JOINT
BUDGET
COMMITTEE

STAFF BUDGET BRIEFING
FY 2019-20

DEPARTMENT OF HUMAN SERVICES
(Services for People with Disabilities)

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

PREPARED BY:
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DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OVERVIEW

The Department of Human Services is responsible for the administration and supervision of all non-medical public assistance and welfare programs in the state. It supervises programs that are administered at the local level by counties and other agencies and directly operates mental health institutes, regional centers for people with developmental disabilities, and institutions for juvenile delinquents. This presentation focuses on the division that provides Services for People with Disabilities, including Regional Centers for People with Developmental Disabilities, the Work Therapy Program, the Traumatic Brain Injury Trust Fund, and Veterans Community Living Centers.

DEPARTMENT BUDGET: RECENT APPROPRIATIONS

DEPARTMENT OF HUMAN SERVICES

FUNDING SOURCE	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20 *
General Fund	$831,980,417	$888,859,937	$982,587,627	$1,017,303,893
Cash Funds	390,905,724	421,971,649	418,697,165	435,822,328
Reappropriated Funds	129,320,756	183,915,841	184,976,303	190,706,212
Federal Funds	556,277,721	582,625,732	612,492,915	633,139,281
TOTAL FUNDS	**$1,908,484,618**	**$2,077,373,159**	**$2,198,754,010**	**$2,276,971,714**
Full Time Equiv. Staff	4,793.4	4,935.5	5,052.9	5,110.8

*Requested appropriation.

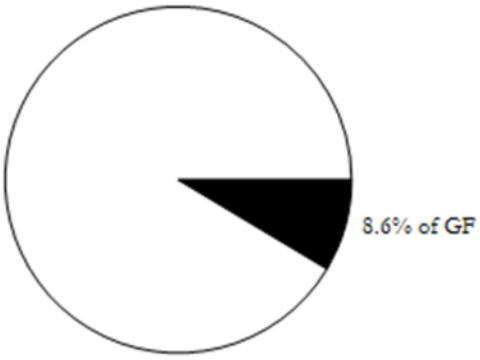
DEPARTMENT OF HUMAN SERVICES, SERVICES FOR PEOPLE WITH DISABILITIES

FUNDING SOURCE	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20 *
General Fund	$1,086,130	$1,045,430	$1,495,430	$3,387,564
Cash Funds	37,392,900	40,340,899	39,168,228	42,426,755
Reappropriated Funds	53,160,691	62,102,450	63,181,181	66,214,418
Federal Funds	21,846,300	21,444,164	21,444,882	21,445,602
TOTAL FUNDS	**$113,486,021**	**$124,932,943**	**$125,289,721**	**$133,474,339**
Full Time Equiv. Staff	1,433.6	1,433.6	1,414.6	1,414.6

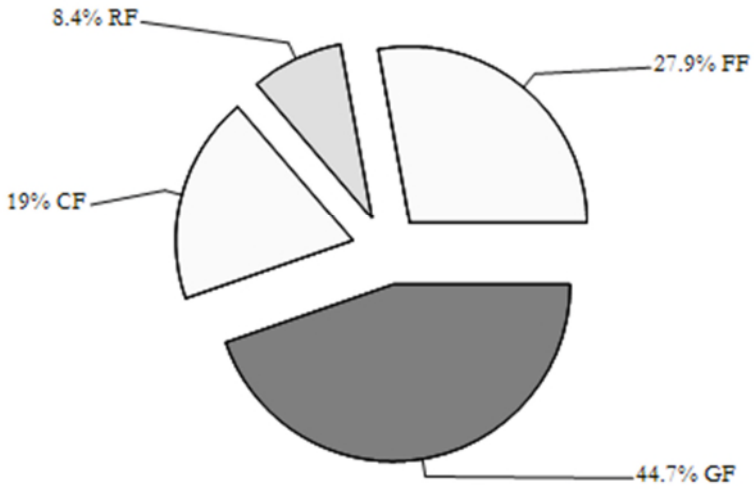
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

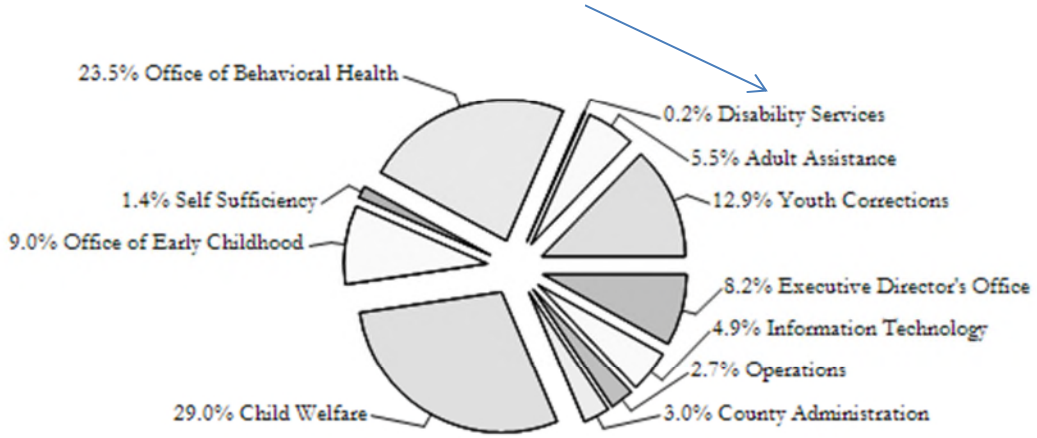


Department Funding Sources

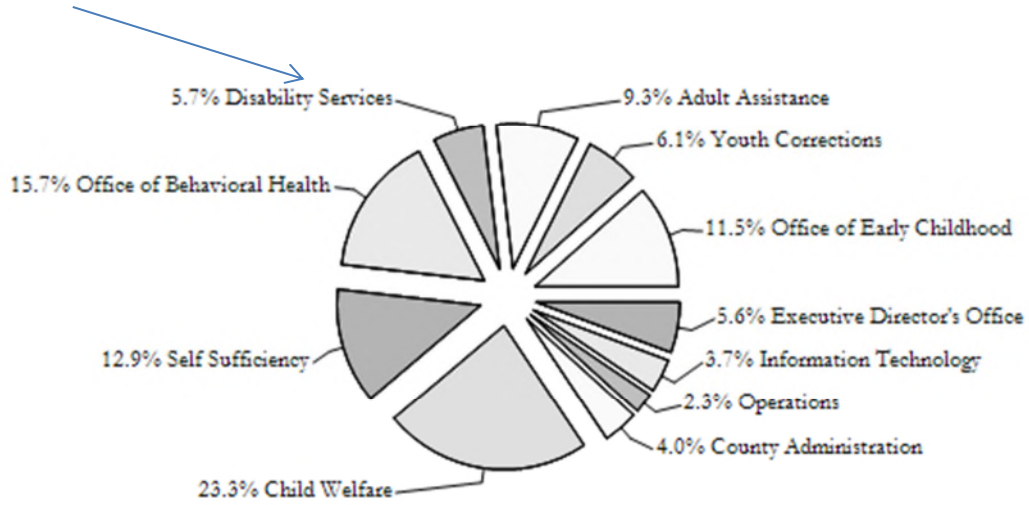


All charts are based on the FY 2018-19 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2018-19 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

Fiscal year 2018-19 funding for the Department of Human Services consists of 44.7 percent General Fund, 19.0 percent cash funds, 8.4 percent reappropriated funds, and 27.9 percent federal funds. This document consists of information on the system of services for intellectual and developmental disabilities, including regional centers and Veteran's Community Living Centers.

REGIONAL CENTERS

Regional Centers are state-operated facilities for individuals with developmental disabilities and they provide residential services, medical care, and active treatment programs based on individual assessments and habilitation plans. Services are provided in one of two settings: large congregate residential campus settings or community-based group homes that serve four to eight individuals. The state operates regional centers in Wheat Ridge, Grand Junction, and Pueblo. The Wheat Ridge Regional Center and the campus facility at Grand Junction are licensed as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The group homes at Pueblo and Grand Junction are licensed as waiver homes (waiver), which is the same license used by community-run group homes. Based on the Department's response to RFI #19, Joint Budget Committee Staff estimates that as of September 30, 2018, the regional centers had the following number of licenses and occupied beds:

REGIONAL CENTER DATA
(JBC STAFF-ESTIMATED CENSUS AS OF SEPTEMBER 2018)

	NUMBER OF RESIDENCES	NUMBER OF LICENSED BEDS	NUMBER OF OCCUPIED BEDS
Wheat Ridge ICF	19 (0 offline)	142	130
Pueblo HCBS	11 (3 offline)	88	45
Grand Junction ICF (on campus)	5 (3 offline)	46	20
Grand Junction HCBS (off campus)	10 (1 offline)	80	63

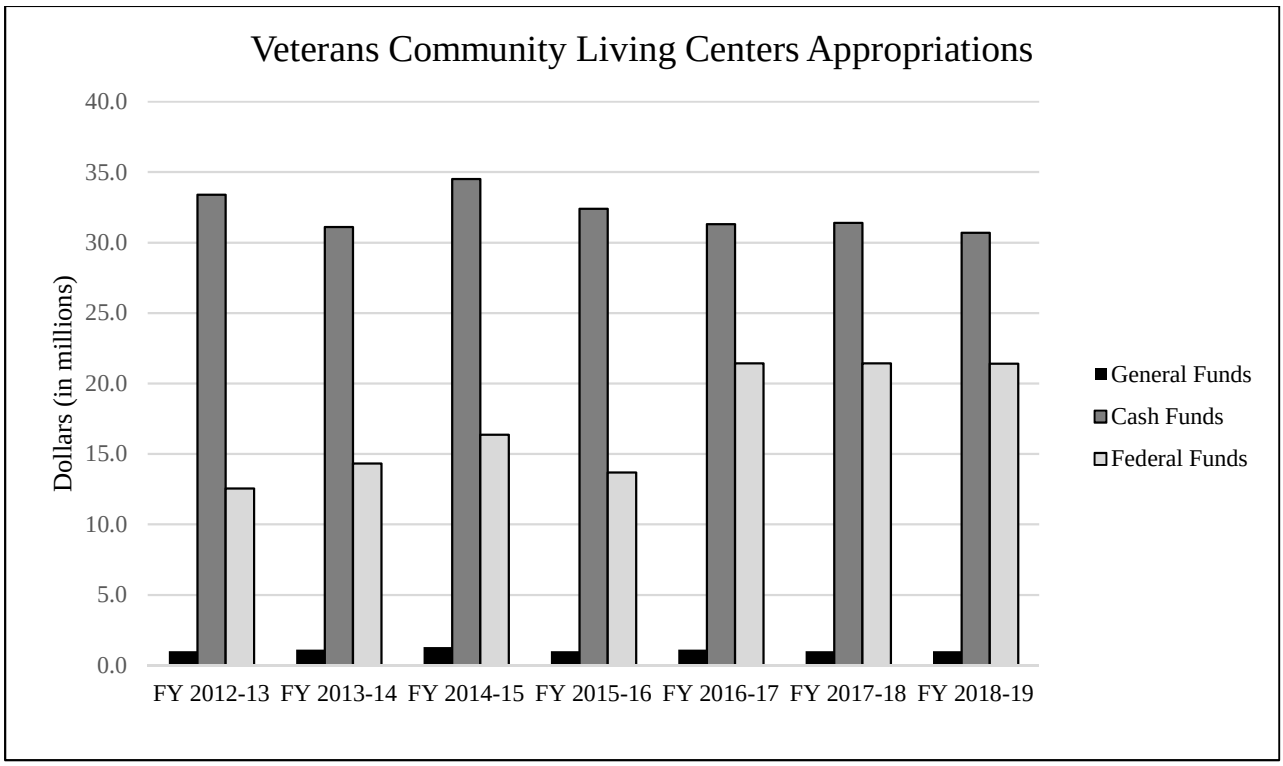
Fiscal Year 2017-18 actual expenditures and FY 2018-19 appropriations for each regional center is provided below.

REGIONAL CENTER MEDICAID FUNDING

FACILITY	CAPACITY	AVERAGE ANNUAL COST PER BED	TOTAL
FY 2017-18 Actual Expenditures			
Wheat Ridge Regional Center Intermediate Care Facility	142	$167,372	$23,766,800
Grand Junction Regional Center Intermediate Care Facility	46	162,967	7,496,495
Grand Junction Regional Center Waiver Services	80	117,109	9,368,684
Pueblo Regional Center Waiver Services	88	115,339	10,149,859
FY 2017-18 TOTAL	**356**	**$142,646**	**$50,781,838**
FY 2018-19 Appropriation			
Wheat Ridge Regional Center Intermediate Care Facility	142	$171,117	$24,298,667
Grand Junction Regional Center Intermediate Care Facility	46	180,311	8,294,316
Grand Junction Regional Center Waiver Services	80	118,585	9,486,803
Pueblo Regional Center Waiver Services	88	107,805	9,486,803
FY 2018-19 TOTAL	**356**	**$144,850**	**$51,566,589**

VETERANS COMMUNITY LIVING CENTERS

The Department manages and operates five state Veterans Community Living Centers with a total of 554 nursing home beds located at the Fitzsimons, Florence, Homelake, Rifle, and Walsenburg campuses. The Homelake campus includes a forty-eight bed domiciliary (assisted living facility). Services provided by the living centers include long-term care, short-term rehabilitation following a qualifying hospital stay, memory care, short-term respite care, and end-of-life hospice. Appropriations to line items that fund each center are primarily cash funds and federal funds. Cash funds are from the Central Fund for Veterans Community Living Centers (Central Fund), created in Section 26-12-108 (1)(a), C.R.S, and are continuously appropriated for direct costs. The Central Fund receives revenue from patient payments, U.S. Veterans Administration operation and construction grants, various sources of other revenue, and a General Fund appropriation pursuant to Section 26-12-108 (1)(a.5), C.R.S. Federal funds are from the U.S. Department of Veterans Affairs. Each fiscal year the informational appropriation is adjusted based on projected expenditures for the upcoming fiscal year.



SUMMARY: FY 2018-19 APPROPRIATION & FY 2019-20 REQUEST

DEPARTMENT OF HUMAN SERVICES	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION:						
HB 18-1322 (Long Bill)	$2,172,833,651	$960,747,033	$419,282,280	$187,608,968	$605,195,370	5,046.4
Other legislation	25,920,359	21,840,594	(585,115)	(2,632,665)	7,297,545	6.5
TOTAL	**$2,198,754,010**	**$982,587,627**	**$418,697,165**	**$184,976,303**	**$612,492,915**	**5,052.9**
FY 2019-20 REQUESTED APPROPRIATION:						
FY 2018-19 Appropriation	$2,198,754,010	$982,587,627	$418,697,165	$184,976,303	$612,492,915	5,052.9
R1 Mental Health Institute at Pueblo bed expansion	5,141,144	5,141,144	0	0	0	47.3
R2 Compensation for direct care employees	13,942,885	10,339,235	3,603,650	0	0	0.0
R3 Youth services capacity and behavioral health	(718,399)	(718,399)	0	0	0	(12.0)
R4 Reducing child neglect via employment	1,709,355	0	0	0	1,709,355	2.0
R5 Improving nutrition in rural and underserved communities	1,030,000	465,000	0	0	565,000	0.0
R6 Child support employment	966,977	0	0	0	966,977	1.0
R7 Employment affairs staffing	589,251	329,981	0	259,270	0	5.4
R8 County child welfare staff phase 5	6,125,404	4,500,647	612,541	0	1,012,216	0.0
R9 Colorado Works basic cash assistance COLA	1,171,848	0	173,135	0	998,713	0.0
R10 Adult protective services support	0	0	0	0	0	1.8
R11 Behavioral health crisis response system enhancements	985,092	985,092	0	0	0	3.6
R12 Contract medical staff salary adjustments	1,127,667	1,127,667	0	0	0	0.0
R13 Colorado Trails maintenance	2,452,920	1,103,814	0	0	1,349,106	0.0
R14 Child welfare provider rate implementation phase 2	10,350,000	4,968,000	2,070,000	0	3,312,000	0.0
R15 Community provider rate increase	9,253,301	5,417,348	1,472,169	104,926	2,258,858	0.0
R16 Old Age Pension Program cost of living adjustment	3,219,665	0	3,219,665	0	0	0.0
R17 State staff for 24-hour monitoring	164,519	136,551	0	0	27,968	1.8
R18 Hotline for child abuse and neglect	228,999	228,999	0	0	0	0.0
R19 Covering child support unfunded disbursements	150,896	150,896	0	0	0	0.0
R20 Food service inflation	150,910	98,442	0	52,468	0	0.0
R21 Salesforce Shield	251,318	29,218	0	222,100	0	0.0
R22 SNAP quality assurance line item	0	0	0	0	0	0.0
Indirect cost assessment	6,605,006	0	1,113,176	2,249,629	3,242,201	0.0
Non-prioritized request items	(14,562,029)	(13,915,138)	(263,701)	1,315,326	(1,698,516)	0.0
Annualize prior year legislation	7,227,873	6,592,005	323,089	190,516	122,263	4.1
Annualize prior year budget actions	(492,407)	(1,305,903)	239,816	(764,193)	1,337,873	2.9
Centrally appropriated line items	21,145,509	9,041,667	4,561,623	2,099,867	5,442,352	0.0
TOTAL	**$2,276,971,714**	**$1,017,303,893**	**$435,822,328**	**$190,706,212**	**$633,139,281**	**5,110.8**
INCREASE/(DECREASE)	$78,217,704	$34,716,266	$17,125,163	$5,729,909	$20,646,366	57.9
Percentage Change	3.6%	3.5%	4.1%	3.1%	3.4%	1.1%

Note: The table above represents the department-wide FY 2019-20 budget request. Requests that directly impact divisions addressed in this briefing document are represented by shading and described below.

R2 COMPENSATION FOR DIRECT CARE EMPLOYEES: For the Services for People with Disabilities division, the request includes an increase of $4,730,339 total funds, including $1,892,134 General Fund, to increase salaries for direct care staff job classifications at the Veterans Community Living Centers.

INDIRECT COST ASSESSMENT: For line items addressed in this briefing, the request includes a net increase of $1,799,414 total funds for the assessment of indirect costs associated with the operations of the Department.

