1:30pm – 3:45 pm Office of Behavioral Health

Presenter(s):
- Robert Werthwein, Director, Office of Behavioral Health

Topics:
- Federal Consent Decree, Questions 1-10 (pages 4-12), Slide(s) 4-15
- Mental Health Institutes, Questions 11-20 (pages 12-23), Slide(s) 17-27
- Community Behavioral Health System, Questions 21-31, (pages 24-42), Slide(s) 30-55

3:45pm - 4:00pm Break

4:00-5:00 Division of Child Welfare

Presenter(s):
- Minna Castillo-Cohen, Director, Office of Children, Youth & Families
- Mollie Bradlee, Deputy Director, Office of Children, Youth & Families

Topics: Child Welfare
- SB 21-277 Allocation Model Report, Questions 32-33, (pages 43), Slide(s) 61
- Collaborative Management Programs, Questions 34-36, (pages 44), Slide(s) 61
- Residential Facilities, Questions 36-38, (pages 45), Slide(s) 61, 64
- R4 Enhancing Child Welfare Support, Questions 39, (pages 45-46), Slide(s) 67-68
- R3 County Trails refresh and Support Question 40, (pages 46-48), Slide(s) 71

Topics: Division of Youth Services
- Request for Information 3 – Youth Services Institutional Programs Report, Question 41-42, (pages 48-51), Slide(s) 80-81

Responses to the following questions were provided by the Governor’s Office of State Planning and Budgeting.
- Ridge View Facility Transition - Questions 43-44, (pages 52-54)
1. [Rep. Ransom] Please discuss the origins of the requests for competency evaluations. What actors (defense, prosecution, etc.) are requesting evaluations? Is there judicial discretion to approve a request for an evaluation? Please explain.

Competency is a legal construct that refers to an individual’s current capacity to function meaningfully and knowingly in a legal proceeding. It may be raised at any point by the defense, prosecution, or court in a criminal case; however, it is most often raised by the defense during pre-trial hearings as a part of protecting due process rights of defendants and ensuring they are able to understand the court proceedings, make reasoned decisions and have the ability to participate meaningfully in their legal defense. Dusky v. United States 420 U.S. 162 (1960) provides that a defendant has the right to a competency evaluation prior to his or her case moving forward to trial and set the standard for competency to stand trial as whether the defendant has a “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and a “rational as well as factual understanding of the proceedings against him.” Dusky v. United States or “The Dusky Standard” is the standard for competency in all 50 states.

2. [Rep. Gonzales-Gutierrez] Please provide additional clarity about the competency evaluation and restoration processes themselves.

- Who is actually conducting the evaluations (e.g., CDHS staff or contractors)? If the evaluators are contracting, are they contracting with CDHS or with Judicial?

The Department has 42 staff evaluator positions including post doctoral fellows and supervisors, and 28 additional contract evaluators provide evaluations for the Department.
3. [Rep. McCluskie] Please discuss any data available regarding whether the current system is ordering inpatient services for patients that do not require that level of services.

- Please discuss the geographic distribution of those orders (ordering inpatient services for individuals that could be served in other settings). Are they coming from specific areas/judicial districts?

The above graph shows the number of referrals made for restoration, broken out by inpatient and outpatient setting and judicial district. The data represents referrals made between October 2020 and October 2021.

*Please see Question 6 for additional information in response to this question.*
4. [Rep. McCluskie] The JBC Staff Briefing Document provides an update on forensic competency issues, the status of the waitlist, and potential budgetary implications (see issue brief beginning on page 14 of the document).

- Please discuss the Department's ongoing efforts 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 services as required by S.B. 17-012.

In 2018, the Department developed a community-based model for competency restoration that focused on education, referral for medication services, treatment planning that addressed specific barriers to competency, and connection to community-based resources and supports. The Department procured contracts with qualified providers in every county and in every court district to ensure outpatient restoration services were available to adults and juveniles throughout the state.

In FY 2020-2021, the Department moved to include Outpatient Restoration in the larger Community Mental Health Center (CMHC) contracts. This was done specifically to secure the participation of all of the CMHC’s across the state in providing restoration as well as to create access to much needed ancillary services that are readily available within the community behavioral health system. This strategy has been effective in some jurisdictions where individuals are receiving timely access to restoration and other services crucial to supporting the individual like medication management and case management. However, the Department is also seeing and addressing concerns with some of the CMHCs who are not prioritizing services for this program. These centers are not accepting referrals, outreaching defendants and not offering services in the cadence according to contractual timeframes. These challenges are reducing the effectiveness of the Outpatient Restoration Program in those jurisdictions due to longer lengths of service which lead to an increase in the duration of the criminal proceedings for that individual as well as the likelihood to recidivate.

Additionally, the Department continues to support and develop private entities to serve competency clients. This ensures that sufficient capacity needs are being met as orders for competency restoration continue to grow exponentially. Outpatient Restoration currently manages 33 private provider contracts in addition to the contracts with the 17 community mental health centers.
5. [Rep. McCluskie] The JBC Staff Briefing Document provides an update on forensic competency issues, the status of the waitlist, and potential budgetary implications (see issue brief beginning on page 14 of the document).

- Please discuss the current drivers of the growth in the competency waitlist and the likely budgetary implications for FY 2022-23.

The following are the drivers of the growing waitlist:

- The Incompetent to Proceed (ITP) system is large and complex with several factors that can redirect a patient into the behavioral health system long before they enter the criminal justice system.
- The primary intervention is the local community mental health systems. Clients who are deemed “difficult”, often are not proactively engaged in treatment and discharged, leaving the criminal justice system to serve as their behavioral health provider.
- The pandemic has interfered with the RISE program operating at capacity, reducing the number of patients being served.
- The pandemic and the national healthcare staffing crisis has resulted in the closure of three and a half units at CMHIP, reducing the number of beds dedicated to forensic patients. Additionally, the pandemic slowed admissions and even halted admissions during outbreaks.
- The Office of Behavioral Health continues to experience a rise in the number of individual inpatient restoration orders. The number of beds dedicated to serve these constitutional issues has not kept up with demand. The following chart outlines the monthly number of individual inpatient restoration orders over the last ten years and forecasts future values using linear regression.
Budgetary impact from noncompliance

- The likely budgetary impact is between $10.6M - $11M in FY 2022-23 for noncompliance with the Federal Consent Decree. Total impact will be determined by annual inflationary increase in the fines rates.
- There are potentially fines coming from contempt of court from District Courts.

6. [Rep. McCluskie] Please discuss any data available regarding whether the current system is ordering inpatient services for patients that do not require that level of services.

- Does the Department have estimates of the number and percentage of patients that are being directed to inpatient services that could/should be served in other settings (making those inpatient beds available for higher acuity patients)? What is the basis of those estimates?

Based on a review of the current waitlist of individuals awaiting inpatient competency services approximately 50% are categorized as low acuity (medication compliant, actively engaged in behavioral health services in the jail, housing) according to the Forensic Support Team protocols. These individuals would be appropriate to be served in the community. The chart below shows the breakdown of the level of charges for these low acuity individuals. At least 42 individuals with misdemeanor and lower charges and some of those who have lower level felony charges are being looked at for transition planning options for community based
services. The Forensic Support Team actively works to coordinate care and resources in the community for these individuals and notifies the judicial stakeholders involved in the case of the transition plan options. If parties agree, the court converts the order for restoration to occur in the community through the Outpatient Restoration Program.

7. [Rep. Gonzales-Gutierrez] Please provide additional clarity about the competency evaluation and restoration processes themselves.

- Please address concerns about the use of a more restrictive setting such as CMHIP for competency services for individuals charged with lower level offenses, given the concerns that have been presented to the Behavioral Health Transformation Task Force. Is CMHIP actually the appropriate setting for the patients that it is serving? Please explain.

As part of the Consent Decree requirements, the Department implemented a triage system to screen each pretrial defendant and make recommendations to the committing court regarding the most clinically appropriate level of care (inpatient or outpatient) to restore the individual to competency. This system aims to admit those individuals with the highest level of acuity to the hospital as quickly as possible. If the evaluator determines that inpatient restoration is the most appropriate setting, the evaluator will then opine if the individual meets Tier 1 (high acuity) or Tier 2 (lower acuity) criteria. The evaluator completes a report with the placement recommendations and sends it to the court. The court makes a final determination regarding whether a defendant is competent to proceed. Pursuant to C.R.S. 16-8.5-111, the court has the option to order outpatient restoration services or order the defendant into the custody of CDHS for the purposes of restoration of competency.
With regard to level of charges, the chart below illustrates the percentage of referrals for restoration with misdemeanor offenses as the highest level charge from January 2019 to April 2021.

![Chart showing percentage of referrals for restoration with misdemeanor offenses]

Ideally, placements for restoration services would be based on the matrix model below. In a perfect scenario an individual would only be placed in a hospital setting if their clinical acuity required it and in a locked setting if there was a safety risk to themselves or others.

<table>
<thead>
<tr>
<th>Low Safety Risk</th>
<th>High Safety Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Acuity</td>
<td>Outpatient</td>
</tr>
<tr>
<td>High Acuity</td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Jail Based Services</td>
</tr>
<tr>
<td></td>
<td>Secure Hospital</td>
</tr>
</tbody>
</table>

8. *Sen. Hansen* Please discuss what kinds of cases/offenses are driving the increase in competency workload. What is the role of misdemeanor cases? How much of the workload is driven by lower level offenses? How many of the inpatient beds and services tend to be devoted to those lower level offenses?

Competency is raised in felony and misdemeanor level cases. However, there has been a significant increase in competency being raised for misdemeanor offenses between 2019-2021. In 2019-2020 of the 5,000 total orders, 1,662 (33.32%) were misdemeanor offenses. In 2021 of the 8,782 orders, 2,910 (33.21%) were misdemeanor offenses.
Additionally, the Department is seeing the same people being charged in multiple counties. It is not uncommon for a person to have competency raised in several different counties. Depending on the date of the court order, the Department is required to complete an evaluation in each county. This is trending in both felony and misdemeanor cases. Hospital level of care is based on acuity and a person's clinical needs. If appropriate, a community recommendation for restoration should be the first choice.

The chart below illustrates the total referrals for inpatient restoration in context of the percent of referrals with a misdemeanor in red as the highest level charge versus total number of inpatient incompetent to proceed orders in blue for the time period between January 2019 and April 2021.

9. [Rep. McCluskie] Please discuss any data available regarding whether the current system is ordering inpatient services for patients that do not require that level of services.

- What is the Department doing to address this issue and maximize the efficiency of the State’s use of the limited inpatient capacity available?
  - In partnership with the Forensic Support Team, the local jails, and CMHIP, OBH is prioritizing patients based on clinical acuity; ensuring that those with the greatest clinical needs are admitted first.
  - OBH will continue to partner with jails to improve medication compliance. OBH would like to implement and expand contingency management programs to improve psychotropic medication compliance. Increasing medication compliance prior to admitting to a CDHS facility will reduce their length of stay.
The Forensic Support Team continually makes efforts to transition individuals awaiting inpatient services to community-based services when appropriate transition plans are in place.

The Department of has been sending out bi-monthly updates to the courts and judicial stakeholders with details related to the number of individuals on the waiting list and available bed capacity.

Stakeholders meetings with judges, district attorneys, and public defenders to provide updates have been held over the last year.

The Department is in the process of contracting for 64 civil and restoration beds with private hospitals.

CMHIP is considering every opportunity to increase the critical workforce essential to running a hospital, including:

- Reinstated the Sitter Program which allows salaried CDHS employees to be compensated for working a direct care shift.
- Canceled all non-emergency clinics and reallocated the staff on the units.
- Clinical Safety Specialists (CSS) are trained in unlicensed nursing functions and were pulled in to provide direct care covered on the units. The Central Transport Unit (CTU) staff were then reassigned to the duties of the Clinical Safety Specialists.
- CMHIP is a training hospital and has over 100 nursing students at the hospital. CMHIP invited nursing students to work 1 – 2 days a week as unlicensed nursing staff.
- Offering and mandating overtime to direct care staff.
- Mandating overtime to maintain staff-to-patient ratios.
- Leveraging contract staffing agencies, including CDHS contracts.
- Requiring nursing leadership to work direct care shifts, “on the floor”.
- Eliminated Subject Matter Expert (SME) application reviews for all open and continuous classifications.
- CMHIP is providing offer letters pending background checks and allows the candidate to start the hospital new employee orientation (NEO) prior to receiving their background check. The employees will not be allowed to have patient contact without a successful background check.
- In the process of executing a contract for a sourcing and recruiting agency for direct care staff.
- Partnering with refugee resettlement programs to match refugee skills to organizational needs.
10. [Rep. McCluskie] The JBC Staff Briefing Document provides an update on forensic competency issues, the status of the waitlist, and potential budgetary implications (see issue brief beginning on page 14 of the document).

- Please discuss any additional options that the State could implement to achieve compliance with the consent decree and provide competency services in a more timely manner.

The Department has responded swiftly to the significant waitlist by seeking funding resources to create additional bed capacity. However, based on the trajectory of the referrals and indications the waitlist likely will continue to grow, additional policy efforts to address where restoration services occur need to be explored, factoring in community-based resources to address concerns related to criminogenic risk factors. Courts and judicial stakeholders need to have the capability to access the community behavioral health system with enhanced partnerships and services to address local concerns. The competency system seems to have become the mechanism to access psychiatric services for individuals who were not able to access mental health care in a timely manner.

The Department has received $19.7 million American Rescue Plan Act (ARPA) State and Local Federal Recovery Funds from the Governor’s Office to contract for 64 private hospital beds to serve forensic and civil patients. The Department has already contracted for 24 beds and is in the process of negotiating contracts for the remaining 40 beds. Through the same funding stream, the Department is in the process of contracting with a psychiatrist to provide consultation services to jail based medical providers and assist in addressing medication needs of acute individuals waiting for a bed.

The Department also received an increase for wrap-around funds for the Momentum Program in the amount of $270,000 to assist with transitional planning and services for individuals who could be served in the community or secure care settings such as assisted care facilities, sober homes, nursing care facilities or independent living arrangements.

The Department has found that courts are more willing to allow individuals to receive services in outpatient settings if housing options are available. Many individuals require nursing homes, assisted living or independent living options. The fines committee has invested in housing options for a number of individuals waiting at Colorado Coalition for the Homeless, and the Department intends to utilize the funding allocation for Momentum to assist with paying for housing options at higher levels of care when appropriate.

Other options the Department is exploring include:

The Department is attempting to continue and expand the Denver jail pilot program for restoration services in Denver jail for an additional year. This program will provide up to 24 beds for restoration services.

Another area of focus to address the waitlist is to reduce the length of stay at CMHIP by improving medication compliance while patients wait in jail. This coupled with increasing the
amount and quality of restoration treatment, and dedicating psychologists at CMHIP to manage evaluations when a restoration patient has possibly been restored in advance of the statutory timelines for evaluations.

Additionally, the Department believes empowering local communities to solve issues at the local level by implementing a Competency Services Planning Committee (CSPC) that requires all local stakeholders (Judicial, Public Defender, District Attorney, Forensic Navigator, Law Enforcement, Treatment Agencies, etc.) to develop a plan to improve competency at each Judicial District. Each Judicial District would be allocated funds according to population, need, resource desert, etc. The plans would be reviewed and approved by the Department.

MENTAL HEALTH INSTITUTES

11. [Rep. McCluskie] The JBC Staff Briefing Document provides an update on forensic competency issues, the status of the waitlist, and potential budgetary implications (see issue brief beginning on page 14 of the document).
   - If the General Assembly funds request R2 to operate the additional 44 beds at Fort Logan, how much will that help with the waitlist situation? Please explain the anticipated impact.

It is anticipated we will be able to serve between 109 and 115 individuals annually in the 44 beds based on an average length of stay of 146 days. The original plan for these beds was to mitigate any future increase in referrals and to maintain compliance of the consent decree, however since the onset of the pandemic the Department is attempting to re-establish the progress it achieved before February 2020.

12. [Sen. Rankin] With request R2, the department is proposing an increase of $10.3 million General Fund and 78.3 FTE to operate the new 44 bed forensic unit at the Colorado Mental Health Institute at Fort Logan. We always talk about catching up on the forensic bed need and the need to expand access to civil beds. Please discuss:
   - The total number of beds needed for both populations (civil and forensic).

