

DEPARTMENT OF HUMAN SERVICES
Office of Operations and Office of Behavioral Health
FY 2020-21 JOINT BUDGET COMMITTEE HEARING AGENDA

Thursday, December 19, 2019

1:30 pm – 3:45 pm

1:30-1:45 INTRODUCTIONS AND OPENING COMMENTS

Presenter: Michelle Barnes, Executive Director

1:45-2:45 OFFICE OF BEHAVIORAL HEALTH AND BEHAVIORAL HEALTH TASK FORCE

Main Presenters:

- Michelle Barnes, Executive Director
- Robert Werthwein, PhD, Division Director

Topics:

- Community Behavioral Health: Slides 4-14 (Page 1, Questions 1-6, 8-12, 27 in the packet)
- Criminal Justice and Behavioral Health Interoperability: Slide 6 (Page 26, Questions 32-33 in the packet)
- Substance Use Disorder Treatment: Slides 5, 15-16 (Page 9, Questions 11-12 in the packet)
- Behavioral Health Task Force: Slides 17-24, 38 (Page 7, Questions 8-10 in the packet)

2:45-3:45 MENTAL HEALTH INSTITUTES AND COMPETENCY SERVICES

Main Presenters:

- Michelle Barnes, Executive Director
- Robert Werthwein, PhD, Division Director

Topics:

- Mental Health Institutes: Slides 25-28 (Page 11, Questions 13-20)
- Competency: Slides 29-38 (Page 17, Questions 21-29 in the packet)
- Consent Decree: Slides 34-35 (Page 25, Questions 30-31 in the packet)

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BEHAVIORAL HEALTH

Common Acronyms:

BHTF - Governor's Behavioral Health Task Force
CDHS – Colorado Department of Human Services
CDPHE - Colorado Department of Public Health and Environment
CMHC - Community Mental Health Center
CMHIFL - Colorado Mental Health Institute at Fort Logan
CMHIP - Colorado Mental Health Institute at Pueblo
HCPF - Colorado Department of Health Care Policy and Financing
OBH - Office of Behavioral Health
PIN Study - Population in Need Study
RISE - Restoring Individuals Safely and Effectively (Jail Based Restoration Program)

GENERAL

1. In terms of the behavioral health system, how does spending on the front end (prevention and providing services early, when issues initially arise) relate to individuals' interactions with the criminal justice system, competency, and higher cost services? How does the Department think about systemic issues, ensuring that sufficient resources are allocated for prevention and front-end services to limit the need for high end, intensive services?

Response:

Currently, the Governor's Behavioral Health Task Force and each of its three subcommittees, Safety Net, Long-Term Competency and Children's (see more detail in Question 8), are working to ensure a cohesive and coordinated behavioral health system. A large emphasis has been focused on systemic improvements to ensure that individuals receive the level of care they need in their community and to prevent avoidable interactions with the criminal justice system. The Department is confident the Task Force will put forth meaningful recommendations through its blueprint required in June 2020 that can result in substantial systemic improvements.

OBH supports prevention and early intervention to address emerging issues when they initially arise in hopes of preventing interactions with higher cost services or alternative systems, like the criminal justice system. OBH also provides critical interventions that avoid further criminal justice involvement, including the Crisis Services System, which has prioritized mobile response in communities; diversion programs that support law enforcement in responding to individuals with behavioral health needs such as co-responder

programs; programs that support successful transitions between treatment settings, intensive community-based services such as Assertive Community Treatment; and case management and care coordination to ensure basic resources and needs are met for at-risk populations.

The Department and its contracted provider Health Management Associates are currently conducting a Population in Need (PIN) Study to understand current treatment capacity, provider network issues, county and regional treatment needs and gaps in services. These are all areas that are critical to the access of behavioral health care. One preliminary recommendation of the PIN study is to ensure that populations with high treatment needs receive care coordination and case management that is robust enough to avoid clients falling through the cracks. Many of these individuals end up involved in the criminal justice system if their needs are unattended. Additionally, for the most acute patients, it is important to continue identifying housing options such as alternative living residences, host homes and supportive housing opportunities that support clients with high behavioral health needs.

2. A request for a 0.5 percent increase for provider rates is essentially a 1.5 percent cut based on the current rate of inflation. How does the Department expect approval of this request to impact:

- Behavioral health service providers' ability to sustain existing services,
- Access to behavioral care, and
- Behavioral health service providers' ability to recruit and retain staff.

Response:

The Governor's Office understands that providers often perform the most important work on behalf of the State of Colorado. As such, the Governor approved a 0.5% rate increase, including \$4.6 million to providers at the Department of Human Services.

OBH will pass the increase onto providers according to the common policy set percentage rate increase on their entire contract value. For our largest providers, the Community Mental Health Centers, OBH funding typically equates to 10-15% of each center's overall revenue, while HCPF may be as high as 70-85% of revenue. OBH's contracts with CMHCs are aimed at funding critical gaps in the State's behavioral health safety net and OBH sets targeted funding allocations to require the Centers to prioritize contract budgets across the statutory requirements.

At this time, the Department has limited visibility into the impact on providers. Providers may face financial pressure if there is a gap created between revenue and costs to serve within service areas, motivating the need to reduce services/costs that do not generate revenue or pursue other productivity savings. The provider rate increase may be used to offset the parts of provider's cost structure most affected by inflation, i.e. wage inflation. Personnel wages are part of the provider's costs, which also include fixed costs, not directly affected by short term inflationary factors, allowing for a higher rate to be applied to personnel budgets.

The PIN study, highlighted in Question 1 response, will help the Department understand capacity, infrastructure and need. However, it is important to note that the issue of parity for behavioral health services can have an even larger impact on the successful sustainability of the community behavioral health system. House Bill 19-1269 requires private health insurers and the state's Medicaid plan to provide medically necessary coverage for behavioral, mental health, and substance use disorder services on par with the coverage for physical health services and to demonstrate compliance through new reporting requirements. Parity means that if a health plan covers mental health or substance use services, those services must be covered equally to standard medical treatment. Parity can be challenging to enforce as other barriers to access may be implemented by payers such as requiring pre-authorization for services or limiting services based on progress in treatment.

In addition, as the Behavioral Health Task Force continues to develop recommendations for the behavioral health system there is an opportunity to address systemic corrections to workforce challenges and access to care.

3. For the R29 request to reduce the appropriation from the Persistent Drunk Driver Cash Fund, please provide a comparison of the campaigns conducted by the Department of Human Services and the Department of Transportation. Describe the purpose of each campaign, the target audience, and the current funding level, and requested funding for next year.

Response:

The Persistent Drunk Driver (PDD) campaign and the Colorado Department of Transportation's DUI campaigns both target adult men Statewide with messages that prevent drunk driving. However, the \$115,000 FY 2020-21 estimated budget for the PDD campaign is not enough to effectively change behavior, and the goals and the messages are virtually identical to CDOT's campaign, which has an annual budget of \$700,000 and no planned reduction in funding.

The PDD committee, which runs the PDD campaign and is made up of the Department of Human Services, the Department of Transportation, the Department of Revenue and the State Judicial Branch, determined that the PDD campaign's objectives and tactics are duplicative of CDOT's efforts and not needed in light of the effectiveness of CDOT's campaign. All DUI campaign efforts will now be run through CDOT. CDOT's budget cut for ~\$1.1 million in their administrative line is mostly due to savings related to process improvements. No reductions are slated for any DUI advertisements.

Although the PDD Committee voted to end the paid media campaign, the Committee also determined that the resources on NoDUIColorado.org, a product of the campaign, will continue to exist and should in fact be improved. The website will include information such as the fines and penalties for both the judicial and DMV processes, as well as info on ignition interlocks and the education and therapy requirements. Resources will include relevant laws, mental health and substance use resources, and links to the PDD Committee agencies. The website improvements are in the works, and the PDD Committee will take over management of the website, with each agency taking turns managing it, beginning Jan. 1, 2020. No funds are needed for the PDD campaign in FY 21 since management of the No DUI Colorado website and resources will be done within the state agencies.

4. Safety net providers have described challenges they face regarding administrative burden. For example, one provider shared that they have up to 13 unique forms required to enroll a client in services, depending on their diagnosis and who is referring them. Often, different forms are required by different agencies, making the task of trying to automate and streamline the process very difficult. This provider also reports that they must complete 139 individual reports (due at various intervals) to show that they are following what they need to for their various public funders. The break down is that 95 of the reports are for OBH, 30 are for the RAE, and 12 are for the MSO. On top of all that, they must stay in good standing with CDPHE for their facilities and disaster response services, with DORA to ensure their clinicians are in good standing, and locally for various programs.

Response:

In general, OBH reporting requirements are required by and align with federal and state statutory and regulations. Since 2013, OBH has been working in close collaboration with a wide range of stakeholders to standardize meaningful outcomes for the behavioral health system by selecting key data elements and to integrate historical substance use and mental health data sets. To fulfill those goals, OBH will replace the outgoing Colorado Client Assessment Record (CCAR) and Drug and Alcohol Coordinated Data System (DACODS) with a new system, COMPASS. COMPASS is scheduled to go live in 2020.

OBH and the Department of Health Care Policy and Financing (HCPF) can use Compass to improve coordination of services for patients receiving services from multiple treatment providers or having multiple services in crisis, detox or other acute treatment episodes. COMPASS will collect basic demographic information for patients using publicly funded behavioral services and will report the agreed-upon provider assessments to better measure behavioral health outcomes.

Under the new system, COMPASS will save providers time by substantially reducing data entry requirements; the new time-saving solutions are listed below:

- For general mental health and substance use services, providers will see a 48% decrease in the number of items required for admissions (from about 105 to 56 data fields).**
- Additional time will be saved as providers will only be required to update fields where information has changed (e.g., newly pregnant; diagnosis change). Under the current system, providers must complete an entirely new CCAR anytime client information is updated.**
- COMPASS allows providers to enter information over time, rather than requiring all fields to be submitted at once. This allows providers to better align data collection needs with their clinical workflow.**
- COMPASS incorporated several data systems and spreadsheets into a single tool in order to drastically reduce redundancy.**
- With COMPASS, providers will be able to submit service encounter data “real-time.” This eliminates the need to create, test, and run batch files.**

In addition to the data work, OBH, HCPF and the Colorado Department of Public Health and Environment (CDPHE) have worked with key stakeholders to streamline the licensing process for behavioral health facilities as outlined in House Bill 19-1237. This legislation will centralize facility licensing at CDPHE and standardize licensure requirements for safety net providers.

OBH is currently in the process of updating OBH Rule Volume to streamline the clinical intake processes and allow consumers to access services without being overly burdened by administrative functions. We continue to welcome feedback on modifications to OBH Rule that does not impede on the ability to track meaningful outcomes and meet statutory and federal requirements.

Furthermore, OBH recognizes the ongoing need to balance the burden of administrative requirements with the need to serve clients. The Department commits to compiling a report by November 1, 2020, to accompany the Governor's Behavioral Health Task Force blueprint that identifies the demand on providers and includes: the current data required by key state agencies; data required by federal agencies; what data request are no longer required; technological advancements that can and have eased administrative burden; rule and policy changes to reduce unnecessary administrative burden; and other opportunities that afford the ability to track necessary outcomes in the least administratively burdensome manner possible.

5. How are state agencies working together to reduce administrative burden for behavioral health providers to increase the amount of time clinicians spend providing direct care and expanding access to more people? What efforts are underway to unwind some of the complexity that is built into the system? Will the Governor's Behavioral Health Task Force address these issues?

Response:

The first two parts of this question are answered in Question 4. The Governor's Behavioral Health Task Force is also addressing administrative burden. The Task Force has acknowledged the many different funding streams from varying state and federal agencies result in administrative burden for providers and contractors, which take away time and resources from the delivery of care. The Task Force plans to put forward recommendations to improve the streamline of government-funded behavioral health care and to build a more efficient behavioral health safety net system. The Task Force is charged with completing a blueprint of recommendations by June 30, 2020.

6. In 2017, funding was provided to create two secure transport pilots to address a needed service in rural and frontier Colorado. What is the status of those two pilots and were there cost savings? Providers have data suggesting the pilots have been successful. Assuming their data is accurate, what plans are there to permanently expand the program to other rural and frontier areas?

Response:

The purpose of the Transportation Pilot Program (TPP) established in Senate Bill 17-207 was to provide transport for clients in behavioral health emergencies and to reduce the

burden that often falls to law enforcement to transport individuals in crisis. The two programs to pilot transportation solutions in rural areas were the San Luis Valley (counties of Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache) and the catchment areas of The Center for Mental Health (counties of Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel).

Key stakeholders, law enforcement, and hospital staff, agree that TPP has had tremendous impact by saving money and staff time and by providing appropriate transportation services to those experiencing a behavioral health crisis. However, both the hospitals and law enforcement were unable to provide specific cost savings information to be able to determine what, if any, the actual cost savings generated.

Key initial outcomes from FY 2018-19:

- San Luis Valley Behavioral Health Group TPP has provided 144 transports to 89 unique individuals during the 14-month timespan;
- The Center for Mental Health TPP has provided 569 transports to 372 unique clients during the 16-month timespan;
- All stakeholders including hospitals, law enforcement, and clients served reported high satisfaction with the programs;
- During the site visit meeting with law enforcement from the San Luis Valley, all participants agreed that the TPP had a significant positive impact on their agency, law enforcement agencies are no longer being utilized to provide transportation for individuals on an psychiatric emergency hold; and,
- Reports from hospitals include decreased wait time in Emergency Departments for individuals on psychiatric emergency holds and decrease in hospital staff allocation to sitting with individuals on psychiatric emergency holds.

The Department will submit the results of the TPP to the Governor's Behavioral Health Task Force for their consideration of incorporating transportation needs into the blueprint for behavioral health systemic improvement.

7. OBH plans to implement the COMPASS initiative this year. Has CDHS calculated how much money community providers have spent to ready their EHRs for this initiative? What steps is the Department taking to ensure that the cost to implement does not affect access to services?

Response:

The Department has worked closely with providers over the past several years to ensure a phased approach and a solution that reduces the burden on clinical staff and meets the required state and federal reporting requirements. Costs to implement this solution vary. Large providers with a high volume of patients have been working to build a direct interface to the new COMPASS solution which has a higher cost to implement. Small providers will log in to the COMPASS tool via a cloud-based solution to report required data at little or no cost. To lessen the fiscal impact, OBH has worked directly with the largest Electronic Health Record vendors to negotiate a single solution on behalf of multiple providers as opposed to individual providers working with the vendors independently. Netsmart, one of the largest vendors, is charging the providers \$1,000,000 for the configuration, but these costs are spread across the multiple large provider agencies and the cost to an individual

agency is just under \$100,000 each. OBH has offered hybrid solutions to these providers to lessen the impact by spreading the costs over time. In 2017, OBH offered each Community Mental Health Center (CMHC) up to \$100,000 of remaining federal funds for developing capacity to report clinical quality measures that are aligned with the measures being reported in COMPASS. A total of \$616,000 was distributed to the CMHCs to support this initial work. The COMPASS changes will greatly reduce agency costs over the coming years, so while the initiative has start-up costs, those costs will slowly be diminished as data collection and reporting for clinicians is reduced. OBH also hired an independent consultant to streamline business rules, train clinicians and align reporting with clinical workflow. See Question 4 response that describes the benefit of COMPASS and how it will reduce duplicative reporting requirements.