INDIRECT COST ASSESSMENT						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
PERA Direct Distribution	$869,552	$0	$159,555	$709,777	$220	0.0
Payments to OIT adjustment	652,789	0	175,740	476,717	332	0.0
NP7 Securing IT operations	213,083	0	57,365	155,610	108	0.0
NP10 Enterprise data integration services	72,880	0	19,620	53,223	37	0.0
R21 Salesforce shield	52,680	0	14,182	38,471	27	0.0
Legal services adjustment	52,364	0	14,097	38,240	27	0.0
ALJ adjustment	35,240	0	9,487	25,735	18	0.0
NP8 Application refresh and consolidation	8,800	0	2,369	6,427	4	0.0
NP9 Optimize self-service capabilities	5,992	0	1,613	4,376	3	0.0
NP6 Essential database support	3,944	0	1,062	2,880	2	0.0
Indirect cost assessment adjustment	2,742	0	(12,744)	15,456	30	0.0
NP5 IDS increased input costs	1,868	0	503	1,364	1	0.0
Workers' compensation adjustment	(97,671)	0	(26,296)	(71,325)	(50)	0.0
Payment to risk management / property funds adjustment	(40,410)	0	(10,879)	(29,510)	(21)	0.0
Capitol Complex leased space adjustment	(21,350)	0	(5,748)	(15,591)	(11)	0.0
CORE adjustment	(9,698)	0	(2,611)	(7,082)	(5)	0.0
NP3 Annual fleet vehicle request	(3,391)	0	(913)	(2,476)	(2)	0.0
TOTAL	**$1,799,414**	**$0**	**$396,402**	**$1,402,292**	**$720**	**0.0**

ANNUALIZE PRIOR YEAR LEGISLATION: The request includes an increase of $134,277 total funds for the annualization of S.B. 18-200 (PERA).

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes an increase of $1,520,588 total funds for the annualization of prior year salary survey.

ISSUE: R2 COMPENSATION FOR DIRECT CARE EMPLOYEES (VETERANS COMMUNITY LIVING CENTERS)

The Department of Human Services (DHS) employs the largest number of direct care FTE in the State of Colorado. The positions are located at 19 24/7 care facilities, including two Mental Health Institutes, four Veterans Community Living Centers, 10 Youth Services Facilities, and three Regional Centers. The Department has experienced increasing difficulty in recruiting and retaining highly-qualified individuals to fill its direct care positions and as a result has been working with the Department of Personnel to evaluate direct care compensation for the past three years. The findings of the Department's analysis indicate that its direct care staff at Division of Youth Services facilities and Veterans Community Living Centers are, on average, making 22.0 percent below the prevailing market wage for similar positions in the private sector.

SUMMARY

The Department of Humans Services has been evaluating direct care staff compensation over the past several years. Between November 2016 and July 2018, the Department has increased direct care staff salaries at the three regional centers and two mental health institutes in order to more competitively recruit and retain employees. During the 2018 legislative session, the Department's FY 2018 -19 R1a budget request was partially funded, however the requested funding to increase staff salaries at Division of Youth Services facilities and Veterans Community Living Centers was denied.

The Department's FY 2019-20 R2 Compensation for Direct Care Employees budget request includes an increase of approximately $4.9 million total funds, including $1.3 million General Fund and $3.6 million cash funds, to increase salaries for direct care positions at the State's Veterans Community Living Centers (VCLC). As of August 2017, the average direct care vacancy rates for VCLCs was 14.0 percent. In August 2018, the direct care vacancy rate for the nursing homes increased to 21 percent. Joint Budget Committee staff is concerned that increasing direct care vacancy rates will have a negative impact on the capacity of the centers and on the care of the residents.

RECOMMENDATION

JBC staff is concerned about the impacts that increasing direct care vacancy rates will have on residents of the Veterans Community Living Centers, and recommends that the Committee ask the Department to respond to the following at its December 21, 2018 hearing:

- How do staffing levels for the direct care providers effect occupancy rates at the Veterans Community Living Centers?
- Please provide an update on the vacancy and turnover rates for direct care staff at the mental health institutes and regional centers since the implementation of salary increases over the past three years.

DISCUSSION

The Department of Human Services (DHS) employs the largest number of direct care FTE in the State of Colorado. The positions are located at 19 24/7 care facilities, including two Mental Health Institutes, four Veterans Community Living Center, 10 Youth Services Facilities, and three Regional Centers. The department has experienced increasing difficulty in recruiting and retaining highly-

qualified individuals to fill its direct care positions and as a result has been working with the Department of Personnel (Personnel) to evaluate direct care compensation for the past three years. The findings of the department's analysis indicate that its direct care staff in Division of Youth Services (DYS) facilities and Veterans Community Living Centers (VCLC) are, on average, making 22.0 percent below the prevailing market wage for similar positions in the private sector. Between November 2016 and July 2018, the Department has increased direct care staff salaries at the three regional centers and two mental health institutes in order to more competitively recruit and retain employees. During the previous legislative session, the Department's FY 2018 -19 R1a budget request was partially funded, however the requested funding to increase staff salaries at DYS facilities and VCLCs was denied. This discussion will focus on the funding request related to VCLC staff.

The Department's FY 2019-20 R2 Compensation for Direct Care Employees budget request includes an increase of approximately $4.9 million total funds, including $1.3 million General Fund and $3.6 million cash funds, to increase salaries for direct care positions at the State's Veterans Community Living Centers (VCLC). The request annualizes to $7.7 million total funds, including $3.0 million General Fund and $4.7 million cash funds in FY 2020-21. As of August 2017, the average direct care vacancy rates for VCLCs was 14.0 percent. In August 2018, the direct care vacancy rate for the nursing homes increased to 21 percent. In addition, the Department's direct care staff turnover rate of 26 percent is significantly higher than the national average of 16.2 percent

Department Authority to Adjust Salaries

The Department worked with the Department of Personnel (Personnel) to evaluate current prevailing wages by position for each of the direct care job classifications included in this compensation initiative. The Department agreed to use the most recent available prevailing market wage data from Personnel, and if no new data was available, agreed to use the midpoint of the job classification pay range from the FY 2018-19 Pay Plan published by Personnel. According to Personnel, the midpoint of the pay range for all job classifications represents the prevailing market wage for that type of position.

Chapter 3 of the State Personnel Rules provides the Department the authority to carry out the initiative proposed in its budget request. Rule 3-9 states: "The appointing authority shall determine the hiring salary within the pay grade for a new employee, including one returning after resignation, which is typically the grade minimum unless recruitment difficulty or other unusual conditions exist." It goes on to define recruitment difficulty as "difficulty in obtaining qualified applicants or an inadequate number of candidates to promote competition despite recruitment efforts." The Department must consider the labor market supply, recruitment efforts, required competencies, qualifications and salary requirements of the best candidate, salaries of current and recently hired employees in similar positions in the department, and other factors when establishing the starting salary. In addition, through State Personnel Rule 3-18, the Department is allowed to provide compression pay/in-range salary increases to existing staff.

General Assembly Approved Salary Adjustment Initiatives

In FY 2017-18, the Department submitted two 1331 supplemental requests for increased funding to cover the cost of salary increases for direct care staff at the Colorado Mental Health Institute at Pueblo (CMHIP) and the three Regional Centers. Salary increases for both requests were necessary in order to address findings by the Centers for Medicare and Medicaid Services (CMS) indicating that the staffing levels were negatively impacting the health and welfare of residents at these facilities. In the case of CMHIP, the JBC approved the FY 2017-18 supplemental budget request for $3.0 million

General Fund specifically to increase salaries for Nurse I, II, and III job classes. In the case of the request concerning regional center funding, the JBC approved the FY 2017-18 supplemental budget request for $6.7 million Medicaid reappropriated funds to restore the regional center line items to FY 2016-17 levels, allowing the centers to maintain staff who had already received increases in salaries as of November 1, 2016. In addition, during the 2018 legislative session, the General Assembly approved a Long Bill amendment that provided funding to increase salaries for remaining direct care job classes at the CMHIP and the Fort Logan Mental Health Institute beginning July 1, 2018.

VETERANS COMMUNITY LIVING CENTER FUNDING

Veterans Community Living Centers qualify as enterprises as defined by Section 20, Article X of the State Constitution. Total funding for the Centers is $51.1 million, including $1.0 million General Fund, $28.7 million cash funds from the Central Fund for Veterans Community Living Centers, and $21.4 million federal funds. The Colorado Constitution defines an enterprise as a "government-owned business authorized to issue its own revenue bonds and receiving under 10.0 percent of annual revenue in grants from all Colorado state and local governments combined." The FY 2018-19 appropriation to the Centers is approximately 1.9 percent General Fund. Leaving room for an increase in General Fund appropriations up to $4.2 million.

RECOMMENDATION

JBC staff is concerned about the impacts that increasing direct care vacancy rates will have on residents of the Veterans Community Living Centers, and recommends that the Committee ask the Department to respond to the following at its December 21, 2018 hearing:

- How do staffing levels for the direct care providers effect occupancy rates at the Veterans Community Living Centers?
- Please provide an update on the vacancy and turnover rates for direct care staff at the mental health institutes and regional centers since the implementation of salary increases over the past three years.

ISSUE: RURAL INTERPRETATION SERVICES PROGRAM

The Rural Interpretation Services Program pilot was created through a budget action by the Joint Budget Committee during the FY 2018-19 budget process. Its intent is to increase access to American Sign Language/English interpreting services in rural areas of the State for individuals who are deaf, hard of hearing, and deafblind.

SUMMARY

During the FY 2018-19 budget process, the Joint Budget Committee (Committee) approved funding from the Telephone Users with Disabilities Fund (TUDF) to: 1) place eight interpreters in Early Childhood Councils in rural areas across the State to provide American Sign Language/English interpreting services; 2) provide grants for initial and advanced interpreter training to increase the number of qualified interpreters in rural communities; 3) to conduct outreach to those who need service and those who may be able to provide such service; and create an exemption from the 16.5 percent limit on the TUDF for three years. The Committee requested that the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind provide a quarterly report containing updates on the implementation of the Rural Interpreting Services Project (RISP) pilot including data in the following categories: 1) expenditures, 2) cash fund balance of the TUDF, 3) locations of interpreting services, 4) number of individuals served, 5) category of services, 6) county location of individuals requesting services, and 7) amount of time between requests for interpreting services and the provision of those services. Data is intended to inform future decision-making.

RECOMMENDATION

JBC staff recommends that the Committee consider asking the Department to respond to the following at its December 21, 2018 hearing:

- Please provide a description of types of communication services (other that ASL/English interpreting services) that may be used to meet the needs of individuals who are deaf, hard of hearing, or deafblind, including but not limited to Video Remote Interpreting (VRI), and Communication Access Realtime Translation (CART).
- Please provide cost estimates for expanding the RISP pilot to include CART and/or VRI services in rural Colorado.
- Given that the Department and Commission would like modifications to the uses of the $700,000 cash funds spending authority approved by the General Assembly, please provide an updated FY 2018-19 and FY 2019-20 budget detailing how the funds would be used, including a cost breakdown for each activity.
- How does the Department and Commission partner with other State Departments or local agencies to raise public and employer awareness concerning the needs of individuals who are deaf, hard of hearing, or deafblind; and the legal responsibilities provider agencies, law enforcement, courts, schools, etc. have in ensuring the availability of effective communication methods for individuals with hearing impairments?

DISCUSSION

The Rural Interpreting Services Project (RISP) is a two-year pilot that was created through a Joint Budget Committee (Committee) decision during the FY 2018-19 budget process. This pilot was granted $700,000 cash funds spending authority from the Telephone Users with Disabilities Fund (TUDF) to do the following:

- Place eight interpreters in Early Childhood Councils (ECCs) in rural areas across the State to provide American Sign Language (ASL)/English interpreting services ($440,000);
- Provide grants for initial and advanced interpreter training to increase the number of qualified interpreters in rural communities ($200,000); and
- Conduct outreach to those who need service and those who may be able to provide such service ($60,000).

In order to determine the effectiveness of the pilot and inform future decisions, the Committee requested a quarterly report including expenditure detail, cash fund balance of the TUDF, locations of interpreting services, number of individuals served, category of services, county location of individuals requesting service, and the time between requests for interpreting services and service delivery.

The Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind (Commission) is responsible for implementing the pilot program and has defined "rural" in this context as the level of community access to ASL/English interpreters. As such, the RISP pilot area includes all regions of the State outside of the Front Range, including Pueblo. The full quarterly report can be found on page 60 of this document, however Joint Budget Committee staff (JBC staff) has summarized the report to highlight the recommendations made by the CCDHHDB.

AMERICAN SIGN LANGUAGE/ENGLISH INTERPRETING SERVICES

The RISP pilot received 61 interpreting requests during the months of July through October. Of these requests, 52 occurred in Western Slope counties and 9 occurred in Eastern Plains/Pueblo counties. Interpreters can be scheduled by submitting a request to the RISP office or by contacting a pilot interpreter directly who will then notify the Commission that the request has been made. The primary challenge faced when providing interpreting services in rural locations in the State is travel distance. The minimum (one-way) distance travelled by an interpreter for each of the 27 requests made in Alamosa County was 31 miles. The greatest (one-way) distance travelled for some interpreting services provided in Mesa County was 254 miles. Due to the lack of services available, 3 of the 61 requests were unfilled.

RURAL INTERPRETING SERVICES PROGRAM PILOT, REQUESTS FOR SERVICES

COUNTY	NUMBER OF REQUESTS
Western	
Alamosa	27
Mesa	11
Garfield	4
Grand	3
La Plata	2
Eagle	2
Routt	1
Pitkin	1
Delta	1
Subtotal	**52**
Eastern	
Pueblo	7
Otero	2
Subtotal	**9**
TOTAL	**61**

INTERPRETER TRAINING

The Americans with Disabilities Act of 1990 prohibits instances of discrimination because of a person's disability. The Act states that "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." Discrimination can include the failure by the person who owns, leases, or operates such a place to take the necessary steps to ensure that "no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services." According to the law, "auxiliary aids and services" includes qualified interpreters or other effective methods of "making aurally delivered materials available to individuals with hearing impairments."

The federal Act is clear that it is the responsibility of the location in which the services are provided to ensure the availability of effective communication methods for individuals with hearing impairments, including medical, legal, law enforcement, educational, and employment settings. In rural areas of the State, the lack of qualified interpreters presents a challenge to service providers and an even greater challenge to the hearing impaired. In order to address the gap in these services, the RISP pilot has partnered with the University of Northern Colorado (UNC) American Sign Language Interpreting Studies (ASLIS) program to coordinate and implement a RISP Readiness Training Program to provide a series of online courses to assist current practitioners who are not yet certified. Additionally, the RISP will offer scholarships to current junior and senior students in the ASLIS program who wish to pursue community sign language interpreting. These opportunities will be available to individuals who are committed to working in rural areas of the State. Finally, the RISP will offer paid mentoring and will support a State Human Services Applied Research Practicum (SHARP) Fellow's training in doing research on the needs of rural individuals who are deaf, hard of hearing, and deafblind.

INTERPRETER TRAINING, ESTIMATED COSTS		
	FY 2018-19	FY 2019-20
RISP SCHOLARSHIPS		
2 Juniors in ASLIS Program	$26,400	$26,400
2 Seniors in ASLIS Program	0	26,700
Stipend for 2 Seniors	0	3,000
Subtotal, RISP Scholarships	**$26,400**	**$56,100**
CERTIFICATION READINESS TRAINING		
Curriculum development and 1 intensive training in Greeley for 1 lead facilitator and 10 facilitators (4-5 days)	$127,870	$227,870
1 year online participant training for up to 20 participants	0	31,776
Subtotal, Certification Readiness Training	**$127,870**	**$259,646**
INTERPRETER TEST SCHOLARSHIPS (40 TESTS AT $500 PER TEST)	$20,000	$0
MENTORING SERVICES	$16,000	$48,000
SHARP FELLOWSHIP	$10,000	$0
TOTAL	**$200,270**	**$363,746**

OUTREACH

In an effort to educate communities about the RISP pilot, the Commission contracted an outreach specialist with expertise in the deaf, hard of hearing, and deafblind communities to develop educational

and outreach materials, organize and facilitate town hall meetings, publicize the availability of the pilot, and improve the RISP website. During the months of September and October 2018, five town hall meetings were held in the following locations: Pueblo, Grand Junction (2), Durango, and Alamosa. Additional town hall meetings are scheduled for Pueblo, Otero/Crowley, and Morgan/Logan Counties in December; and for Garfield, Routt, and Summit Counties in the Spring of 2019.

COMMISSION RECOMMENDATIONS

Based on the data gathered in the first four months of the pilot, the Commission recommends modifications to the currently approved uses of the funding. While the largest portion of the funding is intended to be used to hire 8.0 FTE in ECCs across the State, data supports the hiring of 1.0 FTE in Grand Junction at this time. The Commission has evaluated the infrastructure needs that are required to sustain this initiative and ensure that interpreting service gaps are closed in rural Colorado and proposes the following changes to the use of funds in fiscal years 2018-19 and 2019-20:

- Utilize $230,000 of the FY 2018-19 funding for staffing:
  - Hire 1.0 FTE who is Registry of Interpreters for the Deaf (RID) certified, based in Grand Junction, to perform interpreting services on the Western Slope and be responsible for managing the filling RISP interpreting services requests. Additional FTE will be hired in the future in locations such as Alamosa and Pueblo Counties if data supports such action.
  - Hire 2.0 FTE who to recruit interested individuals and mentor those seeking to become certified interpreters.
  - Hire 1.0 FTE for ongoing development and implementation of the awareness and engagement campaign.
- Establish a sign language interpreter training program on the Western Slope.
- Modify state statute to expand the recognized interpreting credentials to include certifications in addition to the RID.
- Expand the scope of the RISP pilot to include Communication Access Realtime Translation (CART) services.
- Expand interpreting services to ensure that requests do not remain unfilled.