State psychiatric hospital beds for civil and forensics are typically combined when calculating need as it is always the goal to convert forensic beds into civil beds over time. Per the 2015 Western Interstate Commission of Higher Education, Colorado needs an average of 1,005 state hospital beds to serve both civil and forensic populations based on its overall state population projections; with the most aggressive projections predicting a need for 1,125 beds. Today, Colorado has 654 state hospital beds (including this 44 bed request). In order to help assist in addressing the waitlist, the Department is contracting for 80 private beds and 104 jail based treatment beds (these beds can not serve very ill clients).

The long-term mechanism to address the rising court orders for inpatient forensic beds is to build up to the 1,005 beds and implement policy that eases access to civil services and provides the court system with access to outpatient behavioral health services. It should be
noted that the state does not have lower-level residential treatment beds available to promote the discharge of long-term patients into lower levels of care, therefore freeing up inpatient beds. The Department has submitted a capital request to begin this process.

It should be noted prior to the pandemic, the state was making significant progress with its original plan to address the competency waitlist (that original plan included the current 44 bed request). However, with workforce shortages and outbreaks of COVID-19, the state bed capacity has been significantly reduced. The approach going forward must be two fold, continue to progress towards more state beds over time and improve court access to the community behavioral health system.

Currently, CMHIP is serving almost exclusively the forensic population or individuals with a former forensic status who now are considered civil patients. CMHIFL’s 94 beds are for civil patients with the 44 new beds dedicated to forensics.

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>#</th>
<th>Location</th>
<th>Status</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>516</td>
<td>CMHIP</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>94</td>
<td>CMHIFL</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>44</td>
<td>CMHIFL</td>
<td>Pending</td>
<td>Open Early 2022</td>
</tr>
<tr>
<td>Inpatient</td>
<td>80</td>
<td>Private Hospital Beds</td>
<td>Temporary</td>
<td>Summer 2022</td>
</tr>
<tr>
<td>Assisted Care Group Homes</td>
<td>24</td>
<td>Pueblo/ Broomfield</td>
<td>Proposed</td>
<td>Open Summer 2023</td>
</tr>
<tr>
<td>Jail Based Restoration</td>
<td>104</td>
<td>Arapahoe/ Denver/ Boulder jails</td>
<td>Time-limited, as needed</td>
<td>Ongoing; 12 beds expire 6/2022</td>
</tr>
</tbody>
</table>

- The estimated cost of expanding capacity and operating this number of beds.

Based on the analysis that the state should operate a total of 1,005 state hospital beds and it is currently operating 654 state beds (assuming R2 is approved), this table demonstrates the additional costs to build and operate the remaining 351 beds:

<table>
<thead>
<tr>
<th>New Beds Needed</th>
<th>Operating Cost per day*</th>
<th>Annual Operating</th>
<th>Capital Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>351</td>
<td>$1,125</td>
<td>$145M</td>
<td>$877M</td>
</tr>
</tbody>
</table>

*The average general adult cost is based on daily rates at CMHIP and CMHIFL.
The Department is trying to mitigate some of these costs by proposing to operate state-run group homes that will make it easier to discharge people out of the hospital into a setting that is almost a third of the cost. In addition, if these individuals are clinically appropriate for the group home setting and Medicaid eligible, the Department can draw down Medicaid funds.

- How far behind those metrics are we? That is, how does our current capacity on the civil side compare to other states based on a population-based metric?

SEE BULLET ONE RESPONSE

- For the civil beds, please discuss options that the State should consider to provide the necessary beds. Should those beds be state operated in state facilities (such as the Institutes)? Or should the State contract with private providers to support those beds? Please explain the pros and cons of different options.

COMBINED WITH RESPONSE BELOW

- Please provide similar information for forensic populations and for jail-based services, including the current shortfall relative to accepted benchmarks and options to close any potential gap.

State run civil and forensic beds are comparable or cheaper in price to private hospitals. State-run beds also give the Department the ability to ensure admittance regardless of criminal history or other factors which often prevent individuals from being admitted in the private sector. This is not to say that the Department should not take a hybrid approach of using state and private contract beds, both would require state General Fund as a result of the individual's length of stay exceeding what Medicaid will pay.

For jail-based services, the number of beds in this setting is dependent on the number of individuals placed on bond, the acuity of the individual, and the capacity in the state hospital. This is not an ideal setting for individuals who are acutely ill and should only be an option for those that are not acutely ill and may pose a community risk.
13. /Rep. Herod/Rep. Ransom/ Please discuss the pros and cons of the current geographic distribution of state behavioral health services (with the Institutes in Pueblo and Fort Logan).

- Does it make sense to have so much of the capacity in Pueblo, with required transportation costs and the other impacts of that scenario?

Pueblo has been a tremendous community that has supported CMHIP and other CDHS facilities for decades. Any future expansion and investment in additional state beds should be one of the three major frontrange metro areas: Denver, Colorado Springs, or Fort Collins. In addition, the pandemic has significantly impacted our direct care staffing at all our health care facilities, particularly in Pueblo. If staffing issues cannot be resolved in the future, the Department will need to re-evaluate its ability to fully staff the hospital in Pueblo.

- Where is all of our existing infrastructure, and where should it be?

<table>
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</tr>
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</table>

The reality of the current workforce issue is that any future expansion of hospital beds should be in one of the three major frontrange metro areas: Denver, Colorado Springs, or Fort Collins. However, it is important to note that enhancements to the state behavioral health system should include group home beds and an improved community behavioral health system to accompany the expansion of state hospital beds.

- How does the geography of the system interact with the current workforce shortages in the behavioral health field? Please explain.

The state hospital in Pueblo is the fourth largest employer of that community and competes with other hospitals and medical settings in that region. Prior to the pandemic the state was able to operate the hospital to full capacity with some challenges in maintaining appropriate staffing levels. Since the pandemic started and the demand for nurses has risen, the hospital has not been able to run at full capacity, has had to shut down units, and operates most units
at emergency levels. The 2015 WICHE study recommended that if a new hospital were to be built, it should be north of Denver, to account for the rising residential development there and access to available workforce.


- Please discuss potential uses of one-time funds to create capacity throughout the state and reimagine our behavioral health infrastructure.

The demand for competency has risen during the pandemic and the access to beds has decreased. One-time funds are ideal for addressing capital costs or the temporary payment for the use of private psychiatric hospital beds. Any investment in permanent solutions will have on-going operational costs. To date the Governor’s Office has made available the following using emergency stimulus funds:

- $19,746,500 to place approximately 150 of these individuals in 64 private hospital beds over the next year.
- $250,000 for medication-prescribing services for all individuals waiting in jail across the state.
- $270,000 for housing assistance and case management for successful community placement of approximately 40 individuals.

There could be one-time investments that will assist in bringing the state into compliance with the current consent decree. Prior to the pandemic, the state was close to coming into compliance with the consent decree, but has since seen its largest number of individuals waiting for an inpatient bed. There are two main ways to become compliant: increase capacity of beds and to provide alternate treatment options instead of inpatient care. The following rough estimates would create additional capacity:

- Group home beds (98 beds but scalable) will free up inpatient beds in the state hospitals by moving patients who are ready to go into lower levels of care and allow the state to use those freed beds for competency clients.
  - One-time: $22.2M
  - On-going: $13M of which $7.8M is new GF
- Renovate existing unused 16 bed unit at Ft. Logan
  - One-time: $8.6M
  - On-going: $8.0M of which $6.8M is new GF
15. [Rep. McCluskie] The JBC Staff Briefing Document provides an update on forensic competency issues, the status of the waitlist, and potential budgetary implications (see issue brief beginning on page 14 of the document).

- The Department has reported that 95 beds at CMHIP are currently unavailable because of staffing shortages at the Institute. Please discuss the Department's plan to address those staffing shortages and make that capacity available again.

- As a result of the national healthcare crisis, CMHIP closed three units and two half units in order to maintain the staffing ratios necessary to keep our patients and staff safe. Resulting in 95 vacant beds.

- The following chart outlines all of the units at CMHIP and what staffing ratio they were operating at during the A shift (7am - 7pm) and B shift (7pm - 7am). On October 29, 2021, CMHIP closed a half-unit to ensure proper staffing ratios and the hospital still dropped below emergency staffing on November 6, 2021.

- The following table outlines each classification used for direct care staffing, their corresponding hourly wage (mid-point), the total number of positions, and the number of vacancies on a given date.
To open the three vacant units and the two half units, CMHIP would have to fill at least 158.6 of the 232 vacant positions.

CMHIP is considering every opportunity to increase the critical workforce essential to running a hospital, including:

- Reinstituted the Sitter Program which allows salaried CDHS employees to be compensated for working a direct care shift.
- Canceled all non-emergency clinics and reallocated the staff on the units
- Clinical Safety Specialists (CSS) are trained in unlicensed nursing functions and were pulled in to provide direct care covered on the units. The Central Transport Unit (CTU) staff were then reassigned to the duties of the Clinical Safety Specialists.
- CMHIP is a training hospital and has over 100 nursing students at the hospital. CMHIP invited nursing students to work 1 – 2 days a week as unlicensed nursing staff.
- Offering and mandating overtime to direct care staff.
- Mandating overtime to maintain staff-to-patient ratios.
- Leveraging contract staffing agencies, including CDHS contracts.
- Requiring nursing leadership to work direct care shifts, “on the floor”.
- Eliminated Subject Matter Expert (SME) application reviews for all open and continuous classifications.
- CMHIP is providing offer letters pending background checks and allows the candidate to start the hospital new employee orientation (NEO) prior to receiving their background check. The employees will not be allowed to have patient contact without a successful background check.
- In the process of executing a contract for a sourcing and recruiting agency for direct care staff.

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<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Care Aide I</td>
<td>$15.00</td>
<td>61</td>
<td>34</td>
<td>37</td>
<td>34</td>
<td>33</td>
<td>33</td>
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<tr>
<td>Client Care Aide II</td>
<td>$15.79</td>
<td>136</td>
<td>58</td>
<td>61</td>
<td>63</td>
<td>67</td>
<td>72</td>
</tr>
<tr>
<td>Health Care Tech I</td>
<td>$21.08</td>
<td>41</td>
<td>9</td>
<td>11</td>
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| Percentage Vacant              | 28.4%       | 30.8%          | 31.3%     | 33.4%     | 33.4%     |
Partnering with refugee resettlement programs to match refugee skills to organizational needs.


- For the state FTE at the Institutes, please discuss the impact of employee classifications and salary issues? Are those issues driving the staffing shortages? What can the State do to become competitive to support these positions? Please explain.

Nationally, 18% of healthcare workers quit during the pandemic, and the remaining healthcare professionals are moving to better paying positions. Registered Nurses can make up to $5,000/week for traveling nurses and local hospitals are offering $20,000 sign-on bonus. When CMHIP increases pay, the surrounding hospitals are able to quickly adjust their pay to remain more competitive. The following table outlines each classification used for direct care staffing, their corresponding hourly wage (mid-point), the total number of positions, and the number of vacancies on a given date.

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The Department is mitigating the significant number of vacant positions at CMHIP by backfilling with contractors and utilizing overtime to cover shifts. This approach is significantly more expensive than staffing with classified employees at regular time pay as can be seen in the comparative analysis of contractor rates and FTE, below. In some cases, average contractor rates are closer to 200 percent higher than average FTE costs. In addition, the Department continues to experience significant contractor rate increases, which is absorbed in the MHIs’ personal services appropriation.
Comparative Analysis of Average Contractor Rates as Compared to Average State FTE Costs for the quarter ending 12/31/2021.

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<td>Licensed Psychiatric Technician (LPT)</td>
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17. [Rep. Herod/Rep. Ransom] Please discuss the pros and cons of the current geographic distribution of state behavioral health services (with the Institutes in Pueblo and Fort Logan).

- Given the staffing challenges at CMHIP in particular, is the Department thinking outside of the box regarding how we could meet the needs of patients and increase capacity at CHMIP (e.g., contracting out for food services)? Please explain.

CMHIP is considering every opportunity to increase the critical workforce essential to running a hospital, including:

- Reinstituted the Sitter Program which allows salaried CDHS employees to be compensated for working a direct care shift.
- Canceled all non-emergency clinics and reallocated the staff on the units
- Clinical Safety Specialists (CSS) are trained in unlicensed nursing functions and were pulled in to provide direct care covered on the units. The Central Transport Unit (CTU) staff were then reassigned to the duties of the Clinical Safety Specialists.
- CMHIP is a training hospital and has over 100 nursing students at the hospital. CMHIP invited nursing students to work 1 – 2 days a week as unlicensed nursing staff.
- Offering and mandating overtime to direct care staff.
- Mandating overtime to maintain staff-to-patient ratios.
- Leveraging contract staffing agencies, including CDHS contracts.
- Requiring nursing leadership to work direct care shifts, “on the floor”.
- Eliminated Subject Matter Expert (SME) application reviews for all open and continuous classifications.
- CMHIP is providing offer letters pending background checks and allows the candidate to start the hospital new employee orientation (NEO) prior to receiving their background check. The employees will not be allowed to have patient contact without a successful background check.
● In the process of executing a contract for a sourcing and recruiting agency for direct care staff.
● Partnering with refugee resettlement programs to match refugee skills to organizational needs.

A key risk of hiring contractors over filling vacancies is the pay disparities it creates with state staff. Contractors typically are paid at a higher rate than state employees.

● For other (non-state) providers, are we compensating and valuing those providers properly? Please explain.

Per an article in The Colorado Sun on December 12th, 2021, the 17 community mental health centers (CMHCs) have 1,092 job vacancies combined, according to data collected by the Colorado Behavioral Healthcare Council. That includes 233 administrative jobs and 859 openings for clinical workers, or 16.4% of the total clinicians. Clinicians are leaving community mental health clinics to work in hospital systems that are expanding their behavioral health networks, or they are signing on with telehealth startups where not only is the pay better but they can work from anywhere in front of a computer screen. Salaries offered at CMHSs are significantly lower -- approximately $20K lower, per the article -- than salaries offered by healthcare systems and telehealth startups. Since CMHCs often work with clients who have complex needs, the work is harder for less money. Additionally, there is more paperwork required due to government funding sources, which adds to an already-heavy workload.

Without a market analysis we are unable to speculate on the needed provider rate increase to consider the proposed compensation as proper. We do know that our providers along with our state facilities are experiencing staffing challenges during COVID. Many behavioral health providers are starting private practices as it is easier to implement today due to advances in billing and telehealth technologies. In addition, under COVID, there is a surge of the use of contract nursing staff which cost significantly more than salaried employees. These nurses are being reimbursed two to three times more than salaried employees. While the Department does not set its community behavioral health contractors’ compensation rates, it does plan to work closely with HCPF on examining any adjustments needed to rate setting and defining the true cost for services.

At the state institutes, last year the Department increased the salaries of our medical staff and we intend to partner with the University to reevaluate annually in order to stay competitive in the market.
19. [Rep. McCluskie] With regard to recruiting and retention challenges at the community mental health centers, I am concerned that there may be things other than salaries at play. In Summit County we chose to come together to provide additional funding for behavioral health services, in part, because we were frustrated with the services provided by our CMHC. We were able to fill positions by working with our local FQHC. What is the Department aware of related to community-based workforce issues (e.g., salary survey information, other efforts to improve recruitment and retention)? Specifically address any efforts related to bilingual workforce recruitment and retention.

Behavioral health provider shortages are most acute in rural and frontier areas of Colorado. However, no region of the State can be said to be adequately served by a sufficient number of behavioral health clinicians.

Per a recent article in The Denver Post and The Colorado Sun, the State’s 17 Community Mental Health Centers have 1,092 job vacancies combined, according to data collected by the centers’ trade group (i.e., Colorado Behavioral Healthcare Council). That includes 233 administrative jobs and 859 openings for clinical workers, or 16.4% of the total clinicians.

A Behavioral Health Workforce Development Workgroup met from March through September 2021 and developed almost 70 recommendations to address the workforce shortage. Recommendations included:

- Expanding the capacity for a culturally competent licensed and unlicensed behavioral health workforce.
- Increasing the expertise and competency of providers into safety net workforce strategies to improve access and cultural competency. Develop standards for culturally and linguistically responsive treatment programs to improve opportunities for early engagement for acute clients in need of services.
- Increasing compensation for licensed and non-licensed individuals who complete cultural and linguistic training and corresponding assessments.