BEHAVIORAL HEALTH TASK FORCE

8. Provide an update on the work of the Behavioral Health Task Force, including the Long Term Competency Subcommittee.

Response:

The Governor's Behavioral Health Task Force (BHTF) is developing a statewide blueprint by June 30, 2020, to reform the system with the goal of enabling every Coloradan experiencing behavioral health needs to receive timely, high-quality services in their communities. There are three subcommittees, all of which are in various stages of identifying solutions:

- **Safety Net Subcommittee.** This subcommittee wants to ensure that all Coloradans have access to behavioral health services, regardless of where they live, what their income might be, and their circumstances. This subcommittee has identified several key areas to be addressed:
 - Developing a central governance structure for safety net services and overall behavioral health;
 - Addressing the behavioral health workforce shortage;
 - Aligning behavioral health funding streams so that the payment source is the primary focus to access care; and,
 - Increasing access to behavioral health services.

Addressing these items will provide better access to services for Coloradans. It is expected that the subcommittee will develop specific recommendations in these areas.

- **Long-Term Competency Subcommittee.** To date, this subcommittee has been reviewing, revising and developing recommendations to be included in the State's Comprehensive Plan, which will be submitted to Federal Court in January 2020. The recommendations from the Subcommittee's plan focus on quality, with Consent Decree compliance as a component. Between January and May 2020, the subcommittee will develop specific and prioritized recommendations to be included in the blueprint. Recommendations will likely include diversion initiatives and increased community-based services, or services delivered in an individual's community and including psychiatric care as well as wraparound services. Wraparound services may include intensive case management, supportive housing, vocational rehabilitation, and similar services.

- **Children’s Subcommittee.** This subcommittee is identifying the unique needs of children and how Colorado’s behavioral health system needs to address those specific needs. They are looking closely at high-quality, standardized care for children, and are expected to bring recommendations in those areas.

The three subcommittees will share their recommendations with the overall BHTF, which will identify gaps that still need to be addressed, as well as prioritize the recommendations. The BHTF is also currently conducting a financial analysis of the overall behavioral health system, including children’s behavioral health. The analysis will review how state and federal funds are currently allocated in Colorado’s adult behavioral health delivery system, as well as what services these dollars are purchasing. The analysis will also identify the opportunities that exist to reallocate funding to create a similar experience across all counties, minimize administrative costs, and leverage available and matched federal dollars.

When the blueprint is presented to Governor Polis in June 2020, it will include the overall vision/model for Colorado’s behavioral health system and what needs to happen each year to achieve that vision (inclusive of budget, staffing, public policy and accountability).

9. Is the Task Force, and the Long Term Competency Subcommittee, referencing the Consent Decree to ensure that recommendations are in alignment with the requirements outlined in the Consent Decree?

Response:

As a requirement of the Consent Decree, the Department is responsible for creating a Comprehensive Plan that is due to federal court by or about January 2020. The Long-Term Competency Plan was drafted by the Long-Term Competency Subcommittee of the Governor’s Behavioral Health Task Force in accordance with the Consent Decree. The Committee put forth 38 recommendations for the Department to take into consideration. There was a strong emphasis on the quality of services that were provided as well as long-term solutions to divert people away from the criminal justice system when appropriate.

10. A report from the Behavioral Health Task Force in June 2020 does not provide an opportunity for legislative action in the 2020 session. Please provide a preview of the recommendations the Task Force is looking and what legislative action may be requested for the 2020 legislative session.

Response:

While the BHTF has identified a number of areas in need of reform for a better client-centric system, such as streamlining government-funded behavioral health services, currently only the Long-Term Competency Subcommittee has had preliminary conversations on recommendations that would require legislative changes. The initial conversations have focused evaluating if it is necessary for certain individuals to be a part of the competency process: specifically those who only have very-low criminal charges or those whose condition is such that they will likely never improve to the point that they are benefiting from the type of services being provided through the competency process. Permanent and substantial impacts to mitigate the increasing demand for competency services will require substantial improvements to intensive community based services and

an ability to divert individuals with mental health issues away from the criminal justice system.

SUBSTANCE USE DISORDER TREATMENT

11. Regarding substance use disorder treatment capacity, please respond to the following:

- What is the existing treatment capacity across the state? Are shortfalls in particular regions of the state? For certain types of clients? For certain types of services?

Response:

With little information available on capacity and utilization by commercial insurers, the Department does not have complete visibility of current SUD treatment providers' capacity across all providers and payers in the State. According to the recently released Colorado Health Assess Survey conducted by the Colorado Health Institute 95,000 Coloradans report going without needed substance use treatment in 2019, and Colorado likely lacks sufficient capacity to handle increased demands for residential and inpatient treatment. In comparison, the 2017 Colorado Health Access Survey (CHAS) reported that more than 67,000 Coloradans needed SUD treatment and didn't receive it, a 42% increase in unmet need for SUD treatment over two years, as measured by the CHAS. The need is growing rapidly as is the gap between demand and supply. Concerning residential treatment specifically, in FY2018-19, OBH funded treatment services at 15 licensed residential substance use treatment providers, paying for residential treatment services for individuals who are Medicaid enrolled clients or those who are not eligible for Medicaid but with income below 300% of federal poverty line. As Medicaid expands the residential substance use treatment benefit we anticipate that any current availability capacity will be used; higher volumes of clients with a covered benefit will be competing for the same beds.

Efforts are underway to assess this question accurately through a Population in Need (PIN) Study being conducted by Health Management Associates and through collaboration with Health Care Policy and Financing in developing a more robust financial model for the expanded residential and inpatient substance use benefit authorized by HB-1136. A full analysis of current capacity and gaps will be available in late Spring of 2020.

A full continuum of care would meet the need of Coloradans in their communities and allow for family support and participation in treatment. Additional considerations that will be assessed in the PIN study include regional provider capacity and recommendations to prioritize services for at risk populations (i.e. pregnant and parenting women, injection drug use, criminal justice involvement, etc.) in order to address gaps in care.

By January 1, 2021, OBH will have the ability to monitor inpatient and residential supply, through the implementation of a bed tracking system, as required by SB 19-1287. The new system will report daily bed availability within each licensed facility, type of bed, and details on the treatment population being served in the treatment setting to decrease the burden for locating treatment options for patients and providers.

- What are the barriers to building additional capacity?

Response:

The primary barrier to building additional capacity is funding, both to invest capital in the upfront development as well as the funding to operate and provide direct services, as payer sources are currently very limited. As discussed in greater detail in Question 12, residential and inpatient SUD treatment have not been covered benefits under Medicaid. Coverage for low-income clients is limited to OBH funding through the Managed Service Organizations. Commercial insurance coverage is also limited. According to the Colorado Health Access Survey, 53% of survey respondents who reported a need for treatment indicated they did not think their insurance would cover it. Without an established, reliable revenue stream for potential treatment providers to maintain adequate cash flow to support their operations, recover their investment, or generate any return, potential investors are unwilling to commit capital to expand residential treatment facilities. The SUD treatment market does not attract sufficient private investment; therefore, investment in expanding capacity has been limited, and communities often seek government funding to subsidize the necessary expansion. OBH does have access to limited state funding for capacity expansion through the Circle Program, SB 16-202, and HB 19-1287. Federal block grant funds are restricted from investments in capital development.

As Medicaid benefits expand in 2020, this will alleviate part of the operational funding barrier, but does not address the need for the initial capital outlay. Addressing challenges associated with the lack of coverage and network adequacy through commercial insurance providers through the full implementation of parity legislation (see Question 2 response) should also help stimulate some funding in capital development and ongoing services, though it is unlikely to close the gap.

- Are capacity concerns based solely on a shortage of total providers in the state, or is capacity further limited by the number of Medicaid providers?

Capacity concerns stem from both the number of providers and bed capacity throughout the State as well as the number of Medicaid providers. Realizing the full impact of the new Medicaid benefit for residential treatment will require current and new providers to qualify with and enroll in Medicaid. Network capacity continues to be evaluated by OBH and HCPF in alignment with HB-1136, SB-1287 and in collaboration with the Behavioral Health Task Force to understand regional needs and variation. The Population in Need Study will help guide discussions on network adequacy and prioritized services by region.

12. Please provide a deeper dive into the Medicaid eligible population and the overall number of individuals who need behavioral health services. Why would the General Assembly reduce funding for DHS-administered behavioral health services given the overall need for such services?

Response:

Regarding the request to the State budget for residential and inpatient SUD treatment funding, there is a significant net increase proposed in the State budget between HCPF (increase \$87 million) and OBH (decrease \$2.8 million). The Department requested a

modest reduction of \$2.8 million (11.2%) of the current SUD residential treatment services budget of \$25 million. This is because the Department anticipates that some of the population that it currently serves will be eligible for substance use treatment under Medicaid as the Residential and Inpatient Substance Abuse Benefit authorized by HB 18-1136 is implemented through a Medicaid Section 1115 Waiver.

Specifically, HB 1136 gives HCPF authority to add SUD inpatient and residential treatment benefits, including withdrawal management services, to the continuum of SUD services available to Medicaid members. These services, delivered within an inpatient or residential setting, are not currently covered by Medicaid. To implement the 1115 Waiver, HCPF has estimated the FY 2020-21 cost at \$87 million, increasing in year two to over \$174 million, as additional providers seek Medicaid certification and capacity is added in the State to meet demand. These estimates have been refined by HCPF in recent months.

As a result of this, the Department anticipates that residential treatment providers currently funded by the Department in FY 2019-20 will receive Medicaid revenue in FY 2020-21 for the population that is currently funded by the Department. As a result of this shift in residential funding sources for these populations, the Department anticipates that it will have a lower utilization of the Department's funded residential treatment while still seeing an overall increased utilization across all funding sources. The Department will need to retain the remaining base funding for residential substance abuse treatment to fund (a) the full treatment services cost plus room and board costs for the uninsured/underinsured (non-Medicaid eligible) clients, and (b) the room and board costs for Medicaid-covered clients, which will not be covered by Medicaid.

Regardless of the level of demand, the full utilization of both Medicaid and Department funding mentioned above for SUD residential services will also be dependent on the capacity of providers to serve those who need the services. Current capacity limitations of SUD residential providers would likely result in under expenditure of these combined funds.

As mentioned previously, the Department is conducting a Population in Need (PIN) Study to understand current treatment capacity, provider network issues, county and regional treatment needs and gaps in services. Initial recommendations and findings are indicating a need for better coordination and case management. A second finding is to establish a process of separating populations into high-risk, low-risk, and the ever-important rising-risk that need a higher level of service and intervention. For the PIN study, community need for services is estimated from public health survey data. The 2019 Colorado Health Access Survey, conducted by Colorado Health Institute, found that 95,000 Coloradans went without needed substance treatment in 2019; however most individuals can get their needs met through outpatient-based services and do require a residential level of care. As the Behavioral Health Task Force continues to develop recommendations for the behavioral health system, there is an opportunity to align existing resources to the areas of greatest priority.

MENTAL HEALTH INSTITUTES

13. Are forensic services provided at both mental health institutes? If not, does the Department have plans to change that?

Response:

Beds for the sole purpose of Inpatient forensic services are only provided at the Colorado Mental Health Institute at Pueblo, the RISE (Restoring Individuals Safely and Effectively) program at Arapahoe, RISE at Boulder, and 7 private hospital beds. Per the terms of the Consent Decree, the Department agreed the beds at the Colorado Mental Health Institute at Fort Logan will remain allocated for civil patients as of April 2, 2019, and to not use those beds to provide competency services unless previously approved by the Special Master in the federal case. The Department did receive capital funds in FY 2019-20 for the renovation of two cottages at CMHIFL in order to add 44 forensic beds in the Denver metro area.

To address the need for civil capacity, at which time the number of court orders for inpatient competency services stabilizes or reduces, the Department will reassess the composition of civil and forensic beds at both CMHIP and CMHIFL. An opportunity to alleviate the demand for forensic beds affords the Department an opportunity to convert those beds into civil beds, therefore increasing the statewide civil capacity.

14. For each institute, provide data concerning the number of forensic and civil patients served. Further, within forensic services, identify the number of beds that are currently utilized for the provision of competency evaluations and restoration services.

Response:

Breakdown of civil vs forensic patients served at CMHIP and CMHIFL FY 2018-19

| | CMHIP | CMHIFL |
|-------------------|-------|--------|
| Civil Patients | 102 | 305 |
| Forensic Patients | 970 | 10* |

*Prior to the implementation of the Consent Decree, the Department occasionally provided competency services at CMHIFL. Some of these forensic individuals were also court ordered to CMHIFL.

Mental Health Institutes' Bed Capacity

| | CMHIP | CMHIFL | RISE (Arapahoe and Boulder) | Private Hospital Competency Beds |
|---|-----------------------------------|--------|-----------------------------|----------------------------------|
| Civil Only | 0 | 94 | 0 | 0 |
| Multi-purpose* (Civil, Competency, or Forensic other) | 34 (Geriatric) 20 (Adolescent) | 0 | 0 | 0 |

| | | | | |
|--|-----|---|-----|---|
| Forensic Population: Competency | 244 | 0 | 114 | 7 |
| Forensic Population: Not Competency** | 197 | 0 | 0 | 0 |

*The adolescent and geriatric units at CMHIP can serve both forensic and civil populations. Patients can also have more than one type of legal status (i.e., civil and incompetent to proceed (ITP)).

**At times these beds can be used for competency if there is a bed vacancy, however this is limited to a handful of patients per year.

At this time, in order to be in compliance with the federal Consent Decree, the Department does not plan to add more civil bed capacity, only forensic capacity. The Department is funded to add additional new beds over the next two years:

- **Denver Health: 3 beds - December 2019**
- **CMHIP L2 Unit: 24 - November 2020**
- **CMHIFL F2 & F3: 44 beds - December 2021**

As stated in Question 13, an opportunity to alleviate the demand for forensic beds would afford the Department an opportunity to convert those beds into civil beds, therefore increasing the state’s overall civil capacity.

15. What is the status of the Departments master planning process related to facilities on the campuses of the two mental health institutes?

Response:

The Department is in the early stages of phase one of a three-phased project for facilities master planning. This project was approved last year as a cash-funded project contingent on the receipt of proceeds from the sale of a property. The sale concluded in late summer 2019, thus funding the project. Phase one will examine the Fort Logan campus and all Department Denver metro area non-24/7 offices.

(See Question 13 regarding converting forensic beds into civil beds and Question 16 about the need for community services to prevent avoidable inpatient placements.)

16. The Department is requesting a total of \$26.3 million for capital construction projects for the mental health institutes, in addition to \$4.8 million total funds for operations at the new L2 patient unit at the Colorado Mental Health Institute at Pueblo (CMHIP). Significant funding was provided to the institutes last year, as well. What is the Department’s stance on shifting resources to invest in early identification/intervention and community-based treatment, as opposed to putting resources toward the back end when interventions cost more?

Response:

While the continuing investment into the competency system so that we meet our legal obligations to restore individuals who have been found incompetent to proceed is important, there is a need to address the rising demand for competency services by looking at why and how individuals are interacting with the criminal justice system. Since competency is raised as a result of an individual's ability to partake in the court process, if individuals are diverted away from the criminal justice system, then competency is never raised. Diversion from the criminal justice system can come in several forms: most notably, one way to divert from the criminal justice system comes when individuals are able to receive the level of quality care they need and decrease the probability that law enforcement is required to alleviate public nuisance or safety concerns. Other ways to divert individuals away from unnecessary court involvement related to competency, when appropriate, include pre-plea diversion programs that afford law enforcement an opportunity to direct individuals who need services to treatment settings instead of jail.

The Long-Term Competency subcommittee of the Governor's Behavioral Health Task Force has also put forth a series of questions that address the need for alternative solutions to inpatient beds (see Question 8 for greater detail on the subcommittee's recommendations).

17. Please detail staffing increases that have been funded for the Institutes in the last four years, including the number and types of FTE added, the associated funding, and the purpose of each increase.