JBC STAFF RECOMMENDATION

JBC staff recommends that the Committee consider asking the Department to respond to the following at its December 21, 2018 hearing:

- Please provide a description of types of communication services (other that ASL/English interpreting services) that may be used to meet the needs of individuals who are deaf, hard of hearing, or deafblind, including but not limited to Video Remote Interpreting (VRI), and Communication Access Realtime Translation (CART).
- Please provide cost estimates for expanding the RISP pilot to include CART and/or VRI services in rural Colorado.
- Given that the Department and Commission would like modifications to the uses of the $700,000 cash funds spending authority approved by the General Assembly, please provide an updated FY 2018-19 and FY 2019-20 budget detailing how the funds would be used, including a cost breakdown for each activity.
- How does the Department and Commission partner with other State Departments or local agencies to raise public and employer awareness concerning the needs of individuals who are deaf, hard of hearing, or deafblind; and the legal responsibilities provider agencies, law enforcement,

courts, schools, etc. have in ensuring the availability of effective communication methods for individuals with hearing impairments?

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
DEPARTMENT OF HUMAN SERVICES					
Reggie Bicha, Executive Director					
(9) SERVICES FOR PEOPLE WITH DISABILITIES					
(A) Regional Centers for People with Developmental Disabilities					
(1) Wheat Ridge Regional Center					
Wheat Ridge Regional Center Intermediate Care Facility	24,930,030	23,766,800	24,298,667	25,085,044	
FTE	362.8	379.2	373.0	373.0	
Cash Funds	672,301	624,721	779,589	779,589	
Reappropriated Funds	24,257,729	23,142,079	23,519,078	24,305,455	
Wheat Ridge Regional Center Provider Fee	1,568,905	1,536,475	1,435,612	1,435,612	
Reappropriated Funds	1,568,905	1,536,475	1,435,612	1,435,612	
Wheat Ridge Regional Center Depreciation	0	149,672	180,718	180,718	
Reappropriated Funds	0	149,672	180,718	180,718	
SUBTOTAL -	26,498,935	25,452,947	25,914,997	26,701,374	3.0%
FTE	362.8	379.2	373.0	373.0	0.0%
Cash Funds	672,301	624,721	779,589	779,589	0.0%
Reappropriated Funds	25,826,634	24,828,226	25,135,408	25,921,785	3.1%
(2) Grand Junction Regional Center					
Grand Junction Regional Center Intermediate Care Facility	6,174,456	7,496,495	8,294,316	8,662,032	
FTE	125.8	94.3	98.8	98.8	
Cash Funds	148,646	407,134	1,037,320	1,037,320	
Reappropriated Funds	6,025,810	7,089,361	7,256,996	7,624,712	

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Grand Junction Regional Center Provider Fee	316,887	344,636	453,291	453,291	
Reappropriated Funds	316,887	344,636	453,291	453,291	
Grand Junction Regional Center Waiver Funding	10,051,713	9,368,684	9,486,803	9,666,341	
FTE	126.5	164.3	174.2	174.2	
General Fund	0	0	0	0	
Cash Funds	398,264	398,264	398,264	398,264	
Reappropriated Funds	9,653,449	8,970,420	9,088,539	9,268,077	
Grand Junction Regional Center Depreciation	0	412,977	323,681	323,681	
Reappropriated Funds	0	412,977	323,681	323,681	
SUBTOTAL -	16,543,056	17,622,792	18,558,091	19,105,345	2.9%
FTE	252.3	258.6	273.0	273.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	546,910	805,398	1,435,584	1,435,584	0.0%
Reappropriated Funds	15,996,146	16,817,394	17,122,507	17,669,761	3.2%
(3) Pueblo Regional Center					
Pueblo Regional Center Waiver Funding	10,655,557	10,149,859	10,445,804	10,743,118	
FTE	173.5	168.2	181.8	181.8	
Cash Funds	422,765	372,644	539,856	539,856	
Reappropriated Funds	10,232,792	9,777,215	9,905,948	10,203,262	
Pueblo Regional Center Depreciation	0	187,326	187,326	187,326	
Reappropriated Funds	0	187,326	187,326	187,326	

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
SUBTOTAL -	10,655,557	10,337,185	10,633,130	10,930,444	2.8%
FTE	173.5	168.2	181.8	181.8	0.0%
Cash Funds	422,765	372,644	539,856	539,856	0.0%
Reappropriated Funds	10,232,792	9,964,541	10,093,274	10,390,588	2.9%
SUBTOTAL - (A) Regional Centers for People with Developmental Disabilities	53,697,548	53,412,924	55,106,218	56,737,163	3.0%
FTE	788.6	806.0	827.8	827.8	(0.0%)
General Fund	0	0	0	0	0.0%
Cash Funds	1,641,976	1,802,763	2,755,029	2,755,029	0.0%
Reappropriated Funds	52,055,572	51,610,161	52,351,189	53,982,134	3.1%
(B) Work Therapy Program					
Program Costs	494,677	401,334	573,679	581,112	
FTE	1.0	0.5	1.5	1.5	
Cash Funds	494,677	401,334	573,679	581,112	
SUBTOTAL - (B) Work Therapy Program	494,677	401,334	573,679	581,112	1.3%
FTE	1.0	0.5	1.5	1.5	0.0%
Cash Funds	494,677	401,334	573,679	581,112	1.3%
(C) Traumatic Brain Injury Program					
Traumatic Brain Injury Trust Fund	2,040,219	2,540,726	3,005,483	3,016,578	
FTE	2.5	2.9	1.5	1.5	
Cash Funds	2,040,219	2,540,726	3,005,483	3,016,578	
Probation Pilot Program	0	0	450,000	450,000	
General Fund	0	0	450,000	450,000	

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
SUBTOTAL - (C) Traumatic Brain Injury Program	2,040,219	2,540,726	3,455,483	3,466,578	0.3%
FTE	2.5	2.9	1.5	1.5	0.0%
General Fund	0	0	450,000	450,000	0.0%
Cash Funds	2,040,219	2,540,726	3,005,483	3,016,578	0.4%
(D) Veterans Community Living Centers					
Administration	2,034,500	2,034,500	2,034,500	2,039,507	
FTE	11.3	10.5	5.0	5.0	
Cash Funds	2,034,500	2,034,500	2,034,500	2,039,507	
Fitzsimmons Veterans Community Living Center	22,140,700	22,140,700	22,092,757	24,026,181	*
FTE	233.3	220.6	236.4	236.4	
General Fund	0	0	0	773,369	
Cash Funds	10,627,500	10,627,500	10,579,557	11,739,612	
Federal Funds	11,513,200	11,513,200	11,513,200	11,513,200	
Florence Veterans Community Living Center	11,502,900	11,502,900	11,275,686	12,108,047	*
FTE	134.8	137.8	135.0	135.0	
General Fund	0	0	0	332,944	
Cash Funds	7,131,800	7,131,800	6,904,586	7,404,003	
Federal Funds	4,371,100	4,371,100	4,371,100	4,371,100	
Homelake Veterans Community Living Center	7,924,230	7,924,230	7,735,871	8,396,037	*
FTE	81.9	84.4	95.3	95.3	
General Fund	186,130	186,130	186,130	450,196	
Cash Funds	4,797,600	4,797,600	4,609,241	5,005,341	
Federal Funds	2,940,500	2,940,500	2,940,500	2,940,500	

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Homelake Military Veterans Cemetery	0	50,705	66,965	66,965	
FTE	0.0	0.2	0.5	0.5	
General Fund	0	43,405	59,300	59,300	
Cash Funds	0	7,300	7,665	7,665	
Rifle Veterans Community Living Center	8,989,700	8,989,700	8,834,007	10,138,395	*
FTE	98.4	98.1	110.6	110.6	
General Fund	0	0	0	521,755	
Cash Funds	6,382,700	6,382,700	6,227,007	7,009,640	
Federal Funds	2,607,000	2,607,000	2,607,000	2,607,000	
Walsenburg Veterans Community Living Center	373,600	373,600	373,600	373,985	
FTE	0.0	1.0	1.0	1.0	
Cash Funds	373,600	373,600	373,600	373,985	
Transfer to the Central Fund pursuant to Section 26-12-108 (1) (a.5), C.R.S.	1,600,000	800,000	800,000	800,000	
General Fund	800,000	800,000	800,000	800,000	
Cash Funds	800,000	0	0	0	
SUBTOTAL - (D) Veterans Community Living Centers	54,565,630	53,816,335	53,213,386	57,949,117	8.9%
FTE	559.7	552.6	583.8	583.8	(0.0%)
General Fund	986,130	1,029,535	1,045,430	2,937,564	181.0%
Cash Funds	32,147,700	31,355,000	30,736,156	33,579,753	9.3%
Federal Funds	21,431,800	21,431,800	21,431,800	21,431,800	0.0%

* Indicates a decision item

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(E) Indirect Cost Assessment					
Indirect Cost Assessment	0	12,271,172	12,940,955	14,740,369	
Cash Funds	0	3,361,991	2,097,881	2,494,283	
Reappropriated Funds	0	8,902,976	10,829,992	12,232,284	
Federal Funds	0	6,205	13,082	13,802	
SUBTOTAL - (E) Indirect Cost Assessment	0	12,271,172	12,940,955	14,740,369	13.9%
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds	0	3,361,991	2,097,881	2,494,283	18.9%
Reappropriated Funds	0	8,902,976	10,829,992	12,232,284	12.9%
Federal Funds	0	6,205	13,082	13,802	5.5%
TOTAL - (9) Services for People with Disabilities	110,798,074	122,442,491	125,289,721	133,474,339	6.5%
FTE	1,351.8	1,362.0	1,414.6	1,414.6	(0.0%)
General Fund	986,130	1,029,535	1,495,430	3,387,564	126.5%
Cash Funds	36,324,572	39,461,814	39,168,228	42,426,755	8.3%
Reappropriated Funds	52,055,572	60,513,137	63,181,181	66,214,418	4.8%
Federal Funds	21,431,800	21,438,005	21,444,882	21,445,602	0.0%
TOTAL - Department of Human Services	110,798,074	122,442,491	125,289,721	133,474,339	6.5%
FTE	1,351.8	1,362.0	1,414.6	1,414.6	(0.0%)
General Fund	986,130	1,029,535	1,495,430	3,387,564	126.5%
Cash Funds	36,324,572	39,461,814	39,168,228	42,426,755	8.3%
Reappropriated Funds	52,055,572	60,513,137	63,181,181	66,214,418	4.8%
Federal Funds	21,431,800	21,438,005	21,444,882	21,445,602	0.0%

APPENDIX B: RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2017 SESSION BILLS

S.B. 17-163 (SUPPLEMENTAL BILL): Modifies FY 2016-17 appropriations to the Department of Human Services.

S.B. 17-254 (LONG BILL): General appropriations act for FY 2017-18. Includes provisions modifying FY 2016-17 appropriations to the Department.

H.B. 17-1343 (IMPLEMENT CONFLICT-FREE CASE MANAGEMENT): Implements changes to the system of services for individuals with intellectual and developmental disabilities provided through one of the three intellectual and developmental disability waivers to ensure there is not a conflict of interest in the provision of case management services. Requires Community-Centered Boards to implement business changes to ensure the same entity is not providing case management services and direct services to the same individual by June 30, 2020. Requires all individuals receiving services through one of the three Medicaid waivers for intellectual and developmental disabilities is not receiving case management and direct services from the same entity by June 30, 2022. Adds a definition for case management agency and conflict-free case management. Prioritizes the funds in the Intellectual and Developmental Disability Services Cash Fund for the system changes required for conflict-free case management, and repeals the fund on July 1, 2022. Establishes a definition for "case management agency" and how a case management agency will be certified and decertified and the duties of a case management agency. Defines a rural Community-Centered Board. Establishes the following timeline for system changes and how the State can seek a rural exemption for interested rural Community-Centered Boards:

- Timeline of system changes:
  - July 1, 2017 – Department of Health Care Policy and Financing must determine business options for Community-Centered Boards;
  - January 1, 2018 – Department must publish guidance on the components of the business continuity plan;
  - July 1, 2018 – Community-Centered Boards must submit their business continuity plan to the Department;
  - June 30, 2019 – Department must complete an analysis of the continuity plans, unreimbursed transition costs, and community impacts;
  - June 30, 2020 – Community-Centered Boards must complete the business operation changes;
  - June 30, 2021 – At least 25.0 percent of individuals must be served through a conflict-free system; and
  - June 30, 2022 – All individuals must be served through a conflict-free system.
- Rural exemption requirements and timeline:
  - July 1, 2017 – A rural Community-Centered Board must notify the Department in writing they would like the Department to seek a federal rural exemption;
  - The Department must evaluate capacity, and where appropriate, seek a federal exemption;

- The Community-Centered Board upon notification of a federal decision must submit a business continuity plan and make any necessary business operation changes by June 30, 2022;
- If, by July 1, 2019, the Department has not received federal notification of requests, the State Board must promulgate rules for the provision of services and supports; and
- The State Board is required to promulgate rules to ensure there is choice and access to services for individuals served by rural Community-Centered Boards.

Appropriates $222,794 total funds, of which $111,398 is cash funds from the Intellectual and Developmental Disabilities Services Cash Fund and states that this appropriation is based on the assumption that the Department will receive $111,396 federal funds and 1.0 FTE to implement the act.

2018 SESSION BILLS

H.B. 18-1162 (SUPPLEMENTAL BILL): Modifies FY 2017-18 appropriations to the Department.

H.B. 18-1322 (LONG BILL): General appropriations act for FY 2018-19. Includes provisions modifying FY 2017-18 appropriations to the Department.

H.B. 18-1364 (SUNSET COLORADO COUNCIL PERSONS WITH DISABILITIES): Continues the Colorado Advisory Council for Persons with Disabilities and transfers it from the Office of the Governor to the Department of Human Services, changes its membership, and redefines its duties. Appropriates $250,000 General Fund to the Department for FY 2018-19 and states the assumption that the Department will require an additional 1.0 FTE.

APPENDIX C: FOOTNOTES AND INFORMATIONAL REQUESTS

UPDATE ON LONG BILL FOOTNOTES

53 Department of Human Services, Services for People with Disabilities, Regional Centers for People with Developmental Disabilities, Wheat Ridge Regional Center, Wheat Ridge Regional Center Intermediate Care Facility; and Grand Junction Regional Center, Grand Junction Regional Center Intermediate Care Facility -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department may transfer up to 5.0 percent of the total appropriation for Intermediate Care Facilities between the Wheat Ridge Regional Center and the Grand Junction Regional Center.

COMMENT: The Department has annually transferred moneys when necessary.

54 Department of Human Services, Services for People with Disabilities, Regional Centers for People with Developmental Disabilities, Grand Junction Regional Center, Grand Junction Regional Center Waiver Services; and Pueblo Regional Center, Pueblo Regional Center Waiver Services -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department may transfer up to 5.0 percent of the total appropriation for Regional Center waiver services between the Grand Junction Regional Center and the Pueblo Regional Center.

COMMENT: The Department has annually transferred moneys when necessary.

UPDATE ON REQUESTS FOR INFORMATION

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

1 Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations.

COMMENT: The department response can be found on page 27 of this document.

9 Department of Regulatory Agencies, Public Utilities Commission; Department of Human Services, Executive Director's Office, Special Purpose; Department of Human Services, Office of Early Childhood, Division of Early Care and learning – The Departments are requested to submit a quarterly report beginning September 1, 2018 on the status of translation services for the deaf and hard of hearing. The report should include information on expenditures, cash fund balance for the Telephone Users with Disabilities Fund, locations of translation services, number of individuals served, category of services (doctor's office, school, etc.), county location of individuals requesting service, and the amount of time between request for translations services and the provision of those services.

COMMENT: The department response can be found on page 60 of this document.

DEPARTMENT OF HUMAN SERVICES

19 Department of Human Services, Services for People with Disabilities, Regional Centers for People with Developmental Disabilities -- The Department is requested to provide by November 1, 2018 information regarding transitions and readmissions to the Regional Centers for each of the past eighteen months. As part of the response, the Department should include: the number of individuals that have been transitioned from each Regional Center and the setting to which they were transitioned for each month, how many of these individuals have been readmitted to a Regional Center and when, the number of monthly admissions to each Regional Center, the definition of a successful transition, and the monthly number of successful transitions.

COMMENT: The department response can be found on page 74 of this document.

20 Department of Human Services, Services for People with Disabilities, Regional Centers for People with Developmental Disabilities - The Department is requested to provide by January 15, 2019, the monthly census for each Regional Center by licensure type since the beginning of the fiscal year, and annual cost per capita for each Regional Center by licensure type, including the

Regional Center costs for utilities, depreciation, indirect costs, and centrally appropriated personnel items.

COMMENT: The department response is due January 15, 2019.

ADDITIONAL DEPARTMENT REPORTS

Relocation of the Grand Junction Regional Center, Quarterly Update can be found on page 78 of this document.

COLORADO
Department of Public Health & Environment
4300 Cherry Creek Drive South
Denver, CO 80246

COLORADO
Department of Human Services
1575 Sherman Street
Denver, CO 80203

COLORADO
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

November 1, 2018

The Honorable Millie Hamner, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Hamner:

Enclosed please find the response to the Joint Budget Committee's Request for Information #4 regarding the Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE).

Request for Information #4 states:

Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations.

While the three Departments achieved some milestones quickly, others will take several years and a significant investment in time and funding. To date, 36% of the tasks are complete. For the remaining tasks, target ends dates range from January 2019 – June 2020.

In November 2017, HCPF hired a RCTF Project Manager to oversee the remaining recommendations. The RCTF Project Manager is currently working with the three Departments to establish core measures and metrics. The measures and metrics will be used to evaluate progress, identify areas that need improvement, and drive future best practices.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director
Department of Health Care Policy and Financing

Sincerely,

Reggie Bicha
Executive Director
Department of Human Services

Sincerely,

Karin McGowan
Interim Executive Director
Department of Public Health and Environment

KB/RB/KM

Enclosure(s): Response to the Joint Budget Committee's FY 2018-19 Request for Information #4, Regional Centers Task Force Implementation Update.

