DEPARTMENT OF HUMAN SERVICES
(Behavioral Health Services[1])

FY 2015-16 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 16, 2014
2:00 – 4:00 pm

2:00-2:10 INTRODUCTIONS AND OPENING COMMENTS

2:10-2:20 BEHAVIORAL HEALTH SYSTEM STUDY

Study to Assess the Current and Future Behavioral Health Needs of State

1. **How much will the Department spend for the study, and what source(s) of funding are being used to cover these costs?**

   The contracted amount is $339,924 and the source of funding is from the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. The Federal SAPT Block grant application guidance requests states to identify the "needs and gaps of the populations relevant to Block Grant within the State's behavioral health care system."

2. **What role, if any, has the General Assembly played in the Department's decision to conduct this study?**

   In the JBC briefing document the Department received for the Office of Behavioral Health's FY 2014-15 Joint Budget Committee Hearing on Tuesday, December 17, 2013, the Committee asked the Department the following question:

   "Please discuss the need for psychiatric inpatient care in Colorado and the availability of such services..."

   As part of the Department's written responses to the question(s) the Department informed the committee, "The Department will conduct a study that will strategically guide CDHS in its future planning over the next decade. This study will accomplish a number of goals including, but not limited to, providing an inventory of existing state and community resources including inpatient psychiatric beds."

3. **Describe the scope of the study and the anticipated outcomes. Please includes responses that specifically address the following questions:**

   The study commissioned by the Department will help guide the Office of Behavioral Health in its strategic future planning over the next decade. This study will accomplish a number of tasks, including, but not limited to:

[1] This section of the budget includes: Community behavioral health administration; Mental health community programs; Substance use treatment and prevention; Integrated behavioral health services; and the Mental Health Institutes.

1. Provide an inventory of existing state and community resources relevant to the current services provided by the Department, identifying the existing continuum of care bridging state and community resources.

2. Identify existing service gaps in this continuum of care, including service gaps related to other payer sources, such as Medicaid, Medicare and other third-party payers such as private insurance carriers.

3. Evaluate the degree to which Colorado sentencing reforms related to drug possession have and will expand the need for mental health, substance, and co-occurring disorders services.

4. Identify to what degree peer mentors, recovery coaches, and family advocates are currently being used in the provision of behavioral health care services in Colorado.

5. Provide recommendations as how to best align existing resources with future planning, so as to strategically maximize state resources.

6. Anticipate the system effects of the State's infusion of thirty million dollars into the behavioral health system as specified in the Governor's Strengthening Behavioral Health Plan comprising:

a. Establishing an Integrated State-wide Crisis Response System
b. Improved Community Capacity
c. Increasing Access to Mental Health Institute Civil Beds
d. Enhancement of Behavioral Health Services Data Collection System
e. Modernizing Treatment Services at the Colorado Mental Health Institutes

7. Assess the degree to which current system resources effectively serve specific populations in need, e.g. Adult, Geriatric, Dementia, Traumatic Brain Injuries (TBI), Indigent, Severely and Persistently Mentally Ill (SPMI). Additionally, the study will address child and adolescent behavioral health services including its connection with child welfare, juvenile justice, and education.

8. Anticipate the effects of demographic-specific variables, (e.g. growing elderly populations, Hispanic and other minority population growth) on services offered by the Office of Behavioral Health.

9. Provide recommendations as to the most efficient and cost-effective approach to securing services for clients who are both mentally ill and physically compromised.

10. Analyze the projected impact of court-ordered evaluation and competency restorations on civil bed availability at the CO Mental Health Institutes.

11. Assess the need for both civil and forensic beds at the CO Mental Health Institutes (CMHIP, CMHIFL), considering existing and projected wait lists, behavioral health clients in Emergency Departments, community need (e.g. underserved, unserved, homeless) and other factors relevant to the provision of state inpatient beds. Utilizing a

data-based research approach, provide specific recommendations as to the projected number and type (civil/forensic) of inpatient beds required to meet both the current need and the need for state inpatient beds over the next decade.

12. Review and analyze national models and trends with regard to Olmstead considerations in the provision of state psychiatric beds.

13. Utilizing geographical boundaries congruent with Regional Care Collaborative Organization (RCCO), analyze the recommended distribution of services in rural, frontier, tribal communities, and urban population centers.

14. In concert with national trends, identify strategies for integrating behavioral health and physical health care (Whole Health Integration).

15. Identify opportunities and strategies in the field of tele-medicine/tele-health to enhance the delivery of services and maximize financial and staffing resources.

16. Analyze and project the effect(s) of marijuana legalization on the behavioral health needs of Colorado citizens. If warranted, provide recommendations for increased prevention, treatment, and recovery services. Similarly, address the above in the context of prescription drug abuse.

17. Access to safe housing and competitive employment for persons with behavioral health needs remains a significant challenge in Colorado. What successful national model(s) to enhance recovery for the people served in the behavioral health system might OBH adopt?

a. **Will the study evaluate the needs for both mental health and substance use disorder services and the capacity to provide such services?**

   Yes, the study will evaluate both mental health and substance use disorder treatment needs and capacity.

b. **Will the study consider recent changes in the Medicaid benefit for substance use disorder services and recent increases in state funding for substance use disorder treatment services for offender**s?

   Yes, the study will consider recent changes in the Medicaid benefit for substance use disorder services and recent increases in state funding for substance use disorder treatment services for offenders.

c. **Explain the nature of the study objective that concerns evaluating the "degree to which Colorado sentencing reforms related to drug possession have and will expand the need for mental health, substance, and co-occurring disorder services".**

The Department sought to assess the impact that the recent progressive sentencing reform would have on the amount of people in the community referred for mental health, substance use disorder and co-occurring treatment. The Department also wished to learn if the additional funds that have been added to support those individuals through the same sentencing reform legislation are adequately meeting the demand.

2:20-3:00 MENTAL HEALTH INSTITUTES

(R1) New Mental Health Institute Treatment Unit

4. **Describe the process that occurs when patients are transferred from the Colorado Mental Health Institute at Pueblo (CMHIP) to a Department of Corrections (DOC) facility pursuant to Section 17-23-103, C.R.S., and when inmates are transferred from a DOC facility to the CMHIP pursuant to Section 17-23-101, C.R.S.**
   a. **Does the transfer process involve negotiations, a contract, or a memorandum of understanding between the two departments?**

   The Department and the DOC have a memorandum of understanding (MOU), with the last signed copy dated 2006. The Departments are in the process of updating the MOU, with the document currently being reviewed by DOC.

   Transfer process for a CMHIP/CMHFL patient to DOC:
   When a patient is identified as being "so dangerous that he cannot be safely confined" at CMHIP or Colorado Mental Health Institute at Fort Logan, the case is presented to the Executive Committee of CMHIP. The Executive Committee (EC) is comprised of the Hospital Superintendent, Assistant Superintendent for Clinical Services, Assistant Superintendent of Administrative Services, Chief of Medical Staff, Director of Nursing, Director of Quality Support Services. Also in attendance, but not part of EC is the Chief of Psychiatry and the Medical Staff President.

   If the Executive Committee of CMHIP agrees to proceed, the facts and evidence that the patient is, indeed, too dangerous to maintain at CMHIP, are presented to the Attorney General's Office. Upon their concurrence, a hearing commences. Written notice of the facts upon which the allegations of dangerousness are based is provided to the patient and his/her representative. The DOC is notified of the potential transfer and the scheduled date of the hearing. The hearing committee includes a Judge, Psychiatrist, Psychologist and/or a Nurse.

   The committee and the patient's attorney are presented the evidence, which is presented by the Attorney General's Office. The patient, through his/her attorney, is allowed to present witnesses. Upon completion of the hearing, if the committee finds that the patient should be transferred to DOC, the Superintendent of CMHIP prepares an Executive Transfer Order which is then signed by the Executive Directors of the Department and

DOC. The order, along with a package outlining the facts and the decision is sent to DOC.

Transfer process for a DOC inmate to CMHIP:
Pursuant to 17-23-101 C.R.S. (2014), the MOU between the two departments, the following process occurs when transferring an inmate from DOC to a DHS program. The DOC liaison contacts the CMHIP Admission Program Director who, in coordination with the CMHIP Director of Admissions arranges intake upon bed availability and to medically clear the patient. The DOC issues an Executive Order and the inmate is transferred to CMHIP.

b. **Does the transferring department make any payments when transferring an individual, or do the costs of caring for the transferred individual become the responsibility of the receiving department?**

The transferring department (in both instances) does not make any payments when transferring an individual to the receiving department.

5. **The Department has indicated that it determined that the practice of transferring patients to DOC facilities is unacceptable and is potentially a violation of these individuals' civil rights. Did the Attorney General's Office or the courts play a role in analyzing the legal aspects of such transfers? If not, how did the Department reach this conclusion?**

Yes, we did consult with the Attorney General's Office in our legal analysis. The courts were not involved in the analysis.

6. **Describe the Department's current position concerning which agency should be caring for the mentally ill individuals who are eligible for transfers pursuant to the above-referenced statutory provisions.**

The Department believes that a person eligible for transfers should be treated in a secure hospital setting with sufficient staffing and facilities in an environment that is safe for patients and staff.

7. **What factors have been considered in the past when determining that a patient is dangerous enough to be transferred from CMHIP to a DOC facility pursuant to Section 17-23-103, C.R.S.? Have these patients committed acts while at CMHIP that could be charged as a crime?**

The transfer to DOC of civil patients (unsentenced) pursuant to Sections 17-23-101(3) C.R.S. (2014) and 17-23-103 C.R.S (2014) is reserved for those exceptional circumstances in which an individual suffers from a significant psychiatric illness and is prone to extreme acts of repetitive violence towards others. All of the patients transferred to DOC under this statutory provision have engaged in serious physical assaults against other patients and staff, and their presence on the units has had detrimental effects on the therapeutic milieu. In the absence of an environment secure enough to safely manage these patients at CMHIP, transfer to DOC was necessary to provide treatment in a sufficiently secure and contained setting.

Although these patients have committed acts while at CMHIP that could be and are charged as crimes, all of them have significant cognitive impairment and severe and persistent psychiatric symptoms that render them permanently incompetent to stand trial.