Through Senate Bill 21-137, the Office of Behavioral Health received $3.25 million for the Community Mental Health Centers, and one of the allowable expenses was to invest in their direct care workforce with retention bonuses and targeted salary increases.

The Department is building an online training system through SB 137 that will be one tool we use to further train our workforce to serve people of all backgrounds and identities within our state. We are using our block grant stimulus funds to invest $2M in peer services for the Latinx community, $2M in peer services for the Tribal community and $300,000 in BIPOC workforce recruitment. We currently have two contracts in place for peer-delivered recovery support services for the Latinx community and both contracts require the services to be delivered in Spanish and English.
The Department will soon be recruiting for a Workforce Development Specialist, which will be the first time Colorado will have a position solely dedicated to the statewide behavioral health workforce needs.

Proposals currently being considered by the BHTTF include: short-term emergency relief opportunities for providers to use for recruitment and retention such as housing or child care funds; loans and scholarships; trainings to improve competencies and promote a pipeline; increasing entry-level opportunities and promoting a new clinical workforce such as the behavioral health aide program, peers or community health workers.

20. [Rep. McCluskie] Among other changes associated with forensic services, request R13 proposes to create a new Forensic Support Team line item within Forensic Services and move $1,495,996 General Fund and 19.0 FTE from the Forensic Services Court Services line item to the newly created line item. Please provide additional detail on the distinctions between the proposed line items under the new structure. How will this improve transparency and the Department's budgetary management associated with Court Services? Please explain.

The Court Services team consists of the Forensic Evaluators (Psychologists) who are responsible for completing the court ordered evaluations and to provide opinions on competency or sanity or mental condition.

The Forensic Navigators are care coordinators who are responsible for monitoring the pretrial defendants who have been found incompetent to proceed and are awaiting admission for inpatient restoration services. Their clinical input helps the Admissions Team determine priority for admissions for inpatient restoration services. They continually review the acuity level of the defendant and when appropriate make recommendations to the court to consider outpatient restoration services or the potential to resolve the charges. The Navigators are the primary point of contact for judicial stakeholders to track progress towards competency.

The original appropriation for the Forensic Support Team was allocated to the Court Services. As this program has been implemented over the last two years, it has become necessary to track operating expenses separately for the two work units to accurately reflect costs associated with each service type and determine the future costs required to account for the projected increases in the pretrial defendants served.
21. [Rep. Herod] We are seeing holes in the safety net, impacting civil and forensic populations. Patients trying to get services are unable to get them. Other patients may go through criminal justice diversion programs multiple times but never receive the services that they need. As a result, they can end up committing a higher level offense later on, and that is the only way that they can receive services.

- What do we need to do to provide a safety net of community-based services for all of these situations, so that patients can get the services they need and so that diversion programs can have long term outcomes and avoid downstream interactions with the criminal justice system, potentially adding to the need for forensic and competency services that could have been avoided with earlier treatment?

Senate Bill 19-222 requires the state to have a complete and comprehensive behavioral health safety net by January 2024. This will require a significant investment in capacity building to accompany the policies being developed by the Department and HCPF. Colorado is in the process of developing its own safety net model that includes a funding mechanism to sustain the system; standards that should be established; and monitoring performance. The bill requires CDHS and HCPF to strengthen and expand the safety net system so that individuals with behavioral health disorders will not be allowed to be turned away from treatment or discharged without help and coordination unless or until the individual no longer requires behavioral health services. The model establishes the minimum set of behavioral health services that must be provided in each community and is developed as part of the regulatory framework for the Behavioral Health Administration. We are not waiting until 2024 to make a plan for the system or to invest in filling gaps. We are taking full advantage of the influx of federal dollars to add capacity to the system and care coordination to get people to the services they need.

These changes will promote avoidance with the criminal justice system by having a community safety net system that:

- Offers early intervention strategies to ensure that services meet the needs of intended populations, including BIPOC Coloradans, who are less likely to be offered early intervention and routine services that could prevent criminal justice involvement.
- Offers easy access into the community behavioral health system,
- Promote proactive engagement strategies to individuals who may be noncompliant to treatment
- Have services available regardless of criminal history
- Has stronger oversight and a strong set of standards defining quality of care,
- Offers courts access to services without concern that treatment will be discontinued,
- Has community safety net providers that are required to serve individuals discharging from safety net hospitals.
• Is affordable and accessible and can help Coloradans navigate barriers such as transportation and child care and offers supports for social determinants of health
• Offers services in an individual’s native language and/or in a culturally competent manner
• Offers high-intensity behavioral health treatment, or a community-based, client- and family-centered approach specifically designed to engage children, adolescents and adults with severe mental health and/or substance use conditions who are at risk for or experiencing complicating problems such as physical health, developmental challenges and/or involvement in criminal and juvenile justice systems

22. [Rep. Herod] We are seeing holes in the safety net, impacting civil and forensic populations. Patients trying to get services are unable to get them. Other patients may go through criminal justice diversion programs multiple times but never receive the services that they need. As a result, they can end up committing a higher level offense later on, and that is the only way that they can receive services.

• What do we need to do to build that safety net? Where are the geographic gaps in the continuum where services are not available to specific communities or populations? Where are we missing parts of the continuum more broadly (throughout the state)? What do we need to do to build that safety net? And what would it cost?

We are using existing data to build a comprehensive safety net and collecting more information now. The Department is currently contracted with the Colorado Health Institute to assess regional gaps in the safety net to further inform the development of the comprehensive safety net.

From previous research and stakeholder input, including the SB 19-222 Implementation Report and the 2020 Behavioral Health Needs Assessment, we know Colorado’s rural and frontier communities disproportionately struggle with behavioral health. These communities have high behavioral health need and poor behavioral health outcomes (e.g., higher ED rates, suicide and overdose). Stakeholders in the rural and frontier communities described significant challenges with access to crisis, inpatient and other acute care services for high risk behaviors such as overdose, suicide and withdrawal management. Often individuals need to travel hours and sometimes through potentially challenging terrain (i.e., mountain passes that close in the winter) to access these services. Stakeholders and particularly those in rural and frontier regions highlighted the need for an expansion of intensive outpatient services and medication-assisted treatment to meet substance use needs, particularly for adolescents.

Priority populations such as people of color and LGBTQ+ Coloradans have challenges accessing appropriate care because providers lack cultural competence to help engage and support them in treatment. Coloradans have shared that they stopped trying to access services when they could not find a provider that looked like them, could communicate with them or was from their community. Most regions in Colorado report lacking adequate bilingual and bicultural providers and services for non-English speaking, immigrant, and refugee populations.
Delivering services in a culturally and linguistically competent manner is critical to the successful implementation of the Comprehensive Safety Net Model and Framework and to the long-term improvement of behavioral health outcomes for these populations.

The most significant gap in the mental health continuum is residential step-down beds. Colorado has no facilities for adults coming out of long-term civil beds or for youth with co-occurring developmental disabilities. The State also needs more inpatient hospital beds to serve both the civil and forensic populations. On the substance use continuum, Colorado lacks residential step-down as well, including housing for people with criminal justice history. The State also lacks youth outpatient therapy for substance use.

The State is working on funding for safety net capacity building through the Behavioral Health Transformational Task Force, including requesting funding to promote treatment on demand, increasing hospital capacity to refer individuals in ER/inpatient service to care following discharge; holding providers accountable for serving those with the highest needs; promoting access to quality behavioral health in the criminal justice population; maintaining stabilization post-hospitalization or post-crisis; extending I Matter (youth telehealth services) and extending the number of sessions to be covered if not covered by a payer; and strengthening school-based behavioral health access. School-based services receive close to 100% match through Medicaid special financing; this line item could be significantly increased. We’ve asked for a significant investment in the safety net.

23. [Rep. McCluskie] Please respond to some of the recent public reports and discussions of failures in the current system. In addition, please describe the process of planning for the creation of the BHA and the transition to implementing the BHA plan.
   - Given where we are at this point in time, we cannot wait until 2024 to provide services for those who are in crisis now. What measures are we putting in place to meet those needs now, given the urgency of recent public conversations? Please explain the near-term, medium-term, and long-term plans to address these needs, including the BHA.

Near-term - by July 2022

The Office of Behavioral Health has received more than 200 million additional dollars through federal block grant stimulus, state stimulus dollars and Senate Bill 21-137 to invest in the system now while we are setting up the safety net continuum in our state. We are strategically using these funds to build capacity. Investments include more than $7 million in peer services, one of our state’s key workforce extenders, including peers specifically for Tribal and Latinx communities. We are also investing more than $10 million in recovery supports, including housing, to help support and keep Coloradans in recovery and out of the emergency room or treatment.

We have also significantly invested in youth mental health in our state, most notably through the I Matter program, which provides three free therapy sessions to any youth in our state. As of December 10, the program had nearly 1,400 scheduled or completed appointments.
from youth across the state. OBH is also using block grant stimulus and SB 137 dollars to expand services for youth in crisis and youth with serious mental illness.

In July, Coloradans will be able to dial 988—a new, nationwide, three-digit phone number—to connect with crisis support for any mental health crisis. The State of Colorado is one of four states so far that have passed a surcharge to fund services for 988. Senate Bill 21-154 enabled OBH to create an enterprise to oversee 988 and, in collaboration with the Public Utilities Commission, set a surcharge to fund the call center in Colorado, mobile response services and marketing of 988. The surcharge will begin January 1 and is expected to collect almost $14M in its first year.

In 2022, OBH will, in partnership with the Department of Higher Education, invest $9M in paying for certificate or degree programs for rural or low-income Coloradans studying in a behavioral health field. This program will cover eligible students’ in-state tuition in approved programs at Colorado institutions of higher education.

All of these efforts will transition to the Behavioral Health Administration in July 2022. The BHA is how the State intends to bring greater accountability to Coloradans for all behavioral health providers through standard-setting for providers, a master contract, a cross-payer grievance and appeals process, and an Advisory Council of stakeholders. In the 2022 legislative session, the State will also run a bill to give the BHA the teeth it needs for system accountability. Additionally, the BHA will prioritize the strengthening of relationships and trust with its partners in the criminal justice system and create a shared vision across the continuum. Both the BHA and criminal justice representatives will need to work together on prioritizing program development, exploring potential alignment, and identifying funding needs.

Medium-term - by summer 2023
The state has a number of existing care coordinators and navigators whose role it is to serve as the client's primary point of contact and to facilitate client care across systems.

- Medicaid’s Regional Accountable Entities, the state’s Managed Service Organizations for substance use disorder services, the crisis hotline, specific mental health programs and some counties all offer coordination or navigation of services but not in an integrated, person-centered way.

The $26 million OBH received through SB 137 is enabling us to set up a care coordination platform in coordination with HCPF by summer 2023 that will harness the power of AI to:

- Empower our state’s existing care coordinators and navigators to truly give Coloradans a central access point for behavioral health services by elevating their capabilities to connect to each other and to resources.
- Increase our state’s workforce capacity to serve more individuals through streamlined reporting mechanisms that will save time and cut out manual processes.
- Dramatically improve Coloradan’s ability to advocate on behalf of themselves and loved ones by allowing them to take charge of their own behavioral health care.
The State is also investing in the workforce through the creation of a learning management system or an online training system that will help our existing workforce develop new competencies to better serve the diverse needs of Coloradans.

We also expect that the $450M in ARPA funds that the State is dedicating to behavioral health will enable us to make transformational investments in the system beginning summer 2022 or as soon as the legislation is signed that directs those funds. The State has asked that those investments help us further develop the safety net, expand the workforce, invest in communities, add much-needed beds for Coloradans with behavioral health issues, support youth with complex needs, provide integrated behavioral healthcare, and immediately invest in saving lives related to the overdose crisis.

Over the next year, the State will also explore mechanisms by which a regional approach to behavioral health could produce greater integration of substance use services with mental health services and increase transparency and oversight. One such potential mechanism is operating regional behavioral health administrative service organizations accountable for the delivery and funding of behavioral health services, including care coordination, as recommended by the Behavioral Health Task Force.

**Long-term - by 2024**

Our near-term and medium-term efforts are all in pursuit of developing a true safety net for behavioral health that is available to every Coloradan in our state, regardless of identity or geography. By 2024, the State must have this in place, per statute. The safety net will require a comprehensive set of services to be available to each community in our state.

By 2024, the BHA will be fully operational including the Advisory Council of stakeholders to provide feedback on the system, interagency agreements with other state agencies to give the BHA the insights and authority it needs, and standardized system-wide data collection and reporting.

Senate Bill 19-222 requires the state to have a complete and comprehensive behavioral health safety net by January 2024. This will require a significant investment in capacity building to accompany the policies being developed by the Department and HCPF. Colorado is in the process of developing its own safety net model that includes a funding mechanism to sustain the system; standards that should be established; and monitoring performance. The bill requires CDHS and HCPF to strengthen and expand the safety net system so that individuals with behavioral health disorders will not be allowed to be turned away from treatment or discharged without help and coordination unless or until the individual no longer requires behavioral health services. The model establishes the minimum set of behavioral health services that must be provided in each community and is developed as part
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24. /Rep. McCluskie/ Please respond to some of the recent public reports and discussions of failures in the current system. In addition, please describe the process of planning for the creation of the BHA and the transition to implementing the BHA plan.

- Please discuss the strategy for the creation of the BHA and the role and work of the BHA moving forward.

The BHA will be empowered to lead change, to publicly hold itself and its stakeholders accountable, and to take advantage of every opportunity to ensure Coloradans feel a sense of improved quality of life when they intersect with our system. It will be instrumental in achieving the vision to have a comprehensive, equitable, affordable, effective continuum of behavioral health services that meet the needs of all Coloradans in the right place, at the right time, to achieve whole person health and wellbeing.

The BHA will evolve over multiple years with core functions being added over time and full capacity being achieved in 2024. The BHA will require ongoing iteration and refinement as it addresses the priorities in the Blueprint for Behavioral Health Reform, identifies new and emerging behavioral health challenges to tackle, and invests in evidence-based practices to achieve positive outcomes for Coloradans.

As envisioned, the BHA will:

- Provide ongoing system needs assessment and planning;
- Be the single entity that is responsible for driving coordination and collaboration across State agencies to address behavioral health needs;
- Support a statewide approach to behavioral health, with the BHA working collaboratively to set standards that are adopted across State agencies and in both the public and private sector;
- Implement a standard methodology to be used across all State agencies and programs to collect and analyze data;
- Support and work collaboratively with the Colorado Department of Healthcare Policy and Financing (HCPF) on management of a single fiscal management system to account for all publicly funded services while providing transparent reports, dashboards, and insights to the legislature and stakeholders;
- Support and work collaboratively with the Colorado Division of Insurance (DOI) on mental health parity enforcement and compliance;
- Prioritize, invest in, and implement preventive strategies, in collaboration with the Colorado Department of Public Health and Environment (CDPHE), that mitigate escalation and help Coloradans thrive;
- Set standards for behavioral health services and programs;
- Develop a Master Contract for use by all State agencies when procuring services and supports related to behavioral health;
Serve as a subject matter expert (SME), informing best practice expectations for entities with responsibility for behavioral health benefits, in collaboration with HCPF and DOI;

Assist Coloradans in accessing services, identifying providers, and understanding processes such as commitment procedures via a web-based public, centralized gateway;

Engage counties and local governments in consistent strategic planning and shared funding efforts to address regional and community needs, recognizing that rural Colorado has distinct behavioral health needs;

Support consumers, regardless of payer, when traditional grievance processes fail to bring individual or systemic resolution;

Address and ensure the behavioral health system is inclusive and equitable for all populations across all regions of the State;

Identify and address affordability opportunities to make behavioral health services more accessible;

Facilitate a statewide behavioral health financing strategy and policy;

Provide transparency and accountability for behavioral health system expenditures and performance; and ultimately

Be a problem solver with all partners to ensure the needs of Coloradans are put first.

The Governor’s Behavioral Health Task Force identified six pillars that are needed for a strong behavioral health system to exist. Those pillars are: Access; Affordability, Workforce and Support; Accountability; Consumer and Local Guidance; and Whole Person Care. Further details on these six pillars are available in the Blueprint for Behavioral Health Reform.

25. [Rep. McCluskie] Please respond to some of the recent public reports and discussions of failures in the current system. In addition, please describe the process of planning for the creation of the BHA and the transition to implementing the BHA plan.