Cc: Senator Kent Lambert, Vice-Chair, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Katie Quinn, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Health Programs Office Director & Interim Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Long-Term Services and Supports Division Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control & Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF
Mark J. Wester, Director, Office of Community Access and Independence, CDHS
Eric Johnson, Deputy Director, Office of Community Access and Independence, CDHS
Georgia Edson, Director, Division for Regional Center Operations, CDHS
D. Randy Kuykendall, MLS, Division Director, Health Facilities and Emergency Medical Services Division, CDPHE
Kara Johnson-Hufford, MPA, Branch Chief, Health Facility Quality Branch, CDPHE

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Public Health & Environment

COLORADO
Department of Human Services

Health Care Policy and Financing
FY 2018-19 RFI #4

Regional Centers Task Force Implementation Update | November 1, 2018

This report was developed in response to the Joint Budget Committee's Request for Information #4 regarding the Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE) – "Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations."

RCTF Overview

The Regional Centers Task Force (RCTF), created by House Bill (HB) 14-1338, was directed to develop recommendations regarding the future size, scope and role of Colorado's three Regional Centers (RC) serving people with Intellectual and Developmental Disabilities (I/DD). The task force produced 10 recommendations, each with several associated tasks, and published their RCTF Final Report in December 2015. The recommendations include ambitious, broad system changes that involve the Colorado Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE).

Two cross-agency teams were established in 2016 – an operations team (comprised of staff from CDHS, CDPHE, and HCPF) and a sponsor group (comprised of community stakeholders and executives from CDHS, CDPHE, and HCPF). The operations team is responsible for collaboratively implementing practicable recommendations, while the sponsor group is responsible for making key strategic decisions and advising the operations team. Both teams meet monthly and are facilitated by the HCPF RCTF Project Manager.

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Infrastructure

CDHS, CDPHE, and HCPF (the Departments) agree that Colorado must provide person-centered services that are effective and efficient, in the most appropriate and least restrictive setting. At times, RCs are the most appropriate and least restrictive setting – offering short-term treatment and stabilization programs for individuals whose acute or complex needs cannot be met in the community. The Departments also agree that the role of RCs in the continuum of care could be reduced when their referrals near zero and when Colorado has a solid system in place to support every person with I/DD in the community.

Implementation Milestones

The Departments have taken considerable steps toward improving community system capacity and stability by increasing funding and eliminating barriers to accessing services. Recent milestones include: integrating behavioral and physical health services into one Regional Accountable Entity; increasing access to short-term behavioral health (mental health and substance use disorder) services within the primary care setting; authorizing 168 additional enrollments in the Home and Community-Based Services (HCBS) – Developmental Disability waiver; and initiating 300 nonemergency enrollments from the HCBS – DD waiver waiting list.

The Departments continue to steadfastly work toward implementing practicable tasks that directly support the RCTF recommendations. To date, 36 tasks have been collaboratively implemented.

Table 1. RCTF Recommendations

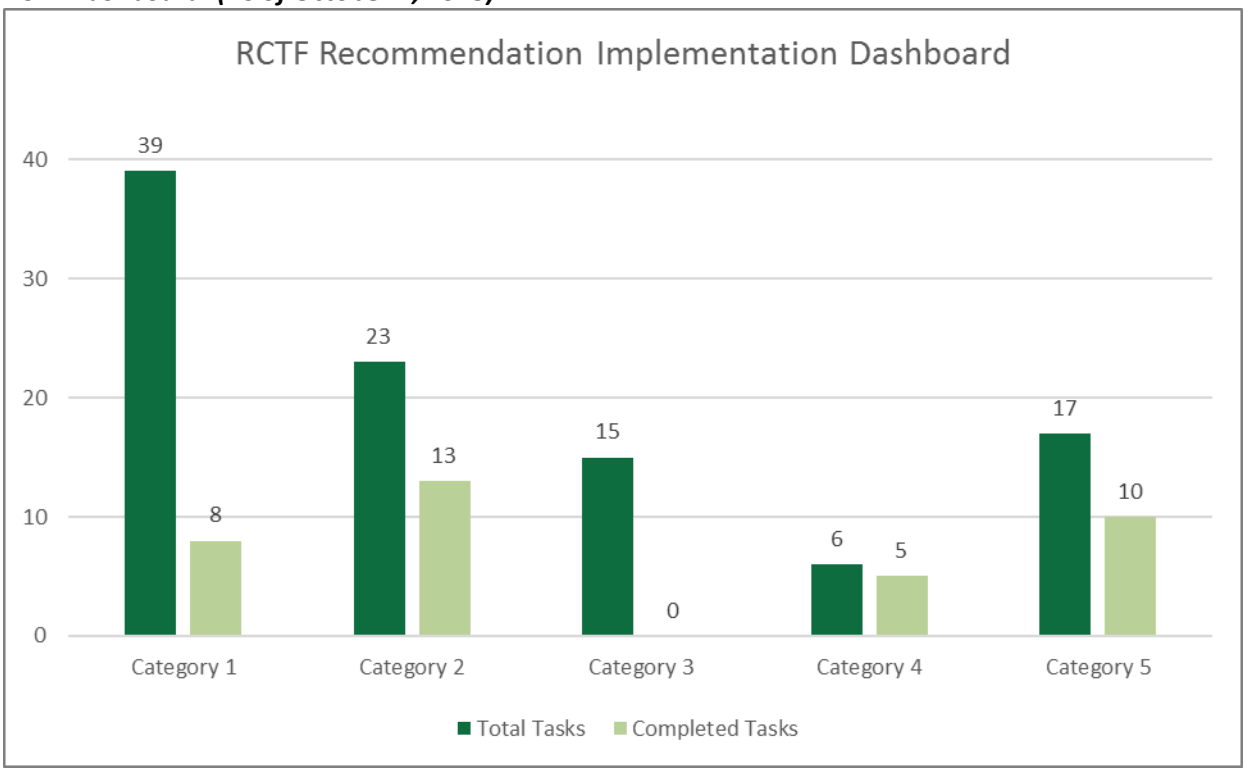
Recommendation	Recommendation Text	Final Report Location
1. Waiver Redesign	Leverage Medicaid waiver redesign efforts already underway pursuant to the requirements of H.B. 15-1318 and explore additional alternatives, ensuring that these efforts take into account the desire to provide more individuals with the opportunity to be served in a community setting.	Pages 19 - 21
2. Include Services for Persons with I/DD in the Mental Health System	Fully include services for individuals with I/DD in the capitated mental health system by basing access and reimbursement of services on the presentation of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks.	Pages 22 -24
3. Workforce Development	Develop guidelines, training, and clinical tools for medical, behavioral and mental health providers to deliver effective services for the I/DD population.	Pages 25 - 26
4. Transition Planning Process	Enhance the transition planning process to include additional person-centered elements and improve outcome tracking.	Pages 27 - 30
5. Care Coordination and Funding Authority	Identify, authorize and fund an entity (or entities) to coordinate service delivery for those individuals with I/DD receiving services from multiple systems of care to optimize on-going access to services and provide support during emergencies, transitions and crises. Identify opportunities to reduce complexity across care delivery systems.	Pages 31- 33
6. No Reject/No Eject Clause	Create contractual agreements with community-based providers across the state that include a no reject/no eject clause and have the Regional Centers serve as a safety net provider as necessary.	Pages 34 - 36
7. Statewide Crisis Stabilization	Formalize the role of Regional Centers and certain community providers as a statewide crisis stabilization system for individuals with I/DD and/or co-occurring serious and persistent conditions.	Pages 37 - 40
8. HCBS Final Rule: Cost and Transition Compliance	Conduct an accurate cost analysis of both community and Regional Center HCBS [home and community-based services] beds related to compliance with the 2014 Centers for Medicare and Medicaid Services (CMS) Final Rule to guide future decisions on the number and location of state-operated HCBS waiver beds. In addition, provide funding and support needed to successfully transition residents, who desire to transition and are deemed ready to transition, to community placements and consolidate these beds as successes allow.	Pages 41 - 47
9. ICF Bed Consolidation	Once no-reject/no-eject contracts with community providers are established, implement a fully-funded transition process to place residents, who desire to transition and are deemed ready to transition, in the community, and over time reduce the number of state-run ICF beds as successes allow.	Pages 48 - 52
10.Implementation and Progress Reporting	Establish an ongoing monitoring, assessment, and reporting structure to ensure that recommendations are implemented and evaluated for impact.	Pages 53 - 55

Dashboard

HCPF maintains a RCTF Recommendation Implementation Dashboard containing widespread, major action steps. The dashboard shows the advancement of each of the five categorical themes listed in the RCTF Final Report.

- **Category 1:** Recommendations 1, 2, and 3. Invest to enhance the necessary community supports to enable more of the individuals of the Regional Centers and more persons with I/DD to live successfully in the community.
- **Category 2:** Recommendations 4 and 5. Enhance the transition, care coordination, and crisis intervention process.
- **Category 3**: Recommendations 6 and 7. Develop a flexible safety net provider system with the Regional Centers and select community providers, serving as crisis stabilization units and as a provider of last resort.
- **Category 4**: Recommendations 8 and 9. As the safety net provider system is established and demonstrated to be effective, concurrently act on consolidation and efficiency opportunities if client census naturally decreases.
- **Category 5**: Recommendation 10. Establish cross agency governance to administer these recommendations and ensure ongoing monitoring of efficacy of services and programs.

RCTF Dashboard. (As of October 1, 2018)



Note: Each task's target start date, target end date, and completion status are provided in *Appendix A – RCTF Implementation Timeline.*

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Category 1

Recommendation 1 – Waiver Redesign

Target Dates: July 2016 – July 2020

HCPF continues to make progress toward implementing HB 15-1318, Consolidate I/DD Waivers[1]. HCPF has revised drafts of the Service and Coverage Standards and has begun setting utilization limits; allocating resources; and applying a fiscal impact analysis, cost saving and quality improvement strategies, and transition plan to the service design.

The requirements in HB 17-1343, Implement Conflict-Free Case Management for Persons with I/DD, will impact the waiver redesign process. The case management agency and case manager qualifications will be used to amend the HCBS waiver agreements, the State Plan, and HCPF regulations. HCPF plans to present these qualifications to the Medical Services Board by the end of 2018.

Recommendation 2 – Include Services for Persons with I/DD in the Mental Health System

Target Dates: July 2016 – June 2019

HB 15-1368 required the creation of a Cross-System Response for Behavioral Health Crises Pilot Program (CSCR Pilot)[2] to address gaps in crisis services for individuals with co-occurring I/DD and behavioral health needs. HCPF is currently analyzing data to: determine which Community Mental Health Centers have implemented best practices; identify assessments that have been normed for individuals who have co-occurring conditions; identify other states that have fully incorporated individuals with co-occurring conditions into their mental health system; and create a crosswalk comparing Colorado's mental health system to determine where systemic improvements can be made.

In addition, HCPF received approval through HB 18-1328 to redesign the Children's Habilitation Residential Program (CHRP) waiver. The redesign will allow children with I/DD and complex behavioral support needs, to receive HCBS services to mitigate out-of-home placement. On September 4, 2018, HCPF hired a full time Development Specialist to lead the CHRP work.

Recommendation 3 – Workforce Development

Target Dates: July 2016 – June 2020

Workforce Development crosses all other recommendations and is essential to achieve optimal and stable services, supports, and transitions for people with I/DD. HB 18-1407 requires HCPF to immediately seek a 6.5% increase in the reimbursement rate for direct support professionals who assist, or supervise a worker who assists, a person with IDD receiving HCBS services. Funding will be available March 2019.

HCPF and CDHS have both achieved workforce development milestones. HCPF introduced a series of Disability Competent Care (DCC) videos[3] designed to increase provider awareness and capacity to provide

DCC[4] (appropriate and accessible health care) to people with disabilities while CDHS implemented the Mandt System[5] for RC staff. The Mandt System facilitates the development of an organizational culture with the following focus - "support people, not just their behaviors"™.

Additionally, HCPF will continue to partner with university training programs and the State Innovation Module (SIM) to address workforce needs and to promote integrated systems of care. HCPF and CDHS are collaborating with the SIM Workforce Workgroup to develop an online Behavioral Health Integration module, concentrating on people with I/DD, for primary care practices as well as other providers. When complete, the module will be available on the University of Colorado's e-learning site.

Category 2

Recommendation 4 – Transition Planning Process

Target Dates: July 2016 – June 2019

HCPF is currently reviewing the findings of 12 Person-Centered Planning Focus Groups and will incorporate essential elements into the Person-Centered Support Plan for people receiving HCBS. HCPF is also redesigning the HCBS Assessment Process and Tool which will offer a unified process for all programs and people receiving Long-Term Support Services. At this time, the Department is working with a vendor to automate the new processes in a new data system for case managers to use and will be piloting the new processes in calendar year 2019.

HCPF is currently gathering Medicaid utilization data as well as qualitative data concerning individuals who transitioned from a RC to the community from July 2017 – present. The data will be analyzed and presented in a future report to the extent privacy regulation allows.

Recommendation 5 – Care Coordination and Funding Authority

Target Dates: February 2017 – June 2020

A key objective of the Accountable Care Collaborative (ACC)[6] was met July 1, 2018. Regional Accountable Entities (RAE) have joined physical and behavioral health under one entity (individuals transitioning from an institution are auto enrolled). Incentive payments are made directly to each RAE, providing greater flexibility to design innovative, value-based payment arrangements.

Additionally, HCPF is enhancing the current transition coordination process by developing a Targeted Case Management (TCM) – Transition Services benefit to help individuals relocate from residential facilities (intermediate care facilities, nursing facilities, and RCs) to a community setting. HCPF drafted the State Plan Amendment, drafted the Rules, conducted stakeholder engagements, initiated systems changes, and plans to implement the benefit in January 2019.

Category 3

Recommendation 6 – No Reject/No Eject Clause

Target Dates: July 2019 – June 2020

The tasks associated with this recommendation are foundational and long-term. They are also dependent on the progress of other recommendations to ensure individuals who transition from RCs are fully supported in community settings.

Recommendation 7 – Statewide Crisis Stabilization

Target Dates: July 2016 – June 2019

Cross-System Crisis Response (CSCR) Pilot data will inform the development of criteria for emergency response, and entry into and operation of crisis stabilization units for individuals with I/DD as well as help to establish a system of follow-up and long-term supports in the community. The CSCR Pilot is testing best practices for a flexible safety net provider system and establishing qualification criteria for community providers who will operate as crisis stabilization units.

The Colorado Crisis Steering Committee submitted a report to the Colorado Department of Human Services, Office of Behavioral Health (OBH) in June 2018. The report identified system efficiency recommendations to improve behavioral health crisis response. OBH approved the report and incorporated many of the recommendations into their Request for Proposal for Mobile Crisis, Walk-In Crisis, Crisis Stabilization, and Crisis Respite Services, issued on September 4, 2018. Applications are due November 4, 2018.

Additionally, the Departments are participating in the Behavioral Health Facility Licensing Task Force to analyze laws, regulations, guidance and practice in behavioral health licensing. The task force will submit a report to the Governor's Office by December 1, 2018.

Category 4

Recommendation 8 – HCBS Final Rule: Cost and Transition Compliance

Target Dates: July 2016 – June 2019

HCPF is analyzing the cost for HCBS providers and RCs to come into compliance with the 2014 CMS HCBS Settings Final Rule[7] (Final Rule). Two RCs are affected - Pueblo Regional Center (PRC) and Grand Junction Regional Center (GJRC). PRC and GJRC are making changes to come into compliance. (Wheat Ridge Regional Center only has Intermediate Care Facility beds).

HCPF has published FAQ documents concerning the general requirements of the Final Rule and aspects of

its implementation. HCPF is working on a third response to address eviction-protections, by lease or other written agreement.

HCPF and CDPHE worked with the Governor's Office of Information Technology to develop a web-based platform to give providers a secure way to develop and provide updates on their Provider Transition Plan (PTP). The first release will cover adult residential settings for which PTPs are required. The platforms for nonresidential and children's residential settings will follow.

Recommendation 9 – ICF Bed Consolidation

Target Dates: July 2017 – June 2018

The sponsor group excluded most of Recommendation 9 because the tasks were either duplicative or non-deliverable. The remaining task (9.B.3) was completed in April of 2018.

Category 5

Recommendation 10 – RCTF Implementation and Progress Reporting

Target Dates: July 2016 – June 2020

The Departments are steadfastly working toward implementing practicable tasks that directly support the RCTF recommendations. To date, 36 tasks have been collaboratively implemented.

Progress reporting is shared via three methods - CDHS provides RC updates to the community on its Division for Regional Centers Operations website; HCPF posts quarterly RCTF Reports to the Legislator Resource Center; and the Departments include a RCTF update in their annual SMART Act presentations.

Furthermore, the Departments are currently establishing a set of core measures and metrics. The measures and metrics will be used to evaluate progress, identify areas that need improvement, and drive future best practices for people with I/DD in the community.

References

[1] HCPF. Quarterly reports on Waiver Redesign. Available at: https://www.colorado.gov/hcpf/legislator-resource-center

[2] HCPF. FY 17-18 Annual CSCR Pilot Program Report. Available at: https://www.colorado.gov/pacific/sites/default/files/2018%20HCPF%20Cross-System%20Reponse%20Pilot%20Annual%20Report%20-%20July%202018.pdf

[3] HCPF. Disability Competent Care Videos available at: https://www.colorado.gov/pacific/hcpf/disability-competent-care

[4] Disability Competent Care is a model of care designed to treat the whole person, beyond a diagnosis or condition. The model encourages participant direction in choices regarding their health, wellness, and life in the community. Resources for Integrated Care. [Online]. June 24, 2018. Available at: https://www.resourcesforintegratedcare.com/taxonomy/term/21

[5] The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others. [Online] June 24, 2018. Available at: http://www.mandtsystem.com/

[6] HCPF. ACC Payment Reform Program Report. April 16, 2018. Available at: https://www.colorado.gov/hcpf/legislator-resource-center

[7] HCPF. HCBS Settings Final Rule. Available at: https://www.colorado.gov/pacific/hcpf/home-and-community-based-services-settings-final-rule

Appendix A - RCTF Implementation Timeline
October 1, 2018

Note: Grey rows indicate the recommendation (task) is excluded and therefore not included in the scope of work. The RCTF Sponsor Group restricted Crosswalk inclusion to only those programs and initiatives having a direct relationship with the RCTF recommendations. The RCTF Sponsor Group also excluded duplicative and non-deliverable tasks as well as tasks that were not a good use of resources.