Response:

| FY | Request | FTE Change | FTE Type | FTE Funding | Purpose |
|----------|---|------------|----------------------------------|-----------------------------|--|
| FY 16-17 | R-3 Court Ordered Comp Eval and Restoration Treatment | 7.5 | 4.5 Clinical 3.0 Non-Clinical | \$4,111,685 General Fund | To increase in the competency evaluators and continue on the interim funding provided for launching RISE. |
| FY 17-18 | R-14 Substance Use Disorder Treatment at the MHI's | 8.0 | 8.0 Clinical | \$661,947 Cash Funds | Provide substance use disorder treatment for civil and forensic patients dually diagnosed with substance use and mental health disorder. |
| FY 18-19 | R-5a Jail-based Bed Space | 3.3 | 1.0 Clinical 2.3 Non-Clinical | \$288,532 General Fund | RISE expansion |
| FY 18-19 | R-5c Court Ordered Reports FTE Caseload | 11.0 | 8.0 Clinical 3.0 Non-Clinical | \$1,085,726 General Fund | Additional evaluators and admin. support staff to address the increase in court orders |
| FY 18-19 | R-5d Purchased Bed Capacity | 3.0 | 3.0 Non-Clinical | \$200,898 General | To provide admin. and transportation support related to |

| | | | | | |
|----------|--|------|-------------------------------------|--------------------------|---|
| | | | | Fund | contracting with private hospitals |
| FY 18-19 | R-5e Outpatient Competency Restoration | 3.0 | 3.0 Non-Clinical | \$240,580 General Fund | Admin. support to implement community-based competency services |
| FY 19-20 | R-1 MHI at Pueblo Bed Expansion | 44.5 | 34.55 Clinical 9.95 Non-Clinical | \$4,905,454 General Fund | Admin. and clinical support to operate an additional 42-bed unit at CMHIP for restorations. |
| FY 19-20 | SB 19-223 Actions Related To Competency To Proceed | 18.6 | 15.6 Clinical 3.0 Non-Clinical | \$1,444,056 General Fund | Add evaluators, case managers, and support staff for competency evaluations and restorations. |

Funding approved last year (R1-Mental Health Institute at Pueblo bed expansion) was to staff a renovated unit (RNRU) at CMHIP for a total of \$4,153,408. The L2 unit at CMHIP is in the current Governor's budget for your consideration.

18. Explain how the Department plans to attract and retain employees to fill the 42.3 FTE positions requested through R4.

Response:

The Department continues to partner with Human Resources and the Talent Acquisition Team to monitor recruitment and retention efforts. CMHIP staff and Human Resources are involved in a continuous quality improvement process to ensure timely hiring of quality candidates. In part due to the help of prior pay increases approved by the Joint Budget Committee for direct care staff, the Department has had success in recruiting and retaining staff.

For recruitment, the Department has taken several steps to fill positions:

- CMHIP regularly participates in numerous job fairs statewide and HR has added paid advertising on Indeed, ZipRecruiter and other social media marketing tools;
- CMHIP and the Department hired two additional Talent Acquisition/Recruiting team members to the CMHIP campus to support the ongoing recruiting efforts;
- To avoid losing candidates to a competitive market, the Department revised its hiring process to include weekly job interviews and to offer two new hire start dates per month; these new processes have resulted in a 95% retention rate of nurses hired to date;
- CMHIP hires contract clinical staff and converts them to full-time state employees;
- CMHIP started an internal Psychiatric Training education program for those interested in professional growth by obtaining a Psychiatric Technician license;
- The Department teamed up with the local community college in Pueblo to create interest among students on clinical tracks to apply for employment at CMHIP, including student on the EMT track;

- CMHIP is working with the Colorado Department of Public Health and Environment and the Department of Regulatory Agencies to increase the function of paramedics at a psychiatric nursing hospital.
- Special out-of-state waivers have been granted to help CMHIP recruit for Psychologists.

For retention, the Department and CMHIP leadership have taken several steps to retain quality staff:

- Utilize listening and sharing tours with staff to keep apprised of concerns, elicit feedback and ideas and to support retention efforts;
- Initiated a Voice of the Employee (VoE) committee led and ran by staff interested in contributing & participating in the positive growth and success of CMHIP, including producing a monthly newsletters to improve communications;
- Hired a workforce manager to oversee the direct care staffing office. One HR Business Partner was also hired to add support to growing CMHIP Campus;
- CMHIP and HR Implemented ongoing monthly Positive Management Training “Above and Beyond Training” for all CMHIP supervisors, managers, and leaders; and,
- Significantly reduced the use of mandatory overtime.

19. Have all of the positions included in the FY 2019-20 CMHIP bed expansion request been filled?

Response:

The newly renovated restoration unit (RNRU) at CMHIP successfully filled most direct care positions. The new RNRU unit has 31 nursing positions, of which to date 18 positions have been filled with state FTEs and 10 positions are being filled with contract nursing staff. The contract staff are used on a temporary basis until the positions are hired and filled with state nursing staff FTEs. It is typical practice for hospitals to hire contracted or traveling nursing staff to temporarily fill positions. Of an additional 11 non-nursing clinical staff, 10 positions have been hired and filled and one social work position is in the interview stage.

For non-clinical staff, the Dietary, Security, and Housekeeping/Maintenance positions have all been filled. The Administrative/Other staff roles that have been filled are the Data Management and Human Resources; the Accountant has not been filled.

20. The staff briefing included tables provided by the Department that outline the daily rates for beds within the Institutes. For comparison, what is the cost of the contracted private hospital beds? Does the Department have one or more contracts in place with private hospitals?

Response:

The Department is contracting with Peak View and is in contract discussions with Denver Health hospitals to provide inpatient acute psychiatric care. Those contract rates per bed are:

- Peak View Behavioral Health \$950/day
- Denver Health and Hospital Authority \$1,200/day

The rate for forensic patients is higher than civil patients as services include restoration services. Private hospital(s) create specified treatment plans for each patient that address barriers to restoration and provide restoration treatment programs. Additionally, the hospital submits monthly progress reports specifying progress made toward each performance measure. Fees include all costs of care and treatment.

COMPETENCY

21. Who determines whether a competency evaluation is inpatient or outpatient? What is the ratio of inpatient to outpatient evaluations?

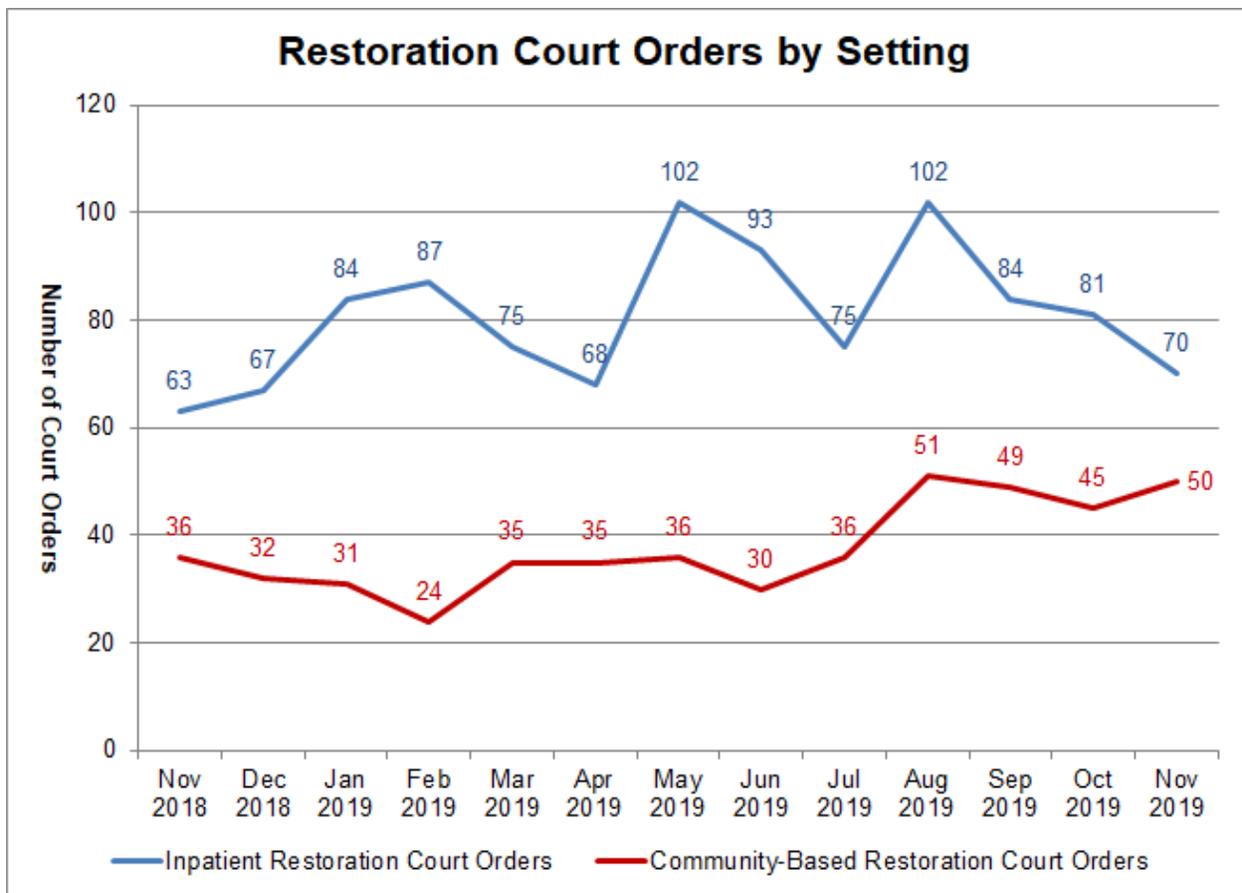
Response:

Under the current statute, the court is responsible for ordering an individual to receive inpatient or outpatient competency evaluation or restoration services.

Outpatient vs. Inpatient Competency Court Orders (Average since July 1, 2019)

| | Inpatient | In-Jail | Outpatient |
|--------------|-----------|---------|------------|
| Evaluations | 7% | 59% | 34% |
| Restorations | 64% | N/A | 36% |

The graph below demonstrates the number of restoration court orders for inpatient (blue line) and outpatient settings (red line).



The Department has been making efforts to increase the number of court orders for outpatient competency services. Specific Department forensic experts have attended judicial district meetings with judicial officers to educate judges about outpatient restoration services. In addition, the Department has created a pilot program with the Mental Health Center of Denver and Denver Pretrial Services to develop an intensive community-based program for restoration patients located in Denver. The mission of this pilot program is to decrease the number of Denver Pretrial Detainees unnecessarily being ordered to Inpatient Restoration Treatment, and to create a multi-disciplinary, Community-Based Restoration program that provides intensive treatment, case management, and pretrial supervision. The program was fully launched as of December 9, 2019, and will accept a total of 30 individuals.

Currently, OBH's Forensic Support Team is identifying individuals who have been ordered for inpatient services but may be appropriate for outpatient services. The Department is determining processes to assist in converting these orders to the appropriate level of care setting.

22. How is the Department measuring the effectiveness of inpatient and outpatient services in terms of reducing the need for competency-related services? What types of services are most effective in addressing this problem? What is the Department doing to ensure that resources are allocated to the most cost-effective services?

Response:

The Department reviewed a sample of individuals who have been court ordered for competency restoration services. It was determined that based on the clinical acuity and the level of criminal charges of those ordered to restoration, a greater number of individuals could be court ordered for outpatient restoration. The review specifically found that:

- Half of the people ordered to CMHIP do not need a hospital level of clinical care
- 18% of individuals ordered to CMHIP had low-level crimes and did not need a hospital level of care

See Question 16 for more information on why it is important not only to meet our legal obligations but also to address the rising demand for competency services through diverting individuals from the criminal justice system.

23. Over the past several years, the number of court-ordered competency evaluations and restorations has grown significantly. Additionally, the majority of these services are ordered on an inpatient, rather than outpatient, basis. These actions have contributed to significant costs to the state, including costs to increase capacity and for the payment of fines for legal proceedings related to competency services provided by the Department of Human Services. Please explain why these numbers continue to grow. What is driving the significant increase? Why are the majority of services ordered in an inpatient, rather than outpatient, setting? What factors influence that decision, and what steps could be taken to increase the number of cases ordered to outpatient services?

Response:

There are a number of likely contributing factors for the increase in court-ordered referrals for competency evaluations and restoration treatment. These include, but are not limited to:

- Increased awareness of and training on mental health disorders in the criminal justice system;
- Increased awareness of the ability to raise the issue of competency in the court process by defense attorneys;
- Insufficient intensive community-based services, which leads to an inability to avoid law enforcement involvement; and,
- Limited opportunities to divert away from the criminal justice system.

There are a number of factors that contribute to flaws of the community-based behavioral health system. The Safety-Net and Long-term Competency subcommittees of the Governor's Behavioral Health Task Force aim to address the deficiencies in the community-based behavioral health system and reduce the number of people with mental health needs ending up in the criminal justice system (see Question 10 for more detail on the Long-term competency committee and Question 8 for more detail the Task Force and both subcommittees).

Since outpatient orders are dependent on the court orders of judicial officers, the Department has engaged those officers directly. The Department's Forensic Services Program Directors have been attending En Bancs with judicial officers Statewide to provide information about the Outpatient Restoration program in an effort to increase orders. The Department has met with judicial officers in 19 of the 21 judicial districts to provide

information and details about the outpatient restoration services available in their local communities.

Current efforts that will likely impact an increased number of outpatient restoration orders include:

1. Effective July 1, 2020 per SB 19-223, competency evaluators will be required to include an opinion to the court on whether inpatient or outpatient restoration is appropriate.
2. The Forensic Navigators (see Question 31 for details on this program) will begin facilitating the conversion of orders for individuals who are awaiting inpatient restoration and may be appropriate for outpatient services.
3. The Department met with judicial leadership of the City and County of Denver to discuss opportunities to pilot an outpatient program that would increase their probability of ordering outpatient restoration. As a result, the Department has contracted with the Mental Health Center of Denver and Denver pretrial supervision services to create a pilot program that has both community-based supervision and intensive case-management services. See more information about this pilot program in Question 21.

24. Discuss the Department's efforts to date to work cooperatively with local behavioral healthcare providers and stakeholders within the criminal justice system to implement community-based competency restoration education services that are integrated with locally available behavioral health services as required by S.B. 17-012.

Response:

Outpatient Restoration services are available in all counties except Rio Blanco, Jackson, Eagle and Pitkin. We have been able to serve people who have orders out of these areas via telehealth. Contracts for Outpatient Restoration services are held by 16 of 17 Community Mental Health Centers and 34 private providers.

The Department currently has a Request for Application out to get more providers in counties where we don't have services at this time and to expand services to include other specialties (Intellectual and Developmental Disabilities, additional juvenile services, etc) and to increase capacity in areas where there is additional capacity need.

As mentioned in Question 23, since outpatient orders are dependent on the court orders of judicial officers, the Department has engaged those officers directly.

Current efforts that will likely impact an increased number of outpatient restoration orders include the three efforts described in Question 23.

25. Provide comparable data from other states to provide context for the growing number of orders for competency evaluations. Are other states experiencing the same increase in court-ordered competency evaluations?