- Discuss the role of the BHA, commitments to improve data and analysis to identify gaps in services and improve services and outcomes. How will the BHA focus on outcomes and evaluation, both with what we know now and with where we want to be?

Under the BHA, data will be streamlined across State agencies, payers, sectors, and providers to illustrate a comprehensive view of what is working and where gaps remain in the behavioral health system. Consolidating data to meet the aims of the BHA will:

- Create consistent clinical quality standards for all behavioral health providers to use to measure performance;
- Create consistent definitions of data elements and metrics, including numerators and denominators, on key quality metrics;
- Improve accountability through reporting requirements to ensure providers and intermediaries report data to the State, including complete, accurate, and timely claims/encounter and administrative data;
● Develop quality metrics and define analyses needed to examine quality for specific populations and subpopulations to improve understanding of potential gaps in care, disparity in quality or outcomes and identification of individuals or groups most in need of improved quality;

● Provide clear guidance on validated assessment tools to promote identification of behavioral health and measurement of progress offering quantitative data on system improvement; and

● Provide meaningful analysis and population health data for the State (and reduce unnecessary data collection) as a result of prioritizing critical data elements.

The development of a performance measurement system provides opportunities to transform the system from current state to a future state that aligns with the data needed for the BHA to be a strategic and data-driven entity.

One of the core functions of the BHA will be to set standards and monitor outcomes. Setting standards for behavioral health providers via clinical quality standards and accountability metrics will promote transparency of outcomes.

The BHA will review and update existing standards of care, including program, service, licensing, and documentation requirements to establish a core set of expectations for behavioral health service delivery within Colorado. The BHA will provide best practices on managed care standards and provide data to HCPF and DOI through the needs assessment on opportunities to improve network adequacy as well as other gaps identified through data, grievances, and other sources.

The BHA will be a conduit of information on how Colorado’s behavioral health system is performing so that other State agencies can use that information to make the necessary modifications. The BHA will hold itself and its partners accountable to achieving agreed-upon outcomes. During the time it will take to establish a data interoperability and a performance measurement system, the BHA must be transparent about the vision for the performance measurement system and the progress in the phased approach for implementation. A BHA Performance Dashboard will set expectations for the key milestones for a quality performance measurement system and the extent to which progress is being made towards this vision.

Additionally, Colorado will develop a methodology to specifically measure access to behavioral health services across payers. Such methodology does not currently exist in any state. To know if and when the behavioral health system is accessible to all Coloradans, a methodology must be developed since that is the broad determination being used to demonstrate compelling progress.
26. [Sen. Rankin] Please discuss how we can walk back from the BHA plan to the needs of various populations (such as individuals with severe and persistent mental illness, those with substance use disorders, co-occurring disorders, those in the criminal justice system, individuals with gambling addiction, etc.). What are the needs of those populations and how will the BHA plan address those needs?

Currently, there is a gap in data to fully understand the gaps in:

- population needs (particularly for priority populations),
- the specific needs and services required, and
- the reasons contributing to priority population disparities.

Per the statewide Needs Assessment that was completed in 2020, there were overarching themes across priority populations:

- **Data gaps on priority populations “hide” the behavioral health disparity and level of need.** Across populations, the availability of key data indicators on prevalence, poor outcomes, and need are limited. It is difficult to obtain consistent key indicators across populations and many of the missing data elements “hide” or under-represent the need identified within communities. The disparity in data both illustrates the disparity as well as contributes to the disparity for these individuals.

- **Provider trainings on priority population specific needs and culture are inadequate.** Many of the priority populations have challenges accessing appropriate care because providers lack expertise in treating priority population specific conditions. In addition to the technical skill needed to work with these populations, providers lack the cultural competence to offer effective services. Lack of cultural competence results in significant stigma, poor outcomes and health disparities.

- **Provider representation and diversity of the workforce.** One of the underlying causes of a workforce without cultural competence is that most providers do not represent the priority population backgrounds or reflect the community within the geography being served. Many stakeholders representing priority populations described an urgent need for providers who reflect their communities and who have a natural understanding of cultural and community concerns.

- **Multiple disparities create more barriers to services.** The disparities in care grow and are experienced more acutely for individuals with membership in multiple priority population groups (e.g., individuals who experience homelessness who also have a history of criminal justice involvement; LBG'TQ+ youth who are tribal members; and individuals with SMI and developmental disabilities who have forensic backgrounds). Any single minority population status creates barriers to treatment and to finding services tailored to support their needs. It becomes increasingly difficult to obtain access due to added stigma, eligibility hurdles and fewer adequately trained providers when these status types intersect.

- **Genuine crisis in communities is not prioritized.** Stakeholders representing priority populations described a sense that the legitimate crises in their communities are both unknown and unnoticed and that when they are noticed they are not
responded to in any meaningful manner. Many of these crises are root causes of health disparities and represent life and death trends in the population.

In addition, the BHA will identify the data needed to improve population monitoring, gap identification, and improved understanding of the causes of behavioral health disparities. The BHA will also implement initiatives that result in improved data collection to capture more accurate data about need and gaps in care. Some of this work has already begun with improvements to data collection systems by both OBH and HCPF.

The BHA has an opportunity to identify, monitor and respond to behavioral health disparities across all populations. To do this work, the BHA will:

- Develop and implement a systemic approach to collecting, reporting, and analyzing data and demographics to identify and monitor inequities in order to improve outcome equity.
- Expand workforce capacity to improve outreach, engagement, and quality of care for priority populations.
- Increase provider awareness about behavioral health disparities and responsiveness to implement effective strategies to increase behavioral health equity.

The BHA will leverage the goals set out in the implementation plan for SB 19-222 (Plan to Expand the Safety Net) as it relates to addressing the barriers for various populations. Specifically, key steps in this work include:

- Enhancing data collection and analysis to improve monitoring of trends and facilitate ongoing quality and health outcome improvement efforts.
- Developing best practices to disaggregate data that lead to identification of disparities in care.
- Providing additional training for providers to understand how improved demographic data are central to member engagement and treatment.
- Implementing expanded demographic options on provider forms to collect additional information such as sexual orientation, gender identity, sex assigned at birth, and relationship status.

One of the activities of the BHA will be to continue to support the Office of eHealth Innovation (OeHI) and the Office of Information Technology (OIT) with the ongoing effort to establish a single identifier for each individual in Colorado across programs. This will dramatically increase the ability to track need, access and utilization and to identify populations that are not receiving needed care.

The ongoing assessment of need -- including evaluation of populations who face additional challenges or gaps within the current system -- is another key function of the BHA. The BHA will set the vision and strategy for behavioral health in the state, including recommendations on solutions for gaps in the continuum. The BHA will work
collaboratively with other state departments, local governments, providers, and other partners to address these challenges.

27. [Rep. McCluskie] With request R9, the Department is seeking an increase of 181,433 General Fund and 1.0 FTE to provide training and technical assistance statewide to improve involuntary mental health treatment. I understand there is a lot of work being done concerning involuntary holds, including stakeholder work. Please discuss the role the Office of Behavioral Health has played and is playing in those processes and how that work interacts with the proposed decision item.

On September 26, 2020, the Mental Health Advisory Board for Service Standards and Regulations, (created pursuant to 27-65-131, C.R.S.), which is administered by OBH, submitted recommendations for how to improve involuntary mental health care in Colorado. The formal recommendations included requesting that OBH convene a multidisciplinary stakeholder group to:

- Redefine the Involuntary Transportation Hold;
- Explore which professionals can and should be able to initiate an involuntary mental health hold; and,
- Address professional training requirements.

OBH partnered with Mental Health Colorado and Disability Law Colorado to establish this recommended multidisciplinary stakeholder group. Although the scope of the stakeholder group has expanded beyond the recommendations of the Mental Health Advisory Board for Service Standards and Regulations and R9, OBH continues to actively participate in the various stakeholder subgroups providing expertise in the current administration/implementation of the care and treatment of persons with mental health disorders (Article 65, of Title 27, C.R.S.).

During stakeholder discussions, it was recommended that OBH provide the training outlined in R9 with or without statute mandating the training for intervening professionals. Section 27-65-128, C.R.S. states that “The department shall make such rules as will consistently enforce the provisions of this article.” which gives OBH the authority to produce standardized 27-65, C.R.S. training as a way to “consistently enforce” the provisions of Article 65, of Title 27, C.R.S.

Additionally, Mental Health Colorado, is pursuing additional statutory changes to 27-65, C.R.S. The statutory changes outlined in R9 have been incorporated into Mental Health Colorado’s 27-65 bill draft plan. Furthermore, the Treatment of Persons with Mental Health Disorder in the Criminal Justice System Legislative Committee has also recommended legislation (Bill D) to address 27-65, C.R.S. concerns. However, Bill D does not address the concerns that R9 is attempting to solve.
28. [Rep. Herod] Request R11 proposes to consolidate the existing Criminal Justice Diversion Programs line item and the Jail Based Behavioral Health Services line item into a single line to increase the Department's flexibility to distribute funds in response to demand from communities.

- Please discuss the types of innovations in these areas that are happening throughout the state (e.g., co-responders, the STAR program, LEAD, and Jail Based Services). What is working? What have we learned?
- For Jail Based Behavioral Health Services, is there still hesitation from jails to provide the services? Please discuss the state of those services statewide, and if there is hesitation then please explain why? For example, is the funding insufficient? Is more technical assistance necessary? Please explain.

Highlights of the innovations are as follows:

JBBS:
- 90% statewide jail participation rate
- HB 21-1211 expanded the use of JBBS funds and SB 21-137 appropriated one-time funding of $5 Million to the JBBS program. The Department is currently processing contracts with jails to improve behavioral health treatment and building renovations in jails to reduce solitary confinement.
- During Covid-19 the Department contracted with a tele-health expert that drove all over Colorado to counsel and set up 29 jails with tele-medicine treatment equipment and training.
- The Department partners with the Department of Revenue to provide jail inmates with drivers licenses/state identification which is vital for the behavioral health population to enroll in Medicaid.
- The recent undertaking of the JBBS Study to explore ways to streamline the process and ease the administrative burden on Law Enforcement Partners.
- The State coordinates a flexible service pool of funding for Medication Assisted Treatment for the jails. This reduces contract amendments and administrative burden.
- Outreach to the 10% of the jails that are not accepting JBBS funds occurs annually during contract renewal time. There is not a shortage of funds, it is simply the 10% that do not have JBBS have declined our funding. Reasons for declining funding vary from 1) not needing the funds, 2) smaller jails could not afford the reimbursement method of OBH contracting; to date this has been changed to accommodate those smaller jails, 3) smaller jails also have informed us they cannot justify the staffing costs for very few inmates but not all have opted in to date. Of those 10%, 1 jail is closed (Lake County).

Co-responder:
- OBH provides a flexible framework for communities to develop their co-responder programs and meet their local needs. Teams can be configured based on local resource availability, with an officer dedicated to the team or with a clinician responding based on officer request. Some agencies have a paramedic on the team...
responding with the officer and clinician. Over half of the programs have case managers and programs are beginning to include more peer support services.

- Among more than 25,900 calls fielded by OBH-funded co-responder teams between July 2020 and June 2021, 98% avoided arrest, according to OBH data.
- Co-responder teams were highly effective at diverting individuals from involuntary holds. About 82% of contacts where involuntary procedure data were available did not result in an involuntary procedure.
- The public is highly receptive to co-responder teams. Co-responders provided some form of service (e.g., behavioral health assessment, behavioral health referrals) to individuals on 93% of active calls.
- 32% of active Co-responder teams response calls facilitated the return of local law enforcement back to patrol duties thus reducing inefficiencies in how law enforcement spends its time.
- Co-responder teams work with communities to establish relationships with individuals that have high law enforcement contact with the goal of referral to the appropriate resource. High utilizers (i.e., individuals seen more than once by the program) represented about 25% of all calls.
- For additional information please refer to the following link to the “The Value of Partnership How Colorado’s Co-Responder Programs Enhance Access to Behavioral Health Care” that was recently released August 2021. https://drive.google.com/file/d/11X3rl0rBJ4jdWHIIkwY7IZ1RtMAe467/view

LEAD Highlights
- Preliminary data shows that LEAD is cost effective as compared to the cost of an arrest. LEAD Clients cost between $7,300 and $10,937 versus the cost of a single arrest $10,001. If a person is arrested more than once, LEAD saves local and State government money.
- Case management teams have generated local collaborative arrangements that have brokered housing, sober living facilities, benefits acquisition, and employment for participating clients.
- The LEAD Program utilizes a screening and assessment tool that has a follow up evaluation component embedded.
- LEAD interim evaluation provides more in depth review of progress to date: http://digital.auraria.edu//IR00000232/00001.

The Department does not operate the STAR program. The STAR program is contracted by the City and County of Denver in a partnership with the Denver Police Department and Denver Public Health and Environment.

There are positive impacts of infusing behavioral health efforts into the criminal justice system. Many individuals who are committing crimes, as a result of an untreated behavioral health diagnosis are better served by being diverted away from the criminal justice system and into treatment services. These diversion efforts aim to reduce the revolving door of the criminal justice system by linking individuals to treatment and ancillary services. It is
important to have community based services available and readily accessible independent of the criminal justice system to reach and treat people in a timely manner.

29. [Sen. Rankin] Please discuss the distribution process and mechanisms for the funds addressed in request R11 (diversion programs and jail based services).

- Are the funds for these three programs distributed by grant? What is required to get the funds?
- What is the distribution by county? Are the application requirements too high for some counties to apply? (Add to hearing agenda for discussion)

The funds for the Diversion (Lead and Co-responder) and Jail Based Programs are not distributed by grant; they are distributed by contract.

The Diversion contractors were originally selected according to a Request for Application process that resulted in the contractors that are noted in Table 1 below. The Department does not have appropriations to cover Diversion programs for all law enforcement agencies across the State.

The Department’s JBBS appropriations are reasonably sufficient to cover all Jails that wish to have a contract with the Department and all jails are offered a contract. Please note that these appropriations however only cover a portion of behavioral health costs for larger jails as larger counties often cover the cost of their behavioral health teams.

The requirements to receive funding is that the county or local law enforcement agency must complete the State contract. Once agencies are under contract with the Department, the contract renewal process has not been an issue.

The Department is not under the impression from jails or local law enforcement agencies that the contracting requirements are too high once they are engaged in the contracting process. The Department recently solicited feedback from Law Enforcement partners through the JBBS study mentioned above. Based on the feedback received, contract changes were made to ease the contract burden on our partners. Feedback was also received from the Departments Law Enforcement Partners, that Diversion and JBBS Programs have competing demands, i.e. if Diversion programs are successful in diverting individuals from incarceration, thus impacting JBBS intakes.

Approximately 90% of all Colorado jails participate in JBBS and are under contract and 100% of the awarded Diversion contractors are under contract. Each year the Department’s staff provides a high volume of technical assistance to county jails and law enforcement agencies that includes individually outreaching each contractor jail or law enforcement agency to provide technical assistance including consultation and review of contract work plans, contract budgets, training resources, recommendations for behavioral health service providers, and support to help their programs grow.
Non-participating jails include the following counties along with the respective current rationale for not participating: Jackson (workforce shortage can’t prioritize right now), Broomfield (maintains their own program and declined a contract with OBH), Gilpin, Costilla, Saguache, and Rio Grande (multiple communications have been sent to counties to engage in contracting with OBH and they have not responded or did not express interest in participating).

The Department’s Diversion Program currently has the maximum number of programs that can be supported by the appropriation and all local law enforcement agencies are under contract. Please see Table 1 below for distribution by local law enforcement agency and the county that the agency is in.

<table>
<thead>
<tr>
<th>Agency/County</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Arvada/Jefferson County</td>
<td>$235,600</td>
</tr>
<tr>
<td>Boulder County Community Services/Boulder County</td>
<td>$264,500</td>
</tr>
<tr>
<td>Summit County Sheriff’s Office/Summit County</td>
<td>$264,500</td>
</tr>
<tr>
<td>Westminster Police Department/Jefferson &amp; Adams Counties</td>
<td>$270,000</td>
</tr>
<tr>
<td>Vail Police Department/Eagle County</td>
<td>$290,000</td>
</tr>
<tr>
<td>City of Alamosa (LEAD)/Alamosa County</td>
<td>$545,703</td>
</tr>
<tr>
<td>City and County of Denver (LEAD &amp; Co-Responder)</td>
<td>$901,517</td>
</tr>
<tr>
<td>City of Longmont (LEAD &amp; Co-Responder)/Boulder County</td>
<td>$893,761</td>
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<tr>
<td>Pueblo County (LEAD)</td>
<td>$535,000</td>
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<tr>
<td>Regents of University of Colorado (LEAD)</td>
<td>$219,993</td>
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<tr>
<td>Public Defender Association (LEAD)</td>
<td>$40,000</td>
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<tr>
<td>City and County of Broomfield</td>
<td>$324,373</td>
</tr>
<tr>
<td>(Co-Responder)</td>
<td></td>
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<tr>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>El Paso County (Co-Responder)</td>
<td>$369,075</td>
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<tr>
<td>City of Evans (Co-Responder)/Weld County</td>
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<tr>
<td>City of Grand Junction (Co-Responder)/Mesa County</td>
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<td>Larimer County (Co-Responder)</td>
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<td>Pitkin County (Co-Responder)</td>
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<td>City of Canon City (Co-Responder)/Fremont County</td>
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<tr>
<td>Douglas County (Co-Responder)</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$7,034,172</strong></td>
</tr>
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Please see Table 2 below for a current snapshot of the Jail Based Behavioral Health Services county jail allocations for FY 2020-21.

<table>
<thead>
<tr>
<th>Table 2</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>CDHS-Office of Behavioral Health</strong></td>
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<tr>
<td><strong>Jail Based Behavioral Health Program</strong></td>
<td></td>
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<tr>
<td><strong>FY 2021-22 Current Contract Allocations</strong></td>
<td></td>
</tr>
<tr>
<td>County Jail Name</td>
<td>Total Amount*</td>
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<tr>
<td>--------------------</td>
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</tr>
<tr>
<td>Adams</td>
<td>$1,259,300</td>
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<tr>
<td>Alamosa &amp; Conejos</td>
<td>$287,000</td>
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<td>Arapahoe</td>
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<td>Boulder</td>
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<td>Chaffee</td>
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<td>Clear Creek</td>
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<tr>
<td>Custer</td>
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<tr>
<td>Delta</td>
<td>$312,526</td>
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<tr>
<td>County</td>
<td>Total Budget</td>
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<td>--------------------------------</td>
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<td>Denver</td>
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<td>Douglas</td>
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<td>Gunnison</td>
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<td>Huerfano</td>
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<td>Jefferson</td>
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<td>Kit Carson</td>
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<td>La Plata, Montezuma, &amp; Archuleta</td>
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<td>Las Animas</td>
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<td>Larimer</td>
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<td>Lincoln</td>
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<td>Logan</td>
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<td>Mesa</td>
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<td>Moffat</td>
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<td>Montrose</td>
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<td>Morgan</td>
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<td>Park</td>
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<td>Pitkin</td>
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<td>Prowers, Bent, Baca, Crowley, &amp; Otero</td>
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<td>Pueblo</td>
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<tr>
<td>County</td>
<td>Funding</td>
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<tr>
<td>Rio Blanco</td>
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<td>Routt</td>
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<td>San Miguel</td>
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<td>Summit</td>
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<td>Teller</td>
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<td>Washington</td>
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<tr>
<td>Weld</td>
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<tr>
<td>Yuma</td>
<td>$129,147</td>
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<tr>
<td>Total 48 (out of 54 jails)</td>
<td>$21,397,662</td>
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</table>

*Includes Long Bill General Fund, Re-appropriated and one-time funding for SB 21-137

30. [Sen. Rankin] One component of request R12 proposes to strike the term “pilot” from the Behavioral Health Crisis Response System Secure Transportation Pilot Program line item to align with statute. The request also indicates an intent to expand the program statewide. What have we learned from the pilot program? How do we know that it is working and should be expanded? Please explain.

The pilot program evaluation showed that it was largely successful in the number of individuals served through a more trauma-informed and dignified method of transport than that of a law enforcement vehicle. Client satisfaction data was available for both sites over the span of two years. The majority (70.2%) of clients surveyed said they were connected with the services they needed and provided high ratings for the overall quality of the service.

The pilots provided 1,020 transports of individuals who were placed on a 72-hour treatment and evaluation hold and/or voluntarily seeking a higher level of care. The average per transport costs ranged from $864.50 to $1,122 across two sites. Reasons for the transport included, but were not limited to, providing a ride home after discharge or because the individual was gravely disabled, homicidal, suicidal, or in need of critical behavioral health services such as withdrawal management.

Challenges included long distances traveled from the pickup site to the dropoff location, which could be addressed through more widely-available and not site-specific funding.

The Department published two “Transportation Pilot Program (TTP)” reports- one for for FY 2019 and one for FY20 and they are provided as an attachment below.

Transportation Pilot Program Evaluation: A Summary of Findings: 2020
Transportation Pilot Program Evaluation: A Summary of Findings: 2019
The Department knows that the pilot worked and should be expanded because of the following reasons:

- The pilot provided over 1000 transports for individuals who might have otherwise used law enforcement or simply not been transported.
- Clients, staff, and community partners commented on the program’s ability to streamline processes, clarify roles, and provide a more dignified, trauma-informed way of getting people to higher levels of care and other necessary interventions.
- The directors of the programs highlighted the necessity of continuing the programs to avoid returning to long wait times, burdens on law enforcement, and people experiencing poor outcomes.
- HB 21-1085 was passed requiring CDPHE to create a regulatory licensing structure and requiring HCPF to create a secure transportation benefit. Additionally, OBH is required to report on how secure transportation is being utilized and supported within the Behavioral Health Crisis Response System.

31. [Sen. Hansen] Please discuss the limited amount of funding we provide for gambling addiction services. Will those services be under the purview of the BHA?

In September 2021, the Office of Behavioral Health received its first funding for gambling addiction programming from the sports betting fund created in Section 44-30-1509, C.R.S. The Office of Behavioral Health is projected to receive $130,000 annually from the fund to the extent the unexpended and unencumbered balance in the fund permits. The Office receives no other funding for gambling addiction. In accordance with statute, the Office is using $100,000 of the funding for prevention, education, treatment, and workforce development and $30,000 to answer the crisis hotline for Coloradans struggling with gambling addiction.

The annual distribution from the sports betting fund for gambling addiction will transfer to the BHA. It is important to note, according to studies cited by the National Center for Responsible Gaming (NCRG), almost 75 percent of those diagnosed with a gambling disorder had a co-occurring alcohol use disorder and almost 40 percent had a co-occurring drug use disorder. People with gambling disorders also have high rates of mental health issues, including personality disorders (more than 60 percent), mood disorders (almost 50 percent) and anxiety disorders (more than 40 percent), also according to NCRG. Studies cited by NCRG have also shown that three-fourths (74.3 percent) of those who develop a gambling disorder did so after experiencing co-occurring disorders. Therefore, a stronger behavioral health system will help improve outcomes for problem gamblers by providing better and easier-to-access mental health and substance use care.
32. [Rep. McCluskie] Please describe how rural counties fare compared to urban counties for the existing allocation model as well as the updated funding model forecast.

Over the past five years an average of 39% of rural and frontier counties have overspent compared to 52% of urban counties. In that same time period, approximately 20% of both urban and rural counties have overspent by greater than 10% of their total annual allocation (Child Welfare Services Block, Core Services and SB 15-242 New County Staffing allocations combined). In FY 2021, 17% of rural and frontier counties overspent by 10% of their allocations whereas 28% of urban counties overspent by more than 10%.

Some rural and frontier county representatives have stated that they have been under-spent because they are unable to hire the necessary personnel due to budget constraints. Per SB 21-277, the Department will be contracting with a third party to begin a workload study beginning in January of 2022, which should aid the Department and the Child Welfare Allocations Committee to better determine staffing and allocation needs.

In any given year, smaller counties are more likely to have their over-expenditures covered by General Fund since the close-out process allows for over-expenditures to be covered as a percent of the remaining funds. In other words, smaller over-expenditures will be covered before greater over-expenditures creating a greater safety net for the rural and frontier counties.

33. [Sen. Rankin] Please describe the Department's plan for implementing SB 21-277 (Child Welfare Allocation Formula). What will be the CWAC's ongoing role in determining county allocations? Does the Department anticipate any challenges to implementation?

Senate Bill 21-277 requires the Department to update and modify the funding model for FY 2022-23 through FY 2024-25 in accordance with the recommendations of the Child Welfare Allocations Committee (CWAC). A Request for Proposal (RFP) was published in September 2021 and no responses were received. Since then, the Department has been working with county partners to identify qualified and interested entities to hold competitive negotiations to determine if an award can be made. To date, this has been unsuccessful and the Department will likely republish the RFP.

We anticipate that the CWAC will continue to have an ongoing role in determining the county allocations. CWAC members will utilize the funding model as a resource to make data-informed decisions about the allocations to the big eleven and balance of state. The funding model may also assist in calculating/determining the total amount of funding for future funding requests to the Joint Budget Committee.
34. [Rep. McCluskie] Has the Department considered any mechanisms through which end of year under-expenditures from S.B. 91-094 programs could be transferred to increase funding for collaborative management programs (CMP)? Please describe these mechanisms and barriers to implementation.

Specific to SB91-094, funds can be used to divert youth who are involved in the juvenile justice system who are at imminent risk of detention. Since CMP serves children and youth who are involved in multiple systems and are not necessarily served by CYDC, transferring unspent CYDC funds to increase CMP funding would likely require a statute change. Locally, other programs or funding sources could be used to enhance CMP funds. This would require approval at the local level, depending on the program.

35. [Rep. McCluskie] What opportunities exist for blending funding on the state level from other mandatory collaboration partners such as the Judicial Department, Office of Behavioral Health, Regional Accountable Entities (RAE) under HCPF, etc., similar to the existing model on the local level?

There may be potential at a State level to create additional CMP funding opportunities through blending and braiding of funds coming from Civil Fees, Cash Fund, Judicial, HCPF, CYDC etc. This would however require mandatory partners of state agencies and other CMP partners to financially 'buy-in', contributing a portion of their funds to CMP to provide an overall resource increase. Statute changes not only permitting but also compelling the transfer of funds from these agencies and partners to the CMP would likely be required.

36. [Rep. McCluskie] How can resources for data and evaluation at the state level be strengthened or expanded to better support local CMPs? How does the Department support engagement and participation from other state agencies to better align with local practice at the state level?

OCYF collaborates with other offices within CDHS as well as other state agencies to share data necessary for the annual CMP evaluations. In some instances, OCYF spends significant resources educating other agencies about CMP and why data sharing is necessary. OCYF has a data sharing agreement with State Judicial that allows routine data transfer. Currently, OCYF has not been able to establish a similar agreement with the Department of Education (CDE) but has been working with our CDE partners to establish one. This dynamic is paralleled at the local levels, where CMP Coordinators have varying levels of routine access to data and at times lack access. The CMP state administrator supports local CMP sites by meeting with local partners, sharing examples of successful agreements, and educating partners in the importance of data sharing.
RESIDENTIAL FACILITIES

37. /Rep. Ransom/ Please provide an update on the implementation of Family First and Medicaid Institution of Mental Disease requirements for child welfare and youth services residential facilities. How many Residential Child Care Facilities (RCCF) have come into compliance with Qualified Residential Treatment Program (QRTP), Psychiatric Residential Treatment Facility (PRTF), and Medicaid Institution for Mental Disease (IMD) requirements? How many facilities have not yet come into compliance? How many beds are available under the QRTP and PRTF designations?

As of December 2021, 15 facilities are now QRTPs, and three are PRTFs. All 15 QRTP facilities that are currently required to be compliant with IMD requirements have demonstrated compliance. We still have 7 facilities that have indicated they plan to become QRTP and are not yet compliant with QRTP and IMD requirements. We still have 3 facilities that plan to become PRTF and are not yet compliant with PRTF requirements. In total, there are currently 184 QRTP beds and 94 PRTF beds in Colorado.

38. /Rep. Ransom/ Please provide an update on the implementation of S.B. 21-276 (Children's Habilitation Residential Program Enrollment). What number of facilities and beds have been made available for children with intellectual and developmental disabilities under the implementation of the bill?

A Request for Proposal (RFP) was published on November 16, 2021. Responses for this proposal are due on December 16, 2021. The RFP indicates that vendors would need to provide 5 beds at implementation, with the capability to increase to 10 beds. The existing contract formed through SB 18-254 provides 10 beds. This facility has averaged 93% capacity during 2021 to date.

R4 ENHANCING CHILD WELFARE SUPPORT

39. /Sen. Rankin/ What feedback has the Department solicited from counties to determine if the requested positions are the positions best suited to meet county needs? Please describe any county outreach and response.

DCW sought county feedback regarding the intermediary role in a survey completed in 2020. This survey was offered to all counties and received 50 responses from caseworker and administrator roles. The largest trend was that county departments do appreciate responsive County Intermediaries (CIs) who provide information with a broader lens, including information about Division of Child Welfare and community programs, Core Program updates, individual unit updates, legislation and rule, and specialized guidance/support. County department feedback also included a desire for CIs who can invest capacity and time to understand their agency and community culture, including in-person support for many of our rural communities. Requests for in-person support have remained consistent since this survey and are voiced both in statewide meetings and as individual requests to division staff. Of the fifty responses, only four responses reported they felt the CI role was not helpful or
punitive. Additionally, DCW has recently offered increased placement support due to feedback from county partners. This support requires an average of five county-facing meetings and three internal meetings weekly to understand high-acuity youth needs and explore solutions. Counties have also shared that they value the support provided by the (currently time limited) permanency specialist, including working with and supporting collaborative efforts between the Wendy's Wonderful Kids program staff and county staff as they seek permanency for youth as well as helping counties connect with appropriate staff across state lines for interstate adoptions.

R3 County Trails Refresh and Support

40. [Sen. Rankin] A few years ago Trails was a poster child for a new "agile development" process. Please provide a review of the agile development process that was used to modernize Trails, and discuss the effectiveness of this approach. Was each phase completed on time and on budget? Were there quantifiable positive results?

In June 2020, OIT and CDHS engaged the Colorado Digital Service on a nine-month engagement with the Trails team to support the transition to agile and build high-performing teams that could iteratively provide value to users. The work with CDS supported several major changes to how the Trails team operates, including:

- Reallocated of existing resources to support onboarding a new Technical Owner (through CDS), Scrum Master, UX Leader, Project Manager, Release Manager, Quality Owner, and several developers;
- Halting parallel work on distant features to focus on the next iteration and shipping working software;
- Further empowering the Trails Product Owner within CDHS to make product prioritization decisions for the Trails product, including development of priorities for both the vendor and OIT;
- Enhancing collaboration between OIT, CDHS, and the vendor; and
- Supporting implementation of a new team structure to support a future state of "feature releases" that deliver iterative value to end users.

In January 2021, Trails officially pivoted to the use of three focused scrum teams, each with an individual Product Owner overseeing work. Each of these teams is composed of individuals who are fully dedicated to Trails, representing a major shift from the previous "shared services" model. This has allowed the team to build expertise and singularly focus technical talent on shipping the next release of software.

The final agile shift entailed two major changes in the team’s operational framework. The first was moving from a “project” to a “product” approach. Years of focusing on the Trails Modernization project without priority given to underlying operations resulted in lopsided funding in which CGI was resourced to develop new code quickly, but OIT and CDHS were not resourced to support the underlying database. Moving to a “product” mindset allows
Modernization including single, into trade-off users real-time the multi-day successfully Oracle April adjust CDHS Prior Plan or substance Act the Safe deployed the major and significant a and substantial CDHS and OIT did that by focusing on creating highly effective teams that use resources to look across the product and maximize values to users, and that are positioned to continue to make improvements long after a vendor has rolled off.

The major shifts have led to a significant evolution in how the team ships code, and influenced several major releases over the past year-and-a-half:

- **Release 6:** Deployed on May 31, 2020, Release 6 used supplemental funding provided by the JTC to incorporate new functionality into Trails to support implementation of the Family First Prevention Services Act ("Family First"). Family First allows local child welfare agencies to use federal funding to prevent out-of-home placements and places new restrictions around accessing federal funds for congregate care facilities. Release 6 deployed needed functionality related to Family First implementation in Colorado.

- **Plans of Safe Care:** Deployed on December 20, 2020: This release also utilized supplemental funding provided by the JTC to bring Trails into compliance with The Comprehensive Addiction and Recovery Act (CARA) of 2016. Plans of Safe Care addresses the needs of infants who are identified as affected by substance abuse, experience withdrawal symptoms, or have fetal alcohol spectrum disorders (FASD). CARA stipulates that a Plan of Safe Care be completed for the infant and their family/caregiver. Plans of Safe Care went live in Trails on December 20, 2020, and all counties complete a Plan of Safe Care when the referral reason is Substance Exposed Newborn.

- **The Oracle Upgrade:** Both Trails Legacy and Modernized Trails use the same Oracle database. Prior to this upgrade, both systems sat on Oracle 10g, which was no longer supported and resulted in frequent system instability. Due to the risk of a long-term outage, CDHS and OIT made the decision to adjust the Product Roadmap to upgrade Oracle to 19c. Oracle 19c was successfully deployed in April 2021 in a major, multi-day release that significantly increased system stability and security and, for the first time ever, moved users from a daily database sync to a real-time reporting server. The tremendous undertaking of the Oracle upgrade resulted in an approximate year-long delay in Trails Modernization releases. This was a trade-off the team made to ensure that the underlying database would not falter and hinder a caseworker’s ability to access critical information to support kids and families.

- **Release 7:** In June 2021, the Trails Team deployed Release 7, which brought 50% of all users, including all Division of Youth Services users, into a single, modernized
While Release 7 entailed an enormous amount of code, it also had more testing coverage than any previous release.

- Since Release 7, the team has moved to smaller, agile releases every few weeks, resulting in an additional nine small releases to implement fixes and improve functionality, including the re-establishment of an interface between Trails and the judicial system.

DIVISION OF YOUTH SERVICES

REQUEST FOR INFORMATION 3 – YOUTH SERVICES INSTITUTIONAL PROGRAMS REPORT

41. [Rep. Ransom] Please describe what qualifies as an assault as reported under RFI 3. What is the Department doing to address this issue and decrease assaults within Youth Services?

The Division of Youth Services (DYS) categorizes assaults into three levels. The corresponding definitions are provided as follows:

- Level 1 Assault: Intentional act of aggression resulting in injury that requires outside medical attention (e.g.: stitches; broken bone; could not be addressed by first aid; not merely a visit to the medical provider). Note: Due to availability of medical staff at the time of the incident, outside medical attention may not necessarily be due to a serious injury, but rather as a precaution to rule out serious injury.
- Level 2 Assault: Intentional act of aggression resulting in injury that requires first aid medical attention (e.g.: sterile strips for cuts).
- Level 3 Assault: Intentional act of aggression resulting in injury that does not require medical attention (e.g.: bruises; scrapes; spit that makes contact with the eyes or skin).

The Division continues to experience an increase in the complexity of the youth population served. The Division is seeing a higher percentage of youth sentenced as an Aggravated Juvenile Offender, Violent Juvenile Offender, and a Repeat Offender. These are enhanced sentencing options within the statute. In addition, 40% of youth are committed on felony person crimes and 43% committed on violent crimes, which include murder, attempted murder, and aggravated robbery. The Division is also seeing an average age of 16.8 for committed youth and an average age of 16.1 for detained youth (at time of commitment and time of detainment, respectively). By the time youth parole, they are past the age of majority (18.2 years old on average), and 19.0 years old at DYS discharge, on average.
<table>
<thead>
<tr>
<th>Characteristics of Newly Committed Youth</th>
<th>FY 2019-20</th>
<th>FY 2020-21</th>
<th>Increase or Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentenced Aggravated Juvenile Offenders</td>
<td>6%</td>
<td>12%</td>
<td>↑</td>
</tr>
<tr>
<td>Sentenced Violent Juvenile Offenders</td>
<td>6%</td>
<td>7%</td>
<td>↑</td>
</tr>
<tr>
<td>Sentenced Repeat Juvenile Offender</td>
<td>7%</td>
<td>9%</td>
<td>↑</td>
</tr>
<tr>
<td>Committed on Violent Crimes</td>
<td>41%</td>
<td>43%</td>
<td>↑</td>
</tr>
<tr>
<td>Committed on Person Felonies</td>
<td>38%</td>
<td>40%</td>
<td>↑</td>
</tr>
<tr>
<td>Committed on Weapons Crimes</td>
<td>15%</td>
<td>16%</td>
<td>↑</td>
</tr>
<tr>
<td>Formal Mental Health Intervention Required</td>
<td>67%</td>
<td>67%</td>
<td>⇐</td>
</tr>
</tbody>
</table>

The Division has increased staff ratios to a 1:5 ratio statewide in an effort to impact assaults on youth and staff, as well as successfully reducing the use of seclusion and physical system-wide. The staff to youth ratio also allows for better professional relationships between youth and staff, meet youth needs, and create an environment that can be proactive.

The Division has implemented a new risk/needs assessment tool for committed youth that provides clear information to target the youths’ treatment needs/plan.

The Division has also started to implement a new treatment service delivery model that increases hours of treatment (dosage) and targets the risk/needs assessment. Both of these efforts are directed towards reducing inappropriate behaviors in the Division’s youth centers, as well as preparing young people for their return to the community.

The Division is implementing Dialectical Behavioral Therapy in the milieu to support youth to make good choices and provide direct care staff with the tools to teach skills to better address trauma and behavior.

The Division continues to work towards certification of the Sanctuary model, a trauma-responsive organizational approach that supports both youth and staff. One youth center has already been certified with the plan to certify two to three per year. The Sanctuary model is focused on understanding trauma and developing systems and interventions to prevent acting out in the milieu.
42. [Sen. Rankin] Please discuss trend data concerning assaults in recent years as reported in RFI 3.

In FY 2020-21, DYS averaged 15.1 youth-on-staff assaults per month. This equates to slightly more than one (1.2) youth-on-staff assault occurring at each youth center each month (e.g., a staff person assaulted every 25 days at a youth center). The level of assault that occurred most frequently throughout the year was Level 3. In terms of seriousness, Level 3 assaults are the least serious of the three levels, and by definition, are those that do not cause injury requiring medical attention.

<table>
<thead>
<tr>
<th>YOUTH ON STAFF Assaults</th>
<th>FY 2020-21</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul</td>
</tr>
<tr>
<td>Level 1</td>
<td>1</td>
</tr>
<tr>
<td>Level 2</td>
<td>0</td>
</tr>
<tr>
<td>Level 3</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11</td>
</tr>
<tr>
<td>Monthly Average</td>
<td></td>
</tr>
</tbody>
</table>

(Youth-on-Staff Assaults only)
The statewide reduction in assaults (all assaults; youth-on-youth and youth-on-staff), over the past two fiscal years, is shown in the following chart.

Table 1: (Youth on Youth and Youth on Staff Assaults)

<table>
<thead>
<tr>
<th>Month</th>
<th>FY 2019-20</th>
<th>FY 2020-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td>Aug</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>Sep</td>
<td>80</td>
<td>70</td>
</tr>
<tr>
<td>Oct</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td>Nov</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>Dec</td>
<td>80</td>
<td>70</td>
</tr>
</tbody>
</table>

Table 2: (Youth-on-Staff Only)

<table>
<thead>
<tr>
<th>Month</th>
<th>FY 2018-19</th>
<th>FY 2019-20</th>
<th>FY 2020-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
<td>30</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Sep</td>
<td>40</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Nov</td>
<td>25</td>
<td>20</td>
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</tr>
<tr>
<td>Jan</td>
<td>15</td>
<td>10</td>
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<tr>
<td>Mar</td>
<td>20</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>May</td>
<td>10</td>
<td>5</td>
<td>0</td>
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</tbody>
</table>

17-Dec-2021
43. [Sen. Rankin] How would the $45 million proposed renovation for the Ridge View facility be coordinated with existing homelessness programs currently available in the Denver metro area? How was the need determined to establish new facilities in the metro area rather than other regions of the state given existing resources in the metro area?

The following response was provided by the Office of State Planning and Budgeting.

The State works closely with the Metro Denver Homeless Initiative (MDHI), the Denver Homeless Leadership Council, and local city and county governments to coordinate funding from the state with local resources, efforts, and needs. Ridge View would be no exception. We have been in discussions with those partners to develop the Ridge View programming and funding, and to ensure that it is connected to existing homeless and recovery related programs. Existing providers would be able to refer individuals to the program as they now refer to other programs or care. Case managers at Ridge View would work closely with the participant and the referring entity to coordinate the return to the community.

Case managers will help connect participants to community-based employment, specialty care, and other supports to help ensure the person is connected to supports upon re-entry into the community.

There is a lack of recovery treatment and support in general in our state. The Ridge View Supportive Recovery Community concept is based on the need identified throughout the state and in particular in the Denver Metro Area. The 7-county region saw over 31,000 people utilize homeless-related services or programs in 2020. 2021 numbers are still being reviewed, but we know that Denver shelters alone saw a doubling of newly homeless between 2020 to 2021.

We estimate that we need at least 14,600 additional housing units with services for people experiencing homelessness with complex needs. That includes people with substance use disorders. We also have lessons learned from operating the Fort Lyon Supportive Residential Community for over six years that people struggle to find recovery options in general, and especially when they do not have housing. Besides Ft. Lyon, there is no other recovery option for people that is as long as the two year model of Ft. Lyon. Through the Office of the State Auditor's research conducted on Ft. Lyon, there was a clear indicator of recovery and housing placement success for those who were able to participate in healthcare, psych-social, and vocational programming and goals at Ft. Lyon. Therefore, if we want to stop the expensive cycle of substance use disorders, homelessness, incarceration, emergency rooms, etc., we need to give people longer time to truly recover.

In addition to the clear need in the Metro Area, this is also a unique opportunity with the available state owned facility. This is a significantly lower cost to renovate the existing space
than to try to construct a full campus. This is an opportunity to utilize this space for a need that is clearly seen in the Metro Area and across the state.

The Competitive Grants Program portion of the Governor’s Homeless Solutions Budget Proposal includes $100M that could support other similar campuses or programs in other parts of the state. Ridge View was specifically called out in the proposal since the site is already owned and available.

44. /Rep. Herod/ Please describe how the proposed facility at Ridge View will be supported by state and local resources. To what extent will the Department and state government as a whole be involved in the transition and long-term management of the facility? To what extent will local governments be involved in the funding and management of the facility? Please provide any implementation plans, as well as one-time and ongoing state, local, and federal funding sources that have been proposed.

The following response was provided by the Office of State Planning and Budgeting.

We are still finalizing the budget, but the aim is for the ARPA funds to cover the one-time capital costs needed to renovate the campus so that it can be used for this new purpose. We anticipate converting some of the classroom buildings into inpatient medical detox and recovery treatment. The dorms will be renovated to have trauma-informed bathrooms and doors on the rooms.

ARPA funds, both state and local, will assist with at least the first year of operating costs. Medicaid (50 state/50 federal) will cover significant portions of the medical detox, inpatient treatment, and FQHC on-site, immediately and on-going.

The campus will also need ongoing maintenance and the transitional housing, vocational and other programming will also need ongoing funding that will not be Medicaid covered.

The State is working with local partners to identify what existing programs/staff and therefore funding can relocate partially or fully onto the campus. With at least 300 people served per year, that is a significant portion of the clientele for service providers, such as mental health centers, vocational programs, re-entry programs, etc.

There will be a gap for ongoing funding, such as the maintenance of the facilities and property, as well as the general case management for the transitional housing portion of the campus. We are working with local partners to identify what resources they may be able to contribute, knowing that the population being served are often the most frequent users of local and state public and emergency systems.

The property is owned by the state and will continue to be owned by the state. CDHS is the owner and contracted out the previous programming, facility and property maintenance. The state will contract the various parts of the care and programming, as well as the facility
maintenance. For example, a provider with licensing and experience with medical detox and inpatient treatment would be required for the treatment portion of the campus. An operator of FQHCs would operate the one on campus. A homeless services and housing placement provider would operate the transitional housing portion of the program. It would be part of the contract that they would work closely together.

CDHS, HCPF, and DOLA would work together to ensure coordination and communication occurs. The state is identifying a Master Planner consultant to create the renovations and programming plan in detail. This will ensure that the renovations are done in conjunction with the programming model and any licensing or other funding regulations parameters that need to be taken into account.
Office of Behavioral Health (OBH)

Putting People First

OBH oversees and regulates Colorado’s comprehensive public behavioral health care system for mental health and substance use disorder services.
Office of Behavioral Health

Community Behavioral Health
Oversees and purchases substance use and mental health prevention, treatment and recovery services statewide and regulates the public behavioral health system.

Forensic Services
Provides evaluation, treatment and other services to the forensic population statewide.

Mental Health Institutes
Provide inpatient behavioral health services for adults, adolescents and geriatric patients.
FY 2022-23 Budget Priorities

Provide Coloradans with inpatient forensic services in a more timely fashion.

Provide transition homes to house Coloradans who no longer need inpatient care.

Offer better training and technical assistance to professionals who are placing involuntary mental health holds and helping severely mental ill Coloradans.

Provide more flexibility in criminal justice programming to better meet the needs of counties and spend state resources.

Clean up OBH budget line items so that they more clearly reflect how funds are being spent to offer maximum accountability to taxpayers.
Competency Services: Federal Consent Decree
Colorado Statute (C.R.S. § 16-8.5-101)

Competency is a legal construct that refers to an individual’s current capacity to function meaningfully and knowingly in a legal proceeding. It may be raised at any point by the defense, prosecution, or court in a criminal case; however, it is most often raised by the defense during pre-trial hearings as a part of protecting due process rights of defendants and ensuring they are able to understand the court proceedings, make reasoned decisions and have the ability to participate meaningfully in their legal defense.

Where competency restoration occurs is determined by each state’s statute.
Who is doing the competency evaluation?

- **42** Staff evaluator positions including post-doctoral fellows and supervisors
- **28** Contract evaluators who provide evaluations for the Department

Up to 16 evaluations completed by staff evaluators per month
Competency Restoration Inpatient Referrals and Waitlist

Referrals

Waitlist

Office of Behavioral Health
FY 2022-23 - JBC Hearing
Competency Restoration Orders by Judicial District (Q3, pg. 3)

Number of referrals made for restoration broken out by setting and judicial district.

Data represent referrals made between October 2020 and October 2021.
Colorado has the largest outpatient restoration program in the nation.
Competency: Current Drivers of Waitlist Growth and FY 22-23 Budget

Drivers of Growth in Waitlist
- Lack of available, dedicated forensic beds.
- Unoccupied beds at RISE and CMHIP due to COVID and the national healthcare staffing crisis.
- Current average length of stay (12 month average: 143.7 days).
- The number of individual inpatient restoration orders continue to increase.

FY 22-23 Budget for Consent Decree Non-compliance Fees

$10.6M - $11M*

* Total impact determined by annual inflationary increase in fines rate and any potential additional fines from courts.
Who needs inpatient competency services?

Based on a review of the current list of individuals awaiting inpatient competency services approximately 50% are categorized as low acuity (medication compliant, actively engaged in behavioral health services in the jail, housing) according to the Forensic Support Team protocols. These individuals would be appropriate to be served in the community.
## Competency: CMHIP as setting

(Q7, pg. 7)

### An Ideal Placement Matrix

<table>
<thead>
<tr>
<th>Low Safety Risk</th>
<th>High Safety Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Acuity</td>
<td>Jail Based Services</td>
</tr>
<tr>
<td>High Acuity</td>
<td>Hospital</td>
</tr>
</tbody>
</table>
Competency: Misdemeanors

(Q8, pg. 8)
Maximizing Inpatient Capacity

- Prioritizing patients based on clinical acuity; those with **greatest clinical needs are admitted first**
- Partnering with jails to improve medication compliance prior to admission, which helps **reduce length of stay**
- Transitioning individuals awaiting inpatient services to community-based services when appropriate
- Bimonthly email updates and stakeholder meetings related to waitlist and available beds
- Emphasizing **community placement** for clients whenever appropriate
- Adding 64 private hospital beds to help get people into inpatient care faster
Additional Options for Competency (Q10, pg. 11)

Underway

- 64 private hospital beds
- Psychiatrist contract for medications for individuals in jail
- Increase in wraparound funding for transitional services

Proposed

- Expand Denver jail pilot program for restoration
- Improve medication compliance for individuals in jail
- Explore Policy Options with Stakeholders

Office of Behavioral Health
FY 2022-23 - JBC Hearing
Mental Health Institutes
Funding to operate 44 new forensic inpatient beds at the Colorado Mental Health Institute at Fort Logan starting in October 2022

- **Year 1**
  - $10,318,585 General Fund
  - 78.3 FTE

- **Year 2 and ongoing**
  - $12,407,778 General Fund
  - 104.3 FTE

Helps address the growing need for forensic behavioral health services and prevents Coloradans from languishing needlessly in jail

Moves CDHS towards compliance with federal consent decree

Helps reduce waitlist and mitigate fines
New Beds Needed | Operating Cost per day* | Annual Operating | Capital Cost
---|---|---|---
351 | $1,125 | $145M | $877M

*The average general adult cost is based on daily rates at CMHIP and CMHIFL.

Current Safety Net: Adult Mental Health Service Continuum by Intensity of Service

<table>
<thead>
<tr>
<th>Current Capacity</th>
<th>10% unmet need</th>
<th>10% unmet need</th>
<th>100</th>
<th>94</th>
<th>540</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity Need</td>
<td>Statewide</td>
<td>Statewide</td>
<td>517</td>
<td>495</td>
<td>540</td>
</tr>
</tbody>
</table>

* The available beds are not funded or contracted via the state and a portion are limited for veterans.
** As a result of a lack of step down beds in residential assisted care settings, up to 20% of state inpatient beds are occupied by a patient who could reside in this lower level of care.
### Pros and Cons of Institute Locations

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>#</th>
<th>Location</th>
<th>Status</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>516</td>
<td>CMHIP</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>94</td>
<td>CMHIFL</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>44</td>
<td>CMHIFL</td>
<td>Pending</td>
<td>Open Summer 2022</td>
</tr>
<tr>
<td>Inpatient</td>
<td>80</td>
<td>Private Hospital Beds</td>
<td>Temporary</td>
<td>Ending Summer 2022</td>
</tr>
<tr>
<td>Assisted Care Group Homes</td>
<td>24</td>
<td>Pueblo/Broomfield</td>
<td>Proposed</td>
<td>Open Summer 2023</td>
</tr>
<tr>
<td>Jail Based Restoration</td>
<td>104</td>
<td>Arapahoe/Denver/Boulder jails</td>
<td>Time-limited, as needed</td>
<td>Ongoing; 12 beds expire 6/2022</td>
</tr>
</tbody>
</table>

Future expansion of beds should be both for state-run inpatient and residential care. These beds should be in one of the three major Front Range metro areas: Denver, Colorado Springs, or Fort Collins.
Transition Homes

Request to renovate three existing buildings to provide an **additional 24 beds** for individuals transitioning from inpatient care into the community. This request addresses an identified gap in the availability of residential transition facilities in the behavioral health system.

$2.4M General Fund / Capital Construction Funds
American Rescue Plan Act (ARPA) Investments to Add More Beds to the System (Q14, pg. 16)

**Emergency Funds:** $19,746,500 to place approximately 150 individuals in 64 private hospital beds over the next year.

**Behavioral Health Transformational Task Force ARPA Proposals:**
- Group home beds (98 beds but scalable) will free up inpatient beds in the state hospitals by moving patients who are ready to go into lower levels of care and allow the state to use freed beds for competency clients.
- Renovate existing unused 16-bed unit at Ft. Logan
CMHIP Staffing Challenges (Q15, pg. 17)

33% Vacancy = Emergency Staffing levels

86% of shifts were at emergency
3.5% of shifts were below emergency
### Staffing and Salaries at the Institutes

For the Period Beginning 10/1/2021 - 12/31/2021

<table>
<thead>
<tr>
<th>Position</th>
<th>Q-2 Contract Staffing Average of Min. and Max Rates</th>
<th>State FTE Cost (midpoint)</th>
<th>Difference ($)</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse (RN)</td>
<td>$67.50</td>
<td>$41.51</td>
<td>$25.99</td>
<td>63%</td>
</tr>
<tr>
<td>Mid Level - Physician Assistant (PA)</td>
<td>$145.00</td>
<td>$48.76</td>
<td>$96.24</td>
<td>197%</td>
</tr>
<tr>
<td>Mid Level - Nurse Practitioner (NP)</td>
<td>$130.00</td>
<td>$48.76</td>
<td>$81.24</td>
<td>167%</td>
</tr>
<tr>
<td>Health Care Technician (HCT)</td>
<td>$40.00</td>
<td>$21.08</td>
<td>$18.92</td>
<td>90%</td>
</tr>
<tr>
<td>Certified Nursing Assistant (CNA)</td>
<td>$40.00</td>
<td>$15.79</td>
<td>$24.21</td>
<td>153%</td>
</tr>
<tr>
<td>Mental Health Clinician (MHC)</td>
<td>$42.50</td>
<td>$24.78</td>
<td>$17.72</td>
<td>72%</td>
</tr>
<tr>
<td>Licensed Practical Nurse (LPN)</td>
<td>$56.00</td>
<td>$17.82</td>
<td>$38.18</td>
<td>214%</td>
</tr>
<tr>
<td>Licensed Psychiatric Technician (LPT)</td>
<td>$40.00</td>
<td>$17.82</td>
<td>$22.18</td>
<td>124%</td>
</tr>
<tr>
<td>Sitters</td>
<td>$36.00</td>
<td>$15.34</td>
<td>$20.67</td>
<td>135%</td>
</tr>
</tbody>
</table>
Leadership/non-clinical staff working/taking sitter shifts

Reallocated staff throughout hospital

100+ nursing students in training

Overtime to maintain minimum staff-to-patient ratios

Contract staffing agencies

Eliminated extra steps in the application review for continuous open positions

Offer letters provided/conditioned on background checks & new hires attend orientation prior to receiving results

Hiring a recruiting agency to assist with sourcing direct care staff

Partnering with refugee resettlement programs
Community-based providers along with our state facilities are experiencing staffing challenges during COVID.

Colorado Sun reported 16.4% clinical vacancies across 17 community mental health centers.

The article also reported lower salaries than healthcare systems and telehealth startups.

Additionally CMHCs face more paperwork due to government funding sources.

Without a market analysis we are unable to speculate on the needed provider rate increase to consider the proposed compensation.
Almost 70 recommendations were developed to address the workforce shortage. Recommendations included:

- Expanding the capacity for a culturally competent licensed and unlicensed behavioral health workforce.
- Increasing the expertise and competency of providers into safety net workforce strategies to improve access and cultural competency. Develop standards for culturally and linguistically responsive treatment programs to improve opportunities for early engagement for acute clients in need of services.
- Increasing compensation for licensed and non-licensed individuals who complete cultural and linguistic training and corresponding assessments.
Request to correct appropriation errors and mitigate annual appropriation transfers by addressing historical shortfalls/surpluses in specific line items.

$0 Net Change
Continuation of Suicide Risk Mitigation

Phase: 1 of 1
Total: $5,123,993
Location: Colorado Institute of Mental Health at Pueblo

Why:
- Suicide risk mitigation is an ongoing process as new regulations from the Centers for Medicaid and Medicare (CMS) are introduced and/or new risk evaluation tools are used by the Joint Commission (JC) to identify risks that were not previously identified.

What We Will Do:
- Install ligature-resistant sinks and ligature-resistant fixtures at handwashing sinks; install ligature-resistant toilet partitions; install ligature-resistant toilets, showers, partitions, doors and grab bars; install ligature-resistant door knobs; install continuous hinges in place of 3-point hinges; mitigate corridor door closures; install hard ceilings.
Building a True Safety Net

- Guarantee access for individuals with complex needs
- Expand “the middle”: services for and connection to community-based services for high need and hard to serve individuals
- Provide opportunities to fund more social services that impact health by including social determinants of health in the new payment model for Medicaid/BHA
- Opportunity to grow “Centers of Excellence” and expertise for specialty populations or conditions, including co-occurring conditions, aggressive clients, individuals with intellectual and developmental disabilities,
- Increase funding flexibility for whole-person care and social determinants of health
- Expand the SUD role of the comprehensive community behavioral health centers, while increasing accountability
- Set network adequacy standards, accountability requirements for CMHCs and CMHC-like entities in exchange for more flexible, value-based payments
Building a True Safety Net: SB 222 (Q22, pg. 25)
Gaps in Mental Health Continuum

**Emergency**
- Emergency Rooms
- Police Response
- Crisis services

**Inpatient Hospital**
- Private Psych Hospitals, limited by payer
- State MHIs
- Long term civil beds: 94 exist, 465 estimated need
- Forensic beds for incompetent to proceed

**Residential Step Down**
- Regional Centers (adult with DD only)
- No facilities fit for adults coming out of long-term civil beds
- Some group homes (children and youth)
- No facilities for youth with co-occurring DD (neuro-psych)

"The Middle is Missing"
- People are still slipping through the cracks in transition services between care
- Need more services between the crisis/emergency and the standard outpatient services

**High Intensity Community**
- CMHCs cover outpatient high intensity services
- Not enough wrap around care for youth or adults
- Few partial hospitalization or intensive outpatient

**Community Level Care**
- Outpatient therapy access limited by payer
- Progress in integrated BH and physical health care, need more
- Forensic outpatient education, restoration to competency

Office of Behavioral Health
FY 2022-23 - JBC Hearing
Gaps in Substance Use Continuum

1. **Emergency**
   - Emergency Rooms
   - Police and Co-Responder models are working
   - Crisis services are more MH focused

2. **Inpatient Hospital & Detox**
   - Very few hospitals have inpatient SUD
   - Seeing growth but need more SUD beds
   - Detox is mostly only available on I-25 or I-70 corridor, jails and EDs are often the 2nd choice

3. **Residential Step Down**
   - Need more housing for people w/criminal justice history
   - Peer-run recovery housing has minimal funding

4. **High Intensity Community**
   - CMHCs cover outpatient high intensity services
   - Not enough wrap around care for youth or adults
   - Few partial hospitalization or intensive outpatient programs statewide

5. **Adult/Youth Outpatient**
   - Outpatient therapy access limited by payer/network
   - Integrated primary care more MH than SUD or co-occurring
   - Need more MAT, integrated care

Gaps for entire populations
- Many rural communities have entire sections missing
- Early treatment for youth and adolescents essential to disrupt paths of addiction
- Recovery services are essential to prevent relapse, should be connected to treatment
### Geographic and Population Gaps in Safety Net

<table>
<thead>
<tr>
<th>Population</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural and Frontier Communities</td>
<td>Need access to crisis, inpatient and other acute care services for high-risk behaviors.</td>
</tr>
<tr>
<td>People of Color</td>
<td>Need racially and culturally responsive providers reflective of diverse communities.</td>
</tr>
<tr>
<td>LGBTQ+ Coloradans</td>
<td>Need providers who specialize in providing compassionate care to the LGBTQ+ community.</td>
</tr>
<tr>
<td>Speakers of English as a Second Language</td>
<td>Need bilingual and bicultural providers and services.</td>
</tr>
<tr>
<td>Youth</td>
<td>Need intensive outpatient services and beds for youth with co-occurring needs.</td>
</tr>
<tr>
<td>Individuals with Chronic Conditions</td>
<td>Need intensive services to support these individuals living in the community.</td>
</tr>
</tbody>
</table>
System Improvements Happening Now (Q23, pg. 26)

Stimulus Funding: Colorado is receiving behavioral health stimulus funding from multiple sources.

- **Block Grant**: $94 million
- **Senate Bill 137**: $100 million
- **Legislative Interim Committee**: $450 million
Near-Term System Improvements - Block Grant Stimulus (Q23, pg. 26)

- $9M for capacity-building based on the Senate Bill 19-222 implementation plan
- $8.8M for CYMHTA and Ascent, both programs to support the mental health of children, youth and young adults
- $7.85M for the behavioral health crisis system, including secure transportation, bilingual services and marketing to diverse populations
- $7.6M for recovery support services through the MSOs
- $6.6M for Individual Placement and Support, a program that helps people with mental illness and/or substance use disorders find and keep jobs
- $6M for Assertive Community Treatment or community-based treatment for adults with SMI
- $5.25M for an online learning management system
- $3.5M for residential substance use treatment, withdrawal management (detox) and involuntary commitment services
- $3.4M for housing support in partnership with DOLA
- $3.4M for the Forward Together prevention campaign
- $3.2M for programs and scholarships that prevent substance misuse among youth, especially within BIPOC and LGBTQ communities
- $3M for Special Connections, a program that connects pregnant and parenting people to treatment
- $3M for substance misuse screening in schools
- $2.8M for workforce support for peers and addiction counselors
- $2.5M for involuntary commitment peer navigation
- $2.4M for Tribal or Native peer services
- $2M for peer services for the Latinx community
- $1.6M for recovery housing
- $1.5M for Invest in Kids
- $1.1M for transitions of care for children, youth and families
- $1M for 988 startup costs
- $1M for an equity and community engagement director position, translation services, and community outreach grants
- $900k for Healthy Transitions EDI work
- $750k for OBH’s bed capacity registry
- $600k for a behavioral health public education campaign related to the impacts of the pandemic
- $400k for prevention programs for rural areas and first responders
- $300k for BIPOC workforce recruitment
Near-Term System Improvements - SB 137

- $26M for a statewide care coordination infrastructure
- $18M for a workforce development program
- $10M to the Managed Service Organizations for increasing access to SUD treatment
- $9M for a county-based behavioral health grant program
- $5M for the crisis system, including statewide access for children and youth
- $5M for Jail Based Behavioral Health Services
- $5M for a pilot program for residential placement of children and youth with high acuity physical, mental, or behavioral health needs
- $4M for a housing assistance program
- $3.25M for Community Mental Health Centers
- $3M to the High-Risk Families Cash Fund
- $2M for services provided to school-aged children and parents by community mental health center school-based clinicians and prevention specialists
- $2M for behavioral health and substance use disorder treatment for children, youth, and their families
- $1.6M for the recovery support services grant program
- $1M for a mental health awareness campaign
- $500k for community transition services for guardianship services for individuals transitioning out of the institutes
- $200k for treatment and detoxification programs
- $200k for recovery residence certification
- $50k for rural behavioral health vouchers
- Continuation of the Maternal and Child Health Pilot Program
I want to understand my feelings because I matter

If you've ever said, “I’m struggling, I want help,” you are in the right place. The purpose of I Matter is to promote youth emotional and mental health. To begin, you will need to take a survey. Try to be honest as possible; your answers are completely confidential and will help match you with a clinician who can best support you. No matter your responses, you will be eligible for 3 free counseling sessions.

Get started below. If you’re 11 or younger, your parent or guardian will have to fill out the survey with you.

Parents, if you feel your child is struggling and needs help, you are in the right place to talk to a mental health professional for free. Seeking support for your child is not a sign of failure—it’s a sign of strength. Start by filling out the survey below.

Parents  Youth
Near-Term System Improvement - 988

Only four states have enacted legislation to fund 988 (Colorado, Washington, Nevada, Virginia).

Colorado will collect $14 million to fund 988 in 2022.
Medium-Term System Improvements - Care Coordination, Workforce, BHTTF, Regional Approach

Care Coordination
Central access point for behavioral health services and connection to care navigators and coordinators

Workforce
Online training system to help workforce develop competencies to serve diverse Coloradans

BHTTF
$450M that could be invested in safety net, workforce, beds, youth, integrated care and harm reduction

Regional Approach
Exploring integration of mental health and substance use services to increase consumer outcomes, transparency and oversight.
Long-Term System Improvement - Safety Net & the BHA
The BHA will improve the system for Coloradans

- Individual is in need of treatment and support following first episode psychosis
- BHA Care Coordination Interface connected the family to programs and support services
- Family need for resources and information was met; individual received treatment
A Positive Change for Colorado’s Behavioral Health System

**BEFORE BHA**

**FRAGMENTED VISION AND STRATEGY**
- Fragmented programs (120) across 19 agencies
- Separate vision/strategy
- Inconsistent communication between programs

**NO SYSTEM COORDINATION**
- Gaps in care and program responsibilities
- Fragmentation with multiple systems of care
- Standards for care are complex, duplicated and difficult on providers
- No standards and accountability

**FUNDING ISSUES**
- Lack of coordinated efforts
- Duplicated processes
- Underutilized federal match opportunities

**FRAGMENTED DATA**
- Data is not trackable
- Data is inconsistent between programs
- Closed ecosystem designed to only meet administrative functions

**BEHAVIORAL HEALTH NOT PRIORITIZED**
- Often second to other priorities in healthcare
- People with behavioral health conditions often feel the system does not receive adequate resources or accountability

**AFTER BHA**

**UNIFIED VISION AND STRATEGY**
- Shared vision and strategy creating a guiding vision for how to improve behavioral health for all populations, building on strengths and opportunities between programs
- Collective impact model of building getting separate entities to build reinforcement activities to reach a shared vision

**SYSTEM COORDINATION**
- Centralized standards and accountability for addressing gaps in the system and for supporting individuals in transitions from program to program
- Leverage solutions and build relationships between programs
- Support system to treat co-occurring needs
- Improved provider training and increase capacity for serving individuals with whole person approaches
- Streamlined processes for credentialing, contracting, and quality measurement to reduce burden and build efficiency

**IMPROVED FUNDING**
- Leadership for resource allocation across agencies
- Shared approach to funding
- Maximize federal match funds
- Transparent spending and reporting

**COMPREHENSIVE DATA**
- Data is accessible and trackable
- Statewide and comprehensive view
- Improved planning, strategy, gap filling and accountability
- Defined data metrics to inform accurate collecting/reporting
- Consumer-first approach to data collection and sharing

**BEHAVIORAL HEALTH PRIORITIZED**
- The BHA and particularly the BHA Commissioner will elevate the importance of Behavioral Health in Colorado
- Governor receives direct information on behavioral health — increasing level of attention and resources for behavioral health

**STAY INFORMED & INVOLVED**
The BHA Bill in 2022 will outline how it will hold the system accountable

- Standard Setting for Providers
- Master Contract
- Cross-Payer Grievance & Appeals Process
- Advisory Council of Stakeholders

Accountability + Transparency
The BHA will provide a comprehensive view of what is working and where gaps remain (Q25, pg. 30)

Create consistent clinical quality standards for all behavioral health providers to use to measure performance

Create consistent definitions of data elements and metrics on key quality metrics

Improve accountability through reporting requirements to ensure providers and intermediaries report data to the State, including complete, accurate, and timely claims/encounter and administrative data

Develop quality metrics and define analyses needed to examine quality for specific populations and subpopulations to improve understanding of potential gaps in care, disparity in quality or outcomes, and identification of individuals or groups most in need of improved quality

Provide clear guidance on validated assessment tools to promote identification of behavioral health and measurement of progress offering quantitative data on system improvement

Provide meaningful analysis and population health data for the State (and reduce unnecessary data collection) as a result of prioritizing critical data elements
The BHA will ensure we have a system to meet the social, cultural, and linguistic needs of Coloradans (Q26, pg. 32)

Enhance and streamline data collection and analysis to improve monitoring of trends and facilitate ongoing quality and health outcome improvement efforts.

Develop best practices to disaggregate data that lead to identification of disparities in care.

Provide additional training for providers to understand how improved demographic data are central to member engagement and treatment.

Implement expanded demographic options on provider forms to collect additional information such as sexual orientation, gender identity, sex assigned at birth, and relationship status.
**R-09 Improving Involuntary Mental Health Treatment**

**Intervening Professional** - Per statute, the following individuals can place a 72-hour-hold: a certified peace officer; a professional person; a registered professional nurse, licensed marriage and family therapist, licensed professional counselor or addiction counselor who has gained relevant education or skill; and a licensed clinical social worker.

Year 1: $181,433 General Fund, 1.0 FTE  |  Year 2 and ongoing: $133,883 General Fund, 1.0 FTE

<table>
<thead>
<tr>
<th>Request</th>
<th>Training</th>
</tr>
</thead>
</table>
| Provide Colorado-specific training to “intervening professionals” | ● Dedicated 1.0 FTE for training of “intervening professionals”  
● Development, placement, and regular updating of training |
**R-09 Improving Involuntary Mental Health Treatment**

**Multidisciplinary Stakeholder Group**

Created at the recommendation of the Mental Health Advisory Board for Service Standards and Regulations, created pursuant to 27-65-131, C.R.S.

**Original objectives**

- Redefine the Involuntary Transportation Hold
- Explore which professionals can and should be able to initiate an involuntary mental health hold
- Address professional training requirements

Scope has since expanded, and OBH continues to participate in stakeholder subgroups.

**What’s next?** MHC to champion 2022 bill to update the involuntary mental health provisions of Article 65 of Title 27, C.R.S., including recommendations by the Mental Health Advisory Board for Service Standards and Regulations.
R-11 CBH Criminal Justice Long Bill Line Consolidation

Combine the Criminal Justice Diversion Programs and Jail Based Behavioral Health Services Long Bill line items

$0 Net Change

- Mitigate funding reversions
- Maximize the number of behavioral health clients served by law enforcement and county jails
- Enhance collaboration with counties
- Increases flexibility and responsiveness to local needs
Innovations in Jail-Based Behavioral Health Services, Co-Responder & Law Enforcement Assisted Diversion

- Telehealth
- Jail renovations to reduce solitary confinement
- Provision of drivers licenses/state identification to detainees
- Flexible service pool for funding Medication-Assisted Treatment

**JBBS**

Flexible framework for communities to develop their Co-Responder programs to meet their unique needs (i.e., use of paramedics, case managers, peers)

**Co-Responder**

- Local collaborative arrangements to broker housing, sober living facilities, benefits acquisition, and employment for clients
- Screening and assessment tool with follow-up component embedded

**LEAD**

Office of Behavioral Health
FY 2022-23 - JBC Hearing
90% of jails participate statewide

All county jails are offered a contract. The appropriations cover only a portion of behavioral health costs for larger jails.
How Diversion Funds are Distributed (Q29, pg. 37)

Programs selected by a request for application process. Appropriations are not sufficient for all law enforcement agencies across the state.

OBH funds or partially funds 28 Co-responder programs, covering more than 80 communities in 24 counties.

OBH funds Law Enforcement Assisted Diversion or LEAD programs in:

- City of Alamosa (San Luis Valley, covers three counties)
- Denver County
- City of Longmont
- Pueblo County
R-12 CBH Community Behavioral Health Technical Correction

Aligns budgets with Long Bill line items to accurately reflect program spending and authorizes the expansion of funding for the Behavioral Health Transportation Program to communities statewide in line with existing statute. $0 Net Change

**TREATMENT & DETOX**

Transfer $1.47 million General Fund and any corresponding annualizations from the Treatment and Detox Programs line to the Jail-Based Behavioral Health Services line.

**COMMUNITY PREVENTION & TREATMENT**

Transfer $264,596 of Persistent Drunk Driver cash funding and spending authority from the Treatment and Detox Programs line to the Community Prevention and Treatment line.

**BH SECURE TRANSPORTATION PILOT**

Remove the term “pilot” from the line item “Behavioral Health Crisis Response System Secure Transportation Pilot Programs” to align funding with the statute.
The Transportation Pilot Program resulted in more than 1,000 transports for individuals who might have otherwise used law enforcement or not been transported. Reasons for the transport included providing a ride home after discharge or because the individual was gravely disabled, homicidal, suicidal, or in need of critical behavioral health services. The majority (70.2%) of clients surveyed said they were connected with the services they needed and provided high ratings for the overall quality of the service. The average per-transport costs ranged from $864.50 to $1,122 across two sites.
The distribution from the sports betting fund for gambling addiction will transfer to the BHA (Q31, pg. 42)
Our Vision for Community Behavioral Health

ACCESSIBLE
All Coloradans need access to a continuum of services and to be connected to those services when needed.

AFFORDABLE
People can afford the care they need and the system incentivizes positive outcomes and removes administrative burden.

ACCOUNTABLE
Collaboration occurs across stakeholders to ensure Coloradans receive the care they need.
THANK YOU.

Questions?
Office of Children, Youth & Families
Office of Children, Youth & Families

Our vision is to ensure children, youth, and families across Colorado are safe and thriving.

Child Welfare
8,603 children currently with open cases.
  Foster Care: 3,785 in out-of-home placement.
  Adoption: 380 children awaiting adoption.

Youth Services
713 youth served each day in detention, commitment or parole.

Domestic Violence
DVP-funded programs served 18,089 individuals last year.

Colorado Sexual Health Initiative
800 youth and 210 adults have been served to date this fiscal year.

Juvenile Parole Board
114 youth parole hearings and 11 violation hearings to date this fiscal year.

Pay for Success
Over 500 individuals and families served to date.
We believe that Colorado’s children and youth have the right to be safe and well in their own homes whenever possible, and that our system needs to be dynamic, adaptive, and rehabilitative to all that are in need of protection and maltreatment prevention services.

What are Child Welfare Services?

- **Assessing** allegations of child maltreatment
- **Providing** prevention and rehabilitative services to children who are at-risk of or have experienced maltreatment
- **Providing** out-of-home care for children who cannot be safe at home
- **Providing** resources, such as case management and support with housing for youth in transition to adulthood
- When it is not possible for a child to maintain successfully in their home, **county departments provide adoption services** to achieve a safe and permanent home for children in the system.
How We Resource Child Welfare Services

(Q32-36, pg. 43)

Child Welfare Services (Block)

Family and Children’s Programs (Core)

Child Welfare Staffing (SB15 242)

Other sources:
Tony Grampsas Youth Services Program
Collaborative Management Program
Child Welfare Priority Areas

- Continuing implementation of the Family First Prevention Services Act
- Rightsizing the Placement Continuum
- Strengthening Foster & Adoptive Parent Recruitment
Increasing access to evidence-based prevention services

Rightsizing the placement continuum
Qualified Residential Treatment Program Capacity

QRTP Total Beds: 184*

Point in time snapshot:
December 10, 2021

* Excludes capacity of a facility in the process of closing.
## Continuum of Care

Our goal is to ensure Colorado children, youth and families have access to the right service at the right place and time.

<table>
<thead>
<tr>
<th>In-home</th>
<th>Family-like settings</th>
<th>Specialized group settings</th>
<th>Short-term stabilization</th>
<th>Treatment focused settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community-based, prevention-focused services aimed at keeping families together.</td>
<td>• Family foster homes • Professional foster parents • Therapeutic foster homes • Treatment foster homes • Kinship placements (certified or non-certified)</td>
<td>• Supervised independent living settings • Residential care and support services to survivors or those at risk of sex trafficking • Settings providing prenatal, postpartum or parenting supports</td>
<td>• Assessment and stabilization • Respite, foster • Respite, transitioning from facility</td>
<td>• Qualified Residential Treatment Programs (QRTPs) • Psychiatric Residential Treatment Facilities (PRTFs) • Division of Youth Services Facilities</td>
</tr>
</tbody>
</table>

Office of Children, Youth & Families  
FY 2022-23 - JBC Hearing
Foster & Adoptive Parent Recruitment

- National Partnership with Raise the Future and the Dave Thomas Foundation
- Support to County Departments of Human Services
- Media campaigns, provider increases, and inquiry forms
Enhancing County Support

$421,448 total funding for 3.8FTE
- Permanency Specialist
- Facilities Monitor
- Specialized Response Team

(Enhancing County Support, Q39, pg. 45)
Support from CDHS to Colorado Counties to help young people achieve safe and meaningful permanency.

Facilities Monitor - 1 FTE

Monitors help ensure safety and well-being of children in Colorado’s provider facilities, as well as compliance to regulation.

Specialized Response Team - 2 FTE

The SRT will provide adaptive real-time support to county departments of human services in partnership with other CDHS staff.
Additional Decision Items

R-17 Realign Child Welfare Hotline Budget: One-time reduction of $456,787 General Fund in FY 2022-23 for the Hotline for Child Abuse and Neglect line item

R-18 Realign Family and Children’s Programs: One-time reduction of $2.6 million total funds to reduce funding for the Family and Children’s Programs, often referred to as Core Services
• Trails is an integrated case management system used by 5,400 users serving children, youth and families across Colorado.

• Users include workers in 64 county departments, 22 judicial districts, and the Division of Youth Services (DYS).

• Those 5,400 users in turn have over 70,000 unique contacts with children and families each month, from screening calls to the child abuse and neglect hotline to conducting safety assessments to connecting families with behavioral health services.
Shifting Our Framework to Agile (Q40, pg. 46)

- Moving from a “project” to a “product” mindset: Moving to a “product” mindset allows Trails to consider all components of the system that support the work of users.

- Focusing resources on the highest-value activities: We are pivoting to focus on creating highly effective teams that use resources to maximize values to users, and that are positioned to continue to make improvements long after a vendor has rolled off.
Major Releases

- SANCA Release: July 2, 2021
- Oracle Upgrade: April 2, 2021
- Plans of Safe Care: May 31, 2020
- Release 6 Family First: Dec 20, 2020
- Release 7 (50% of users in one place): June 6, 2021

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R-03 County Trails Refresh and Support

Two components:

- Adjustment of the Trails Line Item Federal and General Fund split to reflect actual federal drawdown; and
- A request for $1.8 million in a new “County IT Support” line item that will appropriately fund county child welfare technology needs outside of Trails, including computers for caseworkers.
Best practice in technology is to move away from incremental capital requests and instead secure an ongoing, reliable source of funding that allows teams to make constantly make improvements and better meet the changing needs of users. This decision item seeks to make that shift.
To protect, restore, and improve public safety utilizing a continuum of care that provides:

- Effective supervision,
- Promotes accountability to victims and communities, and
- Helps youth lead constructive lives through positive youth development.

DYS Vision

It is the mission of the Division of Youth Services to protect, restore and improve public safety utilizing a continuum of care that provides effective supervision, promotes accountability to victims and communities, and helps youth lead constructive lives through positive development.

DYS Mission
DYS Average Daily Population Trends (ADP)
Youth Treatment Complexities

44.4% of the DYS population is either a mandatory, repeat, violent or aggravated juvenile offender.

Percentage of new commitments with violent committing offenses (FY 19 vs. FY21)

Commitment Offense Type

- Person: 56.9%
- Property: 19.5%
- Weapon: 15.3%
- Other: 5.9%
- Drug: 2.3%

“The total DYS population experienced the second year of growth in person crime population, resulting in an 18% overall increase in two fiscal years.”
Youth Treatment Complexities

- **60%**: Have co-occurring treatment needs (both mental health & substance abuse).
- **68%**: Require formal mental health intervention services.
- **86%**: Require treatment level services for substance abuse.
Assault Reduction (Q41, pg. 48)
Decreasing Assaults

(Q42, pg.50)

- Increased Staff Ratios to 1:5
- New Risk/Needs Assessment
- Dialectical Behavioral Therapy
- New Treatment/Service Delivery Model
- Sanctuary Model
- Increased Professional Relationships Between Youth/Staff

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Reducing Risk

Attitudes & Behaviors
Assessment: 94.0%
Discharge: 47.5%

Aggression
Assessment: 80.4%
Discharge: 33.8%

Relationships
Assessment: 86.6%
Discharge: 45.7%

Social Proficiency Skills
Assessment: 79.2%
Discharge: 13.4%

47%

47%

41%

66%
Educational Services & Outcomes

- Educational services range from 6th grade level through post-secondary
- Career, Technical Education and work experience opportunities
- College credit attainment
- Improve job readiness outcomes

01 Academic Achievement
67.8% of youth discharge with a High School Diploma (HSD) or Equivalent (GED) in-hand

02 Academic Growth
Student growth results indicate that students meet or exceed typical growth (the pace in public school settings).

03 Career & Technical Education (CTE)
Well over one-third (38%) of DYS students obtained a certification or participated in various CTE opportunities while committed.
The most effective living environments to aid in treatment and growth of youth are homelike environments.
R-07 DYS Phone Replacement

- Replaces pay phones in youth centers
- Promotes equity and enhanced family engagement
- Provides youth continued unimpeded access to community resources such as the Child Abuse and Neglect Hotline and the Child Protection Ombudsman
- Trauma responsive therapeutic approach

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For the first time, the Division observed an across-the-board decline in the one-, two-, and three-year post-discharge recidivism rates.

The Division defines recidivism as the adjudication or conviction of a new misdemeanor or felony offense within a specified time period.
Reduction in Parole and Transition Service Caseloads

- Decreased parole caseload
  - FY19: 215
  - FY20: 207
  - FY21: 163

- Requesting a General Fund reduction in the parole and transition services program of $533,784
THANK YOU.

Questions?