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
Recommendation 1	Leverage Medicaid waiver redesign efforts already underway pursuant to the requirements of H.B. 15-1318 and explore additional alternatives, ensuring that these efforts take into account the desire to provide more individuals with the opportunity to be served in a community setting.	No	7/1/2016	6/30/2020
1.B.1	Utilize strategies identified and utilized in the Colorado Choice Transitions program to foster collaboration among the DRCO, providers, and families and guardians regarding transition planning.	Yes	7/1/2016	7/31/2017
1.B.2	Identify CCB case management agencies, I/DD behavioral health providers and BHOs/MHC staff to collaborate on each individual's transition based on where the individual will live. Suggested responsible party: case management agency. Date determined by the transition planning process. (Addressed fully in Recommendations 4 and 5)	Yes	7/1/2016	6/30/2018
1.B.3	Ensure a mental health clinician and I/DD behavioral specialist work together on each case. Suggested responsible party: case management agency. Date: TBD.	No	4/1/2018	1/31/2019
1.B.4	Develop options to incentivize provider agencies, case management agencies, behavioral health providers and BHOs to ensure that each transition is successful. Possible incentives could include review of relative contracts, funding options or rules. Suggested responsible party: HCPF. Date: TBD. (Additional details are available in Recommendation 4)	No	7/1/2017	6/30/2020
1.B.4.a	Based on the person's needs, utilize the support level 7 process to fund a person interested in and choosing to transition from the Regional Center to a community-based placement.	Yes	7/1/2016	6/30/2017
1.B.4.b	Utilize an intensive case management model and rate to ensure robust service coordination and engagement during and after the transition.	No	7/1/2017	1/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
1.B.4.c	Evaluate the behavioral units/caps and costs to address the needs of the person transitioning. Note: The Supports Intensity Scale (SIS) alone may not consistently reflect the support required for individuals with intense needs. The SIS assessment is currently being analyzed for effectiveness. The conclusions reached from this analysis should inform the evaluation recommended above.	Yes	7/1/2016	6/30/2017
1.B.5	Define person-centered standards of success for transition to the community from the Regional Center. Suggested responsible party: case management agency. Date: At least 45 days prior to planned transition.	No	7/1/2016	1/31/2019
1.B.6	Track outcomes of each transition documenting successes and lessons learned, reporting back to DRCO and CCB. Suggested responsible party: case management director. Date: At 3 months, 6 months and 1 year following the transition. (Addressed fully in Recommendation 4)	No	7/1/2017	1/31/2019
1.B.7	Monitor this process and recommend actionable payment and rate reforms consistent with the waiver redesign, any alternative funding change, and capacity development. Suggested responsible party: HCPF. Date: Ongoing.	No	7/1/2018	6/30/2019
1.B.8	Address the lack of capacity to provide DD specific care in the mental health system through contract review, training, workforce development and capacity development. Suggested responsible party: HCPF. Date: Ongoing.	No	7/1/2016	6/30/2019
1.B.8.a	Develop and execute fiscal and actuarial studies to examine the potential fiscal impact of integrating people who have I/DD/Autism into the capitated mental health system funding (H.B. 15-1368)	Yes	7/1/2016	6/30/2017
1.B.8.b	The fiscal analysis should take into account current costs associated with inpatient hospitalizations, emergency department (ED) visits, first responders and other costs associated with behavioral/psychiatric crisis.	No	7/1/2016	6/30/2019
1.B.8.c	Examine bright spots of integrations of I/DD population occurring across the state, including Aurora Mental Health Center's Intercept program, Mental health Partners--Boulder, and Mind Springs Mental Health in Grand Junction.	Yes	7/1/2016	6/30/2017
1.B.8.d	Survey current organizations (CMHC, CCBs) that are successfully providing mental health care to the I/DD populations in order to identify best practices.	No	7/1/2017	6/30/2019
1.B.8.e	Survey Mental Health Centers about barriers to billing/utilization outside the capitated rate.	Yes	7/1/2016	6/30/2017

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
1.B.8.f	Revise the relevant contracts to standardize and require best practices across the state in order to incentivize continued capacity development and integrated care. (Note: This is addressed fully in Recommendation 2)	No	12/1/2017	6/30/2019
1.B.9	Identify the costs associated with the elimination of the exclusionary diagnostic criteria for those with I/DD and Autism under the current mental health Medicaid system. (Addressed fully in Recommendation 2)	Yes	7/1/2016	6/30/2017
1.B.10	Secure funding to develop a model of training, consultation, and workforce development to enhance capacity of working with the I/DD population within the mental health/behavioral health system. (Addressed fully in Recommendation 3)	No	7/1/2017	6/30/2019
1.B.11	Reallocate funding to enhance the flexibility and responsiveness of the community providers to provide support for families as an integral element of treatment for a person with a dual diagnosis.	No	6/1/2019	6/30/2020
Recommendation 2	Fully include services for individuals with I/DD in the capitated mental health system by basing access and reimbursement of services on the presentation of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks.	No	7/1/2016	6/30/2019
2.B.1	Including people with behavioral health needs, regardless of the etiology of those needs, in the mental health Medicaid capitated program would centralize responsibility and integrate this special population into existing community services. Doing so would require BHOs to develop specialized I/DD providers either in-network, through the community mental health providers, or externally through third-party providers. This would eliminate screen-outs or denials that currently leave people under-served or without behavioral health services at all.	No	7/1/2016	6/30/2019
2.B.2	This recommendation acknowledges and addresses the issue that BHOs have not adequately developed the specialized provider networks as required by the HCPF contract. As a consequence, clients are screened away from community mental health centers and are not documented as being denied services, while assessments are performed by untrained clinicians, resulting in erroneous denials due to over attribution of behavioral problems to a person's developmental disability (diagnostic overshadowing).	No	1/1/2017	6/30/2019
2.B.3	This restructuring would require the coordinated work of the Colorado Department of Human Services, the Colorado Department of Health Care Policy and Financing, Offices of Behavioral health, Division for Developmental Disabilities, and will inevitably involve the Regional Care Collaborative Organizations (RCCO).			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
2.B.4	Studies should be conducted to assess the funding needed to support the mental and behavioral health needs of people with I/DD in publicly funded services. CBHC, Alliance and existing providers can collect information from existing programs and providers. Such actuarial studies are necessary to determine the likely increase in costs (through potential additional care) or savings (though avoidance of long-term costs such as ED and hospital visits via early intervention) and must underpin any changes to the BHO contracts. H.B. 15-1368 authorizes and funds an actuarial study similar to what was done for integrating substance abuse treatment with mental health services.	No	7/1/2016	6/30/2019
2.B.5	The $65 million State Innovation Model (SIM) grant awarded to the State outlines a goal of integrated care for 80% of Coloradans by 2020. Coordinated work is already occurring with primary care practice along with a workforce group. This recommendation should be taken to the SIM committee and a plan developed to ensure that people with I/DD are not left out of this groundbreaking work.	No	7/1/2016	6/30/2019
2.B.6	Given that the future plans for BHOs to be embedded within the Regional Care Collaborative Organizations are unclear and undefined, it is uncertain as to the timeframe in which changes to the BHO contract will take place. The current BHO contracts have been recently renewed for a period of one year, expiring on June 30, 201. As those contracts are reviewed, the above considerations should be embodied as practical.			
2.B.7	HCPF should begin an effort to analyze the BHOs to better understand:	No	7/1/2016	6/30/2019
2.B.7.a	Differences in business practices such as variation in fee-for-service billing by region/company;	No	7/1/2016	6/30/2019
2.B.7.b	Disparities in services provided;	No	7/1/2016	6/30/2019
2.B.7.c	Themes of success that can be replicated; and	No	7/1/2016	6/30/2019
2.B.7.d	Opportunities to carry these successes into future program and contract innovations.	No	7/1/2016	6/30/2019
Recommendation 3	Develop guidelines, training, and clinical tools for medical, behavioral and mental health providers to deliver effective services for the I/DD population.	No	7/1/2016	6/30/2020
3.B.1	Provide funding support to develop an adequate workforce that is cross-trained in behavioral health treatment and techniques for teaching and working with individuals with I/DD. This will include new forms of treatment expertise such as behavioral analysis, functional assessment of behavior, and evidence based treatments that are not grounded in traditional psychotherapy models.	No	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
3.B.2	Develop and integrate effective networks of primary care medical providers and other health professionals that can positively impact health outcomes for persons with I/DD.	No	7/1/2016	6/30/2019
3.B.3	Develop and update guidelines for the general, physical, behavioral and mental health recommendations for adults with I/DD, especially for those conditions not screened for by routine health assessments of the general population that takes a comprehensive approach involving:	No	7/1/2017	6/30/2019
3.B.3.a	training primary care providers in the content and use of these guidelines;	No	7/1/2017	6/30/2019
3.B.3.b	developing clinical tools to help apply them; and	No	7/1/2017	6/30/2019
3.B.3.c	establishing clinical support networks that work in concert to increase the use of these guidelines.	No	7/1/2017	6/30/2019
3.B.4	Secure funding to augment recommendations and training efforts coming out of the SIM grant.	No	7/1/2017	6/30/2019
3.B.5	Develop strategic partnerships with university training programs across the state, as suggested in the Colorado Health Workforce Development report. (Note: The University of Colorado's JFK Center for Excellence is the federally designated agent to advance the education of professionals supporting people with I/DD.) Such partnerships could create a well-trained workforce and provide a "feeder" system for the state to ensure that future expertise will be available. This is important as the state moves toward integrated systems of care, in which cross-training and expertise will be essential and foundational to the model's support.	No	7/1/2017	6/30/2019
3.B.6	Actively engage people with I/DD in health awareness, self-advocacy, health literacy, and health promotion activities to enable them to participate in their own healthcare through improved access.	No	7/1/2018	6/30/2020
3.B.7	Add the current Regional Center designation of Psychiatric Technicians to CDPHE certification and determine which types of services these technicians would be authorized to provide.			
Recommendation 4	Enhance the transition planning process to include additional person-centered elements and improve outcome tracking.	No	7/1/2016	1/31/2020
4.B.1	The transition process should be revised to include:			
4.B.1.a	Additional person-centered details: The enhanced transition plan must be a person centered planning process reflecting what is important to, and for, the person receiving home and community-based services. It must address personal preferences and ensure health and safety. The plan must identify the person's strengths and weaknesses, preferences, needs and desires.	Yes	7/1/2016	6/30/2018