8. **How has the return of five patients previously transferred from the CMHIP to DOC affected existing CMHIP operations? Please includes responses that specifically address the following questions:**

   a. **How has the transfer affected the total number of patients receiving treatment at CMHIP?**

      The census at CMHIP is unchanged. Due to the small, specialized nature of this unit, patient flow is not affected on any other units of CMHIP. However, the overall length of time patients are on this new unit will be affected, as these individuals will require a longer length of stay and require significant treatment and oversight.

   b. **How has the transfer affected the required CMHIP staffing levels for FY 2014-15?**

      The Department increased staffing at CMHIP for this new unit as a result of the transfers. In order to provide a safe and secure treatment environment, additional staff were required.

   c. **How has the transfer affected staff safety? Have any staff been injured by any of the five patients who were recently transferred or as a result of such transfers?**

      The Department took careful consideration when analyzing the staffing need for this new unit. However, due to the highly acute and assaultive nature of the patient population on this unit, there have been multiple incidents. Since the CMHIP patients returned from DOC in October 2014, there have been nine acts of aggression reported (menacing, physical assault, etc), and two patient-to-staff assaults. One patient head butted a staff member, the other threw items, kicked, spit and pulled on the officer's clothes. These behaviors further illustrate the need for higher level staffing and specialized treatment. No severe injuries have been incurred by staff or patients to date.

      While there have been incidents on this unit, without the intensive treatment and appropriate staffing levels, the number of incidents would undoubtedly be higher, placing both patients and staff at risk.

9. **How many DOC inmates are currently being treated at CMHIP?**

   Currently, there is one DOC patient being treated at CMHIP for restoration to competency to stand trial.

10. **Explain the staffing assumptions that underlie this request, including the proposal to add a full-time psychologist and a half-time psychiatrist.**

    The Department took careful consideration when evaluating the staffing needs to return these patients from DOC. Two primary factors drove the need for high staffing ratios. One factor is

the very high acuity level of the patients specifically, their propensity for repeated and severe violence. The second factor is the limited suitability of the physical space at CMHIP.

The Department converted an existing unit known as E2 to be used for this program. The space needed to be significantly reinforced (hardened). Examples of this included:

- Cameras and audio equipment were installed in patient rooms which are wired back to the central nursing station;
- A fully padded room was designed for individuals in the midst of a total psychotic state to deescalate;
- Doors on patient rooms were modified for a pass through tray slot

Even with these modifications, some infrastructure challenges could not be overcome. For instance, the rooms were not equipped with toilets. The common space and hallways were not ideal. Because of limitations such as these, additional staffing was required to ensure that patients and staff were safe at all times.

The staffing assumptions that underlie the request include four public safety officers, two nursing staff, and one staff to monitor the cameras on <u>each</u> shift. In addition to the nurses, the treatment team includes a full time psychologist and a part-time contract psychiatrist. The primary focus of this team will be to create a safe and secure unit conducive to treatment.

The staffing requirements for the new unit are reflective of the Institutes not being able to utilize security resources the DOC can use. The DOC can utilize a variety of security resources and tools to address violent behaviors that are not permitted at CMHIP, as mandated in part by the Centers for Medicare and Medicaid (CMS). Such tools include the use of pressure point control tactics (PPCT), oleoresin capsicum (OC)/pepper spray, forced cell entry, and steel cuffs. In lieu of using techniques such as PPCT or OC spray, individual behavior management plans for each of the five individuals were carefully developed, and the unit is appropriately staffed for a safe environment conducive for treatment. Two public safety officers are required to escort patients anywhere on the unit, including the restroom. Meanwhile security must be maintained for the other patients.

Nursing staff provide medical care, psychiatric nursing care, administration of medications/treatments, on-site treatment, therapy groups, one-to-one therapy, monitoring of patient care/advocacy, and 24-hour nursing services. The nursing staff are also responsible for the coordination of care, utilizing the nursing process in the provision of nursing care, performance standards, health assessments, nursing plan of care, quality assurance/quality improvement activities, nursing education, supervision of nursing staff, communication of psychiatric needs, documentation in medical charts, and oversight of the patient’s medical conditions.

The acuity of these patients and the intense demands of their medical care requires significantly greater than normal levels of nursing care. It is very similar to an intensive care unit in a hospital. In an ICU there are typically fewer patients who are very ill and require significant oversight and monitoring. ICUs have a higher staff level to adequately meet labor

and resource intensive needs of the population.

The psychologist formulates individualized treatment plans that assess and identify specific risks and interventions to address violent behaviors and treatment needs. Patients are in programmed treatment from 8:00 a.m. to 8:00 p.m. everyday. Due to the risk for violent behaviors and the lack of correctional tools (such as OC spray), all members of the treatment team participate in ensuring a safe and therapeutic environment. This includes evaluation, monitoring of mental health symptoms and violent behaviors, developing and maintaining quality therapeutic relationships, and creating an environment sensitive to trauma-related histories.

The part time psychiatrist provides continuous medical evaluations and treatment as well as pharmacologic expertise. More crucially, the psychiatrist provides timely crisis management by providing consultation to the treatment team and emergency medication as required. The part time psychiatrist is also required to: evaluate and direct each seclusion and restraint episode, prepare for court testimony; review and present Intractable Injurious Behavior Plan (IIBP) requests; consult with the psychologist regarding behavioral treatment programming; manage special requests for diet, recreation, restrictions and privileges; lead plan of care reviews; order Rights Restrictions; and be available to manage emergencies. The part time psychiatrist is part of the dedicated treatment team that will work specifically with the population on this unit.

11. **If the Department has not yet determined whether additional funding is needed to cover the associated expenditures for FY 2014-15, why is the Department certain that it requires additional funding for this purpose for FY 2015-16?**

    The Department intends to submit a supplemental funding request for FY 2014-15, and is in the process of finalizing the calculations.

12. **Did the Department consider utilizing the CMHIP building that houses the Circle Program to create the new security-enhanced treatment unit? Did the Department consider utilizing any other CMHIP buildings that include restrooms in each patient room to avoid the need for extra security staff to escort patients for restroom breaks?**

    The Department did consider other patient treatment areas on the CMHIP campus, including the building that houses the Circle Program. The High Security Forensic Institute (HSFI) building was the safest, most secure option, the most conducive for patient treatment, required the shortest amount of renovation time, and the lowest renovation costs.

    The building that houses the Circle program was designed as a 20-bed secure juvenile mental health facility. It is not as hardened as the HSFI building and would have required building modifications to harden the doors, walls, windows, flooring and security monitoring system. Additionally the building that houses the Circle Program does not have individual restrooms within the patient rooms, so the staffing requirement would have remained similarly high.

    An additional location was considered on the CMHIP campus that does have individual bathrooms within the rooms; the closed Medical Surgical Unit ("Med-Surg") unit. The Med-Surg unit was closed as part of the state budget reductions in 2009. In order to utilize this

space for the patients returning from DOC, extensive and lengthy renovations would have been required. Such renovations would have included renovating the restrooms to mitigate suicide risks, abatement, address the air management equipment that is accessible in each patient room, address the gas systems within the walls, and replace doors, just to name a few. Preliminary estimates for renovations to Med-Surg exceeded $2.8M. While this location would have provided private restrooms in each patient room, the isolated location of this unit within CMHIP would have presented additional safety and security risks that would not have reduced the number of staff. The Med-Surg location does not have perimeter security or a master control security system. Additionally, this area is not conducive to treatment as it does not have a day hall or other common areas for the patients to attend group programming.

Most importantly, the utilization of the unit at HSFI, is a short-term solution, and a more appropriate long-term solution will be evaluated and appropriate funding requested.

13. **Explain how the care and treatment that these five patients are receiving at CMHIP differs from the care they received at DOC's San Carlos facility, and why CMHIP care is viewed as an improvement.**

Prior to the transfer of the patients back to CMHIP, the Department designed a customized treatment approach for them. The patients receive treatment programming from 8:00 am to 8:00 pm everyday, including specialized treatment including a combination of Dialectic Behavior Treatment (DBT) to address mindfulness, emotional regulation and distress tolerance, as well as Anger Management group therapy. Patients are also encouraged to engage in treatment activities that enhance their social skills and help them with general self-regulation. As patients are demonstrating safer behavior, biofeedback is offered as well. The above services were not provided while the patients were at DOC. CMHIP programming provides access to outdoor activities, enhanced socialization and a general quality of living than could be provided to them in a correctional setting, all of which should enhance their treatment progress.

At DOC, the patients were receiving ten hours of group therapy per week and one hour of recreational time.

14. **Why has the Department elected to move forward with this policy change and to commit the necessary resources to create and staff the new security-enhanced treatment unit before the behavioral health system study is completed and before the General Assembly has had an opportunity to evaluate the fiscal and statewide implications of the policy change?**

The Department of Corrections (DOC) and the Department, in consultation with the Governor's Office, reviewed the practice of transferring individuals from CMHIP to San Carlos Correctional facility pursuant to 17-23-103 C.R.S. (2014). It was determined that these transfers were not in the best interest of the clients we serve and potentially a violation of these individuals' civil rights. Through our research, Colorado was in a very small minority of states that allowed this practice. The parties also agreed that it was of utmost importance for the individuals at San Carlos to be transferred back to the Mental Health Institutes as they have not been criminally convicted or sentenced. While their due process rights were

protected based on the statutory authority for the transfer at 17-23-103 C.R.S. (2014), the transfers could have resulted in a lawsuit against the State. The potential violation of these individual's civil rights coupled with the risk of civil action against the State created an environment that necessitated urgent action.

15. **How does this policy change relate to recent policy changes within the DOC concerning administrative segregation?**

The following response was provided by the Department of Corrections.

The CDOC Administrative Segregation reform efforts included significant policy revisions to AR 650-03 (Restrictive Housing) and 600-09 (Management of Close Custody Offenders). These policies were revised and developed to establish and provide effective restrictive housing management procedures for CDOC offenders who have demonstrated through their behavior that they pose a significant risk to the safety and security of staff and other offenders, as well as to the safe and orderly operation of general population facilities. The use of Restrictive Housing Maximum Security Status is an offender management process requiring specific action and review for placement and/or progression.

