:50 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SYSTEM POLICY

1 Please describe, in detail, the vision and direction for the IDD system in the State of Colorado. (For example, what should this system look, how should it be structured, and how should it function?). Given the changes that have occurred and are underway, what next steps should be taken to ensure that the system adequately and appropriately serves people with intellectual and developmental disabilities within the context of this vision?

2 Through what process does the department analyze the initiatives included in, but not limited to those identified in Appendix E of the briefing document, to determine the impact of each one on any other initiative and on the IDD system as a whole? Are the changes resulting from these initiatives leading to the achievement of the vision described above, or are they impeding the process? Are there additional unfunded federal mandates that should be included in the department's analyses of initiatives? Does the Department have enough resources (staff and time) to perform the necessary analysis?

1:50-2:00 REGIONAL CENTERS

3 Please provide an update on the Pueblo Regional Center Corrective Action Plan progress. What progress has been made toward lifting the placement restriction at this institution?

4 Please describe, in detail, the vision for day programming at the Grand Junction Regional Center? How can they be expanded in order to integrate other service opportunities, such as long term services and supports?

5 Please discuss the Department's proposal and community concerns regarding the size and number of group homes to be built for the Grand Junction Regional Center.

6 Please provide the following data for each regional center for the past five fiscal years:

a. Total number of beds by type
b. Number of occupied beds (census) by type
c. Total number of staff by job classification
d. Salary of staff

2:00-2:10 REGIONAL CENTER TASK FORCE

7 Please provide additional detail concerning the information provided in the Implementation Summary Table (page 54 of the JBC staff briefing document for HCPF). Specifically, please explain how both the Scope and the Resources are reported as "Good" while the status of some deliverables are "On Hold" or "Not Started" and while the status of other deliverables is "In Progress" but not on schedule. Please provide additional information about each project milestone, and indicate by which date the Department expects to complete each recommendation identified in the table.

8 What source and level of funding has been made available to the Department for implementation of the Regional Center Task Force recommendations? Is the level of funding adequate?

2:10-2:25 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM TRANSFER

9 Please provide data reflecting the total number of IDD children in out of home placement receiving services through the CHRP waiver for the past five fiscal years. Of these children, how many children are placed as a result of a dependency and neglect finding and how many are placed as a result of a Petition for Review of Need for Placement?

10 If the requested legislation were to become law, through what process will parents need to go in order to have their child(ren) returned home after an out of home placement that resulted from a Petition for Review of Need for Placement?

11 Is the under-utilization of Medicaid by county child welfare agencies related to the provision of services to children with IDD under the CHRP waiver? Please explain. How will the passage of this legislation affect the county child welfare Medicaid utilization rate?

12 Under current law, what are the legal, professional, and personal implications to parents of having to relinquish their custodial rights in order to receive services for their IDD child(ren)?

2:25-2:30 VETERANS COMMUNITY LIVING CENTERS

13 Please provide details on each funding source for Veterans Community Living Centers, including where the funding originates. What is the balance in cash funds from which spending authority is granted to the centers. How are these funds used?

14 Please provide additional information about the Department's R21 budget request to reduce the spending authority and FTE to align with actual expenditures. Why were the positions at the centers not filled and subsequently the eliminated? Does the reduction in FTE correspond with best practices in caseload per FTE in nursing homes?

2:30-2:45 Compensation Adjustments for Direct Care Positions

15 Has the Department experienced improvement in employee and recruitment at the Colorado Mental Health Institute at Pueblo and the three regional centers since salary increases were implemented for nurses and direct care staff, respectively?

16 How do state salaries for each job type identified in the Department's request, including positions at the regionals center and the Colorado Mental Health Institute (whose salaries have already been increased) compare with salaries for like positions in private provider organizations (CPAs, RCCFs, CCBs, PASAs) with whom the state or counties contract to deliver services? In addition, how are regionals issues factored into the determination of these salaries?

17 For the past ten fiscal years, please provide data on the number of direct care positions by type in:
   a. The State of Colorado (include division), and
   b. Private provider organizations (include organization type, i.e. CCB, RCCF, CPA, PASA, etc).

18 Given the recent data indicating that increased salaries for direct care positions have improved recruitment and retention rates at the state's regional centers, and that such improvements are intended to further result in improved care of and outcomes for individuals served, please discuss options for reducing the negative impact of work force competition with nongovernmental provider agencies (including but not limited to Child Placement Agencies, Residential Child Care Facilities, Community Centered Boards, Program Approved Service Agencies) so that they do not experience increasing turnover and negative outcomes for clients.

19 If the Department's budget request is approved, how will the increased salaries of direct care positions at DYS impact the rate setting methodology process required by H.B. 17-1292?