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
4.B.1.b	Risk factors: The plan should include risk factors for the person, as well as risk mitigation plans. CMS has made clear any reference to the person in the person-centered planning requirements include both the person and their legally appointed decision-making authority.	Yes	7/1/2016	6/30/2018
4.B.1.c	Enhanced communication with CCBs: Materials sent to community providers must include a complete representation of the individuals being considered for placement in the community.	Yes	7/1/2017	6/30/2018
4.B.1.d	An approach for resolving disagreements: The process must also include a way to address disagreements between providers, families and guardians, and any others involved in care delivery.	Yes	7/1/2016	6/30/2017
4.B.2	Each transition plan must include balanced set of outcome measures that indicate successful living for the client. The set of measures could be enhanced by following these steps:	No	7/1/2017	6/30/2019
4.B.2.a (i-ii)	Create a balanced set of core metrics. Care should be taken to design each metric so as to be measurable, traceable, and actionable over time. Categories of metrics might include: (i) Incident rates (e.g. ED visits, negative interactions with law enforcement, self-injurious behavior, elopements, involuntary change in residence, suicidal threats/attempts/completions, etc.); and (ii) Quality of life indicators (e.g. client/family/guardian satisfaction surveys, progress toward significant goals, employment rates, significant changes in health (positive or negative), etc.).	No	7/1/2017	6/30/2019
4.B.2.b	Once such metrics are defined, HCPF, CDHS, and CDPHE should collaborate to fill any gaps between the desired information and the currently available sources.	No	7/1/2017	6/30/2019
4.B.2.c	For each metric, the accountable departments(s) could establish actionable and reasonable goal thresholds to track quality performance. For example, the goal for the number of ED visits should not be set at zero but instead targeted to equal that of non-I/DD Medicaid population, or three visits per year per client.	No	7/1/2017	6/30/2019
4.B.3	Identifying lessons learned and trends from monitoring individuals could be used to drive best practice sharing and continuous improvement activities to improve the quality and efficiency of service for all persons with I/DD undergoing transition.	No	10/1/2017	1/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
4.B.3.a (i-ii)	There are two different systems in use for incident tracking for this population. For HCBS-DD waiver services, the provider agency sends the critical incident report (CIR) to the CCB for entry into the DDWeb application portal (formerly known Community Contract Management System or CCMS). For persons in an ICF-I/DD, occurrence reports (ORs) are entered into the Colorado Health Facilities web portal (also called the Occurrence Reporting Portal or System). (i) To track individuals in a Regional Center who transition to a community setting, future monitoring will need to integrate data from both tracking systems. Tracking these six categories will meet the task force's intention: (a) Abuse (b) Neglect (c) Exploitation (d) Serious injury (e) Missing person (f) Death (ii) Additional categories reported for HCBS but not ICF include: (a) Mistreatment (usually captured in abuse, as that category includes verbal as well as physical abuse) (b) Medical crisis (outside of serious injury, such as an emergency department visit for behavioral issues) (c) Medication error with an adverse health impact (when not a serious injury) (d) Unusual incidents (includes criminal offense by the person, not otherwise captured in the other categories)	Yes	7/1/2016	4/30/2018
4.B.3.b	There is some disagreement over the effectiveness of the Transition Readiness Assessment Tool (TRAT) and the associated process in accurately determining readiness for transition. A re-evaluation should be conducted by a cross-functional team of experts to ensure that the assessment tool and method is balanced and multi-dimensional , and that it is a predictor of an individual's likelihood of succeeding in the community while performing tasks independently in less-restrictive settings.	Yes	7/1/2016	3/31/2018
4.B.4	Current funding mechanisms can present a barrier to successful transitions. In some instances, approving a temporary funding increase to SIS support level 7 is sufficient to provide the additional supports needed during transition. In other instances, an exception to the standard process of support level determination is needed. The departments should work with community providers to propose details of such exception funding and the process for accessing it. Considerations should include:	Yes	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
4.B.4.a	Behavioral supports: Staff within the Regional Centers who have experience with a given resident may be engaged to provide behavioral supports in the new provider's setting for a period after the transition. The RC staff may provide training to community provider staff on the specific behaviors, triggers, and strategies established to ensure the resident's safety and stability. This support will be critical to ensuring a smooth transition and to prevent regression, and care should be taken to ensure that this funding is easily accessible and based on individual need (that is, not "unit-based").	No	7/1/2016	1/31/2019
4.B.4.b	Onboarding funding: Residents transitioning between residential settings may need funding to meet one-time costs. This may include certain durable goods (furniture, housewares, etc.) that are needed to avoid barriers to transition.	No	7/1/2016	1/31/2019
4.B.5	Once the process is enhanced:			
4.B.5.a	An effort should be made to encourage families and guardians to engage in the enhanced process, though transitions should remain voluntary. Part of this effort should include activating "parent to parent" (or guardian to guardian) networks, conducting sessions with concerned guardians to share the experiences of guardians and individuals who recently undergone the transition process. These sessions should focus on lessons learned during the process, both positive and negative, and the progress of the individual with I/DD since the transition was effected. In some states, this has taken the form of a "peer mentor" process where families and guardians whose family member has undergone a transition volunteer to support those who are contemplating a transition.	Yes	7/1/2016	6/30/2018
4.B.5.b	Results of the transitions should be published to the degree possible given HIPAA constraints.	Yes	7/1/2016	6/30/2018
4.B.6	Implementation:			
4.B.6.a	Within 6 months, CDHS and HCPF should review the current transition process and enhance it to include the elements above (CDHS for planning, HCPF for tracking).	Yes	7/1/2016	6/30/2017
4.B.6.b	Each person engaging in an enhanced transition should have their case reviewed for lessons learned.	No	7/1/2016	1/31/2020
4.B.6.c	These actions should be in concert with the implementation of care coordinators, which is described fully in Recommendation 5.	No	7/1/2016	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
Recommendation 5	Identify, authorize and fund an entity (or entities) to coordinate service delivery for those individuals with I/DD receiving services from multiple systems of care to optimize on-going access to services and provide support during emergencies, transitions and crises. Identify opportunities to reduce complexity across care delivery systems.	No	2/1/2018	6/30/2020
5.B.1	Defining "Care Coordination" for purposes of this recommendation:			
5.B.1.a	Purpose: Care Coordination addresses interrelated behavioral, developmental, education, financial, medical, and social needs to optimize health and wellness outcomes. In ties of ongoing stability, care coordination is a person-and-family-centered, assessment-driven, team activity designed to meet the needs and preferences of individuals while enhancing the caregiving capabilities of families and service providers. in teams of emergency or crisis, the care coordination entity will work to coordinate the needed resources across systems of care to limit the severity and duration of the crisis.			
5.B.1.b (i-x)	Core functions: A care coordinator has both the responsibility and authority to work across the MH, BH, DD, physical and dental health systems and social services to support individuals receiving services from these entities and provide effective care coordination in times of stability and crisis. Specific functions include: (i) assess with the family and individual their strengths as well as unmet needs across life domains; (ii) identify all sources of referrals, services, and supports, facilitate connections with these sources, and manage continuous communication across these sources; (iii) identify desired outcomes and establish accountability and/or negotiate responsibility (e.g. who will perform which specific actions to achieve common goals); (iv) develop a comprehensive plan of care and services with the individual, family and provider(s) that includes a plan to utilize strengths and address unmet needs; (v) provide information around purpose and function of recommended referrals, services, and supports; (vi) reassess and modify comprehensive plan of care with the family, individual, and provider(s); (vii) support and facilitate transitions between residences as necessary, both in times of stability and crisis; (viii) share knowledge and information across systems, and facilitate communication, among participants in individual care; (ix) be available 24/7 and have access to real-time data from electronic health records or other similar systems in times of crisis; and (x) authorize increases in funding in times of crisis to allow staffing levels necessary for health and safety, development of an interdisciplinary team, specialist visits, medical transportation, etc.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
5.B.1.c (i-iv)	Additional functions: Care coordination is necessary because care delivery systems are specialized and fragmented, requiring a skilled navigator to access the array of services to which a person with I/DD is entitled. In addition to providing this navigation service, the network of care coordinators should regularly: (i) document and refine the business processes for care coordination; (ii) analyze organizational constraints and barriers to service delivery; (iii) identify opportunities for enhanced communication, service integration and simplification; and (iv) provide this feedback to the legislature through the implementation structure established by Recommendation 10 through existing committees of reference.			
5.B.2	Implementation: There are four recommended actions to execute this recommendation:			
5.B.2.a	Within 1 year, identify existing funding authority and sources, conduct a gap analysis and make recommendations for additional sources of funding for contracted regional lead entities to handle care coordination.	Yes	2/1/2018	6/30/2019
5.B.2.b	Within 1 year, rewrite the exclusionary clause that prevents RCCOs from serving someone coming out of an institution for 12 months.	Yes	2/1/2018	6/30/2019
5.B.2.c	Within 2 years, HCPF, CDPHE and CDHS need to review existing rules to identify rules that act as a barrier to the creation of contracted lead entities for care coordination ; and then amend those rules.	Yes	2/1/2018	6/30/2019
5.B.2.d	Within 3 years, HCPF needs to clearly define criteria for lead care coordination entities, related tiered rate methodology, and clearly identified data collection and implement outcome-based contracts with lead care coordinator(s).	No	7/1/2019	6/30/2020
Recommendation 6	Create contractual agreements with community-based providers across the state that include a no reject/no eject clause and have the Regional Centers serve as a safety net provider as necessary.	No	7/1/2019	6/30/2020
6.B.1	Colorado should ensure that community-based services (least restrictive environment) are available for people with the most intense needs. This could be done through contractual agreements with providers of specialized services with "no reject" clauses while also preserving state-operated services for those individuals who cannot find a suitable placement with a community provider. Such as system would effectively create a hybrid system of "last resort".	No	7/1/2019	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
6.B.2	For such contracts to be successful and for the care provided to meet the needs of the diverse I/DD population, providers must meet specific criteria. Please see "Additional Information" below for these criteria, based on recommendations offered by providers with expertise in serving three common sub-populations of people with I/DD.	No	7/1/2019	6/30/2020
6.B.3	The State of Colorado (at an existing RC location or at other locations) would serve as the "fallback" safety net in cases where no other community-based (or privately-operated) option is available for a person with I/DD. This could include people with I/DD coming out of correctional institutions, hospitals, or those who experience crisis situations where immediate access to a community provider is not available in a timely enough fashion to ensure health and safety. The state-operated system would have established processes in place to work with community-based safety net providers to enable individuals to have access to less restrictive services as quickly as possible. "Quickly" in this context is not measured in days and weeks but in months or even years due to the extended process for stabilizing people with I/DD. There is a distinction between providing buildings and delivering services. It may be that the state's physical infrastructure could be low while still providing services across Colorado's geography. Such a "super CCB" design would enable provision of services to people where they live while maintaining low fixed costs.	No	7/1/2019	6/30/2020
6.B.4	Actions to implement this hybrid system include at least:			
6.B.4.a	The departments should work together to design the details of such a contract, working with community providers to understand their receptivity to such arrangements.	No	7/1/2019	6/30/2020
6.B.4.b	The legislature should specify in statute the need for a safety net system that includes community-based providers as the primary service provider and the State as the fallback provider.	No	7/1/2019	6/30/2020
6.B.4.c	Once the first two actions have completed, the departments could establish both the contractual arrangements and the funding criteria for "no reject" community-based safety net providers for these populations.	No	7/1/2019	6/30/2020
Recommendation 7	Formalize the role of Regional Centers and certain community providers as a statewide crisis stabilization system for individuals with I/DD and/or co-occurring serious and persistent conditions.	No	7/1/2016	6/30/2020
7.B.1	Defining crisis stabilization for I/DD:			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.1.a	Purpose: Promote recovery for individuals with I/DD who are struggling with co-occurring disorders and need intensive interventions. An individual can receive treatment at a Regional Center crisis stabilization unit. However, in times of crisis, entry into a crisis stabilization program should not be the first option. A care coordination entity (and a team directed by that entity) must first attempt to resolve the crisis (Recommendation 7).			
7.B.1.b (i-iv)	Goals: Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care in order to: (i) increase access to appropriate behavioral health services; (ii) decrease utilization of systems of care that do not have DD expertise (e.g. emergency departments, etc.); (iii) utilize an interdisciplinary team to address crisis situations and circumstances; and (iv) increase rates of satisfaction by families and care recipients.			
7.B.2	Details of crisis stabilization units:			
7.B.2.a (i-vi)	Defining emergency admissions and crisis stabilization: The criteria for entry into, and operation of crisis stabilization units require additional analysis. A team representing experts from CDPHE, CDHS and HCPF should conduct a review on this topic, including at least the following actions: (i) complete a compliance review of current emergency admissions in light of the admissions policy and relevant regulations. Use the findings to inform future RC emergency admissions; (ii) explore and analyze other states' approaches to meet the need for crisis stabilization; (iii) clarify the federal requirements and limitations regarding active treatment and other relevant regulations regarding usage of ICFs as emergency placements; (iv) align the current statutory requirement of Imposition of Legal Disability (ILD) for those entering /living in the Regional Centers with the requirements of the Final Rule and other relevant policies. Explore the need and continued functionality of ILDs specific to the Regional Centers and utilize them only when legally necessary. Include in this effort a policy or process to address circumstances when an individual with I/DD is unable to make an informed consent and does not have a legal guardian who can perform this task in their stead. Explore statute change or other steps to produce alignment; (v) explore the development of Acute Treatment Units specifically designed to serve the needs of those with I/DD and function as stabilization and step down environments as needed. This enhances system wide capacity and integration of mental health and I/DD services; and (vi) define the criteria for admission into a crisis stabilization unit, and determine where these criteria should be housed (rule, policy, etc.). Care should be taken that admission criteria be based on need, not diagnoses or condition or I/DD status.	No	7/1/2016	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.2.b	Number and locations of beds: In the near-term, both the WRRC and GJRC could apportion a number of vacant ICF beds to crisis stabilization, assuming this is deemed permissible by the review described above. As community capacity is increased over the coming years, the location of crisis stabilization beds may shift at CDHS' discretion as consolidation options emerge. The task force feels strongly, however, that regionalized solutions be maintained to not pose an undue burden on the families of those persons with I/DD that suffer a crisis. To ensure delivery of crisis stabilization services in locations most advantageous to the I/DD population, CDHS and HCPF should explore utilizing contracts to establish crisis stabilization unit providers within the community, provided these contract providers could deliver suitable service at an acceptable cost. The departments should also contemplate delivery of service by using a cadre of state employees designated to provide stabilization services in situ rather than moving the individual in crisis from their primary residence.	No	7/1/2019	6/30/2020
7.B.2.c	Duration of a crisis stabilization: The length of stay in a crisis stabilization unit will vary as individuals with I/DD often require longer periods for stabilization. The task force recommends a design for crisis stabilization that is relatively short-term rather than indefinite while still acknowledging the specific needs of the person. Regional Center staff report that there are times when individuals require more than the acute 90-120 day placement for assessment and stabilization. This will likely remain true, as individuals with complex co-occurring challenges often require additional time in assessment, planning, and treatment design. A potential method for balancing this reality with the goal of reducing individual time within the Regional Center setting is to engage a standardized process for reviewing cases and maximizing expertise and strategy for improving care and rapid return to the community. For example, developing a review committee comprised of Regional Center professional staff as well as external expertise that conducts a second review of the case. The purpose is not to scrutinize the primary team's work or progress on each individual's transition. Rather, the goal is to have an external support team for the primary care team in thinking carefully about individual needs and strategies for the most effective treatment approach. It can also serve as a second opinion when progress is slower than hoped. In this way, the treatment process can be improved for individuals with more complex needs. When individuals need more time for medication trials or environmental adaptation, the review committee can provide validation of the primary team that additional time is required and/or provide linkage to additional community services.	No	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.2.d	Roles and responsibilities: The division of responsibility will need to be clarified within the service system for members of interdisciplinary crisis management teams, care coordinators **(Recommendation 5)**, CCB case managers, BHO care coordinators, and the case managers at the Regional Centers.	No	8/1/2016	6/30/2019
7.B.3	Measuring success:			
7.B.3.a	It is recommended that community and RC stakeholders participate in "lessons learned" sessions to clarify role division and document improvements of the process after a specific number of crisis stabilizations.	No	7/1/2016	6/30/2019
7.B.3.b	Outcome measures include the average cost and length of stay related to individuals that require inpatient hospitalization, individuals served by local emergency departments, and individuals incarcerated compared to those served by the crisis stabilization center(s).	No	7/1/2016	6/30/2019
7.B.4	Implementation: The initial actions to execute this recommendation would include:			
7.B.4.a	Within 1 year, HCPF and CDHS clearly define criteria for admission into crisis stabilization units, length of stay, and compensation for services provided, establish clearly identified data sources and collection methods to accurately measure outcomes and costs, and draft new policies and promulgate rules as needed to implement these changes.	No	7/1/2016	6/30/2019
7.B.4.b	Within 3 years, establish the relationships and changes in service to enable the delivery of crisis stabilization services as recommended above.	No	7/1/2016	6/30/2019
Recommendation 8	Conduct an accurate cost analysis of both community and Regional Center HCBS beds related to compliance with the 2014 Centers for Medicare and Medicaid Services (CMS) Final Rule to guide future decisions on the number and location of state-operated HCBS waiver beds. In addition, provide funding and support needed to successfully transition residents, who desire to transition and are deemed ready to transition, to community placements and consolidate these beds as successes allow.	No	7/1/2016	6/30/2019
8.B.1	Goals			
8.B.1.a	Increase options for persons with I/DD o reside in less restrictive living situations.			
8.B.1.b	Increase rates of satisfaction by families and care recipients.			
8.B.1.c	Decrease total Regional Center resident costs to enable reinvestment in additional community supports for the entire I/DD population.			
8.B.2	Impending Changes and Analysis			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.2.a	Changes will be required to both residential services and day programs and potentially other aspects of HCBS service in the community and at the Regional Centers.			
8.B.2.b	CDHS should evaluate the gaps between current Regional Center operations and the guidance provided by the Final Rule and develop an estimate of the costs to come into compliance.	Yes	7/1/2016	6/30/2018
8.B.2.c	HCPF should evaluate the costs of compliance to the community providers. The punitive costs of failing to comply should also be investigated. This evaluation report should be directed by the cross-agency operational team described in Recommendation 10 and provided to departmental leadership and the legislature in keeping with the processes also outlined in Recommendation 10.	No	7/1/2018	6/30/2019
8.B.3	Condition-based consolidation			
8.B.3.a	Consolidation of Regional Center HCBS beds could begin with a focus on relocating residents currently living in homes that are below their target census into a single home operating at the target number of beds. This may yield efficiencies in staffing and eventually allow disposition of unneeded infrastructure. Funds gained from this consolidation could be used to further develop community supports.			
8.B.3.b	As community supports are enhanced, it is anticipated that there will be a natural decline in the number of long-term residents of HCBS waiver beds. As these numbers fall, consolidation will become desirable, as the per-resident costs will grow significantly as infrastructure and staffing costs will be distributed over fewer residents.			
8.B.3.c	The task force recommends that the decision to consolidate facilities be based on conditions rather than on a timeline. The target date of March 2019 does not establish a goal of eliminating state operated HCBS homes. Instead, it simply creates a timeframe by which conditions should be in place to allow people to safely transition to community placements, if they choose to do so, and according to the transition process described earlier in this report.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.3.d (i-iv)	Below are four conditions that, together, would indicate that transition of a significant number of residents is likely to be successful. The task force recommends pursuing a target of March 2019, not with the goal of eliminating HCBS beds from Regional Centers, but as a means for providing a goal-date for the community. The four conditions are: (i) The residents with I/DD have met their recommended progress goals; (ii) Availability of a sufficient number of community beds to accommodate the number of residents being transitioned; (iii) A proven no reject/no eject contract with a safety net provider (or network) of providers within the resident's region that has the required facilities and staffing to accommodate the resident's needs (e.g. the specific needs of a medically complex resident v. a resident displaying high behaviors v. a resident with both characteristics); and (iv) The documented enhanced transition planning process has proved successful (as defined in Recommendation 4).			
8.B.3.e	Some residents of HCBS waiver beds may struggle to find a suitable community placement for reasons of their conditions or due to inadequate funding to allow a community provider to meet their needs. For these residents, ICF services may be an option for long-term care but a process must be followed prior to ensure this is a correct placement. For these residents, the department must first try to modify their service plans. If this is not successful, an ICF placement may be an alternative. For those who do not meet he requirements for ICF placement, another financing option must be sought. The intention of this task force is to support the highest number of community-integrated placements while not compromising individual safety or the sustainability of the overall program by lowering the criteria of ICF placements. The task force is opposed to a system-wide, broad movement of individuals from HCBS waiver placements to ICFs merely to accommodate the CMS Final Rule.			
8.B.4	Measuring success: The success measures for these transitions will be the same as those recommended in Recommendation 4 regarding transition planning.			
8.B.5	Implementation: The initial actions to execute this recommendation would include:			
8.B.5.a	within 12 months, the departments complete and publish a gap analysis (to inform the cost analysis) and full cost analysis for the community HCBS and Regional Center HCBS to become compliant with the 2014 CMS HCBS Final Rule;	Yes	7/1/2016	6/30/2018