Response:

Nationwide, states are contending with increased court orders for competency evaluation and restoration of competency services. A 2014 National Association of State Mental Health

Program Directors Survey found that 75% of the states surveyed reported that the demand for forensic services has increased substantially in recent years (54% responded that the demand has increased “a lot” and 21% responded that the demand has increased “moderately”). Lawsuits concerning delays in evaluating detainees for competency, or transferring them to appropriate facilities to restore competency, have been filed in 11 states since 2003. Western states such as Washington, Oregon, and Utah have faced similar lawsuits. From FY 2013 through FY 2018, Washington state saw a 78% increase in total court orders for competency services. From 2000-April 2019, Oregon saw a 253% increase in their competency population (called Aid & Assist patients) at the state hospital.

26. Describe the current status of the RISE Program, including the number of beds funded and the number available, and where these beds are located. Why aren't more of these types of beds available in more jails? What actions is the Department taking to ensure the availability of these types of services statewide?

Response:

Restoring Individuals Safely and Effectively (RISE) has a program capacity of 114 total beds (96 beds at the Arapahoe County jail and 18 beds at the Boulder County jail). The RISE program is for males only and is geared to serve those individuals who raise public safety concerns. These beds are available to individuals in any judicial district in the state. The RISE program is limited to those individuals who have been court ordered to the Department's custody for competency evaluations and restorations; RISE is not a mental health service for any individual waiting in jail.

At this time the Department is not planning to build more RISE beds. It is currently focusing its efforts on educating judicial officers about the Department's outpatient restoration services, so that they are more likely to order outpatient restoration. The Department's philosophy is that individuals who need a hospital level of care should be in a hospital setting and those who do not require such an intensive level of care should receive outpatient services in a community setting. If the demand for inpatient beds can be alleviated and there are a greater number of outpatient orders, the plan is for the RISE beds to be dedicated to individuals who do not need a hospital level of care and do pose a public safety concern.

27. The General Assembly has steadily been increasing funding for behavioral health services in recent years. Yet, the Department continues to revert funding for programs that have been established and funded to address the fundamental problem and reduce the number of people who require competency services. Detail the state funds that the Department reverted in FY 2019-20, by line item and fund source, and explain why these reversions occurred. Additionally, please specifically address the reversions in the table below.

| OFFICE OF BEHAVIORAL HEALTH REVERSIONS | |
|--|--------------------|
| LINE ITEM | DOLLAR AMOUNT |
| Criminal Justice Diversion Programs | \$1,637,624 |
| Jail-Based Behavioral Health Services | 919,962 |
| Rural Co-Occurring Disorder Services | 29,019 |
| Medication Consistency & Health Information Exchange | 171,453 |
| MH Inst. Forensic Jail Based Competency Restoration | 2,483,872 |
| MH Inst. Forensic Outpatient Competency Restoration | 269,131 |
| Total | \$5,511,061 |

Response:

Please see the FY 2018-19 state funds reversion table below that addresses competency-related services. The reversion table details the source of funds and an explanation of why the reversion occurred and the Department’s efforts to mitigate further reversions.

| Office of Behavioral Health Reversions FY 2018-19 | | |
|--|---------------------------|---|
| Line Item | \$ Amount | Reversion and Status Explanation |
| Criminal Justice Diversion Programs | \$1,637,624 Cash Funds | In FY 2017-18 the Criminal Justice Diversion programs were newly funded which required the Department to issue a new procurement and contracts for services which began in April 2018. This program ramp-up by law enforcement agencies also delayed full implementation of programs into FY 2018-19. Many of the programs struggled with hiring and retaining staff in FY 2018-19 as well. For Co-Responder Programs specifically, most programs have a lengthy hiring process that includes thorough background checks and vetting to meet police department clearance standards. For LEAD Programs, the initial start-up activities involve a lot of stakeholder engagement, planning and consensus building which contributed to a slower ramp-up. In FY 2019-20 base diversion programs are contracted and on-track. Finally, the Department is expected to begin five additional Co-Responder programs in the first quarter of calendar year 2020 that were funded through S.B. 19-008. |
| Jail-Based Behavioral Health Services | \$919,962 General Fund | In FY 2018-19 the Department implemented SB 18-250, which expanded Mental Health Services to rural jails. The Department canvased 28 rural jails to contract for Mental Health Services and 5 jails have not participated for various reasons including: the timeframe of the application, administrative transition (ex. numerous new Sheriffs elected in the midst of the contracting process), or OBH not receive a response. The Department is recanvasing jails that are not currently participating to mitigate reversions and ensure that the funds are utilized as intended by the legislation. |
| Rural Co-Occurring Disorder Services | \$29,019 Cash Funds | In FY 2018-19 the rural co-occurring Managed Service Organization contractors reverted \$29,019 cash fund because costs were lower than the fully appropriated contracted cost. Additionally, in FY 2018-19, the General Assembly appropriated \$3.0 million General Fund program for a new residential substance abuse treatment program in rural Colorado. In FY 2018-19, the Department contracted for a multi-state fiscal year renovation of a new residential facility in Clifton, Colorado, near Grand Junction. Delays in spending were the result of the time necessary to execute the |

| | | |
|--|-----------------------------|--|
| | | contract and then for the subcontracted Mental Health Center to purchase the property and begin renovation of the facility. The Department has fully committed funds in FY 2019-20 and is working with contractors to maximize use of these funds. |
| Medication Consistency & Health Information Exchange | \$171,453 Cash Funds | This project required the Department to coordinate with Sheriffs on Jail health information system development. The project required multiple agency involvement (CDHS, Office of Information Technology and the State Internet Portal Authority). In addition, this process required additional time due to new layers of technology. |
| MH Inst. Forensic Jail Based Competency Restoration | \$2,483,872 General Fund | There was a delay in finding a jail where a new RISE program could be implemented according to the program's requirements. The beds were originally expected to go online in fall of 2018, but due to the delays in finding a location, a contract was not signed until May 2019. Boulder County beds went online in June 2019 |
| MH Inst. Forensic Outpatient Competency Restoration | \$269,131 General Fund | The start of the program was delayed. The initial solicitation for bids to provide outpatient restoration services was published in December 2017. The response to the solicitation for a single statewide provider was insufficient; therefore the Department created short-term contracts for a six-month period with the Community Mental Health Centers where Outpatient Restoration referrals were coming in. With the temporary contracts, services were implemented in March 2018. The Department has since then continued to outreach providers and implement additional contracts to ensure statewide program capacity. Those providers started to provide services in May/June 2019. A Request for Applications has once again been reopened in August 2019 for additional capacity in targeted areas. |
| Total | *\$5,511,061 | |

***The reverted funds reported in this table above were provided at the end of FY 2018-19 and included accounts payable estimates. It is anticipated that the Department's final FY 2018-19 accounts payable actuals and corresponding state fund reversions will be completed for FY 2018-19 by January 31, 2020, at which time the amount of reversions will increase.**

Additionally, the table above does not represent negative supplemental adjustments that occurred in FY 2018-19. These actions are indicated in Schedule 3B as "SB 19-223 Actions Related to Competency to Proceed."

In addition to the table above, the Department reported in Budget Schedule 3B that it reverted \$1,660,035 in the Community Transition Services Line item. This reversion was caused in two parts:

- 1. Start-up of new S.B. 18-270 Behavioral Health Crisis Transition Referral Program that began in April 2019 and was slow to expend funds because of program ramp-up.**
- 2. The Department procured a new Momentum program contractor that began on July 1, 2018. This contractor has been more efficient in the use of state funds. The Momentum Program assists with transitioning difficult to place Mental Health Institute clients back into the**

community via intensive case management and wraparound services. As a result of the Department's Momentum contractor efficiencies, the Department is requesting a \$400,000 General Fund reduction to the Momentum program to align with FY 2018-19 expenditure patterns through the decision item titled, "R-28 Post Affordable Care Act Reductions."

The Department continues to actively manage these funds to ensure that reversions are mitigated by procuring and contracting to get to full program capacity that will minimize reversions.

28. How consistently do patients who are receiving competency-related services receive and take their medications? Does this contribute to repeat cycles of competency services?

Response:

On average for fiscal year 2018/2019, CMHIP had 27% (competency evaluations) and 46.2% (restoration) of patients on emergency or court-ordered medications. Many of these are patients court ordered to receive restoration services. Once patients are opined competent to proceed, they are transferred back to the jail and can decompensate if the patient refuses medication. Not all settings are capable or willing to provide court-ordered medications to ensure medication stability. Those settings who have providers capable of managing a patient on a certification might not be willing accept the referral over concerns of liability. Medication alone is not the greatest concern for repeat cycles of competency services. Insufficient services, including medication management, may result in an individual decompensating in settings outside of the hospital. The Long-term Competency subcommittee of the Behavioral Health Task Force has had preliminary conversations about legislative concepts to avoid the unnecessary repetitive cycle of competency services for individuals who are permanently incompetent to proceed. Individuals who are permanently incompetent to proceed are those who will likely never be restored regardless of how much services they receive; this includes individuals who have significant intellectual and developmental disabilities or permanent traumatic brain injuries.

OBH is also working on providing jails with relevant treatment information to increase the likelihood a patient may maintain a consistent course of treatment and avoid interruptions in medications and treatment. See Question 32 for further information regarding this project.

29. How are individuals who receive competency restoration services referred to ongoing services or treatment following their restoration?

Response:

Once completing inpatient restoration services at CMHIP or the RISE programs, most individuals return back to jail in order to continue on with their court process.

For those patients who are restored and returning to jail, the jail mental health teams are provided with a packet of discharge recommendations or instructions and community resources for the individual. The discharge instructions include information on diagnosis, medications and a summary of services offered at CMHIP or RISE. This allows the jail

treatment team to have awareness of each person's needs and to pick up coordination of care if and when that person releases into the community.

The Interim Jail Based Behavioral Health Services funding for the jails is available for jails to continue psychiatric medications and obtain the resources needed to provide ongoing behavioral health care for individuals who are restored and returned back to jail.

As part of the Medication Consistency Project (see Question 32), part of the long-term plan is to modify the CMHIP's electronic health record (see budget request R-13) to electronically transmit treatment information to jails when individuals return back to jails.

In the cases where individuals are discharged to the community from an inpatient setting, coordination of care is patient dependent. If mental health services are needed, the patient is provided with a referral to their community mental health provider; the provider may allow for scheduled appointments in advance or only permit to be seen as a walk-in. A longer-term strategy that will support coordination to treatment upon release is allowing for health information exchange within jails that will improve coordination to treatment upon release (see Question 32 for greater detail on the Medication Consistency Program).

Specific to the RISE program, Re-Entry Specialists assist patients with reintegration back to the originating jail when restored or to the community.

For the Outpatient Restoration program, after restoration services have ended, individuals who are engaged in services that address their barriers to competency are encouraged to continue working with their assigned provider after discharge from our program. The Outpatient Restoration program does not have funding resources to offer continued care; the wraparound services are funded through the Community Mental Health Center contracts or Medicaid.

CONSENT DECREE

30. Address the Department's reason for not including the expected \$10.0 million in fines in the FY 2020-21 budget request, including any alternative plans for covering this cost.

Response:

At the time the budget requests were being constructed (during the summer of 2019) for the Governor's November 1 submission of the FY 2020-21 Budget, the Department had only just started implementing the changes from the consent decree and SB 19-223, and needed more data to predict an amount of fines with greater accuracy. Since the amount of fines is largely dependent on the number of court orders, which is not within the Department's control, and the Department's capacity to meet the court orders, the Department has to make considerable assumptions to determine the final amount related to fines. The Department is currently working with the Governor's Office of State Planning and Budget (OSPB) to better estimate the amount needed for fines in FY 2020-21. The Department will submit the amount needed by January 2 as is statutorily required.

It is important to note that the funding for fines is not a Long Bill line item; instead it is an appropriation from SB 19-223. The appropriation has been offset by re-appropriated under-

expenditures for FY 2018-19 and provides roll-forward authority to cover fines and fees accrued in FY 2019-20.

31. Provide a timeline for what the Department plans to do to come into compliance with the Consent Decree, including actions taken to date and planned actions through 2025. Has the Department implemented the systems (such as the triage system) required by the Consent Decree?

Response:

Attached is a [compliance update](#) by the Department. It outlines the actions the Department has taken toward compliance since the implementation of the Consent Decree in March 2019 and actions in progress. Below are brief updates on actions taken to date:

- The Forensic Support Team was hired by August 2019. All 15 Forensic Navigators were hired along with the program's leadership team. The team is currently fully functional and is checking in on the individuals waiting in jail for inpatient beds.
- The triage system was implemented as of June 1, 2019, per the Consent Decree deadline. Forensic Evaluators have been providing their opinion as to whether a defendant meets Tier 1 or Tier 2 criteria since that date. These tiers indicate the acuity level of an individual and assist the Department in prioritizing admission for higher acute individuals (Tier 1).
- The Department has continued increasing outpatient restoration treatment capacity, with services currently available in 90.6% of the state. Since June 2019, the Department has added more inpatient restoration beds and will continue to add additional beds through December 2021.
- The Department amended jail-based behavioral health contracts to provide interim jail mental health treatment services for those waiting jail to be admitted for inpatient competency services.
- In partnership with the Office of Information Technology, the Department is in the process of developing a data warehouse that will track the status of defendants in the criminal justice system for whom a competency evaluation or competency restoration has been ordered.

CRIMINAL JUSTICE AND BEHAVIORAL HEALTH INTEROPERABILITY

32. Provide an update on the implementation of S.B. 17-019, which requires sharing information between criminal justice system and behavioral health service providers. Are there budget requests related to this implementation?

Response:

OBH is meeting the timelines and intentions of SB 17-019 that directed OBH to test and pilot solutions for exchanging health information in jails. OBH is partnering with county jails to identify viable solutions for sharing relevant health information, specifically medication consistency information, by using technology to coordinate services across various treatment settings. An integral component of this initiative includes the secure transmission of prior treatment information (i.e., emergency room, inpatient, and outpatient treatment information) so that jail providers can better treat inmates upon booking into jail.

In an effort to support jails, OBH is piloting solutions through the use of the two state Health Information Exchanges (HIEs), CORHIO and Quality Health Network (QHN). HIEs help providers better coordinate care for individuals by facilitating safe and secure electronic transmission of health information between different settings.

Ten county jails are piloting HIE: Logan, Mesa, Summit, Garfield, Eagle, Denver, Arapahoe, Broomfield, Pitkin, and Las Animas.

Additionally, OBH is nearing an executed contract with CORHIO to purchase medication history so providers in the jail and the community have more robust medication information about their clients. To cover a portion of the cost, OBH is collaborating with the Department of Health Care Policy and Financing (HCPF) to obtain a Medicaid federal match. The federal match is 90% (\$360,000) of the total cost for some approved expenses. The HI-TECH funding match through CMS is only available through 2021, so the Department will continue to identify additional activities and/or initiatives to provide enhancement to current criminal justice systems through the use of this funding. At this time there is no request for additional General Fund beyond what has already been appropriated for the pilot. When the pilot is expanded to other jails, additional resources will need to be identified.

For a summary of the budget that the Department is utilizing for this project, please see the table below.

| Medication Consistency and Health Information Exchange Budget FY 2019-20 | | | | | |
|---|-----------|--------------|------------|---------------|--|
| Description | Total | General Fund | Cash Funds | Federal Funds | Notes |
| Medication Consistency and Health Information Exchange | \$380,700 | | \$380,700 | | Long Bill Appropriation |
| Medication Consistency and Health Information Exchange (Evaluation Funds) | \$100,000 | | \$100,000 | | Carryover from FY 2018-19 |
| Mental Health Block Grant | \$93,590 | | | \$93,590 | Non-appropriated one-time Mental Health Block Grant |
| Jail Medicaid Technology Funds | \$360,000 | | | \$360,000 | Interagency transfer of Federal Spending Authority from HCPF |
| State Match for Jail Medicaid Technology Funds | \$40,000 | \$40,000 | | | Match from Jail-based Behavioral Health Services line. |
| Total | \$974,290 | \$40,000 | \$480,700 | \$453,590 | |

33. The Legislative Oversight Committee Concerning the Treatment of Persons with Mental Health Disorders in the Criminal and Juvenile Justice System recommended a bill (Bill D) which does the following:

Creates the Trusted Interoperability Platform Advisory Committee in the Department of Public Safety. The advisory committee is charged with developing a strategic plan to implement a trusted interoperability platform that is capable of securely exchanging information between criminal and juvenile systems and community health agencies. The bill outlines that the advisory committee is to consist of 11 members from various agencies, and the plan must be submitted to the General Assembly by September 2, 2021.