2:45-3:00 BREAK

DEPARTMENT OF HUMAN SERVICES
FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA
SERVICES FOR PEOPLE WITH DISABILITIES AND OFFICE OF BEHAVIORAL HEALTH

Thursday, December 14, 2017
1:30 pm – 5:00 pm

OFFICE OF BEHAVIORAL HEALTH

3:00-3:10 INTRODUCTIONS AND OPENING COMMENTS

3:10-3:50 BEHAVIORAL HEALTH SERVICE DELIVERY SYSTEM

System Structure

20 Provide a chart or graphic that describes the criteria for determining whether an individual is eligible to receive behavioral health services through the Department of Health Care Policy and Financing, the Department of Human Services, or both. Please include information about criteria that may apply differently depending on the individual (e.g., age, whether one is pregnant, diagnoses, etc.), the type or level of service, or the service setting.

21 Describe the origin of the regions for community mental health centers, managed service organizations, and the behavioral health crisis response system.

a. If a county would like to change its assigned region, how can it seek such a change?

b. If an individual in a rural area needs access to behavioral healthcare, but does not like the services that are available through their community mental health center, what are their options? Can an individual choose his or her own provider for mental health or substance use services?

22 Describe the ownership structure, for profit/not for profit status, and nature (e.g., community mental health center, hospital, private behavioral health service provider, etc.) of each of the entities that the Department contracts with, including:

a. Community mental health centers;
b. Managed service organizations; and
c. Behavioral health crisis response system vendors.

Adequacy of Resources

23 Given the array of programs and funding sources that support behavioral health services, how should the General Assembly evaluate the sufficiency of resources for individual communities to provide necessary mental health, substance use, and behavioral health crisis services – particularly in rural and frontier areas?

24 Provide information concerning the sufficiency of civil inpatient psychiatric treatment capacity in Colorado, including:

a. available data or estimates concerning the number of "civil" patients who require inpatient psychiatric treatment (i.e., please exclude individuals who are ordered to receive inpatient psychiatric treatment because they are either determined not guilty by reason of insanity or they are incompetent to proceed to trial);
b. the average length of stay for inpatient psychiatric care (i.e., any actual length of stay data that is available and any data that describes a typical length of stay for this type of care along the treatment continuum); and
c. the statewide capacity (both public and private) for inpatient psychiatric care.

Quality of Care and Potential System Improvements

25 The appropriations for behavioral health services have increased significantly in recent years, but do we have any idea if these increases are resulting in quality services? Is the Department using national standards to measure outcomes and success (e.g., access to care in a timely manner)?

26 *[Background information: The behavioral health crisis response system was intended to reduce the use of emergency department services by individuals experiencing a mental health crisis by increasing the availability of community-based care. We have heard reports that many crisis system contractors are asking people to meet "mobile" responders at an emergency department or at their local community mental health center.]* Provide data concerning the services provided through the behavioral health crisis response system and the related outcomes.

a. What are the Department's expectations related to mobile response services? Should an individual in crisis be required to visit the emergency room (and incur the charges for that visit) in order to receive mobile response services?

27 In recent years, the State has appropriated funds to support Mental Health First Aid (MHFA) instructor training. Knowing that this program is widely recommended for schools, healthcare providers, criminal justice entities, the military community and more, is the existing appropriation sufficient? What should the State's goals be, especially considering recent recommendations from the Commission on Criminal and Juvenile Justice concerning the use of MHFA as part of the Peace Officer Standards and Training curriculum?

28 Describe the Department's current efforts to promote integrated (primary and behavioral) health care. What are the existing barriers to advancing integration?

29 Discuss the feedback that the Department received through its recent series of community forums.

30 Given the complexity of the behavioral health service delivery system, how do individuals access the correct services at the correct time? How do service providers determine the appropriate program or funding source for a particular client or service? What ideas should the General Assembly consider to improve the ability of individuals, communities, and service providers to understand and navigate the system?

3:50-4:20 COURT ORDERS CONCERNING COMPETENCY

31 Under what circumstances should a competency evaluation be performed in a psychiatric hospital? Under what circumstances should competency restoration services be provided in a psychiatric hospital?

32 What are the relative costs of performing a competency evaluation or providing competency restoration services:

a. At CMHIP;
b. At the jail-based competency restoration program (RISE);
c. In a jail where a defendant is in custody; and
d. In the community?

33 Discuss efforts under way to comply with the Settlement Agreement with the Center for Legal Advocacy, including:

a. the Department's plans for spending the FY 2017-18 funding that was approved by the Joint Budget Committee on September 20; and
b. the funding requested by the Department for FY 2018-19.

34 The Department's requests related to competency are based on the assumption that the number of competency-related court orders will continue to grow rapidly. What actions is the Department taking or does the Department propose to reduce this rate of growth (e.g., by preventing individuals with mental health disorders from becoming justice-involved or being repeatedly referred for competency evaluations)?

35 The Department requests $1.1 million to provide community-based competency services pursuant to S.B. 17-012 (R5e). Why is this request prioritized last among the proposals to address competency-related services? Are the existing resources available for community-based behavioral health services and the resources requested by the Department for FY 2018-19 sufficient to provide community-based restoration education and treatment for all defendants for whom this level of care is appropriate? Would the Department consider an approach that offers a more balanced allocation of resources between community-based services and inpatient services?

36 The Department requests $7.4 million for FY 2018-19 to expand the RISE program (R5a). How effective is this program in restoring individuals' competency in a timely fashion? What is the average length of stay for individuals in the program? Is this an effective use of State funds?

37 The Department requests $3.4 million to contract with hospitals to expand the capacity to provide inpatient competency-related services (R5d). Has this hospital-based restoration model been tried in other states? How many patients does the Department anticipate serving each year?

38 Provide feedback concerning the additional policy options that are listed in the Staff Budget Briefing document concerning the Office of Behavioral Health *[starting at the bottom of page 20, through page 22]*.

4:20-4:40 COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO

Circle Program Proposal

39 Describe the Department's proposal to move the Circle Program out of the Colorado Mental Health Institute at Pueblo (CMHIP) and instead provide these services through community-based service providers. Please include information concerning the following topics:

a. Has the Department evaluated the Program admission policies and practices to determine if they are aligned with the areas of greatest need for co-occurring services? If so, does the Department plan to change the admission policies and practices?

b. Describe with Department's plans to partner with the Department of Public Safety to maximize local provider services.

c. Has the Department determined what type of licensure would be appropriate for a community-based Circle Program?

d. How will the Department's decisions about admissions policies and practices, program licensure, and program capacity affect the Program's ability to leverage other sources of revenue, including Medicaid and private insurance?

e. Does the Department plan to increase access to these services in geographic regions other than the Pueblo area?

40 If the Circle Program is not opened again on the CMHIP campus (in the space that has previously been used as an emergency shelter location), does the Department have plans for using this space to serve other patients? What additional funding would be required to prepare this space and staff the unit?

Adolescent Unit at the Colorado Mental Health Institute at Pueblo

41 Discuss the adolescent unit at CMHIP, including the following:

a. Explain how and why an adolescent can be referred to CMHIP.

b. Are there safety issues associated with serving civil and forensic patients in the same unit?

c. Describe how moving the adolescent unit to the building that previously housed the Circle Program will improve safety on the unit.
d. Has the Department performed an analysis to determine whether it is cost effective to provide services to adolescents at CMHIP? Are there community-based facilities in the community that could meet the clinical needs of these adolescents?

4:40-5:00 SUBSTANCE USE DISORDER SERVICES AND S.B. 16-202

42 Please describe any existing state statutory provisions that limit local governments' ability to implement zoning restrictions that prohibit community-based residential substance use disorder treatment facilities that have a capacity of 16 or fewer beds. Does the Department or any other state agency monitor local government compliance with these provisions?

43 Describe the availability and adequacy of detoxification services statewide, for both men and women.
a. Does the State currently have the right balance of resources between emergency/crisis services and detoxification/treatment services?
b. What is an appropriate length of stay for detoxification services?

44 The Joint Budget Committee is considering making two changes, described below, to clarify the General Assembly's intent concerning the expenditure of funds available pursuant to S.B. 16-202 by managed services organizations (MSOs). Confirm whether the Department would allow MSOs a full two years to spend each annual disbursement, starting in FY 2017-18, if the following two changes are implemented.

> Statutory change: Amend Section 27-80-107.5 (4)(c), C.R.S., as follows to clearly authorize MSOs to spend the annual disbursement in the fiscal year received or in the subsequent fiscal year:
>
> "It is the intent of the general assembly that each designated managed service organization use money allocated to it from the marijuana tax cash fund to cover expenditures ~~for substance use disorder services~~ that are not otherwise covered by public or private insurance. Except as provided in paragraph (a) of this subsection (4), each managed service organization may use its allocation from the marijuana tax cash fund to implement its community action plan and increase access to substance use disorder services for populations in need of such services that are within its geographic region. EACH MANAGED SERVICE ORGANIZATION IS AUTHORIZED TO SPEND ITS ANNUAL ALLOCATION IN THE STATE FISCAL YEAR IN WHICH IT IS RECEIVED OR IN THE SUBSEQUENT FISCAL YEAR."

Long Bill amendment: Within the Long Bill letter notation associated with the "Increasing Access to Effective Substance Use Disorder Services (SB 16-202)" line item, authorize the Department to record expenditures against the appropriation over a two-year period by adding the following letter notation:

"This amount shall be from the Marijuana Tax Cash Fund created in Section 39-28.8-501 (1), C.R.S. THIS APPROPRIATION REMAINS AVAILABLE THROUGH JUNE 30, 2019."

45 Please review the Department's current contracts related to S.B. 16-202 disbursements and the related processes to determine whether there are any actions the Department can take to streamline the processes and make the disbursements by the statutorily required July 1 date. If not, please describe why the current processes are necessary and specify the earliest date on which the Department can make annual disbursements.