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.5.b	within 3 years, establish safety net provider contracts in each region, each with no-reject/no-eject clauses;			
8.B.5.c	implement an enhanced transition process per Recommendation 4; and			
8.B.5.d	as part of the normal budget process, departments request funding for a transition contractor.	Yes	7/1/2016	7/31/2017
8.B.6	Funding for transition contractor: To ensure successful, person-centered transitions for individuals who desire to transition and are deemed ready to transition, the following action steps are recommended:			
8.B.6.a	CDHS and HCPF develop a cross agency workgroup (Transition Workgroup) to handle the process of transitions.			
8.B.6.b	Transition workgroup establishes a timeline for enhanced transition, based on recommendations of RCTF.			
8.B.6.c	HCPF identifies enhanced rate structure to transition individuals to community with enhanced rates to cover additional staffing as needed, increased behavioral services and supports, and pre-screening/assessment for potential home health services to be provided as needed and appropriate at the provider location through Medicaid Sate Plan.			
8.B.6.d	CDHS and current Inter Disciplinary Team (IDTs) work with families and guardians and representatives from the CCB to conduct comprehensive assessments of Regional Center residents who are interested and deemed ready to determine the residents' transition support needs. (Note: Assessments are used to develop the transition checklist. The enhanced process and tools outlined in Recommendation 4 can serve as a starting point).	Yes	7/1/2016	6/30/2018
8.B.6.e	Assessments are provided to the Transition Workgroup (including placement experts from CCBs) to develop service needs and costs.			
8.B.6.f	HCPF and Transition Workgroup identify enhanced rate structures needed to support transitions. (Note: If Support Level funding is sufficient for these transitions, the timeline for this recommendation will be shorter, and the administrative workload will be less than if waiver redesign is a required predecessor.			
8.B.6.g	HCPF develops budget request based on enhanced rate structure, and assessment of number of people needing enhanced rates and enhanced services.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.6.h	Transition workgroup develops scope of work for transition coordinator. Scope of work would need to take into account RCTF recommendations. Could be a specific, detailed plan, or could be a two stage RFP that include a request for contractors to develop a plan and then re-bid on the implementation of the plan.			
8.B.6.i	Transition workgroup investigates potential funding sources for funding a transition coordinator (or these are provided via FY 2016 supplemental appropriation in Long Bill or FY 2017 Long Bill appropriation).			
8.B.6.j	Transition Workgroup develops a RFP with input from key stakeholders to solicit bids from entities to serve as the transition coordinator.			
8.B.6.k	HCPF develops a RFP for transition coordinator after investigating best practices from other states. Coordinate with CDHS as required.			
8.B.6.l (i)	Onboard the transition coordinator(s). (i) Transition Workgroup meets with transition coordinator frequently to track process/progress against key milestones.			
Recommendation 9	Once no-reject/no-eject contracts with community providers are established, implement a fully-funded transition process to place residents, who desire to transition and are deemed ready to transition, in the community, and over time reduce the number of state-run ICF beds as successes allow.	Yes	7/1/2017	6/30/2018
9.B.1	Goals			
9.B.1.a	Increase options for persons with I/DD to reside in less restrictive living situations.			
9.B.1.b	Increase rates of satisfaction by families and care recipients.			
9.B.1.c	Decrease total Regional Center resident costs to enable reinvestment in additional community supports for the entire I/DD population.			
9.B.2	Conditions affecting the future number and location of ICF beds:			
9.B.2.a	Changes in population demographics, community support development, and the pace of voluntary transition to the community make it impossible to establish a fixed number of ICF beds required at the Regional Centers;			
9.B.2.b	current facilities, particularly the GJRC, have facilities whose maintenance needs are, or may soon be, so great that it will be cheaper to develop new facilities;			
9.B.2.c	certain residents, particularly those with Problematic Sexual Behavior (PSB), require facilities designed specifically to address their conditions;			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.2.d	it is anticipated that state-operated Regional Centers will maintain a certain regional footprint of beds to act as crisis stabilization units (Recommendation 7) while also reducing the number of long-term residents; and			
9.B.2.e	when combined, the dynamics above may require a reduced footprint with changes in facility design and staffing to accommodate the needs of the residents that will be served in the future.			
9.B.3	Compliance evaluation: HCPF, CDHS, and the State Architect should conduct a compliance review of the operational practices at Kipling Village. This review should identify gaps and issues and prescribe corrective actions to ensure compliance with federal standards and licensing requirements. This evaluation report should be directed by the cross-agency operational team described in Recommendation 10 and provided to department leadership and the legislature in keeping with the processes also outlined in Recommendation 10.	Yes	7/1/2017	6/30/2018
9.B.4	Condition-based consolidation and redesign:			
9.B.4.a	The task force recommends that the decision to consolidate and/or redevelop facilities be based upon conditions rather than on a timeline. The target date of March 2019 does not establish a goal of eliminating state operated ICF beds. Instead, it simply creates a timeframe by which conditions should be in place to allow people to safely transition to community placements, if they choose to do so, and according to the transition process described earlier in this report.			
9.B.4.b (i-iv)	Below are four conditions that, together, would indicate that transition of a significant number of residents is likely to be successful. The task force recommends pursuing a target of March 2019, not with the goal of eliminating HCBS beds from Regional Centers, but as a means for providing a goal-date for the community. The four conditions are: (i) residents with I/DD have met their recommended progress goals; (ii) a sufficient number of community beds exist o accommodate the number of residents being transitioned; (iii) a proven no-reject/no-eject contract with a safety net provider (or network) of providers is in place within the resident's region that has the required facilities and staffing to accommodate the resident's needs (e.g. the specific needs of a medically complex resident versus a resident displaying high behaviors); and (iv) a documented enhanced transition planning process has been determined o be effective (as defined in Recommendation 10).			
9.B.5	Measuring success: The success measures for these transitions will be the same as those in Recommendation 4.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.6	Implementation: The initial actions to execute this recommendation include:			
9.B.6.a	within 3 years, establish safety net provider contracts in each region, each with no-reject/no-eject clauses;			
9.B.6.b	implement an enhanced transition process per **Recommendation 4**; and			
9.B.6.c	within 12 months, the departments complete and publish a full cost analysis for the community ICF and Regional Center ICF services.			
Recommendation 10	Establish an ongoing monitoring, assessment, and reporting structure to ensure that recommendations are implemented and evaluated for impact.	No	7/1/2016	6/30/2020
10.B.1	A cross-agency operational team will be assembled to coordinate implementation across agencies and meet at least quarterly to share progress and address implementation issues.	Yes	7/1/2016	9/30/2016
10.B.1.a	This team or a sub-set of this team may initially and during periods of higher activity need to meet more frequently to advance progress on assigned issues.	Yes	7/1/2016	9/30/2016
10.B.1.b	It is recommended that the meetings be offset from the reporting requirements to allow for timely delivery of reports to the JBC and the General Assembly.	Yes	7/1/2016	9/30/2016
10.B.2	The team will deliver a report quarterly to a group of executives from HCPF, CDHS, and CDPHE and to the JBC (Note: The team must work with the JBC to align on specific reporting dates that align with the JBC's quarterly meeting to review economic forecasts and other matters). At the discretion of the JBC, members of this team may be requested to join the JBC meetings to make presentations or answer questions.	Yes	7/1/2016	7/31/2016
10.B.3	The team will also deliver a status update to the General Assembly at least once per year, as a part of the SMART Act hearings in the November-January timeframe and the beginning of the legislative session in January.	Yes	11/1/2016	1/31/2017
10.B.4	Reports should include, at a minimum: overall progress per specific recommendation (dashboard), specific actions taken and actions needed, any special considerations, risks and mitigation plan, as well as any decisions made/required.	Yes	7/1/2016	7/31/2016
10.B.5	As it is fundamental to many changes included in this report, HCPF should report on the progress of waiver redesign activities and interactions with CMS regarding waivers per the requirements of section 25.5-6-409.3, C.R.S. (2015).	No	7/1/2016	7/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
10.B.6	Potential members of such an operational team should include: CDHS representatives (1 for transitions and 1 for operation/finance), HCPF representatives (one for funding, one for waiver administration/client services), one CDPHE representative (focused on licensure and compliance) plus additional operation members as required.	Yes	7/1/2016	9/30/2016
10.B.7	This operational team could be led by an executive-level program manager with knowledge of the complex systems involved and the authority to drive results as well as a project manager who would build and maintain an integrated project plan containing timing, dependencies and resource requirements and coordinate activities across initiative sub-teams. Funding would need to be appropriated for these	Yes	7/1/2016	11/30/2016
10.B.8	An advisory committee of family members, advocates and providers could be established to engage with the operational team twice annually to provide feedback and insight. Committee members could also be on-call to provide expertise as requested by the operational team.	Yes	7/1/2017	7/31/2017
10.B.9	Twice annually, the operational team should publish a summary of progress to the broader community concerned with I/DD issues (families, guardians, advocacy groups, providers, etc.) and hold open forum meetings (in-person and teleconferences) to answer questions and gather feedback.	Yes	7/1/2016	12/31/2017
10.B.10	The team should establish a comprehensive measurements system, tracking both cost and performance measures on both an individual and system-wide level. Implementation steps could include:	No	7/1/2018	6/30/2020
10.B.10.a (i-iii)	Establishment of a balanced set of core measures that indicate the effectiveness and efficiency of the system of care. Care should be taken to design each metric so as to be measurable, traceable, and actionable over time. Categories of metrics might include: (i) incident rates (e.g. ED visits, negative interactions with law enforcement, self-injurious behavior, elopements, involuntary change in residence, suicidal threats/attempts/completions, etc.); (ii) quality of life indicators (e.g. client/family/guardian satisfaction surveys, progress toward significant goals, employment rates, significant changes in health (positive or negative), etc.); and (iii) cost for like services (inclusive of payments for all facets of services, regardless of the funder or payment vehicle).	No	7/1/2018	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
10.B.10.b	Once such metrics are defined, HCPF, CHDS, and CDPH should collaborate on performing a gap analysis between the desired information and the currently available sources (e.g. National Core Indicators, incident reporting systems, etc.). An analysis should be performed to confirm the efficacy of available measurement systems and to identify additional data requirements.	No	1/1/2019	6/30/2020
10.B.10.c	Action should be taken to gather additional data as necessary.	No	1/1/2019	6/30/2020
10.B.10.d	For each metric, the accountable departments(s) could establish actionable and reasonable goal thresholds to track quality performance. For example, the goal for the number of ED visits should not be set at zero but instead targeted to equal that of non-I/DD Medicaid population, or three visits per year per client.	No	1/1/2019	6/30/2020
10.B.10.e	Once such a system of metrics is established, cross-system comparisons on cost, outcomes, incident rates, etc., can be made by HCPF. Disparities in performance can be used to drive best practice sharing and continuous improvement activities with the goal being to improve the quality and efficiency of service for all persons with I/DD.	No	1/1/2019	6/30/2020

COLORADO
Department of Human Services

December 1, 2018

Senator Dominick Moreno, Chair
Joint Budget Committee
200 E. Colfax Ave.
Denver, CO 80203

Dear Senator Moreno,

The Colorado Department of Human Services, in response to the Long Bill FY 2017-18 Request for Information #9 (RFI #9), respectfully submits the attached information concerning the status of interpreting services for the deaf, hard of hearing and deafblind in rural areas for the months of August, September and October 2018.

> #9 Department of Regulatory Agencies, Public Utilities Commission; Department of Human Services, Executive Director's Office, Special Purpose; Department of Human Services, Office of Early Childhood, Division of Early Care and Learning – The Departments are requested to submit a quarterly report beginning September 1, 2018 on the status of interpreting services for the deaf and hard of hearing. The report should include information on expenditures, cash fund balance for the Telephone Users with Disabilities Fund, locations of translation services, number of individuals served, category of services (doctor's office, school, etc.), county location of individual requesting service, and the amount of time between requests for translations services and the provision of those services.

Please see the attached report for the response to this request. If you have any questions, please contact Mark Wester, Director of the Office of Community Access and Independence at (303) 866-4408.

Sincerely,

Reggie Bicha
Executive Director

cc: Representative Daneya Esgar, Vice-Chair, Joint Budget Committee
Senator Dennis Hisey, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
John Ziegler, Staff Director, Joint Budget Committee
Mike Mann, JBC Analyst, Joint Budget Committee Staff
Lauren Larson, Director, Office of State Planning and Budgeting
Lucas Klifman, OSPB analyst, Office of State Planning and Budgeting
Tony Gherardini, Deputy Executive Director of Operations, Department of Human Services
Jerene Petersen, Deputy Executive Director of Community Partnerships, Department of Human Services
Alicia Caldwell, Deputy Executive Director of Legislative Affairs and Communication, Department of Human Services
Melissa Wavelet, Director, Office of Performance and Strategic Outcomes, Department of Human Services
Sarah DeVore, Director of Budget and Policy, Department of Human Services
Mark Wester, Director, Office of Community Access and Independence, Department of Human Services
Eric Johnson, Deputy Director, Office of Community Access and Independence, Department of Human Services
Kyle Brown, Human Services Policy Advisor, Governor's Office
Phil Robinson, Legislative Liaison, Department of Human Services

Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind (CCDHHDB)

Rural Interpreting Services Project (RISP) Pilot

Quarterly Report

December 1, 2018

Table of Contents

I. Introduction

This is the second quarterly report for Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's (CCDHHDB) Rural Interpreting Services Project (RISP) Pilot. The pilot is the result of a Joint Budget Committee (JBC) staff initiative using funding from the Telephone Users with Disabilities Fund (TUDF).

JBC staff made four recommendations:

(1) To place eight interpreters in Early Childhood Councils (ECCs) in rural areas across the State to provide ASL/English interpreting services ($440,000);
(2) To provide grants for initial and advanced interpreter training to increase the number of qualified interpreters ($200,000) in rural communities; and
(3) To conduct outreach to those who need service and those who may be able to provide such service ($60,000); and
(4) To create an exemption from the 16.5% limit on the TUDF for the next three years.

The General Assembly appropriated $700,000 in funding in FY 2018-19 for this initiative with a two-year timeframe, and recommended an approach that would yield additional data for future decision-making. The Department of Human Services (the Department), through CCDHHDB, is charged with implementing the first three JBC staff recommendations. The final JBC staff recommendation regarding the TUDF 16.5% limit exemption is directed at the Public Utilities Commission.

The JBC requested a quarterly report on this initiative beginning September 1, 2018. The report is to include: (1) information on expenditures, (2) the cash fund balance for the TUDF, (3) locations of interpreting services, (4) number of individuals served, (5) category of services, (6) county location of individuals requesting service, and (7) the amount of time between requests for interpreting services and the provision of those services.

This second quarterly report covers the period between August 1 and October 31, 2018. Note that for the purposes of this project, CCDHHDB defines "rural" in terms of a community's access to American Sign Language (ASL) English interpreters. Under this definition, the RISP Pilot includes all areas of the State outside of the Front Range. Pueblo is included in the RISP Pilot.

II. Updates on the Three Project Goals

The RISP Pilot's official rollout began in August 2018. As of October 30, 2018, the RISP Pilot has: (1) received 61 sign language interpreting requests, filling 54 of them; (2) laid the groundwork for a comprehensive approach to initial and advanced sign language interpreter training; and (3) conducted outreach to several rural areas of the state, including holding four town hall meetings.

A. Providing qualified ASL/English interpreting services

The first JBC staff recommendation is to place eight interpreters in ECCs in rural areas across the state. Update: Due to data limitations on the location and number of ASL users in rural areas of the state, CCDHHDB opted to rely on freelance (independent contractor) interpreters to fill RISP interpreting services requests for the first four months of the pilot. This approach allowed CCDHHDB to collect data on the areas of need before making staffing plans.

Currently the RISP Pilot has independent contractor agreements in place with 18 ASL/English interpreters and agencies, four of which are in rural areas of the State (two from southwest Colorado, one from Silverthorne, and one from Grand Junction).

Although the RISP Pilot received two sign language interpreting requests in July 2018, the rollout of the RISP Pilot began in August 2018. As of October 31, 2018, 61 sign language interpreter requests were received. Table 1 presents the number of interpreting requests by county.

Table 1: Number of RISP Pilot sign language interpreting requests by County for July-October, 2018.

County	Number of requests
Alamosa	27
Mesa	11
Pueblo	7
Garfield	4
Grand	3
Otero	2
La Plata	2
Eagle	2
Routt	1
Pitkin	1
Delta	1
Total	61

Alamosa, Mesa, and Pueblo counties had the largest number of sign language interpreting requests. Nearly all of the Alamosa County interpreting requests were filled by one RISP freelance interpreter/agency based in Del Norte, Colorado, 31 miles one-way from Alamosa. For Pueblo County, all requests were filled by various freelancers from Colorado Springs, about 45 miles one-way. The interpreting requests for Mesa County were for Grand Junction, and many of these requests were filled by a local sign language interpreter. There is only one RID certified sign language interpreter currently available in Grand Junction, however, and therefore the RISP Pilot frequently had to send freelance interpreters from the Front Range for team assignments for longer or more complicated assignments. These sign language interpreters had to travel between 176 to 254 miles one-way.

The RISP Pilot offers two options for interpreter scheduling. The first, traditional option allows requesters to contact the RISP office to submit an interpreting request. The second option, newly available for this pilot, allows RISP freelance interpreters/agencies the discretion to go ahead and accept RISP assignments and notify CCDHHDB later. This permits rural areas the flexibility to schedule appointments at a time that is convenient for local providers, deaf consumers, and local interpreters. This approach also allows local interpreters/agencies to maintain strong ties to the immediate community.

The General Assembly appropriated $440,000 each year to provide ASL/English interpreting services in rural areas. To date, $14,623.19 of this money has been spent. Expenses are projected to increase with the growing number of sign language interpreting requests, and plans are in place to hire 4.0 FTE for FY 2018-19. These plans are discussed later in this report.

B. Providing initial and advanced interpreter training

The second JBC staff recommendation is to increase the number of qualified ASL/English interpreters in rural areas. Update: The RISP Pilot will carry out this mandate by: (1) partnering with the University of Northern Colorado (UNC) American Sign Language Interpreting Studies (ASLIS) program; (2) offering scholarships for taking the required tests for professional certification; (3) offering paid mentoring experience; and (4) supporting a State Human Services Applied Research Practicum (SHARP) Fellow's training in doing research on the needs of rural individuals who are deaf, hard of hearing, and deafblind.

First, CCDHHDB staff is working closely ASLIS staff on developing a two-pronged approach to offer initial and advanced interpreter training to those who are committed to working in rural areas of the State:

- Prong 1: RISP Scholarships will be offered to current junior and senior students in the ASLIS program who wish to pursue community sign language interpreting. Graduates of this program will be eligible for Registry of Interpreters for the Deaf (RID) certification because they will hold an undergraduate degree.
- Prong 2: UNC will coordinate and run a RISP Certification Readiness Training Program (formerly known as the "I-GO" training series). This program will assist current practitioners who are not yet certified by providing a series of online courses.

The Department and UNC are working to finalize an inter-agency agreement with respect to the foregoing programs. The projected expenses are summarized in Table 2.

Table 2: Projected Costs of RISP Pilot's Planned Partnership with UNC's ASLIS Program.

	RISP Scholarships		Certification Readiness Training	
FY	**Recipients**	**Total cost**	**Targets**	**Estimated cost**
2018-19	2 juniors	$26,400 (including 10% indirects)	January-June 2019: curriculum development and one 4-5 day intensive training at Greeley for 1 lead facilitator and 10 facilitators	$127,870 (including indirects)
2019-20	2 seniors and 2 juniors, with a $1,500 internship stipend for seniors	$56,100 (including 10% indirects)	One year online participant training with a 4-5 day intensive to be held offsite at a rural location for up to 20 participants (free of charge, although this may be modified)	$259,646 (including indirects) (for 20)
Total		$82,500		$387,517

If the RISP Pilot were to be funded for a third year in FY20-21, an "induction" year would be added for the scholarship and training participants. This third year would provide participants with mentoring support as they establish their professional careers.

Second, the RISP Pilot will set aside $20,000 to assist practitioners with paying for RID interpreter certification tests, which cost $425 to $510 per test for non-members. At an average of $500 per test, this budget would provide support for approximately 40 tests (each person must take two tests, so this would support 20 individuals).

Third, the RISP Pilot plans to offer paid mentoring support for practitioners who are not yet certified and newly certified interpreters. (This effort will require the hiring of a staff interpreter/ mentor and a deaf

culture/ASL language mentor, who will recruit, train, and oversee the RISP mentees. These staffing costs will come out of the $440,000 budget for ASL/interpreting services. These costs are discussed in Section III.) The cost for each RISP mentee is projected to be $40/hour for fifteen hours per week for 20 weeks for each mentee for a total of $12,000 per mentee. The RISP Pilot will be able to recruit mentees once staffing is in place. The goal is to begin working with two mentees in FY 2019-20, at a cost of approximately $16,000. The goal would be to recruit five mentees for FY 2019-20, resulting in $48,000 in mentee costs.

Fourth, the Department of Human Services (the Department) has selected a graduate student to be a FY 2018-19 State Human Services Applied Research Practicum (SHARP) Fellow. This person is receiving training and support to conduct a research project collecting and analyzing data related to the need for ASL/English interpreting services in rural Colorado. The SHARP Fellow stipend is $10,000.

The JBC allocated $200,000 each year to the initial and advanced training component. The current estimated total costs for initial and advanced interpreter training are as follows:

- FY 2018-19
    - RISP Scholarships: $26,400
    - Certification Readiness Training: $127,870
    - Interpreter test scholarships: $20,000
    - RISP Mentees: $16,000
    - SHARP Fellowship: $10,000
    - **Projected grand total: approximately $200,270**
- FY 2019-20
    - RISP Scholarships: $56,100
    - Certification Readiness Training: $259,646
    - RISP Mentees: $48,000
    - **Projected grand total: approximately $363,746**

The projected costs are in line for FY 2018-19, but not for FY 2019-20. This funding shortfall may be addressed by one or more of the following strategies: (1) transferring funds from the ASL/English interpreting services line item; (2) reducing the number of participants (currently budgeted at 20) in the Certification Readiness Training program; and/or (3) charging those participants some of the cost of the training program.

C. Conducting Outreach

The third JBC staff recommendation is to reach out to those that need service and those who might be able to provide those services. Update: CCDHHDB entered into a contract with an outreach specialist/consultant named Katie Cue, who is a doctoral student with knowledge and expertise in the deaf, hard of hearing, and deafblind communities. She has developed educational and outreach materials for RISP; organized and facilitated several RISP town hall meetings; and publicized the availability of the RISP Pilot. She is also working on improving the RISP website experience for users (www.colorisp.com).

The RISP Pilot held town hall meetings in Alamosa, La Plata, Mesa, and Pueblo counties in September and October 2018:

- September 13: Pueblo (Deaf Gathering)
- September 15: Grand Junction (Deaf Access Workshop)

- October 25: Durango (two meetings: general community and deaf/hard of hearing/deafblind meeting)
- October 26: Alamosa (two meetings: general community and deaf/hard of hearing/deafblind meeting)
- October 29: Grand Junction (general community meeting with many deaf attendees)

The Department supported the town hall effort by conducting a media blitz, which led to news stories in each of the targeted areas. The town hall meetings and publicity resulted in a surge of emails and phone calls to CCDHHDB from people expressing interest in the RISP Pilot, particularly those who are interested in sign language interpreter training.