Please provide your feedback on this proposed legislation, and indicate if any funds have been set aside in the Governor's budget request for this legislation.

Response:

OBH is not directly named in the bill and the work is not assigned to OBH so we have not submitted any budget requests related to this legislation. OBH supports the concept of sharing relevant health information and criminal justice data between systems to improve outcomes for individuals involved in criminal and juvenile justice systems. OBH has been working with jails to share health information across treatment settings and improve coordination with healthcare providers upon release back into the community. Please see our response in Question 32 for further detail related to OBH's efforts to coordinate health information between jails and community providers.



COLORADO

Office of Behavioral Health

Department of Human Services

Robert Werthwein, Ph.D., Director

Consent Decree Compliance Update - November 1, 2019

[Actions Taken Toward Compliance]

- **Triage System**
 - OBH developed and implemented a triage system as of June 1, 2019 to screen each Pretrial Detainee and make recommendations to the committing court as to the most clinically appropriate level of care to restore the Pretrial Detainee to competency. Forensic Evaluators include Tier 1 (the most clinically acute individuals) and Tier 2 (individuals that require inpatient restoration, but are not as clinically acute) opinions, as well as inpatient or outpatient restoration recommendations, in their reports.

- **Forensic Support Team**
 - The Forensic Support Team was developed, hired, and implemented through funding in Senate Bill 19-223. This team serves as a centralized structure within OBH to assist forensic clients when competency restoration services have been ordered by the court. The team includes a Program Director, two Program Coordinators, and 15 Forensic Navigators to provide case coordination services to Pretrial Detainees.

- **Outpatient Restoration Services**
 - OBH continues to develop partnerships with Community Mental Health Centers and private providers to provide community-based restoration treatment services, with services currently available in 89% of the state.

- **Boulder RISE Program**
 - OBH took active steps to find a jail facility willing to convert a portion of its space to host the RISE program for the 18 bed expansion that was funded in FY 2018-19. A contract was signed with Boulder County Jail for this expansion and the program began operating on June 3, 2019.

- **Private Hospital Beds**
 - OBH signed a contract with Peak View Behavioral Health in August 2019 for five private hospital beds for low-risk, high-need patients who have a court order for inpatient competency restoration services. Peak View began accepting

patients as of September 12, 2019. OBH is in ongoing negotiations with Denver Health to contract for additional private beds.

- **CMHIP CORE Unit Conversion**
 - CMHIP converted a co-ed psychosocial learning program to an all female restoration unit to meet the increasing demand for female beds and the need for additional units focused solely on inpatient restoration treatment. The unit was successfully transitioned to an all female medium security unit as of September 30, 2019.
- **Senate Bill 19-223, “Concerning Actions Related to Competency to Proceed”**
 - This bill is the primary legislative mechanism that will codify the structure of reforms to the competency evaluation and restoration system. It includes a series of policies to help CDHS implement the Consent Decree and has the court and state systems contributing to best outcomes for individuals in the competency process.

[Actions In Progress]

- **CMHIP Medium Security Restoration Unit**
 - CMHIP relocated a community reintegration unit in June 2019, which created a vacant space that can be modified to appropriately provide services in a medium security restoration unit. This unit is on track to open in December 2019, which will increase the capacity of CMHIP by 42 beds.
- **CMHIP L2 expansion**
 - This expansion will add 24 beds within the High Security Forensic Institute (HSFI) building at CMHIP. Construction began on August 6, 2019 and is on schedule for the estimated opening date of October 2020.
- **CMHIFL F2 & F3 Cottages**
 - The F2 and F3 cottages at CMHIFL will be renovated to become inpatient restoration units, with an estimated occupancy date of December 2021. This will increase the capacity at CMHIFL by 44 beds.
- **Interim Jail Mental Health Treatment Program**
 - The JBBS (Jail-Based Behavioral Health Services) program within OBH is working with County Jails to implement a program that will assist in the provision of coordinated services to screen, treat, assess, and monitor for triage purposes Pretrial Detainees in the least restrictive setting possible. Senate Bill 19-223 allocated \$2.25M in funding for this program. OBH has received proposals from Douglas, Jefferson, El Paso, Pueblo, Larimer, Denver, and Boulder counties,

and will be meeting with sheriffs in Adams, Mesa, Weld, and Arapahoe counties to discuss barriers/opposition to implementing this program.

- **Data Warehouse**

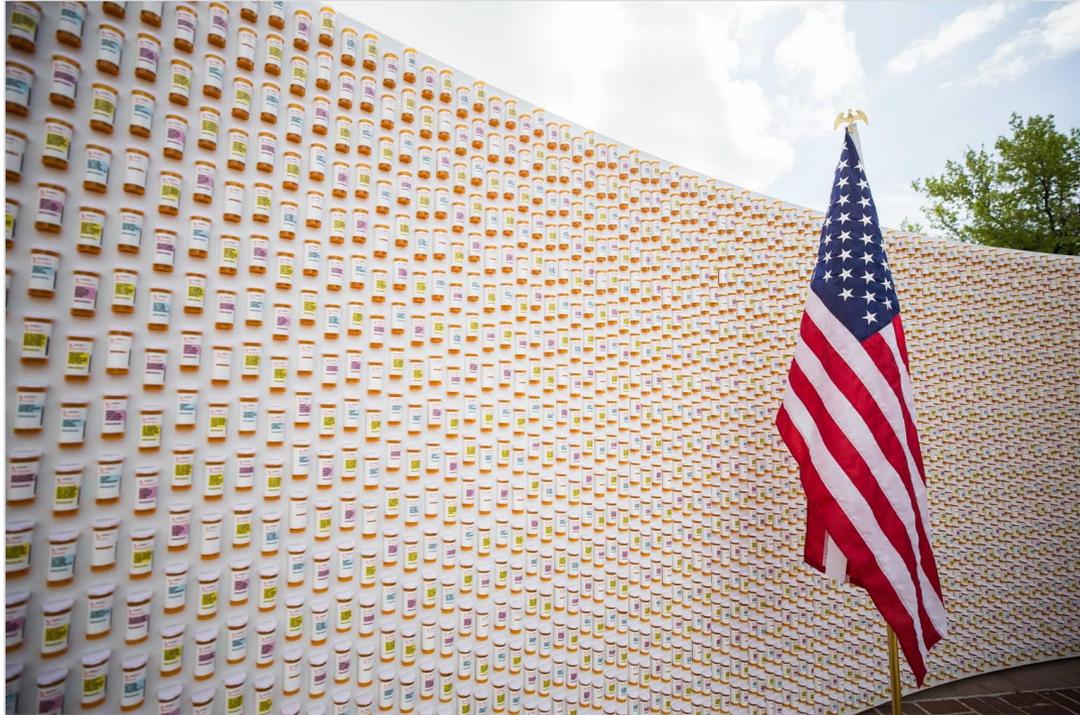
- Per the Consent Decree and Senate Bill 19-223, OBH has created and hired a Data Manager position to assist the Governor's Office of Information Technology with the development of a data warehouse. This will be an electronic system that will track the status of defendants in the criminal justice system for whom a competency evaluation or competency restoration has been ordered.

- **Comprehensive Plan**

- OBH is in the process of developing a long-term comprehensive and cohesive plan in partnership with the Governor's Behavioral Health Task Force Competency Subcommittee. This plan will be the roadmap for improving the competency system and is due to federal court by January 2020.

FY 2020-21

Joint Budget Committee Hearing



Office of Behavioral Health
December 19, 2019



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Office of Behavioral Health

\$ 393,434,361

Proposed FY 20-21

- 2 Mental Health Institutes
- Forensic services for individuals in the criminal justice system who have been diagnosed with mental health disorders
- Emergency behavioral health services and the State crisis hotline, which served 227,669 requests in FY 2019
- Contracts with 208 community mental health and substance abuse programs and providers
- License 670 substance use treatment sites, mental health clinics, and community mental health centers



1,471.2 FTE

Proposed FY 20-21



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Office of Behavioral Health FY 2020-21 Budget Requests

- R-04 L2 Operating and Staffing

\$4,819,669

- R-18 Staffing for Electronic Health Record Support \$274,576
- R-25 Refinance Substance Use Treatment Services
(\$2,800,000)
- R-28 Post Affordable Care Act Reductions
(\$1,284,000)
- R-29 Reduce Duplicative Activities
(\$380,000)
- R-30 Revert Eval. Funding of Discontinued Program

(\$50,000)



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R-34 MHI Division Long Bill Technical Correction
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\$0



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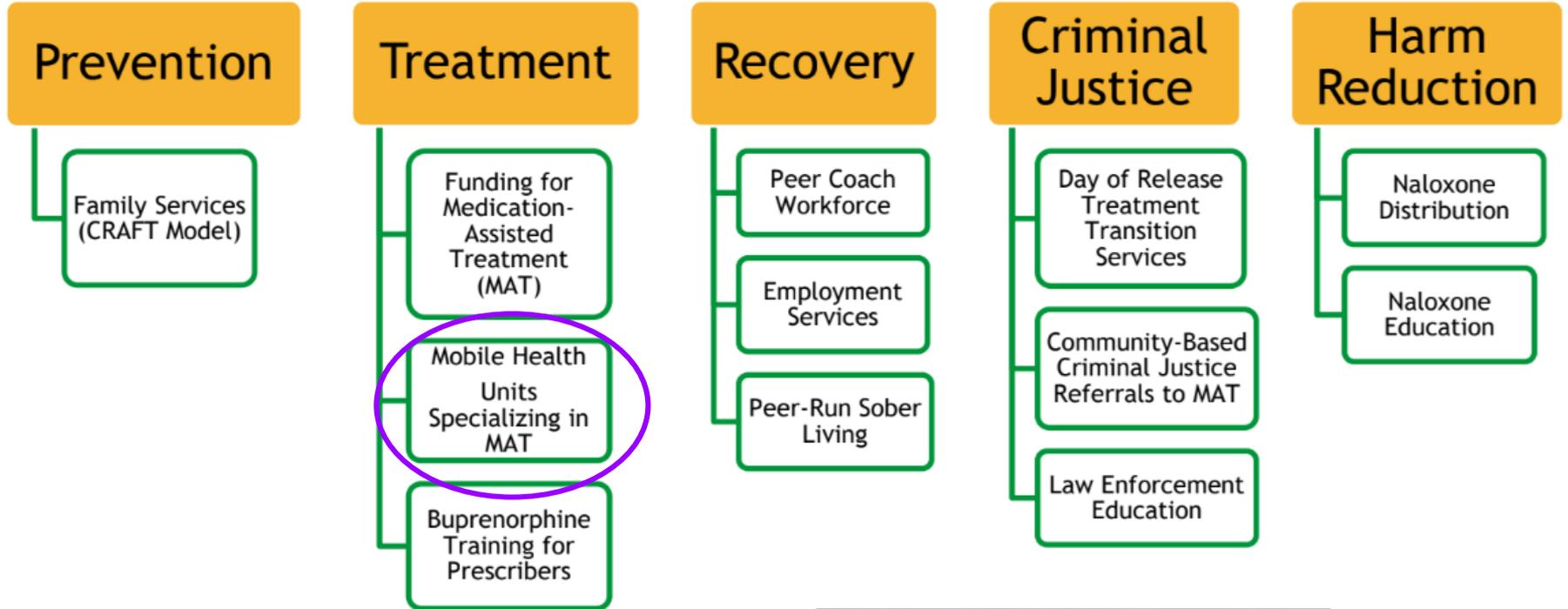
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Community Behavioral Health

Community Mental Health Services
&
Substance Use Disorder Interventions

Opioid Funding



Law Enforcement and Jail Funding

- Co-responder programs (\$5.9 million)
 - 20 programs in 22 counties for 40 law enforcement agencies
 - Adding 5 new programs (SB 19-008 MTCF)
- JBBS for Substance Use Disorders (\$5 million + \$1.9 million)
 - Includes MAT in 16 county jails
- JBBS for Mental Health
 - rural/frontier jail mental health services (\$5 million; SB 18-250)
 - urban jail mental health services (\$2.25 million; SB 19-223)
- LEAD (\$2.6 million)
 - 4 pilot sites through June 2022
- Medication Consistency Program (\$1 million)
 - Health information exchange for jails

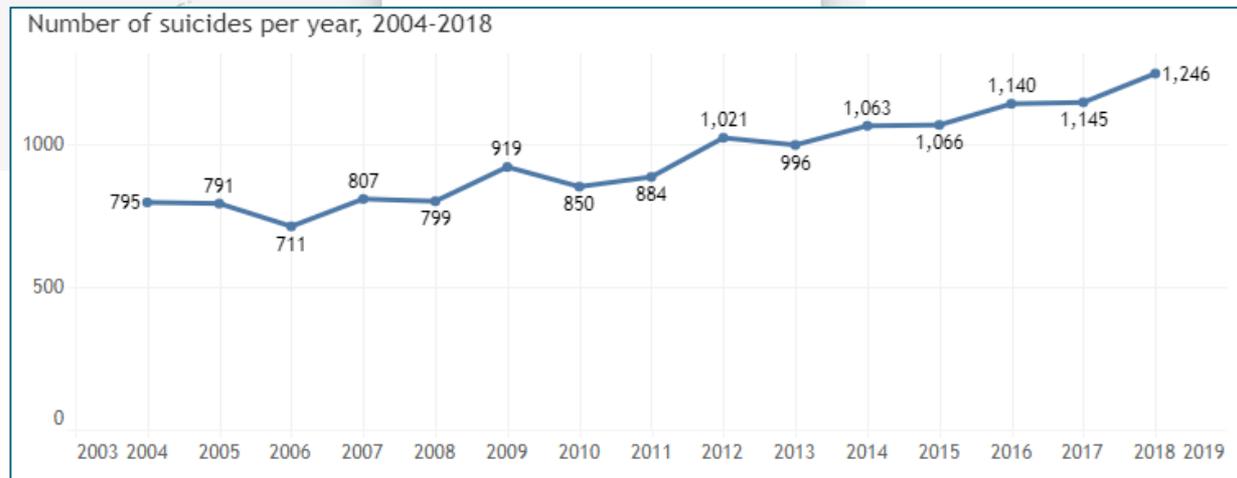
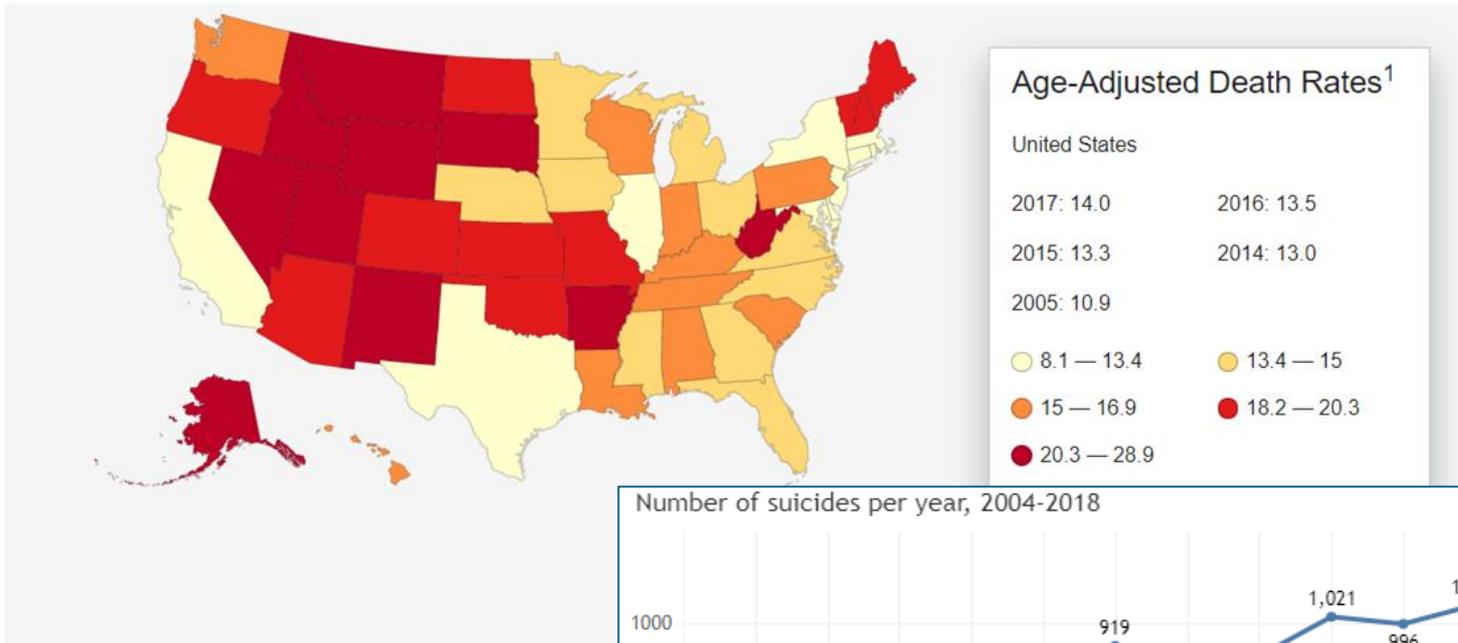
*JBBS = Jail Based Behavioral Health Services



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Suicide Ranking

Colorado's suicide rate was 11th-highest in the nation (2017)

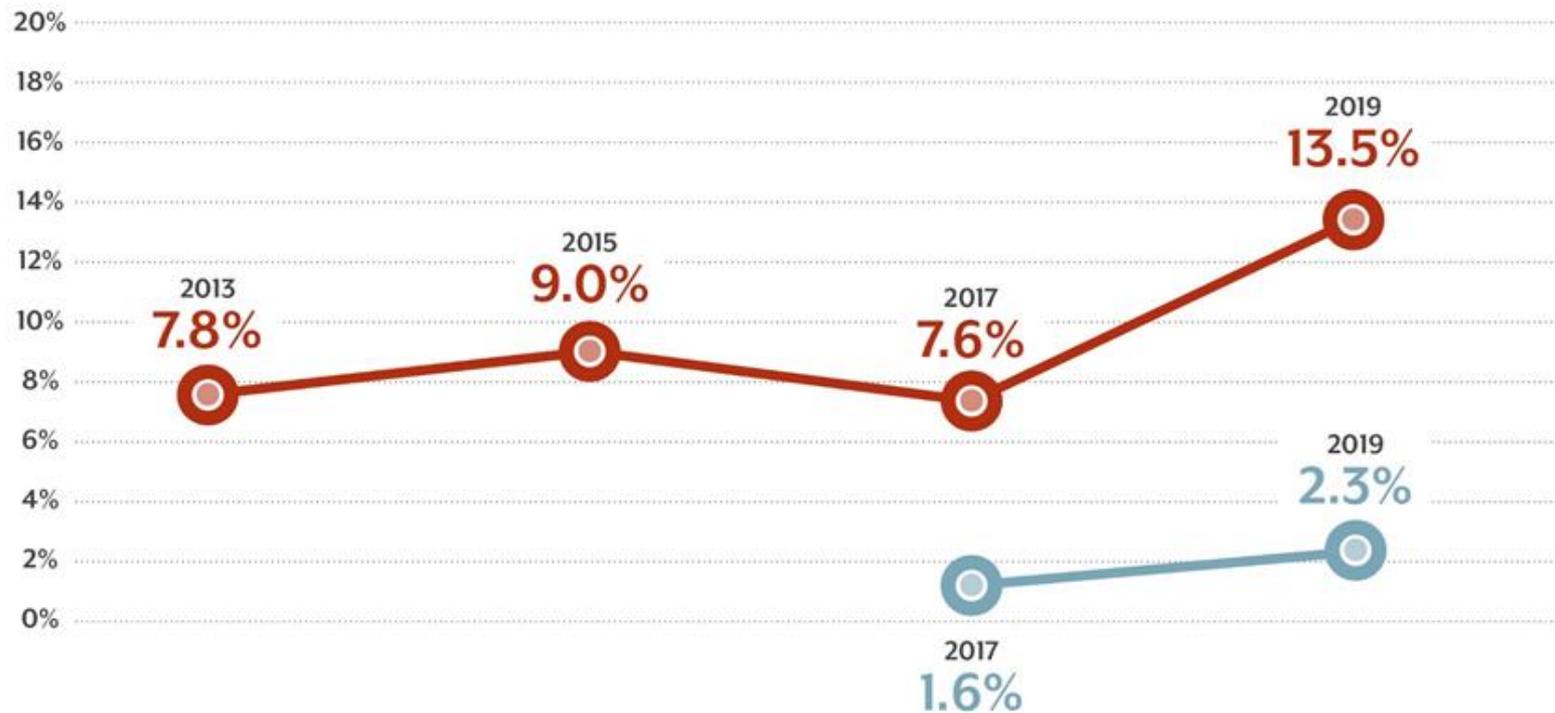


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Behavioral Health Access is Down

Percentage of Coloradans Reporting Not Getting ...

■ Needed Mental Health Services ■ Needed Substance Use Disorder Services



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Source: 2019 Colorado Health Access Survey

Reasons for Not Getting ...

| |  Needed Mental Health Services |  Needed Substance Use Disorder Services |
|--|---|--|
| Cost of treatment | 61.1% 394,185 | 47.7% 43,192 |
| Did not feel comfortable talking about personal problems | 38.2% 244,992 | 72.8% 64,836 |
| Concerned about someone finding out you had a problem | 31.3% 199,644 | 72.4% 64,754 |
| Hard time getting an appointment | 43.5% 269,787 | 32.9% 29,046 |
| Did not think insurance would cover it | 53.8% 300,234 | 52.1% 32,424 |



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Source: 2019 Colorado Health Access Survey

Population In Need Study

- Assess behavioral health need statewide focusing on health disparities and regional need
- Identify gaps in existing services
- Identify unmet needs for sub-populations with disparities
- Identify system design elements to improve health disparities
- Identify resources needed to meet needs and system changes



Significant Sources of Government-Funded Behavioral Health

Regional
Accountable Entity
(HCPF)

Community
Centered Board
(HCPF)

Offender Services
(OBH, DPS, DOC, DYS,
Judicial/Probation)

Mental Health
Block Grant
(OBH)

Administrative
Services
Organization
(OBH)

Managed Service
Organization
(OBH)

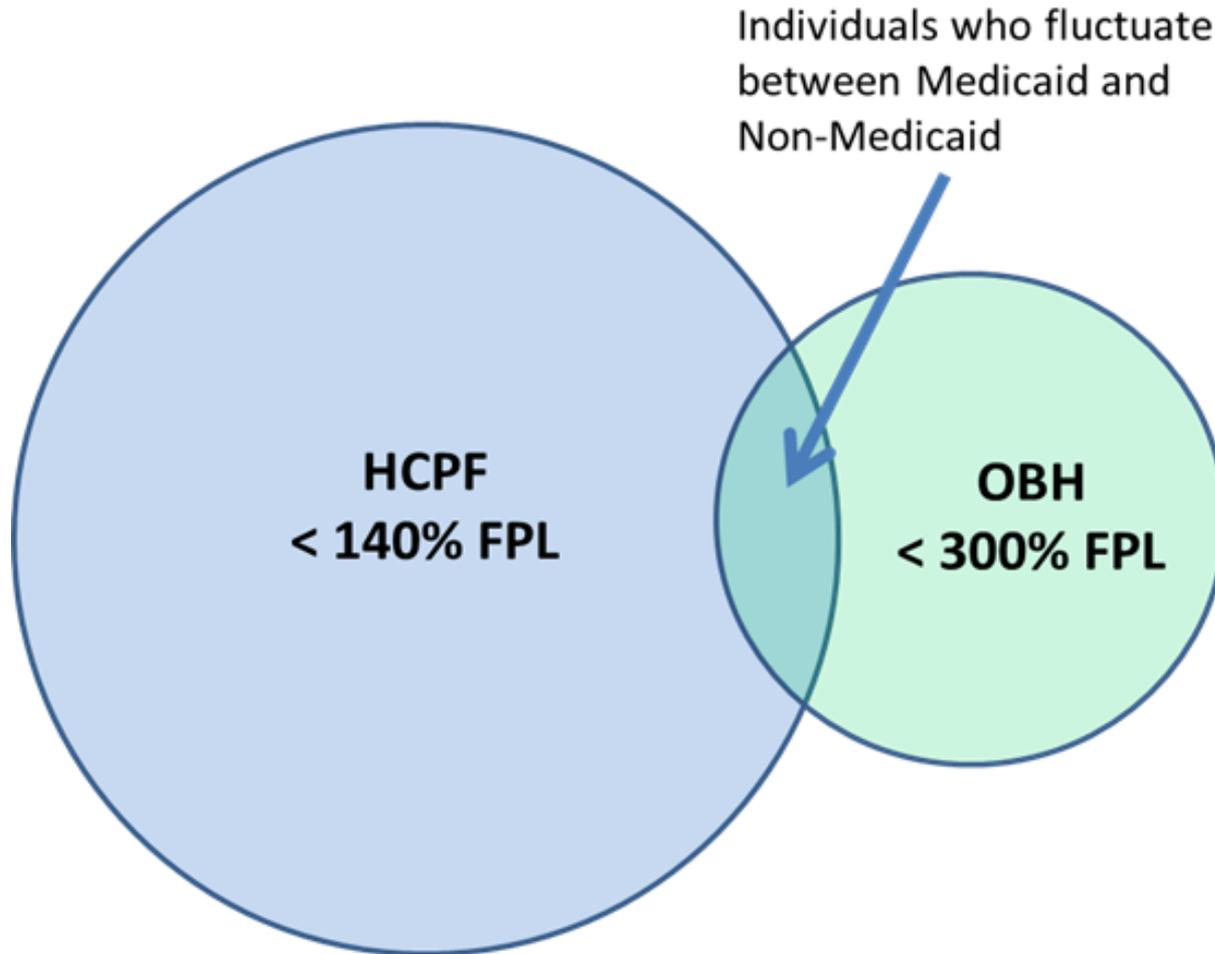


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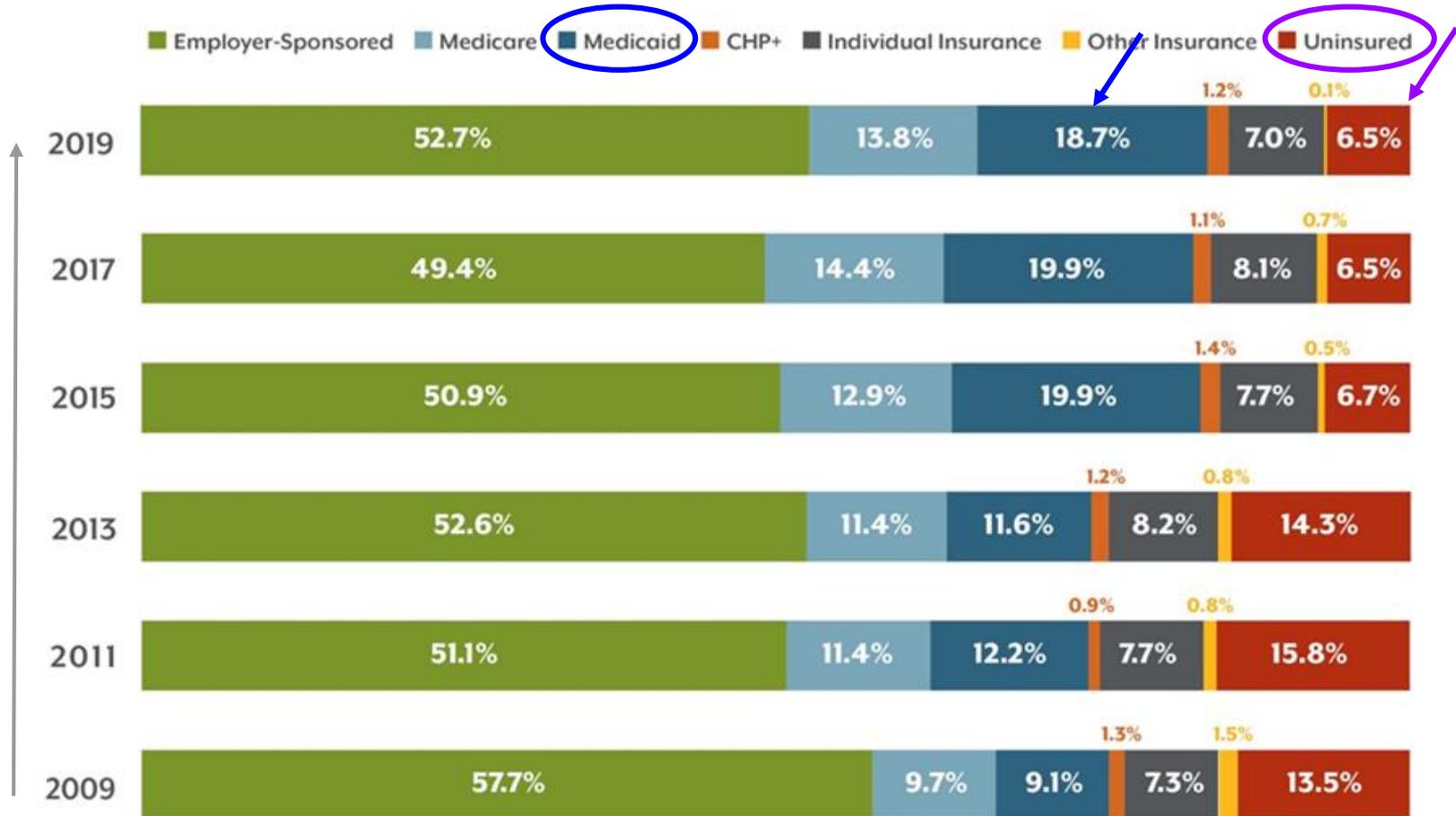
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OBH Funding vs. Medicaid Funding



ACA Impact on Indigent Funding Needs

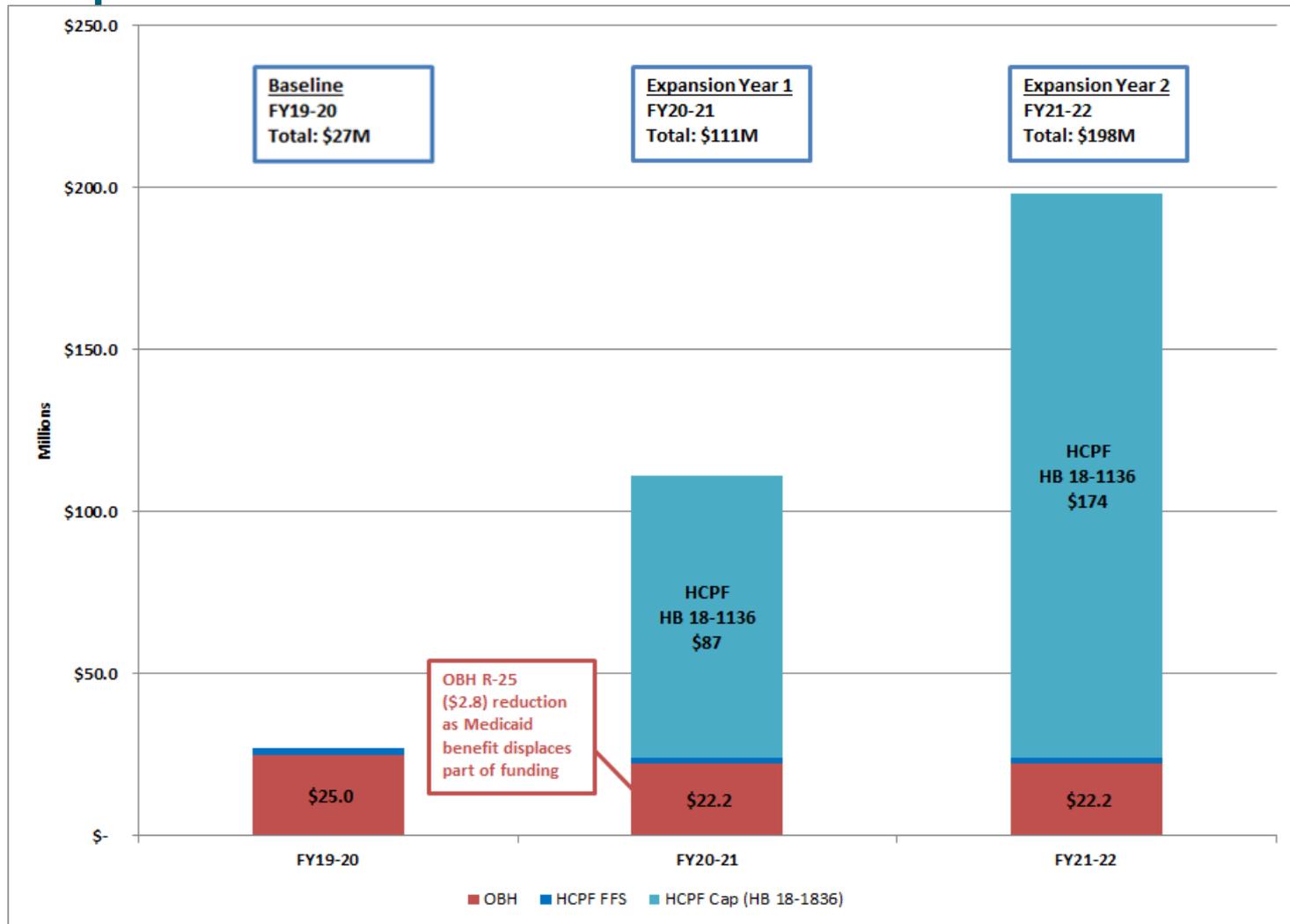
Health Insurance Coverage, All Ages, 2009-2019



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Source: 2019 Colorado Health Access Survey

Impact of HB 18-1136 on SUD Treatment



*Expansion year 1 is based upon the assumption that HCPF R-11 is approved.

Recent efforts to increase SUD residential capacity

- **\$5 Million** available through House Bill 1287 to expand treatment capacity in rural and frontier communities
- **\$7.2 Million** CIRCLE Program expansion
 - Pueblo
 - Mesa County
 - Larimer County
- Portions of the **\$15 million** allocated to MSOs in SB 202 dollars can be and are used for SUD residential treatment capacity





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Governor's Behavioral Health Task Force



Task Force



**Children's
Behavioral Health**



Safety Net



**Long-Term
Competency**

Behavioral Health Task Force Blueprint for June 2020

Community Conversations
with Consumers and Stakeholders

Public Testimonies
to make sure consumer and client
voices are heard

Over 100 members across
the Task Force
and its 3 Subcommittees



We are working toward a framework

September

- Finalize definition and vision(s)
- Review legislative analysis
- Review best practices of other states

October

- Review funding sources
- Review Medicaid
- Review and inventory community services

November

- Brainstorm BH framework
- Define “high intensity BH treatment programs”

December

- Develop BH framework for Colorado
- Draft Competency Plan

January

- Develop initial recommendations to streamline state/federal billing
- Begin working on journey map
- **Submit final Competency plan**

Feb - April

- Develop strategy for funding, access, prevention and billing
- Develop draft recommendations

May

- Subcommittees develop final recommendations
- Draft Blueprint

JUNE 2020

**Blueprint
COMPLETE**



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Children's Subcommittee

Goal: “A comprehensive, equitable, effective continuum of behavioral health services that meets the needs of all Coloradans in the right place at the right time to achieve whole-person health and well-being.”

Target: Specifically looking to make recommendations on:

- Gaps in services -
 - Network adequacy (access & point of entry)
 - Care coordination
 - Workforce
- Finance -
 - Fund a full continuum of care
 - Opportunities to reallocate funding
- Governance - Decision-making at a policy level so services are seamless
- Quality - Tracking outcomes for improved care





Safety Net Subcommittee

Goal: “A safe, community-based behavioral health system that provides person-centered access to a continuum of behavioral health services to marginalized Coloradans regardless of severity of need or ability to pay.”

Specifically, ensure that all Coloradans have access to behavioral health services, regardless of:

- where they live;
- if they are able to pay for the services; and
- their circumstances (criminal justice involvement, homelessness, etc.).

Target: Identified several key areas to be addressed:

- Developing a central governance structure for safety net services;
- Addressing the behavioral health workforce shortage;
- Aligning behavioral health funding streams; and,
- Increasing access to behavioral health services.



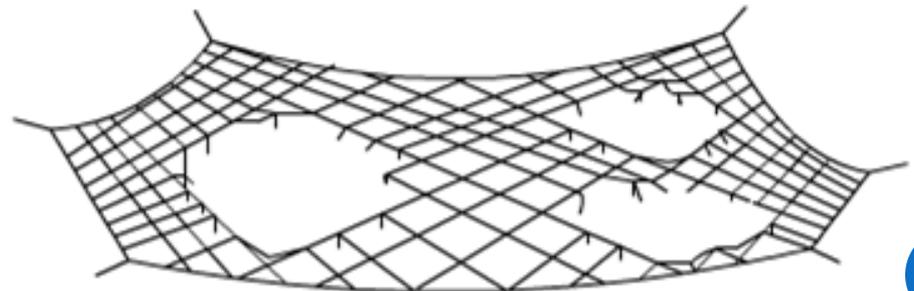
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Colorado's Safety Net System

- Multiple safety net systems: Medicaid safety net systems vs. the various other smaller safety net systems.
- Providers want to serve clients, but system and processes are not client-centric.
- Current safety net provider structure
 - Private providers with discretion (with exception to statutory requirements)
 - Referral reject allowance
 - Only required to provide services defined in statute
 - Are not necessarily linked to all government funded behavioral health efforts
- When safety net system does not serve individuals, they are likely to end up in Emergency Rooms and Criminal Justice System
 - Jails make poor treatment settings

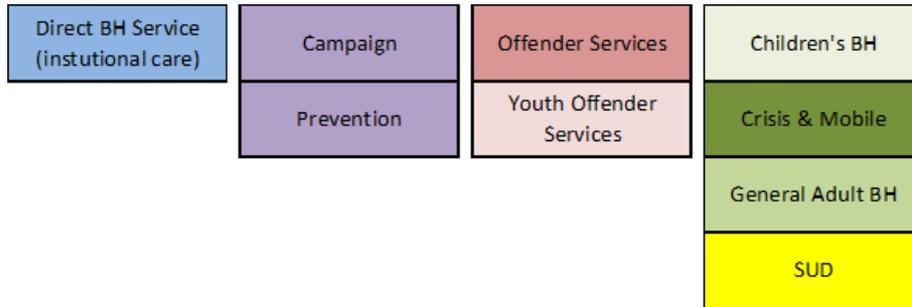


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Government Funded BH by Dept

- Various state agencies fund BH
- Table does not include:
 - CDE
 - DOLA
 - County Local Funding
- 9 High level categories



| | State Department | Population |
|----------|-----------------------------------|-------------------------------|
| CDHS | CDHS - Child Welfare | Children's BH |
| | CDHS - Division of Youth Services | Direct BH Service |
| | CDHS - Division of Youth Services | SUD (Youth Offender Services) |
| | CDHS - Division of Youth Services | Youth Offender Services |
| | CDHS - OCAI | Direct BH Service |
| | CDHS -Office of Behavioral Health | Campaign |
| | CDHS -Office of Behavioral Health | Children's BH |
| | CDHS -Office of Behavioral Health | Crisis & Mobile |
| | CDHS -Office of Behavioral Health | Direct BH Service |
| | CDHS -Office of Behavioral Health | General Adult BH |
| | CDHS -Office of Behavioral Health | Offender Services |
| | CDHS -Office of Behavioral Health | Prevention |
| | CDHS -Office of Behavioral Health | SUD |
| CDOC | CDOC | Direct BH Service |
| | CDOC - Community Services | Offender Services |
| | CDOC - Parole | Offender Services |
| | CDOC - YOS | Youth Offender Services |
| CDPHE | CDPHE | Prevention |
| CDPS | CDPS | Offender Services |
| HCPF | HCPF | Children's BH |
| | HCPF | General Adult BH |
| | HCPF | SUD |
| JUDICIAL | Judicial | Offender Services |
| | Judicial | Youth Offender Services |





Long-Term Competency Subcommittee

Goal: Phase 1: Complete a Long-Term Competency Comprehensive Plan due to the Federal Court in January 2020.

Phase 2: Construct recommendations for systemic improvements for those systems that interact with or impact the competency process

Target: Identified several key areas to which improvements can improve the competency system:

- Community-based services;
- Law-enforcement agency interactions, trainings and diversion;
- Jail-based mental health services;
- Court interactions and potential for avoiding unnecessary involvement;
- CDHS competency evaluations and restorations processes and interventions; and,
- Continuation of care after discharging from competency system.





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Mental Health Institutes

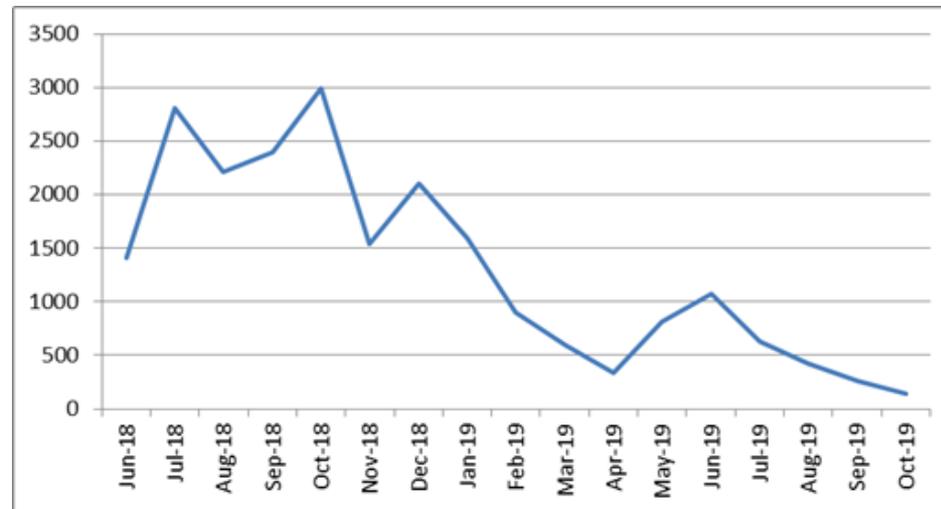
Institute Staffing
&
Institute Bed Capacity

CMHIP Staffing

Recruitment Efforts

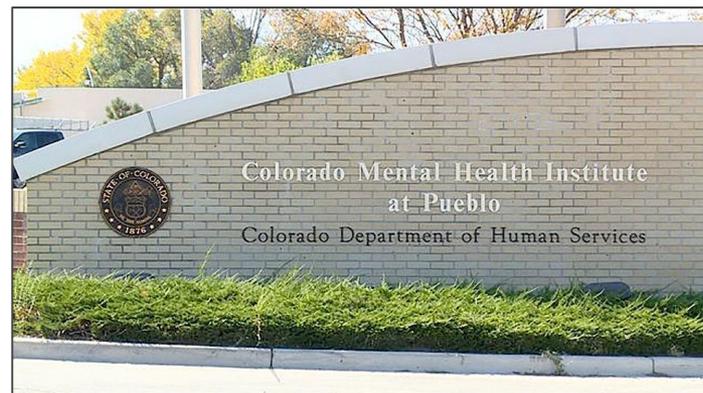
- Job fairs statewide
- Paid advertising
- 2 new Talent Acquisition Recruiters
- Continuous weekly job interviews
- Convert contract staff to state staff
- CMHIP Psychiatric Technician educ. program
- Work with Pueblo Community College
- Special out-of-state waivers

Mandatory OT Hrs/Month



Retention

- Significantly **reduced mandatory OT**
- Listening tours with staff
- Voice of the Employee (VoE) committee led by staff
- Monthly newsletters to improve communication
- Workforce manager to oversee staffing office
- Positive Management Training for supervisors



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CMHIP Staffing

New FTE Request

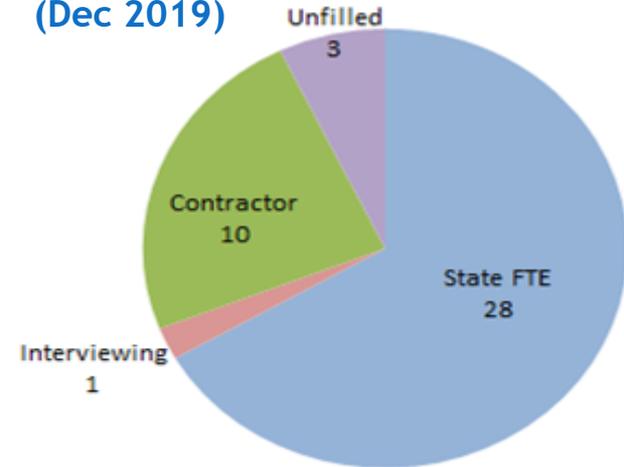
Budget Request R-4: L2 Unit @ CMHIP

- Direct Care
 - Nursing, Clinical, Dietary, Rec. Therapy, Psychology, Social Work, and Security
- Support Staff
 - Unit Admin Asst, Tech Support, Budget Analyst, HR Specialist, Pipe Mechanical Trade, and Custodian

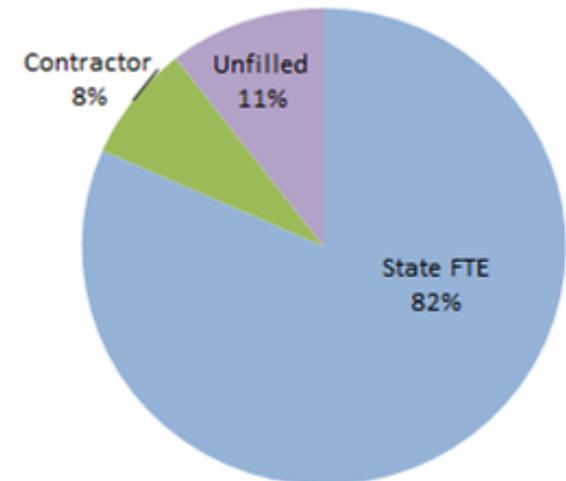
Budget Request R-18: EHR Support

- 2 hospitals & forensic services operate on a new EHR system
- Initially: Develop EHR coding to connect the various systems that contain patient related info
- Ongoing: Maintenance of EHR and manage user access
- FTE request: Developer and IT Desk Support

Renovated RNR Unit Staffing (Dec 2019)



CMHIP Direct Care Staff (571 total)



Institute Beds: Type and Capacity

Civil and Forensic Capacity by Location

| | CMHIP | CMHIFL | RISE (Arapahoe & Boulder) | Private Hospital Beds |
|---|-----------------------------------|--------|------------------------------|--------------------------|
| Civil Only | 0 | 94 | 0 | 0 |
| Multi-purpose* (civil, competency, or other forensic) | 34 (Geriatric) 20 (Adolescent) | 0 | 0 | 0 |
| Forensic Population: Competency | 244 | 0 | 114 | 7 |
| Forensic Population: Not Competency** | 197 | 0 | 0 | 0 |

Patient Type by Location in FY 18-19

| | CMHIP | CMHIFL |
|-------------------|-------|--------|
| Civil Patients | 102 | 305 |
| Forensic Patients | 970 | 10* |





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Competency

Competency Evaluations
&
Competency Restoration

Competency & Consent Decree Background

- In 2011, Disability Law Colorado (DLC) sued the State in federal court over the length of time defendants were waiting in jail to receive competency services
- In March 2019, the two parties entered into a Consent Decree via mediation.
- Consent Decree Specifics:
 - Outlines a structure of fines the Department shall pay
 - Conditions for compliance
 - Requires expansion of outpatient restoration services
 - Requires a new team of care coordinators to assist in the management of individuals' care
- From FY 2001 to FY 2019
 - 531% increase in court order evaluations
 - 1,636% increase in court order competency restorations



Competency & Consent Decree Background

Contributing Factors

- Increased awareness of
 - MH in criminal justice system
 - Ability to raise competency in court
- Insufficient intensive community-based services
- Need services to divert away from the criminal justice system

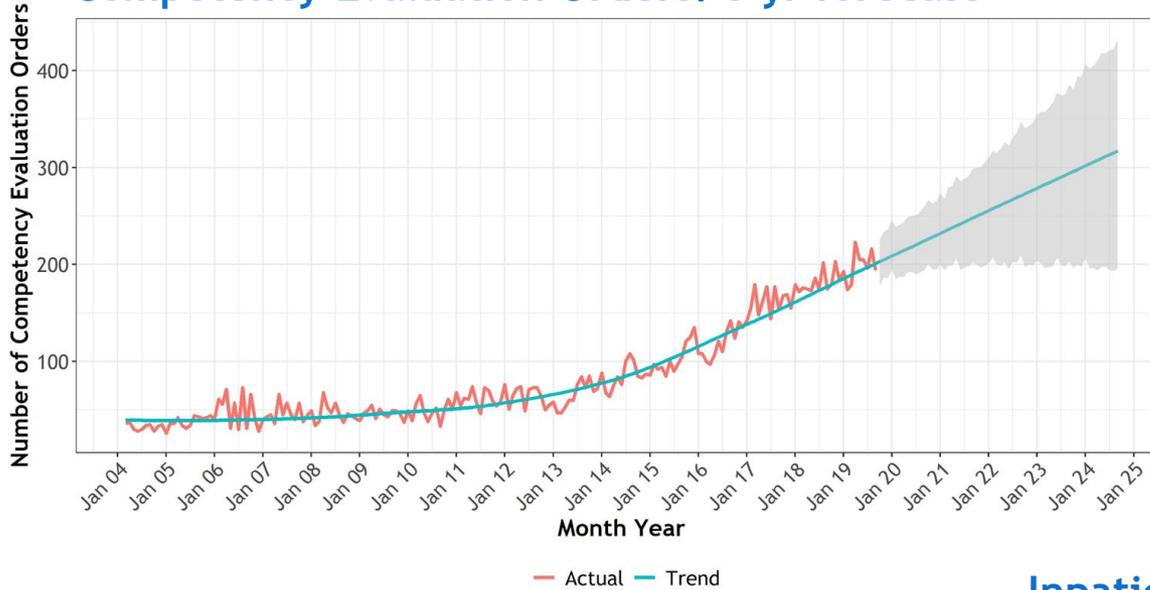
Other States

- 75% of states saw moderate to large increases (2014)
- Washington - 78% increase order for competency services (from FY13 - FY18)
- Oregon - 253% increase at hospital (from 2000 - 2019)
- Lawsuits filed in 11 states since 2003



Court Orders

Competency Evaluation Orders: 5 yr forecast



Inpatient orders by offense and acuity*

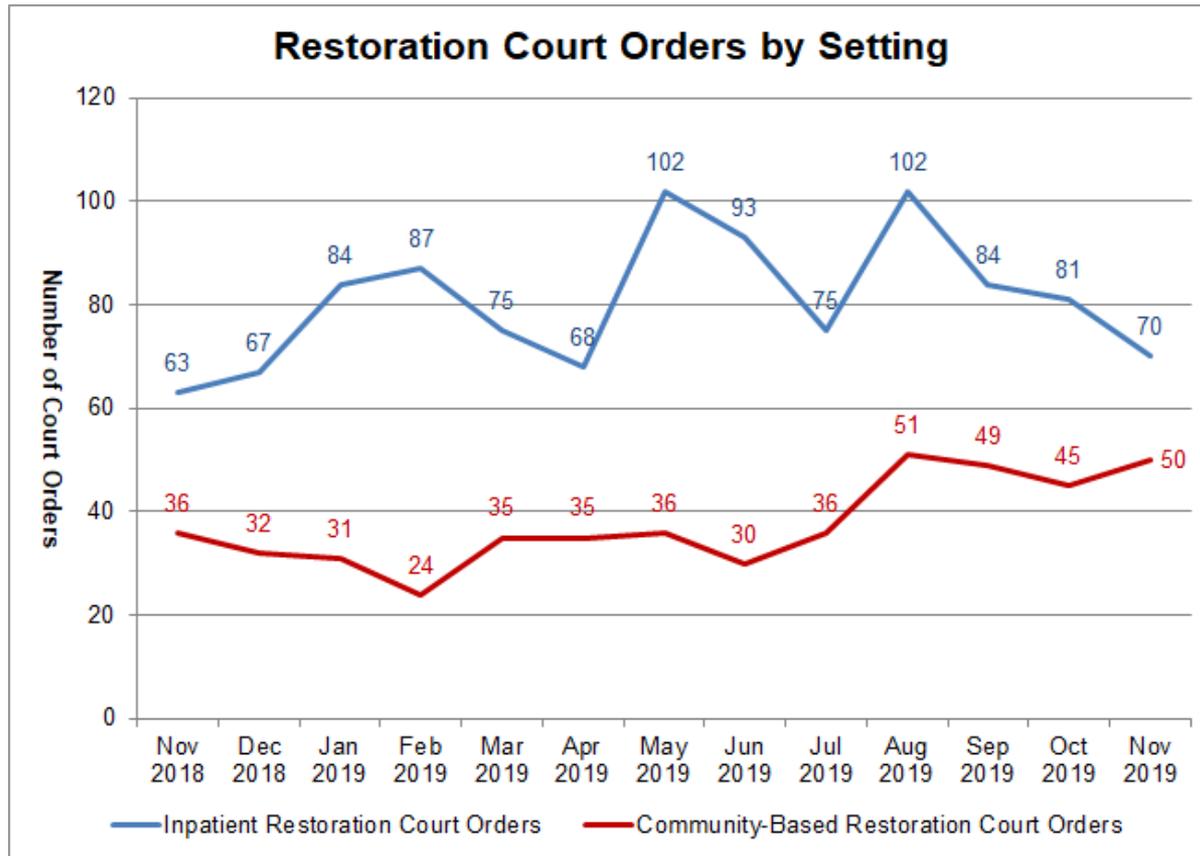
| Offense Level (low to high) | Low/Mod Acuity (lower level care) | High Acuity (hospital level care) |
|------------------------------|-----------------------------------|-----------------------------------|
| Misdemeanors, Petty, Traffic | 12% | 9% |
| Felony 5, 6 | 6% | 11% |
| Felony 4 | 19% | 23% |
| Felony 1, 2, 3 | 9% | 10% |



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* Data is a snapshot over 188 admissions in Fall 2018

Restorations Court Orders: Inpatient vs Outpatient



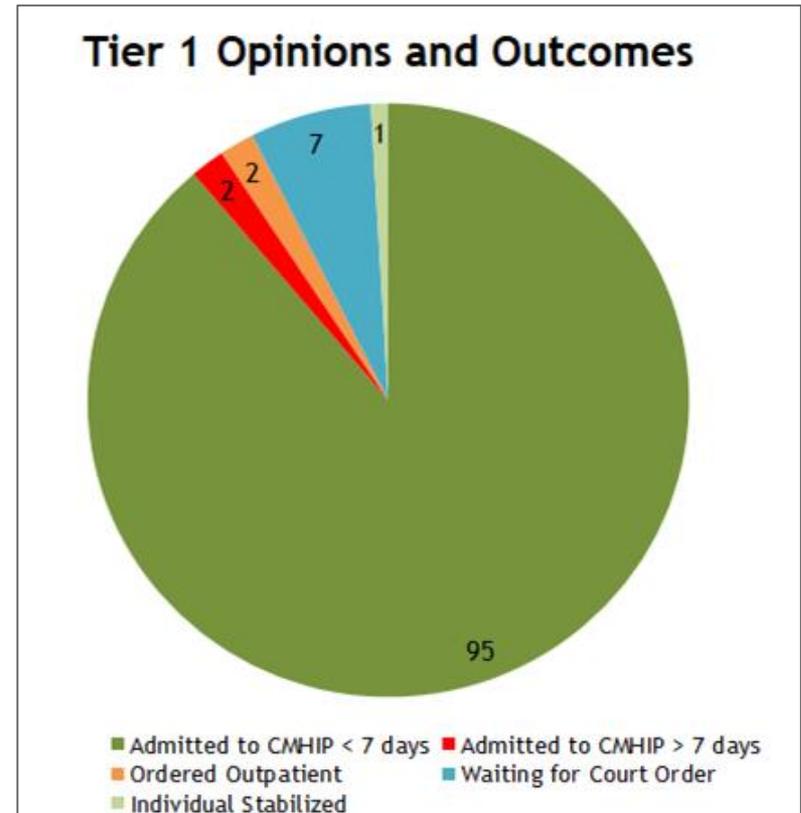
Competency Restoration Triage

Tier 1 A/B

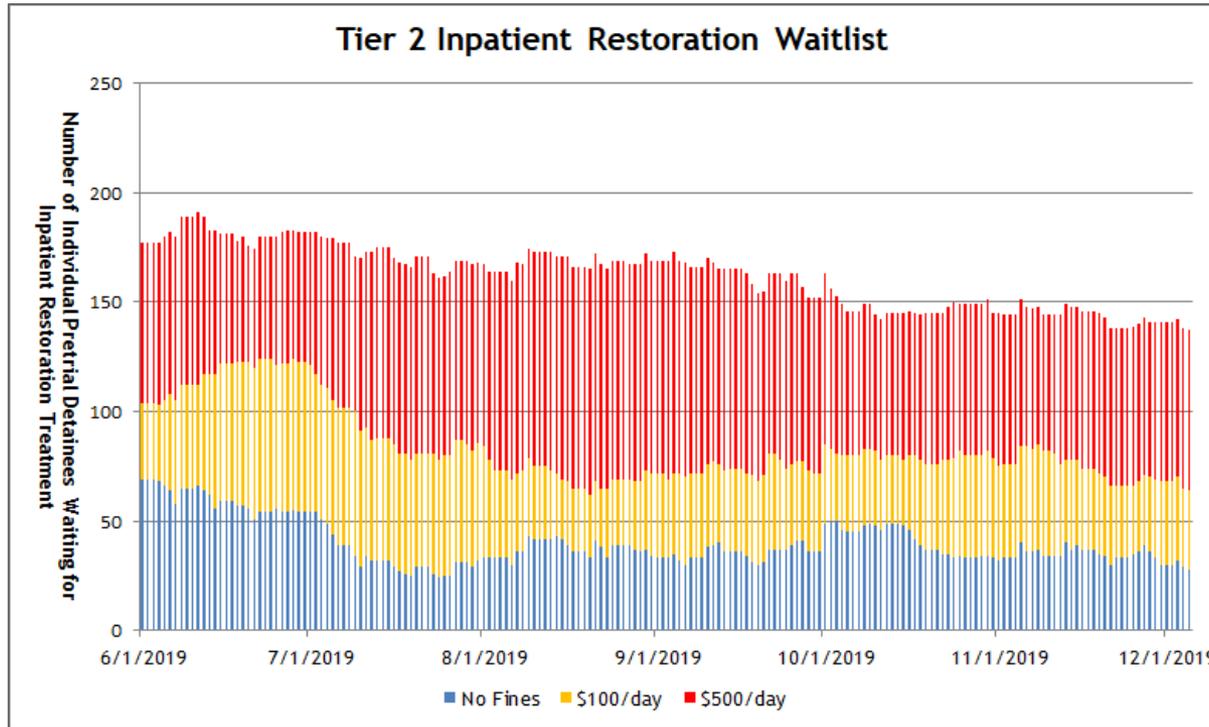
- Most acute clients to be admitted within 7 days of court order
- Most 1A are admitted under an emergency M3 hold prior to court order
- Are prioritized over Tier 2

Tier 2

- Per consent decree, should be admitted with 28 days



Fines for Competency



- \$10 Million cap per 12 months (June - May)
- Started June 2019
- Hit first \$10 Million by February 2020
- Restart June 2020
- Estimated Compliance Spring 2021



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Efforts toward Compliance: New Beds

| | | |
|-----------------------------|----|------------|
| Boulder County RISE | 18 | June 2019 |
| Peak View Hospital | 5 | Sept. 2019 |
| Peak View Hospital | 2 | Nov. 2019 |
| Denver Health Hospital | 3 | Dec. 2019 |
| CMHI-Pueblo R&R Unit | 42 | Dec. 2019 |
| CMHI-Pueblo L2 Unit | 24 | Nov. 2020 |
| CMHI-Ft Logan F2 & F3 Units | 44 | Dec. 2021 |



Efforts toward Compliance: Outpatient Restoration

- Educated 82% of Judicial Officers
- Increase # of outpatient restoration providers
 - (91% of state covered)
- Pilot: Pre-trial supervision + psychiatric care + restoration educations
- Purchased 28 housing units via Colorado Coalition for the Homeless
- Ask courts for reconsideration on low-risk and low-acuity individuals



LTC Committee Recommendations

Community Services

- Expand and enhance the crisis services system
- Enhance co-responder models, wraparound services, and intensive case management

Law Enforcement

- Stronger jail-based behavioral health services
- Expand CIT training
- Evaluate models for secured treatment settings

Court Processes

- Expansion of pre-trial supervision and case management services
- Divert people from the criminal justice system
- Potential legislation to eliminate unnecessary competency services for people determined PITP
- Potential legislation for alternatives to the competency process for those with low-level offenses

Competency Services

- Increase court orders for community restoration.
- Enhance outpatient restoration treatment and support services array (i.e., housing, transportation)
- Expand Denver Pilot for Comprehensive Community Restoration Program
- Explore less restrictive state administered residential services

Discharge

- Enhance community treatment and case management services when exiting competency system



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Office of Behavioral Health

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