3:00-3:15 BREAK

3:15-3:35 MENTAL HEALTH INSTITUTES (CONTINUED)

<u>Capacity-related Questions</u>

16. **Provide data concerning the actual number of patients receiving services at the CMHIP and at the Colorado Mental Health Institute at Fort Logan (CMHIFL). Please include data for FY 2013-14 and for November 2014 (or the most recent month for which data is available), and separately identify forensic and civil patients.**

The numbers of individuals that received inpatient services at the Colorado Mental Health Institutes at Pueblo and Fort Logan are shown below, during both FY 2013-14 and in the month of November 2014. Included are individuals that were present at the start of each time period and admitted during the time period.

Table 1.
Individuals that Received Inpatient Services at the Mental Health Institutes, FY 2013-14

Institute	Forensic Individuals Served	Civil Individuals Served	Total Individuals Served
Colorado Mental Health Institute at Pueblo	876	567	1,443
Colorado Mental Health Institute at Fort Logan	13	515	528
Total	889	1,082	1,971

Table 2.
Individuals that Received Inpatient Services at the Mental Health Institutes, November 2014

Institute	Forensic Individuals Served	Civil Individuals Served	Total Individuals Served
Colorado Mental Health Institute at Pueblo	378	108	486
Colorado Mental Health Institute at Fort Logan	3	128	131
Total	381	236	617

17. **Provide trend data concerning the number of individuals requiring court-ordered psychiatric evaluations to determine competency, as well as the number of individuals requiring competency restoration services. Please discuss whether the Department has been successful in reducing the number of offenders in jail who are waiting to receive such services, or in reducing the average wait time.**

    The table and figure below are reflective of the trend data which identifies the number of individuals ordered by the Colorado courts each fiscal year for inpatient competency evaluations and restorations. The data illustrates the numbers have been increasing steadily in recent years. Please note that that the projections for the current fiscal year are based on the rate of court referrals reported as of November 11 (i.e., straight-line projection as of 11/11/2014), and projections for the later fiscal years are based upon the addition of the average change over the last 10 complete fiscal years.

Figure 1

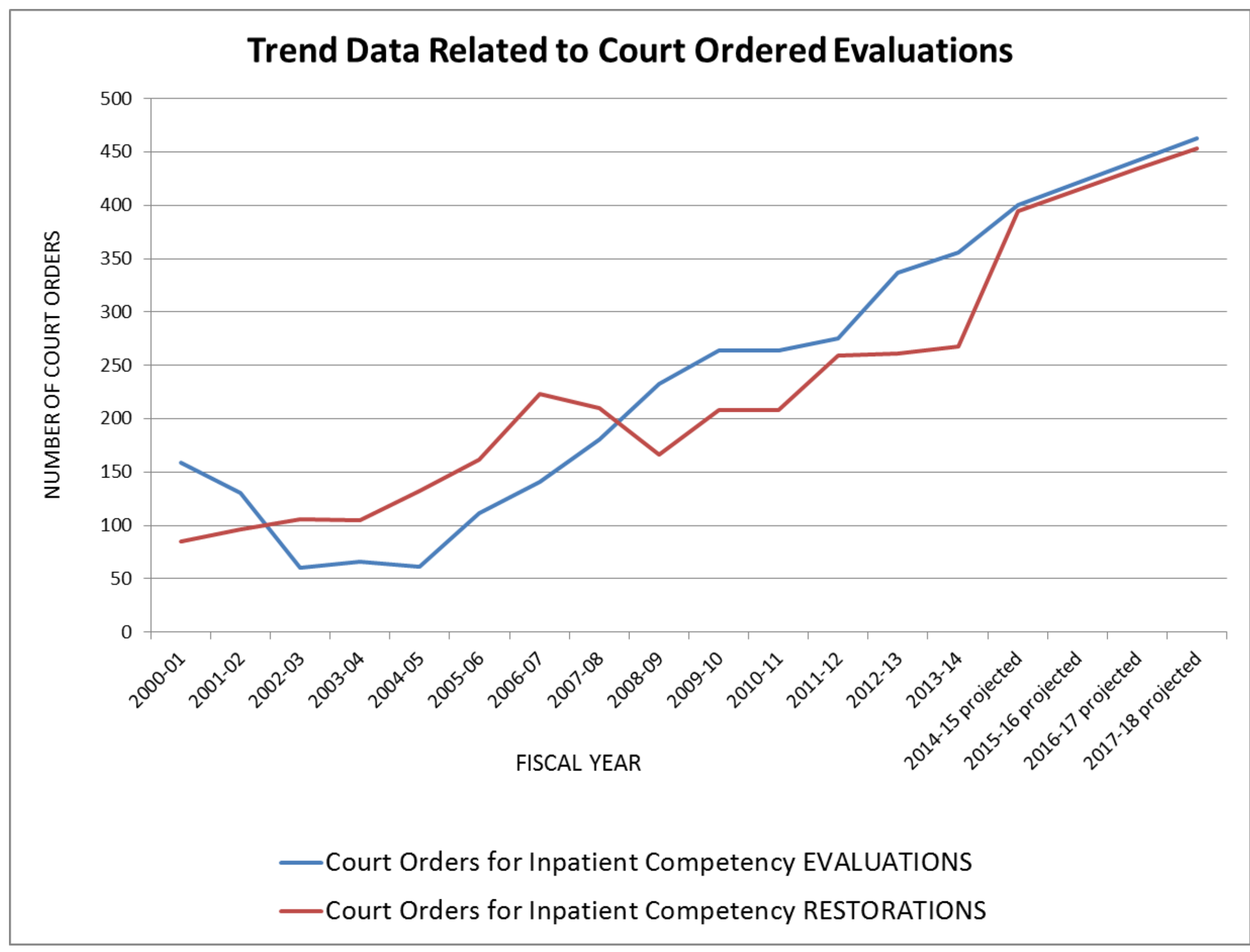


Table 3.

Trend Data Related to Court Ordered Evaluations

Fiscal Year (FY)	Court Orders for Inpatient Competency Evaluations	Court Orders for Inpatient Competency Restorations
FY 2000-01	159	85
FY 2001-02	130	96
FY 2002-03	60	106
FY 2003-04	66	105
FY 2004-05	61	132
FY 2005-06	111	162
FY 2006-07	141	223
FY2007-08	181	210
FY 2008-09	233	166
FY 2009-10	264	208
FY 2010-11	264	208
FY 2011-12	275	259
FY 2012-13	337	261
FY 2013-14	356	268
FY 2014-15 projected	*400*	*395*
FY 2015-16 projected	*421*	*414*
FY 2016-17 projected	*442*	*434*
FY 2017-18 projected	*463*	*453*

The Department has been very successful at reducing the number of offenders waiting in jail for competency evaluation services as well as competency and restoration services. In our court ordered settlement agreement, the Department must serve an offender within 28 days from receiving the information packet from the court. Since the settlement went into effect in July 2012, no one has exceeded the court ordered wait time. For FY 2013-14, the average length of wait time for Incompetent To Proceed 13.88.

Table 4.

Number of Days for Current Wait List - Those Awaiting Admission (in jail), and Ordered Admitted to the Department for Competency Evaluation or Competency Restoration, as of December 12, 2014

Type of Order	Current Days Waiting				Settlement Limit for Days Waiting
	Number	Average	Minimum	Maximum	
Ordered for Inpatient Competency Evaluation	10	11.8	3	16	28
Ordered for Inpatient Competency Restoration	8	13.9	8	21	28
Ordered for Outpatient Competency Evaluation	43	14.2	2	25	30

18. **What is the capacity of the 17 community mental health centers given current funding levels? Do the centers have an ability to provide services for additional patients transitioning from the Mental Health Institutes?**

    The Department does not currently have the information necessary to assess the capacity. The Department regulatory purview does not address private non-profit Community Mental Health Center's (CMHCs) staffing or physical capacity. The Office of Behavioral Health's Needs Analysis on Current Status, Strategic Positioning, and Future Planning will address the State's Behavioral Health System capacity and service gaps. This study will include input from the State's seventeen Community Mental Health Centers. The study should be available April 2015.

    Through the Governor's Strengthening Behavioral Health budget package and subsequent budgetary approval by the General Assembly, the seventeen Community Mental Health Centers collectively received $4,048,711 for the provision of Assertive Community Treatment (ACT) team capacity. This initiative added high-intensity behavioral health service capacity staff (60 FTE) and operating costs to address long-term needs clients which transition from the Mental Health Institutes back into the community or clients which are at risk of rehospitalization. As of December 12, 2014, there have been 319 clients added to these new ACT team caseloads.

    While Community Mental Health Centers have capacity for additional patients transitioning from the Mental Health Institutes, the Governor's Plan also provided resources which the Department used to establish a new initiative called "Money Follows the Individual." This initiative, which was established November 2014, provides enhanced services and supports for people clinically ready to move to the community, but who have a higher level of need than can be met by the current CMHC contracted services.

(R13) Circle Program

19. **Why is the Department requesting funding to contract with an outside agency to conduct a business model analysis for the Circle Program? Given the Department's involvement in licensure activities, why doesn't the Department have the internal resources and expertise to conduct such an analysis?**

    The Department is requesting funding to contract with an outside agency to conduct a business model analysis and efficacy study of the Circle Program in order to provide an external, specialized, and unbiased review. With the expansion of benefits for substance use treatment disorders through the Affordable Care Act (ACA), and the interest of expanding the Circle Program to other areas of the state, an external unbiased review by a contractor with specialized expertise will allow the Department to analyze the program, evaluate expansion, and consider potential options that may allow the Circle Program to access additional revenue sources. While the Department has involvement in some licensure activities, it does not have the internal resources to conduct an analysis of this scope, as it involves more than licensing.

20. **Describe what is meant by potentially operating the Circle Program as an "autonomous" program, separate from the CMHIP. What is the Department's long-term objective with respect to the Circle Program?**

    As an inpatient psychiatric hospital, CMHIP is an Institute for Mental Disease (IMD). Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds, whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64, referred to as the IMD exclusion. As a State operated program on the CMHIP campus, the Circle Program is classified as an Institution for Mental Diseases (IMD), which limits the ability to receive revenue from public (Medicaid) and private insurance. The cost of the Circle Program is approximately $2 million annually with General Fund supporting approximately 87% of the costs since FY 2003-04. The balance of the funding is 12% Cash Funds and 1% Reappropriated Funds.

    We wish to explore a business model in which the Circle Program operates separately from the Department (autonomous), thus possibly eliminating its designation as an IMD, allowing potentially expanded access to additional revenue sources. Further, being under the State's purview may limit this program's ability to meet the demand represented throughout the state and suppresses other private providers that may also wish to meet this service need. The Department's long-term objective is to maximize opportunities for increased availability of effective substance use disorder treatment.

R14 (Institute equipment replacement)

21. **Please explain why this request includes $800,000 for the Department to install an intercom system at CMHIFL and replace the existing intercom system at CMHIP. Why hasn't the Department submitted these requests through the capital development budget process so that these facility-related issues can be prioritized among other state facility controlled maintenance needs?**

    The request was made as an operating request as it is consistent with the definition of capital outlay as included in the Office of State Planning and Budgeting FY 2015-16 Budget Instructions. The Executive Branch Capital Construction and Information Technology submission instructions, page 4, define capital outlay as "minor construction, renovation, or routine maintenance, and smaller information technology projects" The intercom systems requested are two separate projects, one at each Institute.

22. **What process does the Department use each year to identify Institute equipment and maintenance needs? What process does the Department use to then prioritize and allocate existing appropriations for operating expenses to address Institute needs as well as the needs of other Department facilities?**

    Across the Department, each Facility Director for all facilities (State Hospitals, Community Living Centers, Youth Corrections facilities, Regional Centers) is responsible to identify the equipment and maintenance needs for their facilities in conjunction with the Division of Facility Management (DFM). Prioritizations are made locally and directors are expected to fund most equipment and maintenance costs within their operating budgets. Those equipment and maintenance costs that require additional resources are submitted at the Department level and prioritized across all Department needs. Factors for this prioritization include safety of patients and staff, programmatic or treatment needs, costs, funding sources, administrative effectiveness, and therapeutic and homelike environment, among others.

    The Mental Health Institutes review equipment and maintenance needs annually and replace equipment and makes minor renovations as each hospital (Pueblo and Fort Logan) operating budget allows. Safety and security of patients and staff are primary considerations. With a limited operating budget, the Institutes must address urgent situations immediately. For example, a patient recently broke two sprinkler heads in two separate locations at CMHIP causing extensive flooding. When a patient damages property or a security risk is identified, the costs can be extensive. As a result, equipment identified for replacement or minor renovations are often delayed in order to address more immediate needs. Programmatic and hospital specific equipment (such as lab equipment), and maintenance needs (such as renovating a treatment area), are not funded through the Division of Facilities Management, as they fund facility and maintenance needs specific to the infrastructure of the hospitals.

    The Division of Facilities Management, funded through the Office of Operations line, provides building and infrastructure maintenance, grounds and housekeeping services for the Department Facilities through the operating expenses appropriation. DFM District Managers coordinate Department facility equipment and maintenance needs that will be funded through the existing Office of Operations operating expenses appropriation as the budget will allow.

3:35-4:00 OTHER TOPICS

Implementation of S.B. 14-215

23. **What factors did the Department consider when deciding which programs should continue to be supported by marijuana tax revenues in FY 2015-16? Specifically, why is the Department proposing continuing MTCF allocations for the Circle program and the Tony Grampsas Youth Services Program, and eliminating allocations for jail-based behavioral health services, substance use disorder treatment services for adolescents and pregnant women, and S.B. 91-94 programs?**

    In consideration of funding decisions to be supported by marijuana tax revenues in FY 2015-16, the Department worked closely with the Governor's Office of Marijuana Coordination, partner agencies, and other stakeholders to prioritize a wide variety of programming that had a direct nexus to impacts of marijuana legalization. Protecting and promoting public health and safe, responsible adult use of marijuana is one of the administration's top priorities, reflected in both the FY 2014-15 and FY 2015-16 marijuana tax revenue allocations.

    After setting aside portions of available revenue for current obligations from the Marijuana Tax Cash Fund (MTCF), the revenue forecasted to be available for additional spending in FY 2015-16 is close to $6 million less than what was assumed available last year, necessitating prioritization of last year's budget request. The Department took into account a variety of program-specific factors when deciding which programs should continue to be supported by marijuana tax revenues in FY 2015-16, such as cost effectiveness, ability to be leveraged by existing infrastructure, and long-term sustainability. The Circle Program and the Tony Grampsas Youth Services program were determined to be more in alignment with the Governor's priorities. These considerations were also reconciled with other intents of the MTCF such as regulatory oversight and public safety.

    In reference to specific programs funded in FY 2014-15, the Department considered The Tony Grampsas Youth Services Program funds community-based programs that serve children, youth and their families with prevention and intervention services. One of the long-term outcomes is to decrease alcohol, tobacco, and other drug use. The appropriation from the Marijuana Tax Cash Fund is intended to be used specifically for the prevention of youth marijuana use. The funding is provided to agencies that prevent underage marijuana use through a variety of evidence-based positive youth development programming. For the grant cycle beginning July 1, 2014 TGYS was able to fund an additional 21 agencies. Contracts and purchase orders were effective for grantees to begin work as of October 1, 2014. These grantees are implementing Positive Youth Development prevention programs such as tutoring, before and after school programs, life skills development, and mentoring. Grantees working with youth in the 9-25 year age range will measure youth attitudes towards and use of marijuana, among other risk and protection related factors (such as school engagement, etc). TGYS has engaged its evaluator, CSU, to conduct this survey as well as qualitative studies this year to compare to statewide baseline data collected through Healthy Kids Colorado and other surveys.

In FY 2015-16, each awardee will also be required to include a state youth marijuana use prevention campaign component in its programming. The allocation from the Marijuana Tax Cash Fund to the Circle Program was intended to follow the intent of the General Assembly. Please also see response to Question #25.

24. **What would be the impact of discontinuing marijuana tax revenue funding for latter three programs listed above?**

    The impact of discontinuing marijuana tax revenue funding for the jail-based behavioral health services will result in the discontinuance of $2,000,000 of appropriations. Current contractual allocations to county jails are included in Exhibit 1, attached at the end of the packet.

    The impact of discontinuing marijuana tax revenue funding for the jail-based behavioral health services will result in the discontinuance of $1,500,000 of appropriations for substance use disorder treatment services for adolescents and pregnant women. Specific contractual allocations to Managed Service Organizations are included in Exhibit 2, attached at the end of the packet.

    The Division of Youth Corrections (DYC) is not requesting to continue marijuana tax revenue funding for SB 91-94. The funds are currently being used to train providers on the ability to provide evidence based treatment for marijuana abuse and therefore does not consider this an ongoing cost - and therefore no anticipated impact is expected.

25. **Was the Department's proposal to continue transferring moneys from the Marijuana Tax Cash Fund (MTCF) to the General Fund rather than directly appropriating moneys from the MTCF for the Circle Program simply an oversight, or is there a compelling policy reason to make statutory changes to continue this practice?**

    It is our read of the bill that there are two transfers from Marijuana Funds to the General Fund to pay for this program. One transfer occurs in FY 2014-15 and one in FY 2015-16. We are open to continuing working with JBC staff to clarify the intent of the law.

<u>**Mental Health First Aid**</u>

26. ***Background Information: The FY 2014-15 Long Bill included footnote (#38), stating the General Assembly's intent that the Department use the Mental Health First Aid appropriation for the purpose of augmenting existing contracts with the approved agencies as specified in Section 27-66-104, C.R.S., rather than using an RFP process. The Department chose to use an RFP process for FY 2014-15.*** **Does the Department plan to use an RFP process for awarding the $210,000 General Fund that has been requested for Mental Health First Aid for FY 2015-16? If so, should the General Assembly consider appropriating the $210,000 through a separate bill that includes a statutory change to require the Department to use the money as intended by the General Assembly (rather than relying upon a Long Bill footnote stating the General Assembly's intent)?**

    No, the Department is not required to use an RFP process for awarding the $210,000 General Fund that has been requested for Mental Health First Aid in FY 2015-16.

In FY 2014-15, after consideration of Section 27-66-104 C.R.S (2014) and State Procurement Code Section 24-101-101 through 24-103-201, which requires all State agencies to competitively procure services when there is awareness that competition exists, the Department finalized the Request for Proposals (RFP) procurement for one contractor to administer a statewide Mental Health First Aid program. The Colorado Behavioral Health Council (CBHC) was awarded the contract under this procurement. This RFP procurement allows for the Department to renew the contract with CBHC for an additional 4 years which includes FY 2015-16 through FY 2018-19. In FY 2014-15, the Department anticipates that the $210,000 will be contracted with the Colorado Behavioral Health Council barring any unforeseen issues that would cause the Department to not contract with CBHC.

Treatment and Detoxification Contracts

27. ***Background Information: The FY 2014-15 Long Bill included footnote (#40), stating the General Assembly's intent that the Department continue to use the appropriation for Treatment and Detoxification Contracts to fund the provision of substance use disorder treatment and detoxification services consistent with existing contract requirements, and that the Department refrain from withholding base funding from contractors for the purpose of making subsequent incentive-based payments until the Department has: (a) clearly identified the performance measures and procedures that will be used to implement performance-based payments; and (b) provided contractors with a reasonable period of time to make the data system and programmatic changes that may be necessary to achieve the Department's desired performance goals.*** **Describe any changes the Department has made to substance use treatment and detoxification contracts that relate to incentive-based payments. Further, describe the impact that such changes are having on the affected service providers and their clients.**

The Department complied with the Long Bill, HB14-1336, and footnote #40. The Department negotiated extensively with the four Managed Services Organizations (MSO). The final contracts for FY 2014-15 (a) reflect clearly identified performance measures and procedures that will be used to implement performance-based payments; and (b) provided contractors with a reasonable period of time to make the data system and programmatic changes that may be necessary to achieve the Department's desired performance goals.

The Department made the following changes to substance use disorder treatment and detoxification contracts that relate to incentive-based payments and performance measures:

1. Specific (not all) contractual line items are subject to a 10% reimbursement that is contingent upon meeting clearly identified performance measures.

2. The Department exempted the first quarter of FY 2014-15 from the performance based reimbursement terms in order for contractors to gauge performance results and also to allow for contractors to adjust their data systems.

   The overall potential impact of the performance based reimbursements for MSO contracts ranges from only 6% to 6.57% of the total contract, and not the presumed 10% of the total contract amount.

   The Department directly asked the MSOs and their representatives regarding any service

delivery interruptions or significant financial impacts that may be the direct result of performance based contracting. While the MSOs have reported that this impacts the historical cash flow patterns, there have not been reports of insolvency or service delivery interruption.

28. **Detail which appropriations and fund sources are subject to the contract changes described in response to the above question. Specifically, has the $1.5 million appropriated from the Marijuana Tax Cash Fund to the Department for treatment services for adolescents and pregnant women been subject to these contract changes?**

The appropriations that are subject to the contract changes include the following Long Bill sections and line items:

(8) Behavioral Health Services, C) Substance Use Treatment and Prevention

(1) Treatment Services: Treatment and Detoxification Contracts, Case Management for Chronic Detoxification Clients, Short-term Intensive Residential Remediation and Treatment (STIRRT).

(3) Other Programs: Community Prevention and Treatment.

The fund sources subject to the contract changes include: General Fund, federal Substance Abuse Prevention and Treatment Block Grant funds, Correctional Treatment Cash Fund pursuant to Sections 18-19-103 (3.5) (b), (3.5) (c), and (4) (a), C.R.S., Persistent Drunk Driver Cash Fund created in Section 42-3-303 (1), C.R.S. (2014).

No, the Department and the Managed Service Organizations mutually agreed that the contract changes noted in question number 27 above would not pertain to the $1.5 million appropriated from the Marijuana Tax Cash Fund for treatment services for adolescents and pregnant women.

Service Delivery/Catchment Areas

29. **The counties or groups of counties that are served by community mental health centers, managed service organizations, behavioral health organizations, and the new contractors that are delivering behavioral health crisis system services differ, and do not appear to align well for some counties. Please describe how the regions or catchment areas were determined for each type of service delivery. Further, please discuss whether this misalignment causes challenges for service providers or for clients who access behavioral health services.**

The following table describes how the regions and catchment areas were determined for each type of service delivery, with information about each type of service delivery.

Table 5.

Catchment Area and Region by Service Delivery

Managed Service Organization (MSO)	
Role	Intermediary for provision of non-Medicaid substance use treatment services and capacity. 27-80-106 (2)(a), C.R.S. (2014)
Region / Catchment Area Determination	Seven Single State Planning Areas (SSPA) are based on a 1997 DRCOG* study of Colorado population density, performed in 1996. 27-80-107 (1), C.R.S. (2014)
Reference	Identified in section, 27-80-107 (1) through (7), C.R.S. (2014).
Selection and Count	Annual contracts based on Competitive Selection (request for proposals) executed in FY 1997-98. There are currently 4 MSOs (subcontract with 42 licensed entities).

Community Mental Health Centers	
Role	Contractors for the provision of non-Medicaid mental health services and capacity. 27-66-104 (2)((a)(I), C.R.S. (2014)
Region / Catchment Area Determination	This is based on a 1974-75 publication titled “Colorado Mental Health Master Plan”, submitted by the Division of Mental Health 1974-1975 Master Planning Committee.
Reference	Identified in section, 27-66-101 (1), C.R.S. (2014).
Selection and Count	Annual non-competitively bid contracts. Last competitive selection is unknown. There are 17 Community Mental Health Centers (22 referenced in the 1974 publication).

Behavioral Health Organization (BHO) – ***Narrative Provided by Department of Healthcare Policy and Financing***	
Role	The Community Behavioral Health Services program is a statewide managed care program that provides comprehensive mental health and substance use disorder services to all Coloradans with Medicaid. Medicaid members are assigned to a Behavioral Health Organization (BHO) based on where they live. BHOs arrange or provide for medically necessary behavioral health services to clients in their service areas
Region / Catchment Area Determination	The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties, and in 1998 in the remaining 12 counties of the state. From 1998 through 2004, eight contractors operated the Program. In 2005, the Department reconfigured the counties into five geographic service areas in order to realize sufficient economies of scale to better operate as managed care entities. Each contractor operates the Program in a specific geographic area
Reference	Section 25.5-5-411, C.R.S. (2014) directs the Department to administer a statewide, prepaid, capitated system for providing behavioral health services to Members under the state medical assistance program. The Department has the authority to operate these Programs under Section 1902(a) of Title XIX of the Social Security Act and a waiver approved by CMS under Section 1915(b) of Title XIX of the Social Security Act.
Selection and Count	The Department procures the BHOs through a competitive solicitation process. The Department's contracts with the BHOs are executed for one year, with four possible one-year renewals.

Crisis Service Contract Providers	
Role	Contractors, selected through a competitive procurement process, to create a "seamless and coordinated" crisis response system to provide crisis intervention services. 27-60-103, C.R.S. (2014).
Region / Catchment Area Determination	"The Department worked to align the request for a statewide approach based on five regions aligned with population density (1 million people per region) and along the Accountable Care Collaborative Organizations (ACCO-RCCO)." After public input, Larimer and Elbert counties were moved from the RCCO region alignment to a BHO alignment to enhance behavioral health services delivery.
Reference	Regions are not defined or referred to in statute, regulation, or rule.
Selection and Count	Competitive selection (request for proposal) conducted by the Department in FY 2014-15. There are four crisis service contractors.

*Denver Regional Council of Governments

The Department is not aware of specific challenges based on the "misalignment" of regions and catchment areas, for service providers or clients at this time. Since these areas have been created over time, new providers adjusted to existing service areas of other providers as their contracts/services were established. However, based on the current behavioral health catchment area/region design, the ability to access services across regions is not conducive to seamless service delivery based on the primary need to align benefits and services. The “no wrong door” approach that the crisis service system is built on will improve the access and delivery of services to all visitors to and citizens of Colorado.

Exhibit 1:

Colorado Department of Human Services

FY 2014-15 S.B. 14-215 Jail Based Behavioral Health Services

Contract Allocations as of 12-4-14

COUNTY	SB 215 Funding Allocation	SERVICES
ADAMS	$42,000	1 FTE Additional case manager
ALAMOSA (partnering with Conejos County)	$0	No request submitted
ARAPAHOE	$167,400	2 FTE clinical case managers, .5 transitional case manager, psychiatrist time,
BOULDER	$163,166	1 FTE Therapist, 1 FTE case manager and sheriff's indirect costs
CLEAR CREEK	$23,420	Additional .5 FTE to make the case manager position FTE
DELTA (partnering with Gunnison, Hinsdale, Montrose, Ouray San Miguel Counties)	$0	no request submitted
DENVER	$74,188	.5 FTE case manager, recovery support housing and .25 FTE admin support
DOUGLAS	$11,900	Recovery Support Services
EL PASO	$59,325	Would like to contract with a community based provider for post release services
JEFFERSON	$62,000	1 FTE case manager, supplies and salary adjustment
LA PLATA (partnering with Montezuma County)	$120,000	Additional 1 FTE therapist and 1 FTE case manager. Positions will serve Montezuma and La Plata Counties
LARIMER	$100,000	1 FTE therapist
LOGAN (partnering with Cheyenne, Elbert, Kit Carson, Lincoln, Morgan, Phillips, Washington and Yuma counties)	$145,530	3 FTE case manager for transitional services in the community
OTERO	$207,482	New program to serve Baca, Bent, Crowley, Kiowa, Otero and Prowers counties
PUEBLO	$124,000	1 FTE clinician, case manager benefits and to make position FTE, training for deputies, coordinator, supplies.
MESA (partnering with Garfield, Summit, Eagle, Grand & Routt Counties)	$30,000	Add .5 FTE for case managers
WELD	$169,802	2 FTE clinicians and 1 FTE case manager. Equipment for new positions, training and
Other Contractual Services	$47,000	JBBS Clinician Training/Temp program assistant for OBH
Total*	**$1,547,213**	

* Through the first round of funding, the Department allocated funding to all counties that requested funding. The Department will engage all 64 counties in a second round of funding.

Exhibit 2:
Colorado Department of Human Services
FY 2014-15 S.B. 14-215 Adolescent and Pregnant Women Fee for Service Treatment.
Contract Allocations as of 12-4-14

Managed Service Organization (MSO)	State Service Planning Area (SSPA)	FY 2014-15 Allocation	Counties Served
Signal Behavioral Health	SSPA1:	$114,737	Larimer, Weld, Logan, Sedgwick, Phillips, Morgan, Washington, Yuma Elbert, Lincoln, Kit Carson, Cheyenne.
Signal Behavioral Health	SSPA2:	$798,658	Clear Creek, Gilpin, Jefferson, Denver, Adams, Arapahoe, Douglas.
Aspen Pointe Health Services	SSPA3:	$149,188	Lake, Park, Chaffee, Teller, El Paso, Fremont, Custer.
Signal Behavioral Health	SSPA4:	$256,557	Mineral, Saguache, Rio Grande, Conejos, Alamosa, Costilla, Huerfano, Las Animas, Pueblo, Crowley, Otero, Bent, Kiowa, Prowers, Baca
West Slope Casa	SSPA5/6:	$114,902	Moffat, Routt, Jackson, Rio Blanco, Garfield, Eagle, Grand, Summit, Mesa, Pitkin, Delta, Gunnison, Montrose, Ouray, San Miguel, Hinsdale, San Juan, Dolores, Montezuma, La Plata, Archuleta
Mental Health Center of Boulder*	SSPA7:	$65,958	Boulder
	Total	**$1,500,000**	

*In FY 2014-15 the Department Issued a request for application for this MSO SSPA and Mental Health Partners of Broomfield and Boulder Counties was awarded the contract that is scheduled to begin January 5, 2015. Prior to January 5, 2015 Boulder County Public Health was the MSO.

FY 2015-16
Joint Budget Committee Hearing:

Office of Behavioral Health

Colorado Department of Human Services
December 15, 2014

Strategic Priorities

Three Strategic Priorities make it clear that CDHS will strive for every Coloradan to have the opportunity to:

Thrive in the community of their choice

- To expand community living options for all people served by the Department.
- To ensure child safety through improved prevention, access and permanency.

Achieve economic security through meaningful work

- To achieve economic security for more Coloradans through employment and education.

Prepare for educational success throughout their lives

- To improve kindergarten readiness through quality early care and learning options for all Coloradans.
- To return youth committed to the Division of Youth Corrections (DYC) to the community better prepared to succeed through education received while in the custody of the Department.

Colorado Department of Human Services
Reggie Bicha
Executive Director

- **Dee Martinez — Deputy Executive Director of Enterprise Partnerships**
  - Communications Director
  - Executive & Legislative Liaison
  - Boards & Commissions
  - County Services
  - Client Services/ Controlled Correspondence
- **Nikki Hatch — Deputy Executive Director of Operations**
- **Office of Performance & Strategic Outcomes**
  - Audits
  - Quality Assurance
  - Performance Management
  - Budget & Policy

- **Office of Community Access and Independence**
  - Deputy Director
    - Adult Protection Services
    - Regional Centers
    - Veterans Community Living Centers
    - Disability Determination Services
    - Vocational Rehab. Services
- **Office of Children, Youth & Families**
  - Deputy Director
    - Child Welfare
    - Youth Corrections
- **Office of Economic Security**
  - Deputy Director
    - Child Support Services
    - Employment and Benefits
    - Food & Energy Assistance
    - Refugee Services
- **Office of Administrative Solutions**
  - Employment Affairs
  - Accounting
  - Facilities Management
  - Business Technology
- **Office of Early Childhood**
  - Deputy Director
    - Early Care & Learning
    - Community & Family Support
- **Office of Behavioral Health**
  - Deputy Director Operations
  - Deputy Director Clinical Services
    - Colorado Mental Health Institute at Pueblo
    - Colorado Mental Health Institute at Fort Logan
  - Deputy Director Community Programs

Contact CDHS at 303-866-5700 or online at www.colorado.gov/cdhs

Updated: November 2014

Office of Behavioral Health

Behavioral Health Needs Study

(Questions 1, 2, and 3a, b, and c)

- Study will evaluate the needs for both mental health and substance use disorder services and the capacity to provide these services
- Recent changes in the Medicaid benefit for substance use disorder services will be evaluated
- Recent increases in state funding for substance use disorder treatment services for offenders will be included in the scope
- Evaluate sentencing reforms and asses the impact that the recent progressive sentencing reform related to drug progression
- $339,924 Substance Abuse Prevention and Treatment (SAPT) Block Grant

Behavioral Health Needs Study – Scope (Question 3)

- Identify existing service gaps
- Inventory of inpatient and outpatient behavioral health treatment beds
- Evaluate both mental health and substance use disorder treatment needs and capacity
- Consider recent changes in the Medicaid benefit for substance use disorder services
- Drug abuse prevention, treatment, and recovery services
- National model(s) to enhance recovery
- Strategies (Whole Health Integration)
- Tele-medicine/tele-health
- Align existing resources with future planning
- Identify effects of the Governor's Strengthening Behavioral Health Plan
- Assess services of specific populations in need
- Effects of demographic-specific variables
- Services for mentally ill and physically compromised
- Competency restorations on civil bed availability
- Civil and forensic beds at the CO Mental Health Institutes
- Olmstead considerations in the provision of psychiatric beds
- Services in urban, rural, frontier, and tribal communities

New Mental Health Treatment Unit Background (Question 7)

- Law provides authority to transfer to DOC an individual described as “so dangerous that he cannot be safely confined”
  - Civil patients are transferred in exceptional cases such as:
    - Prone to extreme acts of repetitive violence
    - Have engaged in serious physical assaults
    - Permanently incompetent to stand trial
- This provision requires no criminal court action
- While there are due process protections in law, a judicial review is not required
- The practice has resulted in reduced levels of treatment for these patients

New Mental Health Treatment Unit Policy Review (Questions 5 and 6)

- DOC and DHS reviewed the appropriateness and effectiveness of this practice - Spring 2014
- Governor's Office, Attorney General's Office were consulted and contributed to the decision
- Plan was developed to take all appropriate actions to return individuals safely to the State Mental Health Hospital (May 2014)
- Renovations were made to the unit (Summer 2014)
- Patients transferred to CMHIP in late September, early October 2014

These individuals are *patients* of the State Mental Health Hospital; therefore, they should be cared for by the State in a secure hospital setting.

Process for Transferring Individuals

(Question 4)

CMHIP/CMHFL *patient* to DOC

- 17-23-102, 103 C.R.S. (2014)
- Executive Committee of CMHIP
- Attorney General's Office
- Patient is represented by an attorney, can call witnesses
- Hearing Committee
  - Judge, Psychiatrist, Psychologist and/or a Nurse
- Executive Transfer Order

DOC *inmate* to CMHIP

- 17-23-101 C.R.S. (2014),
- DOC liaison contacts the CMHIP Admission
- DOC issues an Executive Order

*No payments are made when transferring individuals between DOC and CDHS. Both processes are managed through an MOU.

"Behavioral Health ICU"

(Question 10)

Infrastructure

- Cameras and audio in patient rooms linked back to central station
- Fully padded room
- Doors on patient rooms were modified with a pass through tray slot
- Specialized therapeutic table
- Lavatory fixtures reinforced
- Reinforced windows

Staffing

- Staffing per shift 4 safety officers, 2 nursing staff, 1 staff to monitor camera
- Dedicated treatment team
  - Full time psychologist
  - Part time psychiatrist

Impact of Transfers to CMHIP

(Questions 8, 9 and 10)

- Census is unchanged given the small size of the unit
  - 1 DOC inmate being treated at CMHIP for restoration to competency to stand trial
  - CDHS unable to meet previous commitment of 24 beds allotted to DOC – this is unrelated to the return of these patients
- Factors for staffing levels
  - High acuity level of patients and propensity for repeated violence
  - Limited suitability of the physical space
- Staff safety
  - 9 acts of aggression
  - 2 patient to staff assaults
  - No severe injuries to staff or patients

Options Explored

(Questions 11 and 12)

- Other facility options considered
  - Circle Program building
  - Medical/Surgical Unit
- Supplemental funding request for FY 2014-15 is under consideration
  - Due January 2, 2015

Treatment of Patients at CMHIP

(Question 13)

Treatment at CMHIP

- Customized treatment approach
- Treatment provided 8am to 8pm daily
- Dialectical behavior therapy (DBT)
- Anger Management Group Therapy
- Social skills
- Biofeedback
- Outdoor activities
- Socialization

Treatment at DOC

- 10 hours of group therapy per week
- 23 hours per day of administrative segregation
- 1 hour per day of solitary recreational time (concrete, confined, open roof location)

Why now?

(Question 14)

- Treatment needs of the patients were compromised
- Potential violation of an individual's civil rights
- Few, if any, other states exercise this option for civil patients
- Moral obligation to these individuals
- Waiting 1-2 years for the completion of a gap analysis would be unethical

The risk to patients and to the State was too high to continue with this practice

Mental Health Institutes Patients Served FY 2013-14 (Question 16)

Table 1.
Individuals that Received Inpatient Services at the Mental Health Institutes, FY 2013-14

Institute	Forensic Individuals Served	Civil Individuals Served	Total Individuals Served
Colorado Mental Health Institute at Pueblo	876	567	1,443
Colorado Mental Health Institute at Fort Logan	13	515	528
Total	889	1,082	1,971

Mental Health Institutes Patients Served November 2014 (Question 16)

Table 2.
Individuals that Received Inpatient Services at the Mental Health Institutes, November 2014

Institute	Forensic Individuals Served	Civil Individuals Served	Total Individuals Served
Colorado Mental Health Institute at Pueblo	378	108	486
Colorado Mental Health Institute at Fort Logan	3	128	131
Total	381	236	617

Mental Health Institutes
Court Ordered Evaluations (Question 17)

Trend Data Related to Court Ordered Evaluations

NUMBER OF COURT ORDERS

500
450
400
350
300
250
200
150
100
50
0

2000-01
2001-02
2002-03
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15 projected
2015-16 projected
2016-17 projected
2017-18 projected

FISCAL YEAR

Court Orders for Inpatient Competency EVALUATIONS
Court Orders for Inpatient Competency RESTORATIONS

MHI Court Ordered Evaluations

(Question 17)

- Must serve an offender within 28 days from receiving the information packet from the court
- No one has exceeded the court ordered wait time since July 2012

Type of Order	Current Days Waiting				Settlement Limit for Days Waiting
	Number	Average	Minimum	Maximum	
Ordered for Inpatient Competency Evaluation	10	11.8	3	16	28
Ordered for Inpatient Competency Restoration	8	13.9	8	21	28
Ordered for Outpatient Competency Evaluation	43	14.2	2	25	30

Community Mental Health Centers' Capacity (Question 18)

- Behavioral Health Needs Assessment to determine the community capacity

- Assertive Community Treatment (ACT)
  - Added high-intensity behavioral health service capacity staff (60 FTE)
  - Operating costs to address long-term needs
  - For clients that transition from the Mental Health Institutes back into the community or clients which are at risk of rehospitalization
  - December 12, 2014, there have been 319 clients added to ACT team caseloads

- "Money Follows the Individual"
  - Established November 2014
  - Provides enhanced services and supports for people clinically ready to move to the community
  - Have a higher level of need than can be met by the current CMHC contracted services

Circle Program

(Question 19)

Background

- Created in 2004 to provide a comprehensive 90-day inpatient therapeutic-community to address mental illness, chemical dependence, personality disorders and criminal behavior.
- Services provided to men and women ages 18-65
- Many individuals are referred as condition of legal charges
- Total investment since 2004 - $19.4 million total funds, of which 87% is General Fund

Proposal

- Requesting funding to contract with an outside agency:
  - Evaluate the Institutions for Mental Diseases exclusion
  - Evaluate options to expand payor reimbursement
  - Evaluate options for program to become autonomous from the State

Circle Program

(Question 20)

- Institute for Mental Disease (IMD)
  - Inpatient facilities with more than 16 beds
  - More than 51% patients with severe mental illness
  - CMHIP and CMHIFL are both IMDs

- Circle Program
  - State operated program on the CMHIP campus
  - Classified as an Institution for Mental Diseases (IMD)
  - Limits the ability to receive revenue from public (Medicaid) and private insurance

Institute Equipment Replacement

(Question 21 and 22)

- Intercom system
  - Capital outlay – minor construction, renovations, routine maintenance and smaller IT projects
  - Two separate projects, one at each Institute
- Factors for prioritization (Department-wide) include:
  - Safety of patients and staff (first priority)
  - Programmatic or treatment needs
  - Costs
  - Funding sources
  - Administrative effectiveness
  - Therapeutic and homelike environment, among others

Implementation of S.B. 14-215

(Question 23)

All good programs, tough decisions to be made given $6 million decrease in projected revenues

- Governor's Priorities:
  - Public health
  - Public safety
  - Youth prevention
- Specific CDHS Programmatic Factors most aligned with Governor's Priorities
  - Cost effectiveness
  - Long-term sustainability
  - Prevention of youth marijuana use

Impact of S.B. 14-215 Funding Changes

(Question 24)

- Fully funded local law enforcement requests of $1.5 million ($2.0 million appropriation)
- Division of Youth Corrections (DYC) is not requesting to continue programming
  - Funds are currently being used to train providers on the ability to provide evidence based treatment for marijuana abuse
  - Therefore does not consider this an ongoing cost
  - No anticipated impact is expected
- $1.5 million for substance abuse treatment services for adolescents and pregnant women

Implementation of S.B. 14-215

(Question 25)

- Two transfers from Marijuana Funds to the General Fund to pay for this program:
  - FY 2014-15
  - FY 2015-16

- Working with JBC staff to clarify the intent of the law

Mental Health First Aid

(Question 26)

- Procurement Requirements
  - Section 27-66-104 C.R.S (2014)
  - State Procurement Code Section 24-101-101 through 24-103-201
  - Requires all State agencies to competitively procure services when there is awareness that competition exists

- Department finalized the RFP procurement for one contractor to administer a statewide Mental Health First Aid program
  - Colorado Behavioral Health Council (CBHC) was awarded
  - Allows for the Department to renew the contract with CBHC for an additional 4 years

- Not required to seek a new RFP for these funds if the General Assembly appropriates additional funds for the same purpose

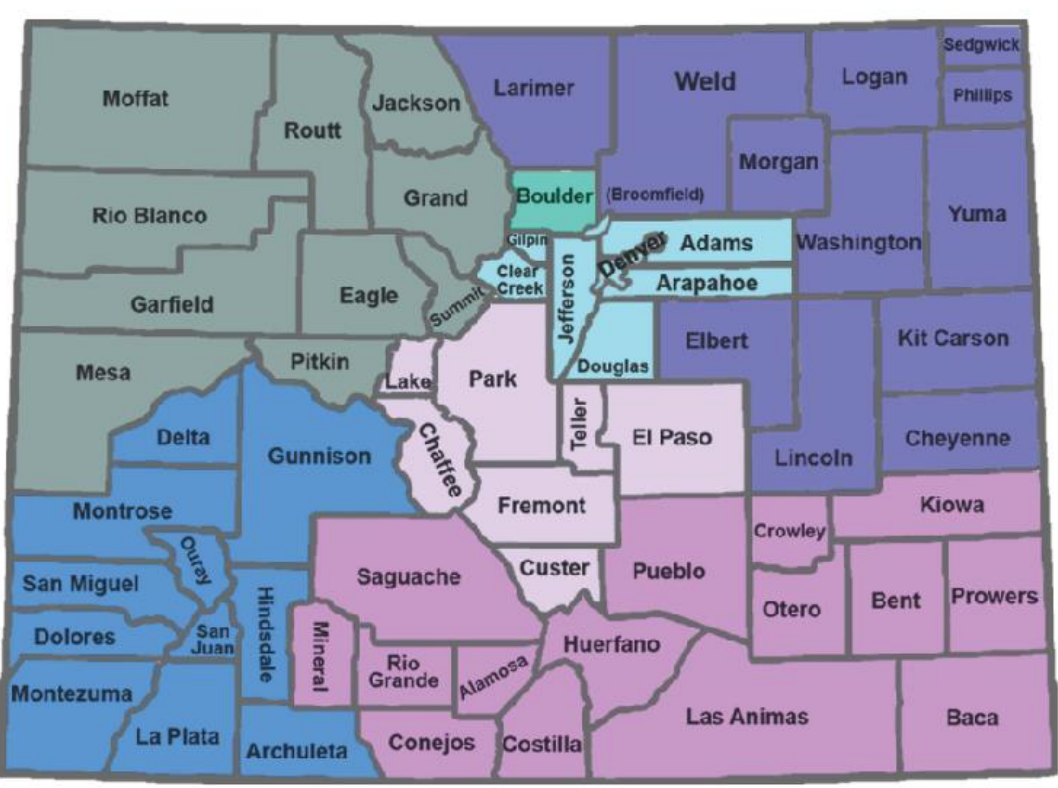
Treatment & Detoxification Performance-Based Contracts (Questions 27 and 28)

- **Negotiated extensively with the four Managed Services Organizations (MSO)**
- **The final contracts for FY 2014-15**
  - Reflect clearly identified performance measures and procedures that will be used to implement performance-based payments
  - Provided contractors with a reasonable period of time to make the data system and programmatic changes that may be necessary
- **Changes to contracts that relate to incentive-based payments and performance measures:**
  - Specific (not all) contractual line items are subject to a 10% reimbursement that is contingent upon meeting clearly identified performance measures, with the exception of Marijuana Tax Cash Fund
  - Exempted the first quarter of FY 2014-15 from the performance-based reimbursement terms in order for contractors to gauge performance results and also to allow for contractors to adjust their data systems

Service Delivery/Catchment Areas

(Question 29)

Managed Service Organizations (MSO)



1 Signal

2 Signal

3 AspenPointe

4 Signal

5 West Slope Casa

6 West Slope Casa

7 Boulder

Service Delivery / Catchment Areas

(Question 29)

Community Mental Health Centers (CMHC)

Moffat, Routt, Jackson, Larimer, Weld, Logan, Sedgwick, Phillips, Morgan, Rio Blanco, Grand, Boulder, (Broomfield), Yuma, Gilpin, Adams, Washington, Clear Creek, Denver, Arapahoe, Garfield, Eagle, Summit, Jefferson, Elbert, Kit Carson, Mesa, Pitkin, Lake, Park, Douglas, Teller, El Paso, Delta, Gunnison, Chaffee, Lincoln, Cheyenne, Montrose, Fremont, Kiowa, Crowley, Ouray, Saguache, Custer, Pueblo, San Miguel, Otero, Bent, Prowers, Hinsdale, Mineral, Dolores, San Juan, Huerfano, Rio Grande, Alamosa, Montezuma, Las Animas, Baca, La Plata, Archuleta, Conejos, Costilla

Mind Springs Health

Midwestern Colorado Mental Health Center

Axis Health Systems

San Luis Valley Comprehensive Mental Health Center

Spanish Peaks Mental Health Center

Southeast Mental Health Services

Centennial Mental Health Center

West Central Mental Health Center

AspenPointe

Arapahoe/Douglas Mental Health Network

Aurora Mental Health Center

Jefferson Center for Mental Health

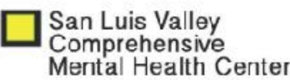
Mental Health Partners

Mental Health Center of Denver

North Range Behavioral Health

Community Reach Center

Touchstone Health Partners



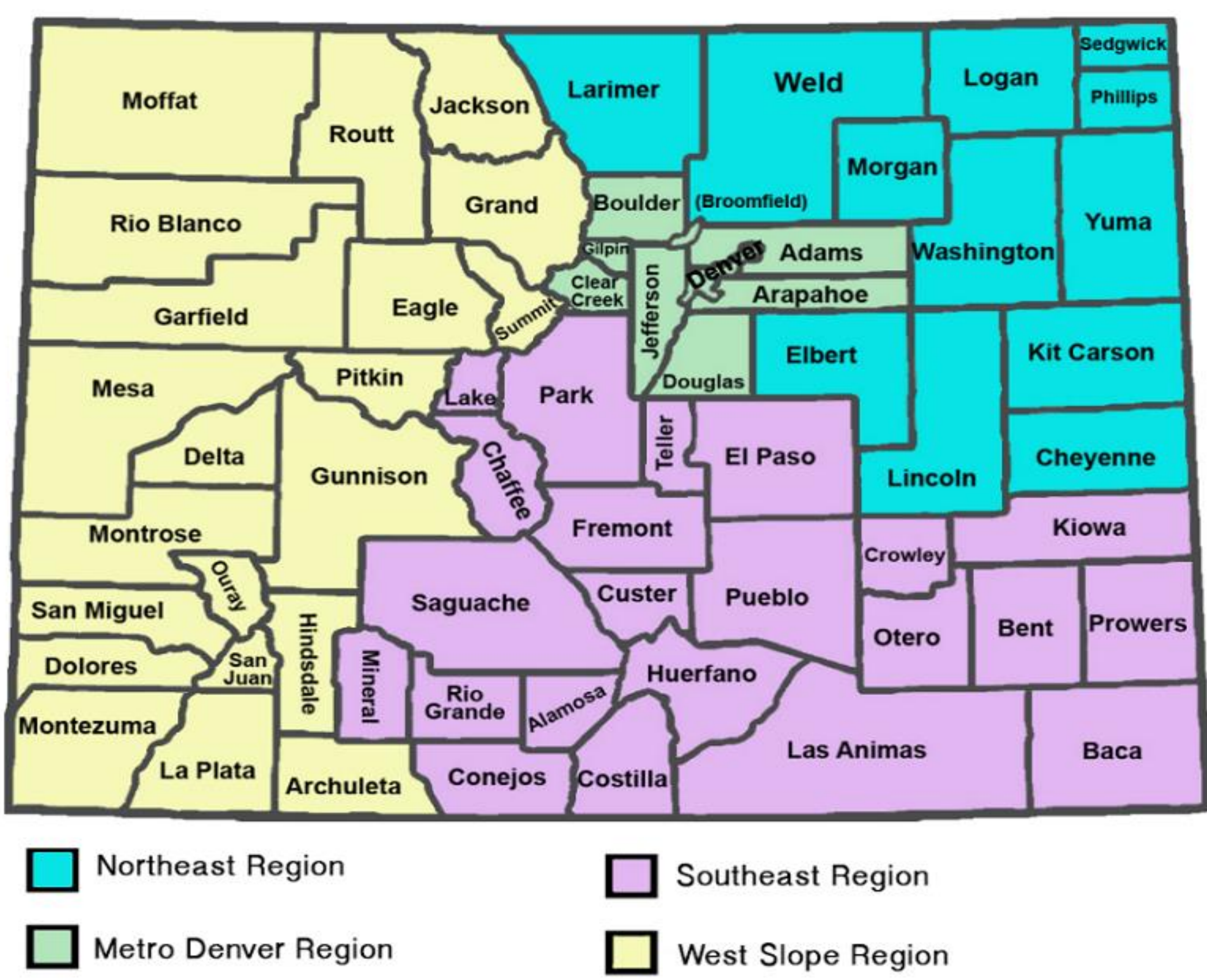
Service Delivery / Catchment Areas (Question 29)

Behavioral Health Organizations (BHO)

Moffat, Routt, Jackson, Larimer, Weld, Logan, Sedgwick, Phillips, Morgan, Rio Blanco, Grand, Boulder, (Broomfield), Yuma, Gilpin, Adams, Denver, Washington, Clear Creek, Arapahoe, Garfield, Eagle, Summit, Jefferson, Elbert, Kit Carson, Mesa, Pitkin, Lake, Park, Douglas, Teller, El Paso, Delta, Gunnison, Chaffee, Lincoln, Cheyenne, Montrose, Fremont, Kiowa, Ouray, Crowley, San Miguel, Saguache, Custer, Pueblo, Otero, Bent, Prowers, Dolores, San Juan, Hinsdale, Mineral, Huerfano, Rio Grande, Alamosa, Montezuma, La Plata, Las Animas, Baca, Archuleta, Conejos, Costilla

- Colorado Health Partnership (CHP)
- Foothills Behavioral Health Partners (FBHP)
- Behavioral Healthcare, Inc. (BHI)
- Colorado Access/Access Behavioral Care Northeast (ABC)
- Colorado Access/Access Behavioral Care Denver (ABC)

Service Delivery / Catchment Areas (Question 29)



CDHS CO

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DEPARTMENT OF HUMAN SERVICES
(Behavioral Health Services[1])

FY 2015-16 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 16, 2014
2:00 – 4:00 pm

2:00-2:10 INTRODUCTIONS AND OPENING COMMENTS

2:10-2:20 BEHAVIORAL HEALTH SYSTEM STUDY

Study to Assess the Current and Future Behavioral Health Needs of State

1. How much will the Department spend for the study, and what source(s) of funding are being used to cover these costs?

2. What role, if any, has the General Assembly played in the Department's decision to conduct this study?

3. Describe the scope of the study and the anticipated outcomes. Please includes responses that specifically address the following questions:
   a. Will the study evaluate the needs for both mental health and substance use disorder services and the capacity to provide such services?
   b. Will the study consider recent changes in the Medicaid benefit for substance use disorder services and recent increases in state funding for substance use disorder treatment services for offenders?
   c. Explain the nature of the study objective that concerns evaluating the "degree to which Colorado sentencing reforms related to drug possession have and will expand the need for mental health, substance, and co-occurring disorder services".

2:20-3:00 MENTAL HEALTH INSTITUTES

(R1) New Mental Health Institute Treatment Unit

4. Describe the process that occurs when patients are transferred from the Colorado Mental Health Institute at Pueblo (CMHIP) to a Department of Corrections (DOC) facility pursuant to Section 17-23-103, C.R.S., and when inmates are transferred from a DOC facility to the CMHIP pursuant to Section 17-23-101, C.R.S.
   a. Does the transfer process involve negotiations, a contract, or a memorandum of understanding between the two departments?

[1] This section of the budget includes: Community behavioral health administration; Mental health community programs; Substance use treatment and prevention; Integrated behavioral health services; and the Mental Health Institutes.

b. Does the transferring department make any payments when transferring an individual, or do the costs of caring for the transferred individual become the responsibility of the receiving department?

5. The Department has indicated that it determined that the practice of transferring patients to DOC facilities is unacceptable and is potentially a violation of these individuals' civil rights. Did the Attorney General's Office or the courts play a role in analyzing the legal aspects of such transfers? If not, how did the Department reach this conclusion?

6. Describe the Department's current position concerning which agency should be caring for the mentally ill individuals who are eligible for transfers pursuant to the above-referenced statutory provisions.

7. What factors have been considered in the past when determining that a patient is dangerous enough to be transferred from CMHIP to a DOC facility pursuant to Section 17-23-103, C.R.S.? Have these patients committed acts while at CMHIP that could be charged as a crime?

8. How has the return of five patients previously transferred from the CMHIP to DOC affected existing CMHIP operations? Please includes responses that specifically address the following questions:
   a. How has the transfer affected the total number of patients receiving treatment at CMHIP?
   b. How has the transfer affected the required CMHIP staffing levels for FY 2014-15?
   c. How has the transfer affected staff safety? Have any staff been injured by any of the five patients who were recently transferred or as a result of such transfers?

9. How many DOC inmates are currently being treated at CMHIP?

10. Explain the staffing assumptions that underlie this request, including the proposal to add a full-time psychologist and a half-time psychiatrist.

11. If the Department has not yet determined whether additional funding is needed to cover the associated expenditures for FY 2014-15, why is the Department certain that it requires additional funding for this purpose for FY 2015-16?

12. Did the Department consider utilizing the CMHIP building that houses the Circle Program to create the new security-enhanced treatment unit? Did the Department consider utilizing any other CMHIP buildings that include restrooms in each patient room to avoid the need for extra security staff to escort patients for restroom breaks?

13. Explain how the care and treatment that these five patients are receiving at CMHIP differs from the care they received at DOC's San Carlos facility, and why CMHIP care is viewed as an improvement.

14. Why has the Department elected to move forward with this policy change and to commit the necessary resources to create and staff the new security-enhanced treatment unit before the behavioral health system study is completed and before the General Assembly has had an opportunity to evaluate the fiscal and statewide implications of the policy change?

15. How does this policy change relate to recent policy changes within the DOC concerning administrative segregation?

3:00-3:15 BREAK

3:15-3:35 MENTAL HEALTH INSTITUTES (CONTINUED)

Capacity-related Questions

16. Provide data concerning the actual number of patients receiving services at the CMHIP and at the Colorado Mental Health Institute at Fort Logan (CMHIFL). Please include data for FY 2013-14 and for November 2014 (or the most recent month for which data is available), and separately identify forensic and civil patients.

17. Provide trend data concerning the number of individuals requiring court-ordered psychiatric evaluations to determine competency, as well as the number of individuals requiring competency restoration services. Please discuss whether the Department has been successful in reducing the number of offenders in jail who are waiting to receive such services, or in reducing the average wait time.

18. What is the capacity of the 17 community mental health centers given current funding levels? Do the centers have an ability to provide services for additional patients transitioning from the Mental Health Institutes?

(R13) Circle Program

19. Why is the Department requesting funding to contract with an outside agency to conduct a business model analysis for the Circle Program? Given the Department's involvement in licensure activities, why doesn't the Department have the internal resources and expertise to conduct such an analysis?

20. Describe what is meant by potentially operating the Circle Program as an "autonomous" program, separate from the CMHIP. What is the Department's long-term objective with respect to the Circle Program?

R14 (Institute equipment replacement)

21. Please explain why this request includes $800,000 for the Department to install an intercom system at CMHIFL and replace the existing intercom system at CMHIP. Why hasn't the Department submitted these requests through the capital development budget process so that these facility-related issues can be prioritized among other state facility controlled maintenance needs?

22. What process does the Department use each year to identify Institute equipment and maintenance needs? What process does the Department use to then prioritize and allocate existing appropriations for operating expenses to address Institute needs as well as the needs of other Department facilities?

3:35-4:00 OTHER TOPICS

Implementation of S.B. 14-215

23. What factors did the Department consider when deciding which programs should continue to be supported by marijuana tax revenues in FY 2015-16? Specifically, why is the Department proposing continuing MTCF allocations for the Circle program and the Tony Grampsas Youth Services Program, and eliminating allocations for jail-based behavioral health services, substance use disorder treatment services for adolescents and pregnant women, and S.B. 91-94 programs?

24. What would be the impact of discontinuing marijuana tax revenue funding for latter three programs listed above?

25. Was the Department's proposal to continue transferring moneys from the Marijuana Tax Cash Fund (MTCF) to the General Fund rather than directly appropriating moneys from the MTCF for the Circle Program simply an oversight, or is there a compelling policy reason to make statutory changes to continue this practice?

Mental Health First Aid

26. *Background Information: The FY 2014-15 Long Bill included footnote (#38), stating the General Assembly's intent that the Department use the Mental Health First Aid appropriation for the purpose of augmenting existing contracts with the approved agencies as specified in Section 27-66-104, C.R.S., rather than using an RFP process. The Department chose to use an RFP process for FY 2014-15.* Does the Department plan to use an RFP process for awarding the $210,000 General Fund that has been requested for Mental Health First Aid for FY 2015-16? If so, should the General Assembly consider appropriating the $210,000 through a separate bill that includes a statutory change to require the Department to use the money as intended by the General Assembly (rather than relying upon a Long Bill footnote stating the General Assembly's intent)?

Treatment and Detoxification Contracts

27. *Background Information: The FY 2014-15 Long Bill included footnote (#40), stating the General Assembly's intent that the Department continue to use the appropriation for*

Treatment and Detoxification Contracts to fund the provision of substance use disorder treatment and detoxification services consistent with existing contract requirements, and that the Department refrain from withholding base funding from contractors for the purpose of making subsequent incentive-based payments until the Department has: (a) clearly identified the performance measures and procedures that will be used to implement performance-based payments; and (b) provided contractors with a reasonable period of time to make the data system and programmatic changes that may be necessary to achieve the Department's desired performance goals. Describe any changes the Department has made to substance use treatment and detoxification contracts that relate to incentive-based payments. Further, describe the impact that such changes are having on the affected service providers and their clients.

28. Detail which appropriations and fund sources are subject to the contract changes described in response to the above question. Specifically, has the $1.5 million appropriated from the Marijuana Tax Cash Fund to the Department for treatment services for adolescents and pregnant women been subject to these contract changes?

<u>Service Delivery/Catchment Areas</u>

29. The counties or groups of counties that are served by community mental health centers, managed service organizations, behavioral health organizations, and the new contractors that are delivering behavioral health crisis system services differ, and do not appear to align well for some counties. Please describe how the regions or catchment areas were determined for each type of service delivery. Further, please discuss whether this misalignment causes challenges for service providers or for clients who access behavioral health services.