Additional town hall meetings are being planned in December for Pueblo County (general community meeting), Otero/Crowley County (general and deaf community meetings), and Morgan/Logan County (general and deaf community meetings). Meetings also are planned for the spring for Garfield, Routt and Summit Counties. In addition, staff received feedback that a webinar would be useful for people who cannot travel to a town hall meeting, so a presentation will be recorded and posted online for easy access.

Two types of data are being collected at the town hall meetings. First, Department and CCDHHDB staff collaborated with the SHARP Fellow to develop a general community survey and a deaf, hard of hearing, and deafblind community survey. These surveys are distributed and collected at the town hall meetings. Second, CCDHHDB staff interview town hall attendees on the barriers the community faces to sign language interpreting services. Staff noted the reported barriers for research purposes.

Table 3 summarizes the number of surveys that have been collected to date. The SHARP Fellow is in the process of entering and analyzing the data. Department and CCDHHDB staff also will collaborate with the SHARP Fellow to develop a RISP consumer satisfaction survey.

Table 3: Attendee and Survey Data from RISP Pilot Meetings, September-October 2018.

	Number of Attendees	Number of returned surveys
Durango		
General community	13	12
Deaf community	2	1
Alamosa		
General community	17	15
Deaf community	11	7
Grand Junction		
Mixed	35	
General community		19
Deaf community		8
Totals	78	62

In addition, CCDHHDB has convened a RISP Pilot Stakeholder Advisory Committee, which has held two meetings to date. The committee is composed of about 20 stakeholders from all across the State representing requestors, consumers, interpreters, agencies, Early Childhood Councils (ECCs), and advocates.

III. CCDHHDB Recommendations and Issues for Consideration

CCDHHDB has gathered a lot of information since the first quarterly report and therefore makes the following recommendations:

- Staffing plans: the JBC estimate was that 8.0 FTE of ASL/English interpreters would be hired and placed in ECCs across the State. The aggregated average annual salary for ASL/English interpreters was estimated at $55,000 for eight positions for a total salary cost of $440,000 per year. At this point, interpreter services request data support the hiring of one RID certified interpreter to be based in Grand Junction. This person could cover sign language interpreting requests for the Western Slope and also would be responsible for managing and filling RISP interpreting services requests. This person may also be able to assist the RISP Pilot with providing 24/7 access to interpreting services. Possible future interpreting staff hires may include a staff interpreter for Alamosa and Pueblo Counties.

  In addition to hiring one staff interpreter, CCDHHDB recommends investing in developing the infrastructure that would support increasing the number of qualified sign language interpreters in rural areas. The recommendation is to hire 2.0 FTE of mentors who would recruit and work with individuals seeking to become certified interpreters. They likely would be based out of CCDHHDB's Denver office but would travel frequently throughout the State. One mentor would be an experienced, highly regarded certified sign language interpreter with training in providing mentoring. The other mentor would be an expert in deaf culture and American Sign Language, and would provide cultural and language training. Ideally, this person would also be a certified deaf interpreter (CDI) and would provide mentoring for individuals interested in becoming deaf interpreters.

  Finally, the RISP Pilot would like to hire a community engagement specialist because the program requires consistent technological support to maintain the website and interpreting services requests, keep an ongoing channel of communications, make deaf community-friendly videos and video-logs, and publicize the program.

  CCDHHDB intends to make the following RISP Pilot hires:
  - Sign language interpreter/scheduler based in Grand Junction (1.0 FTE)
  - Interpreter/mentor (1.0 FTE)
  - Deaf culture/American Sign Language mentor (1.0 FTE)
  - Community engagement specialist (1.0 FTE)
  - Total: $230,000/year

  The goal is to hire for these positions before the end of FY 2018-19.

- Training: feedback from the town hall meetings indicated a strong desire for local sign language interpreter training opportunities, particularly in Grand Junction. Colorado has three college-level sign language interpreting programs, but they all are based in the Front Range (Front Range Community College, Pikes Peak Community College, and UNC). Grand Junction's Colorado Mesa University offers three ASL classes. There are 30 students in each class for a total of 90 ASL students each year (with waiting lists for the classes). There are 90 ASL students at local high schools in Grand Junction as well. This amounts to a significant pool of ASL students each year in that community. It's been estimated that about 10% of these students would be interested

in pursuing a career in ASL/English sign language interpreting, but do not have any local resources to do so. CCDHHDB recommends establishing a sign language interpreter training program on the Western Slope. CCDHHDB is aware that some stakeholders in Grand Junction plan to approach CMU about a possible partnership with UNC.

- Interpreter certification: Colorado's Consumer Protection Act only recognizes RID certification for sign language interpreters Per § 6-1-707(1)(e) (C.R.S.) 2018. This presents an obstacle to obtaining qualified sign language interpreting services because RID has been struggling to provide the necessary tests for certification and because the State does not recognize professionals with other credentials, such as certification by the Texas Board for Evaluation of Interpreters (BEI). In addition, RID certification requires a bachelor's degree or equivalent, which poses an additional barrier to increasing the number of professional sign language interpreters. This barrier is particularly acute in rural areas, which lack the financial resources and educational opportunities found in the Front Range. CCDHHDB is aware that The Independence Center of Colorado Springs and Disabled Resources Center of Fort Collins intend to approach the Legislature this coming session to ask for recognition of other sign language interpreter certifications or credentials. In discussions in rural areas about interpreter certification requirements, many have expressed frustration with the difficulty of becoming certified under current Statelaw and have favored expanding the options for sign language interpreter certification. For example, the Texas BEI requires only an associate's degree or 60 hours of college credit as a threshold before taking the certification examination and Utah only requires only a high school degree.

- CART services: There are individuals who are deaf, hard of hearing or deafblind who do not use sign language. For these persons, other auxiliary aids and services may be more appropriate, particularly Communication Access Realtime Translation (CART), which provides instanteous English captions of communications. CCDHHDB would like to see the scope of the RISP Pilot expanded to include CART services.

- Additional issues:
    - Emergency and 24/7 coverage: Rural areas have requested access to sign language interpreting services 24/7. CCDHHDB is not equipped to provide 24-hour services but will explore possible avenues for doing so, such as staff hires, an answering service, and/or Video Remote Interpreting (VRI) services.
    - Unfilled requests: The demand for sign language interpreting services continues to grow in Colorado and it is becoming more difficult to meet the demand, even along the Front Range. To date, the RISP Pilot has been fairly successful in fulfilling most requests, but 3 out of 61 (5%) requests went unfilled because an interpreter could not be found.

IV. Conclusion

Over the next three months of the RISP Pilot, CCDHHDB anticipates that: (1) the number of sign language interpreting requests will continue to grow; (2) an intra-agency agreement with UNC will be finalized, with the RISP Scholarships and a Certification Readiness Program in place by the end of the fiscal year; (3) three more town hall meetings will be held; (4) the website capability will be upgraded; and (5) the hiring of 4.0 FTE of staff will be in process.

V. Appendix

Appendix A presents the data requested by the JBC (expenditures, cash fund balance for the Telephone Users with Disabilities Fund, locations of translation services, numbers of individuals served, category of services (doctor's office, school, etc.), county location of individuals requesting service, amount of time between request for services and provision of those services).

Appendix A: JBC Staff Specific Data Report as of October 31, 2018

Expenditures (note: period 4 not yet closed)	
Interpreting services	$14,623.19
Training (SHARP Fellow)	$2,234.85
Outreach	$15,562.25
Total	$32,420.29
Cash fund balance for Telephone Users with Disabilities Fund	$664,137
Locations of services	
Number of counties	11 counties
Alamosa	27
Mesa	11
Pueblo	7
Garfield	4
Grand	3
Otero	2
La Plata	2
Eagle	2
Routt	1
Pitkin	1
Delta	1
Total	61
Number of individuals served who are deaf, hard of hearing, or deafblind*	105
Category of services	
Medical	29
Dentist	8
Mental health	2
Meeting	8
Legal: municipal court	2
Law enforcement: police, sheriff, or State Patrol	1
Employment-related	4
Presentation	2
School-related	2
Training	1
Government-related	1
Other	1
Total	61
Disposition	
Filled	54
Cancelled	2
On hold by provider	2
Unable to fill	3
Total	61

* Some consumers were repeat clients.

Amount of time between request for services and provision of services	
Average time elapsed	15
Most frequent number of days between a request and provision of services	
1 day of lead time	6
4 days of lead time	5
6 days of lead time	3
14 days of lead time	4
17 days of lead time	3

COLORADO
Department of Human Services

November 1, 2018

The Honorable Millie Hamner
Chair, Joint Budget Committee
Legislative Services Building, 3rd Floor
200 East 14th Avenue
Denver, Colorado 80203

Dear Representative Hamner,

The Colorado Department of Human Services, in response to the Long Bill FY 2017-18 Request for Information # 19 (RFI # 19), respectfully submits the attached information regarding transitions and readmissions to the Regional Centers for each of the past eighteen months.

> Department of Human Services, Services for People with Disabilities, Regional Centers for People with Developmental Disabilities – The Department is requested to provide by November 1, 2018 information regarding transitions and readmissions to the Regional Centers for each of the past eighteen months. As part of the response, the Department should include: the number of individuals that have been transitioned from each Regional Center and the setting to which they were transitioned for each month, how many of these individuals have been readmitted to a Regional Center and when, the number of monthly admissions to each Regional Center, the definition of a successful transition, and the monthly number of successful transitions.

Please see the attached report for the response to this request. If you have any questions, please contact Mark Wester, Director of the Office of Community Access and Independence at 303-866-4408.

Sincerely,

Reggie Bicha
Executive Director

1575 Sherman Street, Denver, CO 80203 P 303.866.5700 www.colorado.gov/CDHS
John W. Hickenlooper, Governor | Reggie Bicha, Executive Director

cc: Senator Ken Lambert, Vice-Chair, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
John Ziegler, Staff Director, Joint Budget Committee
Mike Mann, JBC analyst, Joint Budget Committee Staff
Lauren Larson, Director, Office of State Planning and Budgeting
Lucas Klifman, OSPB analyst, Office of State Planning and Budgeting
Tony Gherardini, Deputy Executive Director of Operations, Department of Human Services
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Melissa Wavelet, Director, Office of Performance and Strategic Outcomes, Department of Human Services
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Mark Wester, Director, Office of Community Access and Independence, Department of Human Services
Eric Johnson, Deputy Director, Office of Community Access and Independence, Department of Human Services
Kyle Brown, Human Services Policy Advisor, Governor's Office
Phil Robinson, Legislative Liaison, Department of Human Services

Admissions:

Table 1 shows admissions to the Regional Centers from April 2017 through September 2018.

Table 1: Regional Center Admissions
April 1, 2017 through September 30, 2018

	April 2017	May 2017	June 2017	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
WRRC ICF/IID	2	0	1	0	2	2	3	1	3
GJRC ICF/IID	0	0	0	0	0	0	0	0	0
GJRC HCBS/ DD	1	0	0	1	0	1	2	1	1
PRC HCBS/ DD	0	0	0	0	0	0	0	0	0
Total	**3**	**0**	**1**	**1**	**2**	**3**	**5**	**2**	**4**

	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	Total
WRRC ICF/IID	0	0	1	2	1	9	0	1	2	30
GJRC ICF/IID	0	0	0	0	0	0	0	0	0	0
GJRC HCBS/ DD	0	0	0	0	1	0	0	0	0	8
PRC HCBS/ DD	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**2**	**2**	**9**	**0**	**1**	**2**	**38**

WRRC ICF/IID = Wheat Ridge Regional Center, Intermediate Care Facility/Individuals with Intellectual Disabilities
GJRC ICF/IID = Grand Junction Regional Center, Intermediate Care Facility/Individuals with Intellectual Disabilities
GJRC HCBS/DD = Grand Junction Regional Center, Home and Community Based Services/ Developmentally Disabled
PRC HCBS/DD = Pueblo Regional Center, Home and Community Based Services/ Developmentally Disabled

Readmissions:

During the 18-month period from April 1, 2017 through September 30, 2018, there were three individuals who transitioned and then were readmitted to the Regional Centers.

- One individual was readmitted in June 2018 after transitioning from WRRC-ICF in September 2017; this individual was out of the regional center for 288 days.
- One individual was readmitted in May 2018 after transitioning from GJRC-HCBS in March 2018; this individual was out of the regional center for 64 days.
- One individual was readmitted in June 2018 after transitioning from WRRC-ICF in May 2018, this individual was out of the regional center for 36 days.

Transitions:

It should be noted that there is no formal legal definition of "successful transition". The Regional Centers consider the transition process to be successful when a provider is identified that is acceptable to the resident and their parents/guardians, and the individual moves to the community. To improve the success of transitions, the Division enhanced the transition process in February 2015. Process enhancements included development of a checklist to ensure that all needed services and supports are in place for the individual in the community prior to the transition. Additionally, the Division developed the Transition Support Team to provide staff resources to help transfer knowledge of how best to serve the individual and to provide support to the resident and the new provider during the transition process and for up to 90 days following transition. If additional support is needed, the Transition Support Team can continue to be involved.

Table 2 shows the transitions from the Regional Centers from April 2017 through September 2018. The table also shows the community setting to which the residents transitioned.

Table 2: Regional Center Transitions
By Month and Regional Center, Including Type of Placement
April 1, 2017 through September 30, 2018

	April 2017	May 2017	June 2017	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
WRRC ICF/IID	0	1- FC 2-HH	1 - HH	0	0	1-HH 1 - FC	1- PCA	0	0
GJRC ICF/IID	0	0	0	0	0	0	0	0	0
GJRC HCBS/ DD	0	0	0	0	0	0	0	0	0
PRC HCBS/ DD	0	1-HH	0	0	0	0	0	0	1-PCA
Total	**0**	**4**	**1**	**0**	**0**	**2**	**1**	**0**	**1**

	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	Total
WRRC ICF/IID	1-PCA	1-FC 1-HH 1-PCA	1-FC 1-HH	2-HH	1-HH	2-HH	2-HH	2-HH 1-GH	2-HH 1-GH	26
GJRC ICF/IID	0	0	0	0	0	1-HH	1-HH	0	0	2
GJRC HCBS/ DD	0	0	1-HH	0	1-HH	0	0	0	1-HH	3
PRC HCBS/ DD	0	0	0	0	0	0	1-PCA	0	0	3
Total	**1**	**3**	**3**	**2**	**2**	**3**	**4**	**3**	**4**	**34**

Location Definitions:
FC = Family Caregiver (4 total)
HH = Host Home (23 total)
PCA = Personal Care Alternative (5 total)
GH = Group Home (2 total)

COLORADO
Department of Human Services

November 16, 2018

Senator Dominick Moreno, Chair
Joint Budget Committee
200 E. Colfax Ave.
Denver, CO 80203

Dear Senator Moreno,

To ensure receipt, this letter is being resubmitted for your information. The Department is pleased to provide an update on the relocation of the Grand Junction Regional Center (GJRC). As we have discussed previously with the Joint Budget Committee, the Department's plan is to move administrative and day program staff off the campus first and then move residents off the campus at a later date. The purpose of this two-step approach is to minimize disruption for the residents as much as possible. In addition, the Department has been in the process of closing the laundry, garage, and warehouse. Finally, the Department has begun the planning process for building the two new group homes and renovating two existing homes for which capital construction funds were appropriated during the 2018 legislative session. Below is a table summarizing the progress that the Department has made in each of these areas as of August 20, 2018.

Area	Completed/In-Progress Items as of August 20, 2018
Administrative and Division of Facilities Management (DFM) Staff	• Administrative staff moved to new location on July 16, 2018. The Division of Facilities Management staff also moved on the same date. DFM staff continue to use their existing equipment on the GJRC campus until the workshop space at the new location can be modified to accommodate all of their equipment. This work is expected to be completed by October 2018.
Day Program Staff	• Day program staff moved to new location on July 16, 2018.
Garage	• Garage was closed on June 30, 2018.
Laundry	• Laundry was closed on June 30, 2018.
Warehouse	• Warehouse was closed on June 30, 2018.
GJRC Campus Residents	• We are currently revising the initial draft of the Facilities Program Plan (FPP) for the new homes to ensure that it fits within our appropriated budget. We are estimating the costs for renovating the two other homes in preparation for putting the projects out to bid.

If you have any questions, please contact Mark Wester, Director of the Office of Community Access and Independence at 303-866-4408.

Sincerely,

Reggie Bicha
Executive Director

cc: Representative Daneya Esgar, Vice-Chair, Joint Budget Committee
Senator Dennis Hisey, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
John Ziegler, Staff Director, Joint Budget Committee
Mike Mann, JBC Analyst, Joint Budget Committee Staff
Lauren Larson, Director, Office of State Planning and Budgeting
Lucas Klifman, OSPB analyst, Office of State Planning and Budgeting
Tony Gherardini, Deputy Executive Director of Operations, Department of Human Services
Jerene Petersen, Deputy Executive Director of Community Partnerships, Department of Human Services
Alicia Caldwell, Deputy Executive Director of Legislative Affairs and Communication, Department of Human Services
Melissa Wavelet, Director, Office of Performance and Strategic Outcomes, Department of Human Services
Sarah DeVore, Director of Budget and Policy, Department of Human Services
Mark Wester, Director, Office of Community Access and Independence, Department of Human Services
Eric Johnson, Deputy Director, Office of Community Access and Independence, Department of Human Services
Kyle Brown, Human Services Policy Advisor, Governor's Office
Phil Robinson, Legislative Liaison, Department of Human Services

APPENDIX D:
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(a)(I), C.R.S., by November 1 of each year, the Office of State Planning and Budgeting is required to publish an **Annual Performance Report** for the *previous fiscal year* for the Department of Human Services. This report is to include a summary of the department's performance plan and most recent performance evaluation for the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the department is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

For consideration by the Joint Budget Committee in prioritizing the department's FY 2019-20 budget request, the FY 2017-18 Annual Performance Report and the FY 2018-19 Performance Plan can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans