DEPARTMENT OF CORRECTIONS

FY 2025-26 JOINT BUDGET COMMITTEE HEARING AGENDA

Friday, December 13, 2024

9:00 am – 11:00 am

9:00-9:25 Introductions and Opening Comments

Main Presenters:

- Andre Stancil, Executive Director
- Ashley Clark, DIrector Finance & Administration

9:25-9:30 Common Questions

Main Presenters:

- Ashley Clark, Director Finance & Administration
- Andre Stancil, Executive Director

Topics:

- Question 1: Page 1-2, Questions 1 a-e in the packet, Slides 9-10

9:30-9:45 Budget Request

Main Presenters:

- Eddie Caley, Director of Business Innovation
- Michele Cottingham, Director of Human Resources
- Ashley Clark, Director of Finance & Administration

Supporting Presenters:

- Andrew Ross, Associate Director of Human Resources

Topics:

- R3 Upgrade Pharmacy System: Page 2-3, Questions 2-3 in the packet, Slides 12-13
- R6 Recruitment and Retention: Page 3-6, Questions 4-6 in the packet, Slide 14
- R7 Broadband: Page 6, Questions 7-8 in the packet, Slide 15
- Inmate communications: Page 6, Questions 9-10 in the packet, Slide 15

9:45-10:15 Prison Caseload

Main Presenters:

- Ashley Clark, Director of Finance & Administration
- Mitchell Karstens, Deputy Director of Finance & Administration

Topics:

- Capital projects: Page 19-21, Questions 30-34 in the packet, Slides 16-19
- Vacancy rates and custody classifications: Page 7-10, Questions 11-14, 16 in the packet, Slides 21-23
- Sex offender treatment: Page 15-17, Questions 23-27 in the packet
- Special needs parole: Page 17-18, Questions 28-29 in the packet
- Proposition 128: Page 21-22, Questions 35-36 in the packet

10:15-10:30 Private prisons

Main Presenters:

- Ashley Clark, Director Finance & Administration

Supporting Presenters:

- Mitchell Karstens, Deputy Director of Finance & Administration

Topics:

- Private prisons: Page 22-25, Questions 37-43 in the packet, Slides 24-25

10:30-10:50 Community Reintegration

Main Presenters:

- David Wolfsgruber, Director of Adult Parole
- Merideth McGrath, Deputy Executive Director of Community Operations

Topics:

- Technical parole returns: Page 11-14, Questions 17-19 in the packet, Slides 26-31
- First-time vs. repeat inmates: Page 14-15, Questions 20-22 in the packet

10:50-11:00 Medical issues

Main Presenters:

- Lacy Monday, Director of Clinical Services and Correctional Services

Supporting Presenters:

- Leonard Woodson III, Assistant Director of Clinical Services

Topics:

- Clinical care: Page 28-30, Questions 49-51 in the packet, Slide 34
- Inmate medical fees: Page 30-32, Questions 52-54 in the packet, Slide 35

Department of Corrections

FY 2025-26 Joint Budget Committee Hearing

Friday, December 13, 2024

9:00 am – 11:00 am

Common Questions For Discussion at Department Hearings

1 Please describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information:

a. Original fund source (General Fund, ARPA, other), amount, and FTE;

b. Original program time frame;

c. Original authorization (budget decision, legislation, other);

d. Requested ongoing fund source, amount, and FTE; and

e. Requested time frame (one-time extension or ongoing).

DOC Response:

- R-12 Inmate Legal Access – In FY 2022-23, the Department received American Rescue Plan Act (ARPA) funds for 13.0 FTE and operating funds to provide inmates better access to court hearings, and attorney visits through video conferencing. The request was approved by the Governor's office and was finalized with an Interagency Agreement between the DOC and the Governor's office. In FY 23-24 the Department added an additional 6.0 CO I FTE for security purposes through vacancy savings. Beginning in FY 2023-24, the ARPA funding ceased. However, due to previous court orders and advice from the Attorney General's Office, the Department continued this program using personal services vacancy savings to fund these positions. In FY 2023-24 and FY 2024-25, the Department funded and continues to fund these positions with the Department's personal services vacancy savings, which is not a sustainable long-term solution. The current R-12 Inmate Legal Access Decision Item requests 3.0 FTE of the original 19.0 FTE via General Fund for those positions beginning in FY 2025-26 and ongoing. These 3.0 FTE positions are for technological and administrative support.

- R-06 Recruitment and Retention – The Talent Acquisition Group (TAG) was started in FY 2022-23 using one-time ARPA funding.The Governor's office approved the original request via an Interagency Agreement with the Governor's office for $949,195. ARPA funding expired on 6/30/2023. Due to the success of the initial start-up the Department continued the TAG program after ARPA funds

expired. For FY 2024-25, the Department's R-03 request was approved and JBC appropriated $644,540 GF for job fair/event registration, advertising plus travel, and 3.7 FTE on a one-time basis ending June 30, 2025. Given the success of this program, the Department is requesting $644,540 GF in FY 2025-26 and ongoing to continue the work of its successful recruiting and retention programs.

Budget Request

R3 Upgrade pharmacy system

2. [Sen. Bridges] If this request is approved, how much does the DOC anticipate in savings from not having to rely on pharmaceuticals dispensed through third-party vendor?

- DOC Response: The approval of the new pharmacy system will reduce the need to procure pharmaceuticals from local pharmacies by reducing the prescription transfer time between the prescriber and pharmacy. The limitations from the current software requires the prescriber to physically print, sign and then mail a significant number of physical prescriptions to the pharmacy in order to comply with the applicable state and federal prescribing rules. As such, the facilities have had to rely on local pharmacies for a number of these medications due to the long turnaround times. For example, the same course of pain management therapy that the central pharmacy can procure for $3.08 will cost between $17.78 - $20.89 at a local pharmacy, not including the additional staffing needed to pick up the prescription from the local pharmacy. Based on purchase data from 2023, it is not unreasonable to expect annual savings of at least $10,000 or more for schedule 2 controlled substance medications alone.

  In addition, the new pharmacy system will allow the CDOC to participate in the 1115 Medicaid waiver program and seek reimbursement for parole medications dispensed by the central pharmacy. This is due to the new pharmacy system's insurance billing capabilities that are currently lacking in our present system. In FY 23-24, CDOC has dispensed 9,759 parole prescriptions costing around $1.17M. Recovering even a fraction of the funding spent by submitting claims for Medicaid reimbursement will result in significant savings. The savings will be restricted in a new cash fund that can only be used for Medicaid.

3. [Rep. Taggart] Is it possible to offset these costs with savings from 340B pricing? If yes, how and how much? If not, why not?

- DOC Response: The 340B program has introduced significant cost avoidance for total pharmaceutical costs, but prescription rates have increased 3%-5% every year for the past four years. The Department is looking to expand the 340B program but it is not clear if the 340B savings will cover these additional increasing expenses ongoing. However, the Department intends to use 340B savings to procure a new pharmacy system, which will be submitted as a supplemental IT capital request.

The largest financial benefit from the approval of the new pharmacy system lies in its ability to allow the CDOC to expand our participation in the 340B drug pricing program. This is possible through the new system's better medication dispensation tracking and reporting capabilities. By expanding our participation in the program, we will be able to reduce drug spending by millions of dollars each fiscal year. Based on dispensation data from 2023, we can reduce drug spending by $1.02M by adding just 5 additional HIV medications into the 340B drug pricing program.

R6 Recruitment and Retention

4. [Rep. Sirota] How does this compare with the original request from the previous budget cycle?

- DOC Response: Last year's submission (R-03 Critical Staff Retention and Talent Acquisition), included three parts: 1) $798,500 in operating funding and 4.0 FTE for the Talent Acquisition Group for marketing and recruitment; 2) $850,000 in operating funding and 2.5 FTE to establish a Staff Mentorship Pilot Program at four locations, and 3) $900,000 for uniform stipends for new staff. The 2024 Long Bill (H.B. 24-1430) included $1,997,061 General Fund and 6.2 FTE on a one-time basis for TAG and the staff mentorship pilot program.

  Recognizing both the statewide budget challenges and the successes of these efforts, the Department's November 1 submission for FY 2025-26 (R-06 Recruitment and Retention) requests $644,540 General Fund ongoing and prioritizes operating funds for continued recruitment strategies, including paid multi-media campaigns, attendance at job fairs, and fast-track hiring events. The Department has made significant progress in reducing its vacancy rate and boosting the number of applications and new hires. In order to build on this success and not risk returning to a higher vacancy rate, ongoing funds are needed.

5. [Sen. Gonzales] How does the Department plan to deal with an aging workforce? What is the long-term plan?

- DOC Response: Due to changing demographics, generational differences, as well as many DOC staff becoming eligible for retirement over the next several years, recruitment and retention has been a focus area for the Department. In order to address this, the Department has or is developing multiple staff-focused initiatives to meet the needs of its changing workforce and to provide much needed support, growth, and empowerment to our team. One of the primary strategies is to continue the successful increases in recruitment and Basic Training (BT) class sizes so the Department can rapidly backfill upcoming retirements.

  - <u>BT Changes (New Staff)</u>

    DOC recently re-imagined how it provides Onboarding and BT to new staff to improve relevance, transparency, and incorporate adult learning

best practices to account for generational differences and the changing workforce.

- Statewide Office of Human Resources (OHR) Supervisor Training and Frontline Supervisory Training
  - OHR Supervisor Training has been geared towards preparing new supervisors and refreshing seasoned supervisors to be equipped in their role as a supervisor and further their career development for managerial roles in the future.

  - Frontline Supervisory Training is being implemented which will encompass Supervisor Training, plus an additional 2 or 3 days and will be presented to Lieutenants, or equivalents.

- Retention Coaches (All Staff) – Already being piloted at 4 locations, with 4 more in early 2025
  - The DOC is currently piloting a Retention Coach program at several locations with a goal of providing an additional resource (not in their supervisory chain) that helps promote, support, and develop new and existing staff. Initial feedback from all levels has been extremely positive and the CDOC is in the process of expanding this to other locations.

- Focus on Staff Wellness
  - The wellness program is designed to promote resilience and longevity, ensuring staff can manage the challenges of long-term service with the department.

6. [Sen. Bridges] What is the number and staff vacancy rate DOC and turnover rates for correctional officers, case managers, education program staff, vocational program staff, community parole officers, nurses, social workers, medical health professionals, dental care professionals, and behavioral health professionals currently and at the beginning of FY21-22? (using the beginning of FY21-22 as "baseline" to compare progress in closing the vacancy by DOC job type)

DOC Response:

Classification	**FY 21-22 Turnover Rate**	**FY 21-22 Vacancy Rate**	**FY 24-25 Turnover Rate (YTD)**	**FY 24-25 Vacancy Rate (YTD)**	**Turnover Rate Difference**	**Vacancy Rate Difference**

Correctional Officers (I-V)	30.62%	11.73%	6.56%	11.91%	-24.06%	0.18%
Case Managers (I-III)	15.51%	7.63%	3.99%	9.76%	-11.52%	2.13%
State Teacher (I & II)	37.39%	19.79%	4.35%	23.49%	-33.04%	3.7%
CSTS (I-III) (vocational program staff)	24.73%	14.43%	3.46%	17.67%	-21.27%	3.24%
Community Parole Officer	17.32%	10.71%	3.52%	22.95%	-13.8%	12.24%
Social Workers (I-IV)	31.15%	45.45%	5.56%	39.41%	-25.59%	-6.04%
Nurses (I-III)	47.86%	21.43%	12.43%	19.51%	-35.43%	-1.92%
Dentist (I-III)	15.38%	35.00%	0.00%	26.32%	-15.0%	-8.68%
Psychologist (I & II)	42.86%	30.77%	0.00%	11.11%	-42.86%	-19.66%
Addiction Specialist (I & II)*	N/A	N/A	7.89%	40.63%	N/A	N/A
Health Professionals (I-VII)	39.42%	28.32%	2.00%	12.50%	-37.42%	-15.82%
Total Average of the Above Classifications	30.22%	22.53%	4.52%	21.39%	-26.00%	-3.06%
CDOC Agency Total	29.15%	19.68%	5.92%	15.48%	-23.23%	-4.2%

*The Department reclassified several Health Professionals to Addiction Specialists in FY 2024-25.

R7 Broadband

7. [Sen. Bridges] The request shows that the broadband projects already completed have resulted in an 11.8% decrease in the need for medical transport because of expanding access to telehealth. Why wasn't there an FY25-26 offset submitted as part of the budget request?

- DOC Response: The 11.8% decrease in the need for medical transports was only for 5 of DOC's 19 facilities that have broadband-enabled telehealth. Overall, DOC is realizing cost avoidance, but not overall savings, from broadband-enabled telehealth, as increases in medical transport costs are outpacing realized savings. From FY 2023-24 to FY 2024-25, medical transports have experienced increased staffing costs and variable mileage rate increases.

8. [Sen. Amabile] How does expanding broadband help with inmate communications? Will this lead to any cost savings? If so, how much? If not, why not?

- DOC Response: The investment in broadband helps the Department balance competing interests for our limited internet bandwidth, including for inmate communications. While these upgrades expand our capacity, cost savings for inmate communication specifically would be difficult to achieve. The department relies on an external vendor for the calling platform and management system to manage and maintain phone services to the population. The agency would need to partner with OIT or an external vendor to develop a self-managed system to shift away from the current model. The department has actively worked to improve costs in this area and has negotiated some of the most modest rates provided to incarcerated persons, far less than the maximum allowable billing rate set by the Federal Communications Commission recently, in September 2024.

INMATE COMMUNICATIONS

9. [Sen. Amabile] How are individual tablets affecting phone time?

- DOC Response: Tablets allow inmates to make phone calls without having to stand in line for wall-mounted phones in living units, increasing access and availability to make phone calls. Sales of phone time units from Canteen have increased since the tablets were introduced. The increase in inmate utilization is a combination of additional access to making calls with the tablets, and the new rates and cost sharing for the department. Overall, monthly minutes have increased from an average of 8.2 million with the old vendor to 12.9 million with the new vendor.

10. [Sen. Amabile] Please provide a full explanation of the cost of inmate communications. What is the revised cost expectation for the cost of inmate phone calls?

- DOC Response: The cost to the Department is based on the cost per minute of inmate phone calls. The Department does not pay for or subsidize media or video visits/calls to family or friends. The per-minute rate charged by the vendor supports the platform, infrastructure and maintenance of the inmate phone system.

The revised cost expectation for the implementation of H.B. 23-1133 will be submitted as a budget request on January 2, 2025. The Department's experience so far is that inmate phone call utilization has greatly exceeded initial estimates.

Prison Caseload

Vacancy rates and custody classifications

11. [Sens. Bridges and Amabile] In addition to funded beds that are excluded for maintenance and to preserve a 2.5% vacancy rate, please list all the other types of beds that are excluded, the # of beds that are excluded by facility, and how many inmates are currently housed in those beds. Specifically, are restrictive housing beds and residential treatment beds included or excluded from the calculation of funded bed capacity?

- DOC Response: For the purposes of calculating prison caseload adjustments, the Department has historically excluded Restrictive Housing (RH) and Infirmary beds in the available capacity totals. These beds are excluded because these beds are temporary placements for inmates who will return to a permanent bed when appropriate; if DOC were to treat their permanent beds as vacant and fill them, inmates could be left in Restrictive Housing or Infirmary beds longer than is warranted and appropriate while waiting for a bed to move to.

  DOC generally utilizes non-permanent beds when an incarcerated person needs to address a medical or clinical issue or in emergency situations where there is an increased safety risk. Including these temporary placement beds in the overall capacity would inflate the number of available beds. The table below shows the number of RH and Infirmary by facility. The number of inmates currently housed in those beds fluctuates as facility and inmate needs change. With current data collection, it is difficult to establish averages for the bed vacancy rates for RH and Infirmary beds.

Facility	**RH Beds**	**Infirmary Beds**
Centennial Correctional Facility	32	0
Colorado State Penitentiary	31	0
Denver Reception and Diagnostic Center	32	36
Sterling Correctional Facility*	64	0
Limon Correctional Facility	28	0
Arkansas Valley Correctional Facility	16	0

Facility	RH Beds	Infirmary Beds
Buena Vista Correctional Complex	70	0
Colorado Territorial Correctional Facility	32	32
Fremont Correctional Facility	63	0
Arrowhead Correctional Center	4	0
Four Mile Correctional Center	4	0
Trinidad Correctional Facility	8	0
Delta Correctional Facility	4	0
Rifle Correctional Facility	4	0
Total	**392**	**68**

*The November 2024 Population and Capacity Report contains an error and will be corrected for the December 2024 report. There are currently 64 RH beds at Sterling Correctional Facility.

Residential Treatment Program (or RTP) beds are included as part of the total capacity since inmates are assigned to these beds on a permanent basis. Inmates housed in RTP units (i.e. Drug and Alcohol Therapeutic Communities, SOTMP Intensive Treatment Communities, etc.) must meet certain criteria to qualify for placement.

12. [Sen. Bridges] How does R1 Prison caseload map to the Department's needs, especially for custody classifications?

- DOC Response: Historically, the beds with the lowest vacancy rate and highest demand are Level III beds. With this in mind, the Department is requesting to open the remaining available capacity at the two private facilities, Bent and Crowley, both level III facilities. Level II beds are also in high demand, with a similarly low average vacancy rate. The Department is requesting to open Level II beds at Buena Vista instead of Sterling because of the Sterling Access Controls capital renewal project, which will begin construction next fiscal year. Statewide, the Department is running out of options for capacity expansions and chose to prioritize Level II and III beds where available. Below is a chart showing the remaining unfunded male prison capacity as of FY 2024-25, and does not include the beds requested in the FY 2025-26 bed caseload request.

Facility (Security Level)	Custody Level	Remaining Unfunded Beds
Buena Vista Correctional Complex (Level III)	Level II	200
Centennial Correctional Facility (Level V)	Level V	316*
Delta Correctional Facility (Level I)	Level I	86
Sterling Correctional Facility (Level V)	Level II	100
Sterling Correctional Facility (Level V)	Level I	100
Private facilities (Level III)	Level III	227

*Would require legislation to utilize.

13. [Sen. Marchman] Is budgeting without a focus on specific custody classifications the right thing to do, especially if there appears to be issues with specific classifications?

- DOC Response: When budgeting for expected prison population changes, the Department does take into account which beds are in the highest demand and where capacity exists in the system. For this reason, the Department is requesting to open Level II and III beds in FY 2025-26, as they both have the lowest vacancy rates.

  From a prison operations perspective, a certain level of flexibility is needed as classifications are fluid over time due to the ongoing progression and regression of the internal offender population. Throughout the year, continual movement between custody levels occurs, creating ebbs and flows, which are stabilized over time by ongoing intake and release. The department must continually review and assess its offender populations to manage beds through natural progressions, classification overrides where appropriate and response to unexpected behaviors. This dynamic movement of offenders is contingent on numerous factors, but the department strives to ensure offenders are housed at the lowest appropriate custody and security level possible.

  DOC is currently undergoing a performance audit that was approved by JBC, which will look at and evaluate the bed caseload methodology, including options such as vacancies at each level.

14. [Briefing presentation] What would R1 Prison Caseload look like if it applied a 2.5% vacancy rate for each custody classification?

- DOC Response: The R-01 Prison Caseload budget request currently applies a 2.5% across-the-board vacancy rate encompassing all custody classifications. If instead the vacancy rate were applied to each individual custody level (taking into account beds offline due to capital-funded projects), the total number of needed vacant beds would not change. The challenge would be to find capacity within the system for each custody classification.

15. [Briefing presentation] What is driving the high vacancy rates in the minimum custody classifications?

- DOC Response: Minimum Custody Offenders are highly sought after for parole and community placements. In addition to being the preferred candidates for parole and community, their sentence lengths are shorter than their counterparts in higher custody levels, these factors combined create a naturally high rate of turnover.

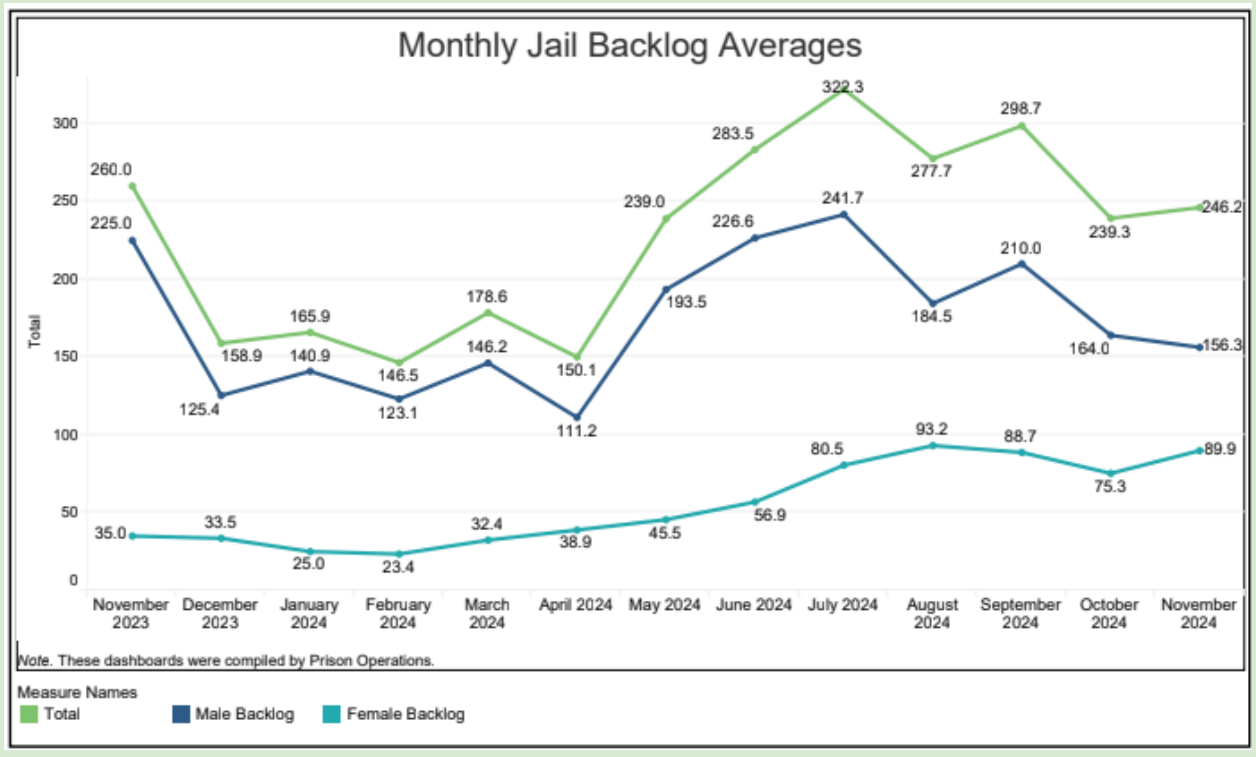
  The criteria for placement at minimum custody is based on several elements that serve to identify offenders who would not pose a significant security risk.
  - Offenders must have less than 36 months remaining to parole eligibility date (PED), less than 10 years to mandatory release date (MRD)/ institutional discharge date (IDD).
  - Offenders must also meet clinical matrices for physical and mental health needs.
  - These limited clinical codes are a result of minimum custody facilities not being able to provide 24hr medical care found in higher custody facilities.
    Crimes of violence, escapes history, active warrants and detainers are also considered when reviewing offenders for placement at minimum custody.

  This criteria serves to disqualify a large number of offenders currently at higher custody levels. Offender Services continually reviews higher custody populations in regard to the availability of viable progressions to minimum custody.

16. [Sen. Bridges] What does jail capacity look like for temporary housing while we address capacity issues?

- DOC Response: DOC has been very attentive to the jail backlog for the last two years in light of decreasing capacity. The current total backlog as of December 5, 2024 is 240, with 139 available for intake. Currently, these 240 offenders consist of 152 males and 88 females. While the female backlog number is considered high, the overall capacity is within manageable levels for the department and its ability to serve all 64 counties. If the Department were to reduce intake to only mandatory admissions to manage capacity issues, it would significantly increase the jail backlog and the counties' ability to manage DOC offenders in their physical plants. Additionally, this will cause substantial impact to the external capacity line as it is based on a daily jail backlog of 354 inmates. Any significant

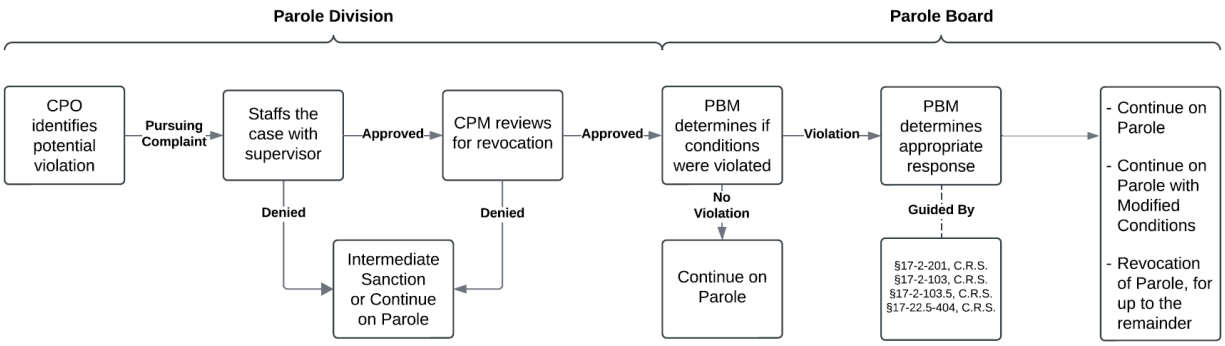
increase to backlog will be difficult to reduce, as DOC can only intake a certain number of inmates at a time. This approach poses significant long-term issues for DOC and its ability to regulate intake in a manner that is mutually beneficial to counties and the Department. Jail backlog is an important piece of the conversation around capacity, but it exists as a temporary placement for inmates who are ultimately DOC's responsibility.



Technical parole returns

17. [Sen. Amabile] In a flowchart, please show the path(s) of a technical parole return. It should show each point where a decision is made. This path should address:

- The order of events
- Who makes the decision(s)
- Whether the decision is mandatory (e.g. based on statutory requirements) or discretionary (requiring the decision maker's judgement)



CPO: Community Parole Officer
CPM: Community Parole Manager
PBM: Parole Board Member

- DOC Response: When a parolee violates a condition of parole, the supervising Community Parole Officer (CPO) is responsible for responding to the violation. The Division of Adult Parole is statutorily mandated to file complaints seeking revocation in certain instances. 17-2-103.5 (1)(a) specifically states:
  - (1)(a) Notwithstanding any provision of section 17-2-103, a community parole officer shall file a complaint seeking revocation of the parole of any parolee who:
    - Is found in possession of a deadly weapon as defined in section 18-1-901, C.R.S.;
    - Is arrested and charged with:
      - A felony;
      - A crime of violence as defined in section 16-1-104(8.5), C.R.S.;
      - A misdemeanor assault involving a deadly weapon or resulting in bodily injury to the victim;
      - Sexual assault in the third degree as defined in section 18-3-404(2), C.R.S., as it existed prior to July 1, 2000; or
      - Unlawful sexual contact as defined in section 18-3-404(2), C.R.S.; or
    - Has removed or tampered with an electronic monitoring device that the parolee is required to wear as a condition of his or her parole; except that, before making such an arrest, the community parole officer shall first determine that the notification of removal or tampering was not merely the result of an equipment malfunction.
    - Pursuant to C.R.S. 17-2-201, 17-2-103, and 17-2-103.5, *(HB 14-1044, HB 15-1122, HB 17-1326, SB 18-091, HB 20-1019, HB 22-1257)*, the attached document *(Revocation Outcome Guide)* explains how the Parole Board determines the outcome of parole

violations based on the type of violation. See the attached link below.

Revocation Guide

In all instances of a CPO filing a parole complaint seeking the revocation of parole, the CPO staffs the case with a Supervisor. Prior to the parole revocation hearing, the Community Parole Manager (CPM) reviews the case and determines if going forward with seeking revocation is the most appropriate course of action. If the CPM approves, the CPO presents the case to the parole board and the parole board makes the final decision in accordance with applicable statutes.

18. [Sen. Amabile] What is driving the increase in technical parole returns?

- DOC Response: The Colorado Department of Corrections (CDOC) does not have a singular database that tracks reasons the Colorado State Board of Parole revokes the parole of a parolee. Although there is no singular database, self-audits conducted by the Division of Adult Parole have consistently identified that offenders are being revoked most often for the statutorily-driven technical reasons listed below:

  The technical parole return numbers include:
  - Self-revocation requests granted by the Parole Board.
  - Parolees convicted of a new felony offense but are not sentenced to prison on the new case by the courts.
  - Parolees convicted of a new misdemeanor offense.
  - Parolees with no new criminal convictions (felony or misdemeanor), who have serious technical violations as defined in statute:
    - Refusing or failing to comply with requirements of sex offender treatment
    - Absconding
    - Willful failure to appear for a summons
    - Unlawful contact with a victim
    - Possession of a deadly weapon
    - Willful tampering or removal of an electronic monitoring device

19. [Sen. Amabile] What are the reasons that people are being returned for technical violations? Please indicate whether the reason is mandatory (per statute) or discretionary (non-statutory).

- DOC Response: Please see question #18 above for the reasons parolees can be returned for parole violations.

  The Division of Adult Parole is statutorily mandated to file complaints seeking revocation in certain instances. 17-2-103.5 (1)(a) specifically states:

  (1)(a) Notwithstanding any provision of section 17-2-103, a community parole officer shall file a complaint seeking revocation of the parole of any parolee who:

  - Is found in possession of a deadly weapon as defined in section 18-1-901, C.R.S.;

- Is arrested and charged with:
    - A felony;
    - A crime of violence as defined in section 16-1-104(8.5), C.R.S.;
    - A misdemeanor assault involving a deadly weapon or resulting in bodily injury to the victim;
    - Sexual assault in the third degree as defined in section 18-3-404(2), C.R.S., as it existed prior to July 1, 2000; or
    - Unlawful sexual contact as defined in section 18-3-404(2), C.R.S.; or
- Has removed or tampered with an electronic monitoring device that the parolee is required to wear as a condition of his or her parole; except that, before making such an arrest, the community parole officer shall first determine that the notification of removal or tampering was not merely the result of an equipment malfunction.
- Pursuant to C.R.S. 17-2-201, 17-2-103, and 17-2-103.5, *(HB 14-1044, HB 15-1122, HB 17-1326, SB 18-091, HB 20-1019, HB 22-1257)*, the attached document *(Revocation Outcome Guide)* explains how the Parole Board determines the outcome of parole violations based on the type of violation.

The Division of Adult Parole does not generally recommend revocation for discretionary reasons, instead utilizing intermediate intervention and sanctions or additional parole conditions to address less serious technical parole violations. Discretionary parole revocation is only sought when documented non-compliance to parole conditions and intermediate interventions and sanctions have proven ineffective. Some examples of serious technical violations resulting in the issuance of a parole complaint include:

- Refusing to Comply with requirements of Sex Offender Treatment
- Failing to Comply with requirements of Sex Offender Treatment
- Absconding from Parole Supervision
- Willful Failure to Appear for a Summons
- Unlawful Contact with a Victim

The Division of Adult Parole does not have decision-making authority on whether a parolee is revoked. In accordance with C.R.S. 17-2-201, the authority whether a parolee is revoked is with the Colorado State Board of Parole. See the attached Revocation Outcomes Guide for the Parole Board which is linked below.

Revocation Guide

First-time vs. repeat inmates

20. [Sen. Amabile] How many DOC inmates are under the Department's jurisdiction for the first time?

DOC Response: As of November 30, 2024, 9,499 (or 53.5%) of inmates are the result of new commitments.

21. [Sen. Amabile] How many DOC inmates are repeat inmates?

- DOC Response: As of November 30, 2024, 8,269 (or 46.5%) of inmates are “repeat” inmates. “Repeat” inmates are those that have recidivated within three years of release, either through a technical parole violation or new crime while on parole, or having committed a crime within three years of release from prison while not paroled.

22. [Sen. Amabile] Of those that are repeat inmates, how many are there because of a technical parole return and how many are there due to a new crime/conviction either during parole or after they’ve completed parole?

- DOC Response: Of those who are repeat inmates;
    - 4,882 (or 59% of repeat inmates) are returns for a new court commitment. These are inmates who commit a crime within three years of release from prison and who are no longer on parole.
    - 1,166 (or 14.1% of repeat inmates) are returns due to a technical parole violation.
    - 2,127 (or 25.7% of repeat inmates) are returns due to a new crime or conviction while paroled.
    - The remaining 94 (or 1.1% of returns) are returns for other commitments, such as regressions from community residential placements.

Sex Offender Treatment

23. [Sen. Amabile] How many people that are on indeterminate sentences are at or over their parole eligibility date?

- DOC Response: There are currently 867 people with an indeterminate sentence that are at or over their parole eligibility. To provide context and better understanding of that population, it would be best to break down the number.
    - Of the 867 people:
        - 147 are “D” meaning they either have denied previously or are currently denying they committed a sexual offense or are unwilling to participate in the SOTMP Program.
        - 84 individuals have indeterminate sentences, meaning that they do not have a set PED and parole is determined by the parole board upon completion of programming.
        - 78 have been revoked back to CDOC from parole
        - 64 had been terminated from SOTMP for engaging in risk related behaviors such as engaging in sexual contact with other offenders, contact with a victim of their sexual offending behavior, or possession of sex offense related pornography.
        - 59 are pending further assessment (majority revocation) or information (majority probation resentence) to determine treatment needs
        - 39 are currently under appeal of their offense

- There are approximately 50 people who have “M”, “J”, “L”, and/or “T” qualifiers.
    - “M”: The offender is compliant with program recommendations but is unable to participate in treatment due to a verified medical or mental health condition. Examples include individuals with dementia or those with unmanaged, severe and persistent mental illness.
    - “J”: Juvenile adjudication of a sex offense
    - “L”: The offender has a sex offense conviction but is a low resource priority for DOC SOTMP treatment. Individuals identified as a low resource priority present are well below average risk for sexual reoffense and will not benefit from SOTMP treatment in DOC.
    - “T”: The offender is currently being evaluated to determine sex offense-specific treatment needs.
- 118 individuals are currently in treatment for the first time and 41 are currently participating after previous attempts
- After all of the above considerations, approximately, 207 are past their PED and on the global referral list (GRL) .

24. [Sen. Amabile] How many people who have received treatment are past their parole eligibility date?

- DOC Response: There are currently 157 people participating in SOTMP who are past their parole eligibility date as of 12/09/2024

25. [Sen. Amabile] How many people who have not received treatment are past their parole eligibility date?

- DOC Response: There are 207 inmates currently eligible for treatment and past their PED.

26. [Sen. Amabile] Are cost savings possible if we put more money into treatment instead of just more beds? If so, how much? If not, why not?

- DOC Response: Allocating additional funds towards treatment - specifically treatment providers - and incentivizing a specialty niche in the behavioral health field may attract new graduates to this specific field or attract seasoned providers in other behavioral health fields to provide sex offender services within the CDOC. While additional money for treatment may attract additional providers, which could increase the overall amount of treatment availability, this alone would not directly correlate to a reduction in overall bed needs or cost savings. Individuals must still successfully complete treatment, which is highly dependent on the willingness of the individual to participate in the treatment itself, and upon completion, the individual must still meet any other non-treatment related qualifications they may have for parole eligibility, and then be granted parole by the Parole Board. In addition, bed space needs are driven by overall population projections, not just sex offender population projections. Reductions in the use of beds

by one population wouldn't necessarily mean that we would have an overall decrease in the need for bed space.

27. [Rep. Sirota] Please provide a prioritized list of factors driving the treatment backlog. In order of importance/impact, what factors are driving the backlog? How can the General Assembly address the backlog? What would need to happen and in what order?

- DOC Response: 25% of inmates in CDOC's population have committed a sex offense. This figure includes both indeterminate and determinate sentenced individuals. Factors that drive the backlog within CDOC include the lack of therapists willing to commute and/or live in Canon City where most of the programming is located. More broadly, there is a lack of Sex Offender Management Board (SOMB) providers in the State. Treatment providers must obtain a listing with the Sex Offender Management Board in order to provide sex offender treatment. Aside from Colorado's statutes around the Lifetime Supervision Act, clients who have completed SOTMP continue to face difficulties being released from CDOC. This is due to the number of parole deferrals, the lack of housing available to this population, and the low admittance rate into community corrections programs. The department has an average of 80 offenders in the maintenance level of sex offender treatment. These individuals have completed treatment but are deferred by the parole board. These individuals remain in treatment as long as clinically appropriate, continuing to strain treatment provider resources.

  Areas that could be taken into consideration and require further exploration and discussion include:

  - Lack of treatment providers and retaining current providers: To draw more interest into the program, incentives to pursue a specialty within a behavioral health field like offense-specific treatment could be offered.
  - Retention of current therapists is equally important. In addition to providing monetary incentives to attract new therapists, flexibility that promotes work/life balance could help retain therapists in this field.
  - Housing resources to support individuals being released from DOC could include incentivizing community corrections systems to accept these clients, which in turn makes their full transition into the community a safer one.

Special Needs Parole

28. [Sen. Amabile] There is a problem with not enough people being eligible for special needs parole taking up beds and also driving a big cost because of geriatric care. Can you ask them to provide details on this population group? How many people and the medical costs for this group?

- DOC Response: The criteria for special needs parole is very specific to the following conditions: serious impairment that limits the inmate's ability to function,

incapacitation, does not have a substantial probability of being restored to competency (including those with dementia), and terminal illness. Of the 268 who have submitted applications under the above conditions, 32 actually met the special needs criteria and moved forward with the SNP process. Several who applied and did not meet the SNP criteria were paroled or were already paroled through the typical parole process.

While there are a number of inmates with chronic conditions, they do not meet the additional criteria for SNP. It is true that DOC has a number of inmates that have been within the system while they age into their geriatric years, but it is also true that there are a number of inmates that come into prison during their geriatric years with crimes that preclude their release. The Department addresses their health care needs just as with any other inmate.

With the available data, it is clear the medical needs of the inmates increase as they age into specific age bands. For example, between the age of 34-50, 25% of that population have chronic care. Between 50 - 64, that percentage jumps to 62%. After the age of 64, that number is 68%. The vast majority of these issues do not meet the criteria for special needs parole and are managed within the department.

	FY 2020-21	**FY 2021-22**	**FY 2022-23**	**FY 2023-24 **Est**
Total Claimants	5,870	6,998	7,340	8,473
Percentage of claimants over 50 years of age	35%	32%	31%	32%
Total Paid Claims	$37.2 M	$43.9 M	$49.4 M	$56.0 M
Percentage of paid claims over 50 years of age	59%	51%	50%	50%

Data obtained from Colorado Health Partners, DOC's contracted provider for external medical services

29. [Sen. Gonzales] How is the DOC utilizing (or not utilizing) this Special Needs Parole? Please elaborate.

- DOC Response: The CDOC has a number of pathways to Special Needs Parole (SNP). Requests for SNP can come from the inmate, the inmate's case manager, a provider, a health services administrator, the SNP committee, or even an outside concerned constituent. Once the request for SNP is submitted, it is recorded and tracked by the SNP committee, which consists of the associate director of benefit acquisition, a case manager, two nurse case managers, and the chief medical officer. The request is assigned to and evaluated by one of five clinical providers who reviews the chart and completes a worksheet that has been constructed around the legislation that governs the SNP process. These criteria include whether they are older than 64 or if they have a terminal condition. If the candidate meets the criteria outlined in the statute, they are

submitted to the parole board. If they do not meet the criteria, the inmate may appeal the decision and the chief medical officer who completes a subsequent and separate review of the chart and provides a decision. If, after that appeal, the inmate does not meet the criteria for SNP, they can resubmit and be reviewed again in 6 months. If they are submitted to the parole board, they may be approved for release, approved and tabled pending a parole plan or denied.

Capital projects

30. [Sen. Kirkmeyer] Is there any reason why the JBC cannot get some information about the operational impact of capital projects ahead of time?

- DOC Response: No. The department is happy to work with and engage JBC in the operational impacts of capital projects as soon as they are known. Shortly after funding is appropriated for capital projects, the Department works collectively to identify the prison capacity impact of the newly appropriated capital project. In previous years, with a higher inmate vacancy rate, the Department was able to absorb capital projects' impact on caseload, with only minor operational impacts. Because of the growing population and fewer releases, the Department no longer has capacity to absorb capital projects' operational impacts.

- Additionally, the caseload and other operational impacts of capital projects are dependent on JBC decisions on specific DOC operational requests, particularly the annual caseload supplemental and budget amendments. In particular, in recent years JBC has often funded different numbers of beds, and sometimes at different facilities, than what DOC requested. Only once funding for both operational and capital requests is set by the legislature can the Department determine the final outcome.

The Department is amenable to attempting to provide a range of potential impacts to caseload in capital submissions, knowing that these numbers and timeframes are highly dependent on updated forecasts by DCJ and decisions by the JBC.

31. [Briefing document] If the FY 2025-26 DRDC capital project is approved, how and when would that impact future prison caseload requests? How many beds would have to be taken offline at any given time and for how long?

- DOC Response: This project would not affect the bed caseload in FY 2025-26. If approved, the first year of the project, FY 2025-26, and the first half of FY 2026-27, would focus on design, permitting, contracting, bidding, and approval of construction shop drawings for the ordering of the required materials. It is anticipated construction would not begin until January 2027. Each Living Unit Day Hall is anticipated to take 10 weeks for the improvements. The Living Unit Day Hall sizes range from 31-96 inmates.

32. [Briefing document] How would the DRDC capital project affect prison capacity and population management, especially given its unique qualities (e.g. intake facility and specialized health care units)?

- DOC Response: The DRDC project would be handled by dayhall to minimize the impact on capacity and the facility. Living Unit size ranges from 62-188 inmates, with two day halls per living unit. Because of the unique nature of DRDC, this would be managed through the intake of new inmates and the temporary movement of some infirmary beds to other locations. Due to the frequent use of the infirmary beds we would likely have to utilize contracted hospital support.

33. [Briefing document] Does the Department intend to relocate intake and processing functions from DRDC to Centennial South, like it requested in FY 2019-20 at a cost of $11.1 million (which was denied)? If so, what is the estimated cost today?

- DOC Response: No, the department will keep intake at the current location at DRDC.

34. [Briefing document] How are current projects affecting prison capacity and population management?

- DOC Response: Current capital renewal projects include the following:
    - Arkansas Valley Correctional Facility (AVCF) Shower, Toilet, and Drain Improvements. This is a 12-phase project requiring 60 vacated beds per phase. The project is anticipated to be completed in December 2026. This project additionally will provide Medium Custody ADA toilets and showers in four of the six Living Units.
    - Sterling Correctional Facility (SCF) Kitchen Renovation has no prison population capacity impact.
    - Sterling Correctional Facility (SCF) Access Controls Electronic Security System Replacement will not impact beds until January 2026. The improvements will be by individual Living Unit, impacting Living Units 1-8, with each Living Unit anticipated to be offline for approximately ten weeks. The eleven Minimum-R & Minimum units will not require external capacity. DOC is evaluating these impacts in light of the latest DCJ population forecast for potential inclusion as part of the January 10 caseload request.
    - Buena Vista Correctional Facility (BVCF) Lower North Cell Fronts. This initial project was set up as four phases, though once under construction, and due to sequential controlled maintenance funding, the first two phases were done at one time. These are the last two phases of the four phase project requiring 70 beds offline. The first two phases were completed in October 2024. The next 2 phases are already in production off site and will begin installation in FY 2025-26 and take approximately four months.
    - Although there are several maintenance projects affecting capacity in FY 2024-25, the Department has been able to manage the prison population due to the other beds that were funded and opened this year, including 116 private prison beds and an additional 24 beds brought online at BVCF in September 2024

and the other 70 beds brought back online at BVCF after the completion of the cell front project in October 2024.

Proposition 128

35. [Rep. Sirota] When is the earliest that the Department expects Proposition 128 to have an impact on prison caseload? Please elaborate in your response.

- Revised DOC Response: When evaluating the impacts of Proposition 128 on Department caseloads, it is estimated that a statistical minority of cases will begin impacting caseloads within two years, with the impact increasing exponentially in subsequent years.

  The average sentence length for current enumerated convictions that would be impacted by Proposition 128 going forward is approximately 20 years. Individuals currently sentenced for enumerated crimes are typically eligible for earned time; however, those sentenced under Proposition 128 will no longer qualify. Based on the average sentence length and the estimated effects of good time and earned time, an individual under current law would be eligible for parole after approximately 11 years.

36. [Rep. Sirota] Please provide a list of crimes applicable under Prop 128, the earliest date when the changes from Prop 128 would be applicable for each crime, and the number of people currently serving a sentence for each crime.

- DOC Response: Proposition 128 applies to individuals convicted of certain violent crimes after January 1, 2025. Proposition 128 does two things:
  - Increases the amount of prison time a person convicted of violent crime must serve before becoming eligible for discretionary parole or earned time reductions from 75% to 85%;
  - Prohibits discretionary parole or earned time reductions for individuals convicted of a violent crime for the third time.

  The list of applicable crimes, the sentencing range, as well as the number of inmates currently incarcerated for those crimes (as of November 30, 2024) are included below. Please note that the number of years actually served would be 85% of the listed number (currently 75%) (ex: if the minimum sentence length is 5 years, then under the current statute, the person would serve about 3 years and 9 months (less any earned time) and then become parole eligible. With Proposition 128, this would become about 4 years and 4 months before parole eligibility, meaning they will occupy a bed for about 7 months longer before parole eligibility).

Crimes impacted by Prop 128	**Number of current DOC inmates**	**Minimum sentence length (Years)**	**Average Sentence Length**	**Average Length of Stay (Years)**

			(Years)	
Murder (second degree)	1,043	2.00	41.35	7.39
Sexual Assault (first or second degree)	779	Less than 1 year	84.60	30.04
Aggravated Robbery	1,793	Less than 1 year	15.91	9.06
Assault (first degree)	1,280	Less than 1 year	18.96	8.14
Kidnapping (class 2 felony)	35	5.00	30.16	8.28
Arson (first degree)	85	1.50	10.18	9.85
Burglary (first degree)	435	1.50	10.36	9.36

PRIVATE PRISONS

37. [Briefing presentation] How many times in the past 20 years has the Executive Branch/Department requested a per-diem rate increase for private prisons? Please indicate the fiscal year, the change in the per-diem rate requested (both $ and %), and the outcome of the request.

- DOC Response: In the past 20 years, the Department requested an increase to per diem rates once, as part of its FY 23 S-01, BA-01 Private Prison Per Diem budget request. Please see the table below from the request. The Department requested to increase the per diem to $62.19 (increase of $3.40 or 5.8%) in FY 2021-22 and to $63.32 (increase of $4.53 or 7.7%) in FY 2022-23.

Table 2: Proposed Private Prison Per Diem Increases

	# Beds	# Days	Per Diem Increase	Supp/BA Request	New Per Diem
FY 2021-22	2,617	122	$3.40	$1,085,532	$62.19
FY 2022-23	2,614	365	$4.53	$4,322,118	$63.32

- The Legislature approved a new rate of $63.32 for both FY 2021-22 and 2022-23.
- In addition, the per diem was increased by the Legislature in the fiscal years listed below.

FY	Private Prison Per Diem	Increase

2006-07	$51.91	$1.63
2007-08	$52.69	$0.78
2013-14	$53.74	$1.05
2014-15	$55.08	$1.34
2015-16	$56.02	$0.94
2017-18	$57.37	$1.35
2019-20	$57.94	$0.57
2023-24	$65.22	$1.90
2024-25	$66.52	$1.30

38. [Sen. Bridges] Why are inmates in private prisons excluded from the pharmaceutical population used to calculate medical caseload adjustments?

- PPMU offenders are excluded from the pharmaceuticals POPM (per offender per month) figures because the contract between DOC and the PPMU (private prison monitoring unit) vendors states that private facilities are responsible for all routine healthcare services, including medications. DOC only pays for pharmaceuticals for PPMU offenders for certain manageable chronic conditions, certain high-cost drugs, and non-formulary items.

39. [Rep. Taggart] Are pharmaceutical costs included within the per-diem rate for private prisons or are those costs supplemented by another line item in the Department's budget?

- DOC Response: CDOC only reimburses for certain high-cost meds and non-formulary medications otherwise, it is part of the per diem. Also, the Department will pay for labs for certain conditions. Otherwise, the contractor is generally responsible for all routine primary health care, including all medications associated with that care.

40. [Sen. Bridges] Given that people housed in private prisons are specifically screened for having low or no ongoing medical treatment or pharmaceutical needs, then what is the rationale for including them in the POPM for external medical services?

- DOC Response: Offenders are placed in the private prison based on the medical "M" code. The M code is based on control of chronic conditions. Stable chronic conditions often still require specialist external medical care. Also, based on age there are screenings (such as colonoscopy) that are provided by external providers.

The PPMU ADP (average daily population) is reduced from the External Medical Services Population with regard to Pharmaceuticals. PPMU offenders are not included in the POPM for pharmaceutical costs, but are included in the POPM for external medical services because the DOC is still responsible for paying for medical services provided by external providers (outside of the PPMU facility) should an offender be referred or transported for medical care, if the DOC's Utilization Management contractor has authorized the care based on program benefits, medical necessity, specialized care need, and appropriateness of care on a case-by-case basis.

41. [Sen. Amabile] How does compensation for private prison employees compare to the DOC?

DOC Response:
The Department looked at CoreCivic Compensation based on their job openings, and compared them to DOC compensation set by DPA. The results are below.

Classification	**CoreCivic Compensation**	**DOC Compensation***
Correctional Officer (CO I)	$24.49/Hour	$27.09-37.94/Hour
Registered Nurse (Nurse I)	$42.05-53.97/Hour	$42.93-60.10/Hour
Mental Health Therapist (equivalent to Social Work/Counselor III)	$88,340 - $103,360 / Annually	$81,000 - $113,400 / Annually

*The pay scale provided is for the base salary only and does not account for shift differential or POTS.

42. [Sen. Amabile] What are the current staff vacancy and turnover rates for the private prisons?

DOC Response: CoreCivic provided the following data to the Department. The turnover rate was for the past year, whereas vacancies are as of 12/8/2024.

Classification	**BCCF Vacancy**	**CCCF Vacancy**	**BCCF Turnover**	**CCCF Turnover**
Correctional Officer	113 total 14% (16 vacancies)	148 total 15% (22 vacancies)	65%	60%
Registered Nurse	10 total 20% (2 vacancies)	13 total 15% (2 vacancies)	30%	20%
Mental Health Therapist	4 total 50% (2 vacancies)	2 total 0% (0 vacancies)	39%	22%

43. [Sens. Amabile and Bridges] What is the maximum design capacity at both Bent County Correctional Facility and Crowley County Correctional Facility?

- DOC Response: Bent County Correctional Facility (BCCF) 's maximum designed capacity is 1388, and that facility is currently funded for 1388 beds. Crowley County Correctional Facility (CCCF) 's maximum capacity is 1720, and that facility is currently funded for 1493 beds.

DOC INMATES IN THE COMMUNITY

44. [Division of Criminal Justice briefing document] There has been a large decline in the percentage of inmates in the DOC's Intensive Supervision-Inmate (ISP-I) program. Why? Please prioritize the factors that are hindering the number and efficiency of DOC ISP-I placements.

DOC Response:

DOC established criteria for placement on ISP-I is listed below. A decline in the number of inmates in ISP-I may be attributed to reduced eligibility pool and inmate voluntary waivers. Inmates must demonstrate acceptable institutional behavior/criteria, including:

- An offender must be within 180 days of their parole eligibility date (PED).
- No Class I COPD convictions within the previous 18 months.
- No Class II COPD convictions within the previous 12 months.
- Participating in available DOC-recommended programs.
- No documented Security Threat Group activity as defined by C.R.S. 17-1-109 for two (2) years.
- Has not been assigned to any Management Control Unit status as defined by AR 600-09, Special Management for two (2) years. Offenders must meet eligibility criteria outlined in AR 550-01, Integrated Case Management System, conforming to requirements of Colorado Senate Bill 20-085 concerning offenders convicted of a sexual offense and sentenced to lifetime supervision.
- The offender's prospective residence plan must be within the geographical area of the ISP-I or community corrections board authorization.
- The offender must not have a felony warrant/detainer/pending charges, to include an ICE detainer/notification, or any extraditable warrant/detainer/pending charges. These offenders are ineligible to be referred until the issue has been resolved.

Some additional factors to consider in evaluating numbers/decline:

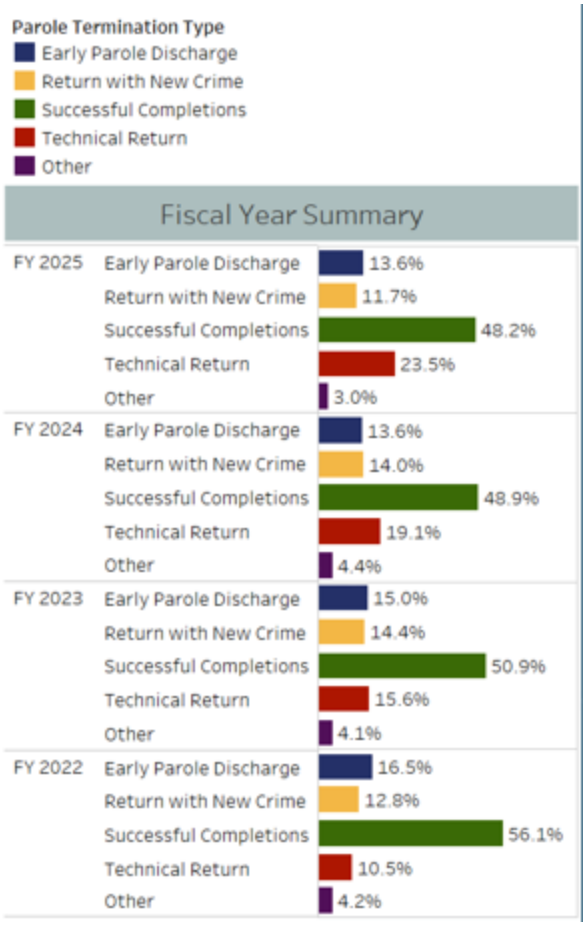
- It should be noted that Inmates may opt-out or waive referrals for community corrections, ISP-I, as well as parole hearings with cause. For the purposes of community corrections and ISP-I the inmate drives whether or not a referral is initiated, to include the initial statutorily driven referral which can be waived by the inmate.
- HB 18-1251: For those who are in community corrections residential, upon completion, if parole eligible, these are prime candidates for consideration of parole release, and if eligible for parole, require a full board to deny parole release, therefore, reducing the numbers of those who may otherwise transition from community residential to community based ISP-I.
- Inmates eligible for ISP-I, Community Corrections, and Parole, though they can be independently eligible for each, are often eligible for these three release options simultaneously, and as such competition can exist for inmate placement.
- There may also be a COVID-related surge that amplifies the decline when ISP-I was considered/utilized in some cases for depopulating congregate living environments both in prisons, jails and community corrections centers for social distancing and COVID safety responses

45. [Division of Criminal Justice briefing document] The proportion of DOC inmates transitioning to community correction is also lower than it was a decade ago, despite efforts to improve placements. Why? Please prioritize the factors that are hindering the number and efficiency of DOC transition placements.

- DOC Response: This question is replicated in the DPS Hearing question list and will be addressed in the DPS Hearing answers, with consultation of DOC as appropriate.

46. [Sen. Bridges] What do we know about the recidivism outcomes for individuals who are released in different ways? Parole, ISP-I, ISP-P, community corrections, etc.

DOC does not have data on recidivism outcomes based on release type, because the different ways by which inmates ultimately exit DOC's population do not overlap evenly with inmates' participation in the State's various pathways to release. Inmates often follow multiple pathways to release, such as ISP Parole and Community Corrections, and progress towards release along one of these pathways is not always one-way. Individuals on ISP-I status sometimes regress to Community Corrections, and Community Corrections clients sometimes return to prison due to violations, and so forth. The Department collects data on parole-specific outcomes, but this is distinct from recidivism outcomes based on release type for the aforementioned reasons. A chart displaying parole termination outcomes is shown below.



However, to better speak to the question above, the Department is reviewing data to assess if we can look at successive/regressive outcomes by release type annually. This would not speak directly to recidivism as we define it, however, may give a better sense of regression/progression by each individual release type. We hope to provide the Joint Budget Committee with this information by the end of 2024.

47. [Sen. Bridges] For people who complete those release types successfully, how many of them end up back in prison?

- DOC Response: Recidivism is not tracked by release type or program completion.

48. [Rep. Taggart] How and how much does the Department collaborate with the Division of Criminal Justice? What does the Department want or need from the Division of Criminal Justice in order to increase the number of community placements?

- DOC Response: DOC has an excellent working relationship with the Department of Criminal Justice (DCJ) and the Office of Community Corrections, housed within DCJ. In the past, we have worked collaboratively to respond/present legislation, internal policy revisions and specific projects (SOA-R transition, HB 18-1251 working group, facility in-reach efforts, conferences, Case Management training and Case Manager Supervisor Quarterly Meetings).
- Neither DOC nor DCJ have the ultimate decision on community placements as this decision rests with the local community correction boards and community centers. DOC has representatives on the various community corrections boards, which operate in each Colorado county; these boards have decision making authority over the acceptance of referred cases.
- Community placement eligibility is mandated by statute and further delineated in department policy, however, inmates are able to waive community placements and continue incarceration to their parole eligibility.

- As of December 6, 2024 there are 458 inmates awaiting community corrections review. DOC continues to collaborate with DCJ and community corrections boards to obtain responses to

- The Divisions of Adult Parole, Prison Operations and Offender Services maintain a strong relationship with DCJ. We have open lines of communication with them, and they participate in our quarterly Case Manager III meetings to provide updates. Our discussions typically focus on changes or challenges within Community Corrections. Whenever the DCJ sponsors training sessions or conferences, we make an effort to send as many staff members as possible for networking and educational opportunities. Currently, we have no issues with the DCJ; they are extremely helpful in facilitating community placements. It is important to note that our department does not make the final decisions regarding placements in community beds.

Medical issues

49. [Sen. Amabile] Please describe the routine health care that inmates get.

    - DOC Response: Clinical Services in the DOC is structured to function similar to a community health care organization. DOC provides a range of health care services to the inmate population which includes but is not limited to medical, dental, behavioral health, support services, quality management, staff recruiting, training, and compliance with the Americans with Disabilities Act. Primary care services are handled by licensed medical professionals employed by DOC in the clinic at the inmate's assigned correctional facility. Determination of the plan of

care, including all treatments, restrictions, and medication orders is at the discretion of the health care provider based upon their evaluation of the inmate and medical knowledge/training. Primary medical, behavioral health, and dental care is provided by state and contract employees, which includes but is not limited to physicians, pharmacists, physician assistants, nurse practitioners, nurses, dentists, psychiatrists, psychologists, social workers, certified substance use disorder clinicians, sex offender therapists, and ancillary staff. Clinical Services provides direct patient care, which includes but is not limited to dental services, pharmacy services, X-ray services, dementia care, infirmary care, dialysis, a special medical needs unit, end-of-life care, 24-hour emergency care, on-site emergency acute care, crisis intervention, and 24-hour on-call providers. Healthcare services outside of DOC facilities are managed through a contracted third-party administrator. Mental health services are provided for inmates, such as group therapy, psychiatric services, and crisis intervention which vary in levels of intensity to include inpatient mental health programs, intensive mental health services, and Residential Treatment Programs (RTP). RTPs offer highly specialized treatment to inmates with mental health disorders and/or intellectual and developmental treatment needs. These programs utilize a planned incentive-level system to promote pro-social behavior and treatment progress while meeting behavioral goals. Alcohol and Drug Services provide substance use disorder treatment and education that produces long-term change, increasing quality of life, reduces or eliminates substance use and criminal conduct, and facilitates successful reintegration into the community. Medication Assisted Treatment (MAT) is used primarily to alleviate withdrawal symptoms for substance use disorders in both male and female inmates. MAT is offered to all inmates who have a substance use disorder and are willing to receive treatment which includes prescribed medication as well as individual and group counseling services. Inmates are treated to facilitate long term treatment and recovery during incarceration and re-entry into the community. Therapeutic Community Programs are also available at designated facilities for inmates with histories of substance use and an identified need for this specialized treatment program.

Clinical staffing

50. [Briefing document] Please comment on:

- Contract clinical staff costs in the current year
  - DOC Response: The FY 2024-25 invoiced costs are: Medical = $8,348,934 and Mental Health = $2,381,085. Clinical billing often lags and this may not represent all the costs YTD.
- The cause of clinical staffing shortfalls

- DOC Response:
  - a limited number of credentialed staff in a highly competitive job market;
  - Colorado is experiencing shortages of medical and mental health providers;
  - Salaries have not always been immediately comparable to community opportunities, though state employment generally offers more valuable benefits. The competitiveness of salaries is beginning to shift with the state's updated compensation plan;
  - remote locations of prisons;
  - specialized care of the prison population;
  - higher rates of remote opportunities for behavioral health staff in community-based care (DOC is offering remote positions but has hit barriers in success due to the logistics of telehealth in a prison setting);
  - specialty recruiting of clinical positions (this is shifting with the CAREER team and incorporating SMEs in recruitment events).
- The apparent increase in centrally-appropriated transfers
  - DOC Response: Until recently, vacancy savings has been able to cover the clinical staffing increase in costs. More recently, in the absence of vacancy savings, DOC has been using centrally appropriated transfers to cover some of these costs.
- The impact of incentives for clinical staff.
- DOC Response: Based on early evidence this year, incentives have proven effective; the Department has hired 46 new clinical staff who were incentive-eligible. DOC projects to double the amount of new hires for clinical services compared to last FY.

51. [Briefing document] For the Department of Personnel and Administration: How does the critical staffing job market analysis square with reports of contract clinical staff making considerably more than DOC clinical staff? How did the Department arrive at its conclusions?

- DPA is developing a response to this question to be included within DPA's January 2 submission.

INMATE MEDICAL FEES

52. [Sen. Amabile] Please describe the medical co-pay fees that inmates pay.

- DOC Response: Under CRS 17-1-113, "The department shall assess a copayment, in an amount established by written procedures of the executive director pursuant to subsection (4) of this section, not to exceed five dollars per visit, against an inmate's account for every inmate-initiated request for medical or mental health services provided to the inmate by a physician, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse. The department shall assess a copayment, in an amount established by written procedures of the executive director pursuant to subsection (4) of this section, against an inmate's account for every inmate-initiated visit by the inmate to a dentist or optometrist. The amount of the copayment for the dental or optometric services need not be the same as the copayment for medical or mental health services."

All inmates are provided a Clinical Services Handbook at the time of admission to the DOC which outlines how they can access health care as well as the co-pay guidelines.

Kites/Appointment requests: The most commonly used method to access routine health care from DOC is a sick call. Requesting health care services is a self-referral process by the inmate, done by completing the Request for Sick Call Form, commonly known as "a kite." An inmate is never charged a fee for submitting a kite. Upon receipt of a request (kite) for health care services from an inmate, designated Clinical Services DOC employees or contract workers at each facility clinic will review the inmate initiated request for health care and schedule appointments accordingly. Each inmate is responsible for all applicable co-pay fees that are incurred; however, offenders are never denied health care because of their inability to pay. A $3.00 co-pay fee will be charged for each health care appointment that is initiated by an offender with a health care professional, a dentist, or an optometrist (sick call). There is no charge for submitting a kite. There is no co-pay charge for behavioral health or psychiatry services. This includes mental health services for offenders with serious mental illness or offenders assigned to a Residential Treatment Program (RTP). A $3.00 refusal fee may be assessed if the offender refuses to attend their scheduled appointment. They may also be charged a $3.00 no-show fee for failure to appear in the clinic for their scheduled appointment or failure to notify the clinic 1 hour prior to their appointment time.

Medical Emergencies: Inmates who believe they are experiencing a medical emergency and require emergency care may notify staff they are having a medical emergency and will be seen and assessed by a nurse who will assess the patient and determine if a higher level of care is necessary. A $5.00 co-pay may be assessed if an offender self-declares a medical emergency.

- By fee type (e.g. visit co-pay, no-show), please show how much money the Department receives from these fees.

The Department reported that user fees can be lumped into two broad categories: inmate payments for medical fees (i.e., co-pays) and sex offender treatment surcharges. Medical payments are essentially co-pays that inmates pay for doctor visits. The Department charges $5 for self-assessed emergencies that may or may not require transportation outside of the facility, and $3 for non-emergent health care services requested by an inmate. The Sex Offender Surcharge is established in statute, and is paid by the offender at the time they are convicted of a sex offense. The charge is dependent on the severity of the offense and ranges from $150 for a class 3 misdemeanor to $3,000 for each class 2 felony. The chart below shows the categories and average revenue for each of these user fees between Fiscal Years 2019 through 2023.

Fund	Average Revenue Over Five Years (FY 2019-2023)

Medical Services—Personal Services	$102,864
Medical Services—Indirect Cost Assessment	$1,258
Sex Offender Treatment—Personal Services	$30,995
Sex Offender Treatment—Operating	$500

53. [Sen. Amabile] How are these fees collected and where does the money go? Is there a cash fund that they are deposited into?

- DOC Response: The funds are collected in the clinic via a Withdrawal Ticket, which the inmate signs, if available. Inmate Accounts processes the tickets, by charging the inmate account, and crediting a transfer account. General Accounting moves the funds to a cash fund. Ultimately, those funds are applied to the Medical General Fund for Personal Services appropriation (CGBFA004G).

54. [Sen. Amabile] How is it that inmates "no-show" to an appointment when they are in custody?

DOC Response: Offenders have the right to refuse treatment. They are notified of their scheduled appointment time in accordance with specific facility operations. Offenders may notify medical they would like to cancel their appointment via a kite or verbally notifying custody staff. If operations prevent an offender from attending their appointment, they will not incur a no-show and subsequent fee. Offenders who refuse to attend are asked to sign a refusal document, thereby incurring a "no-show". If an offender refuses to sign the form, DOC staff are required to sign a refusal to sign.

Joint Budget Committee
FY 2025-2026 Budget Hearing

Colorado Department of Corrections
Andre Stancil, Executive Director

December 13, 2024

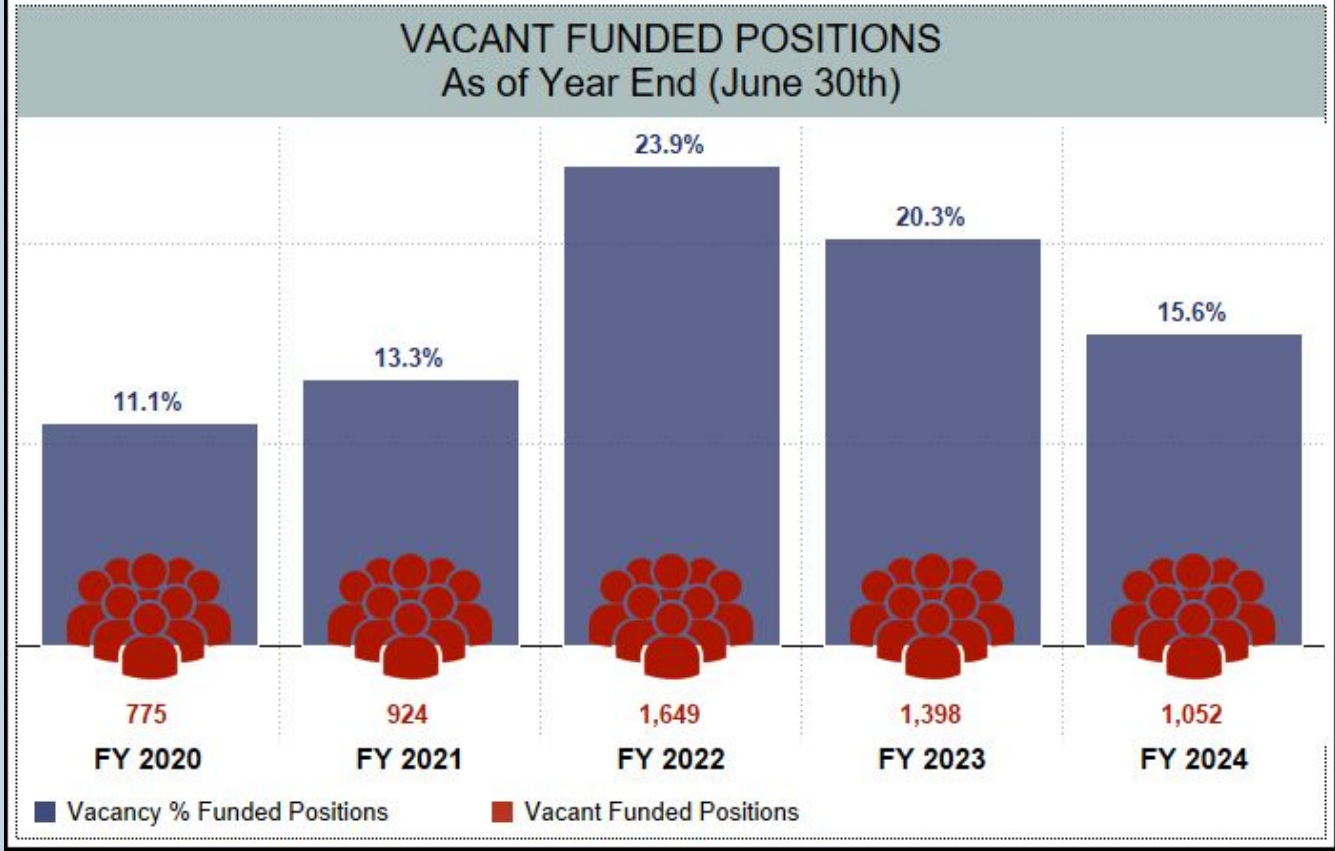
Gains and Strides

Modernizing the Department

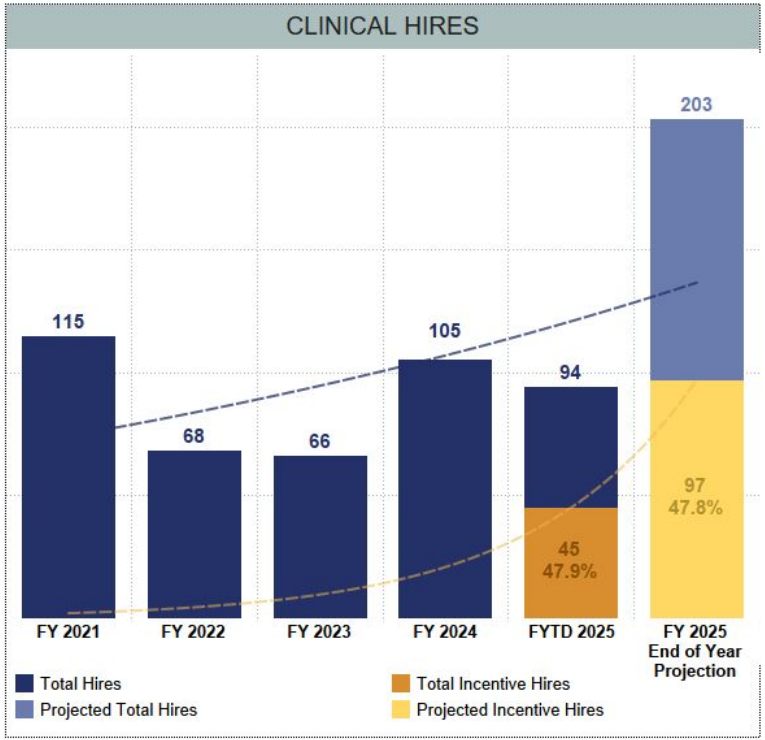
Modernizing Human Resources

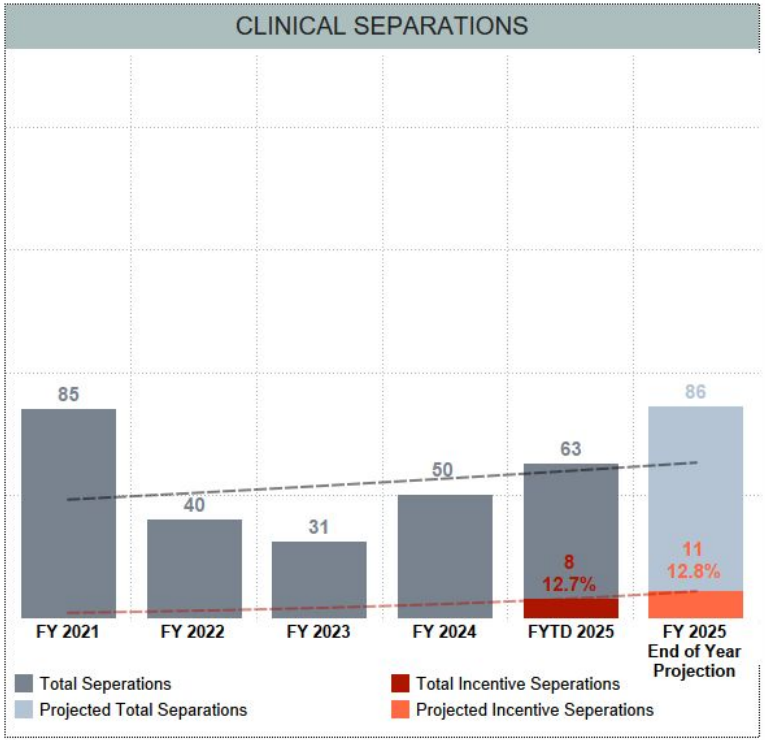
- Revamped Basic Training
- Enhanced CORDICO/Wellness app
- Hired Retention and Culture Coaches
- Increased Exit Survey Responses
- Forged creative solutions
  - nurse minimum qualifications exception for new graduates
  - Food Service apprenticeship and State Service Professional Trainee work based learning
- Improved communication
  - AA and staff Info sessions, quarterly newsletter
  - Training on HR hot topics

STAFF VACANCY



CDOC CLINICAL INCENTIVE HIRES/SEPERATIONS WITH END OF YEAR PROJECTION

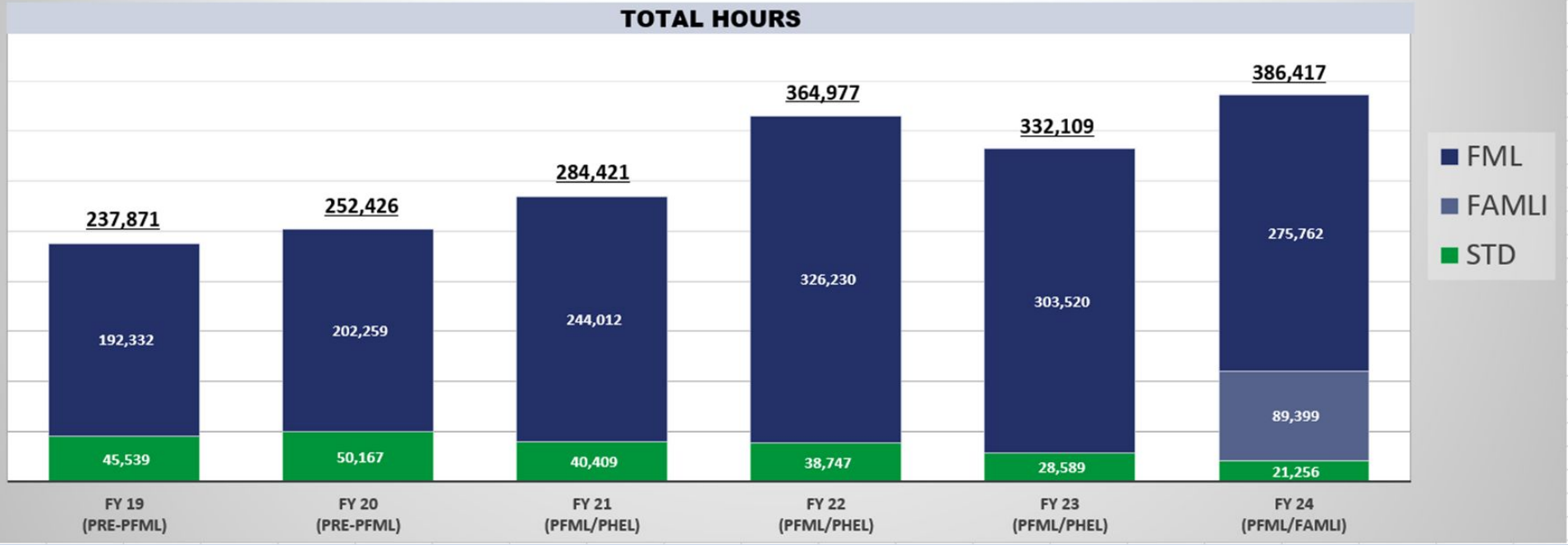




***Note:** Clinical incentives began on July 1, 2024. All FY 2025 data is Fiscal Year to date as of November 2024.*

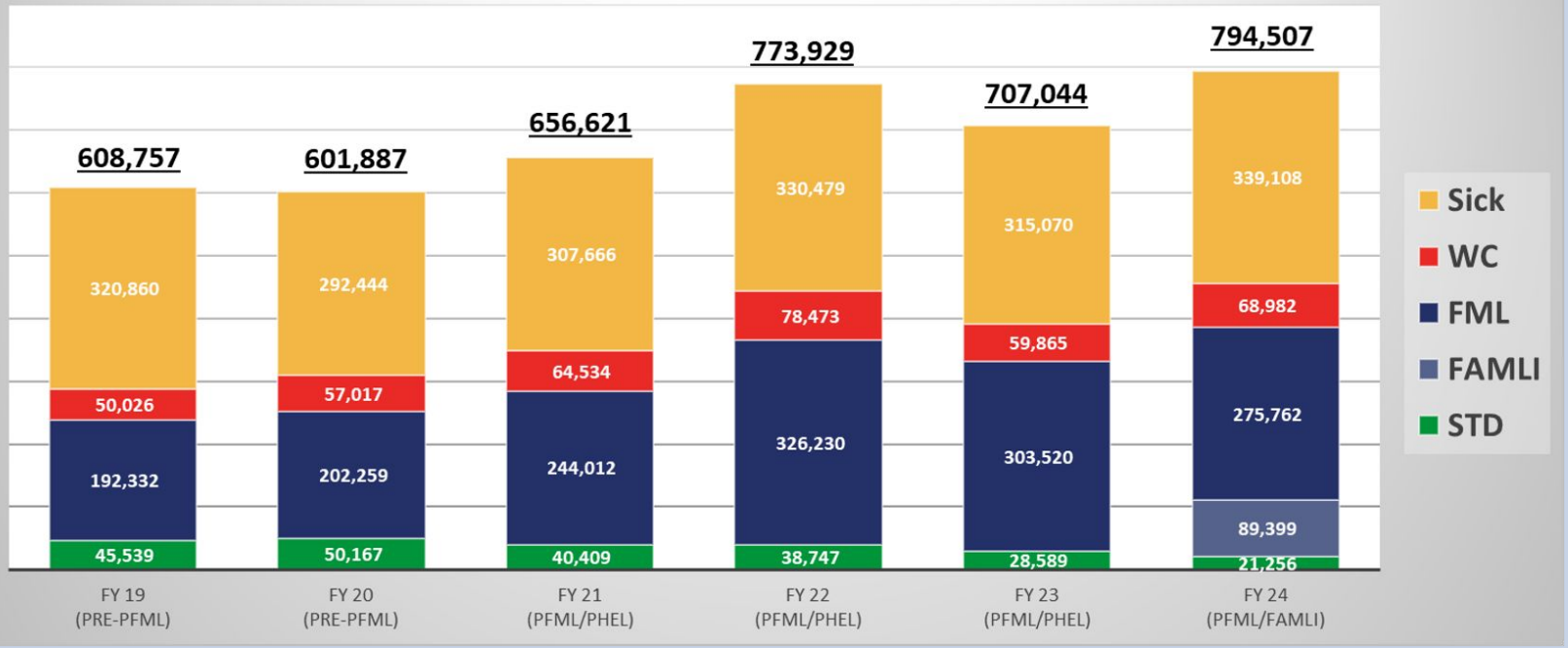
Family and Medical Leave (FML) and Family and Medical Leave Insurance (FAMLI)

FY19 (Before Paid FML) – FY24 (Paid FML + FAMLI)

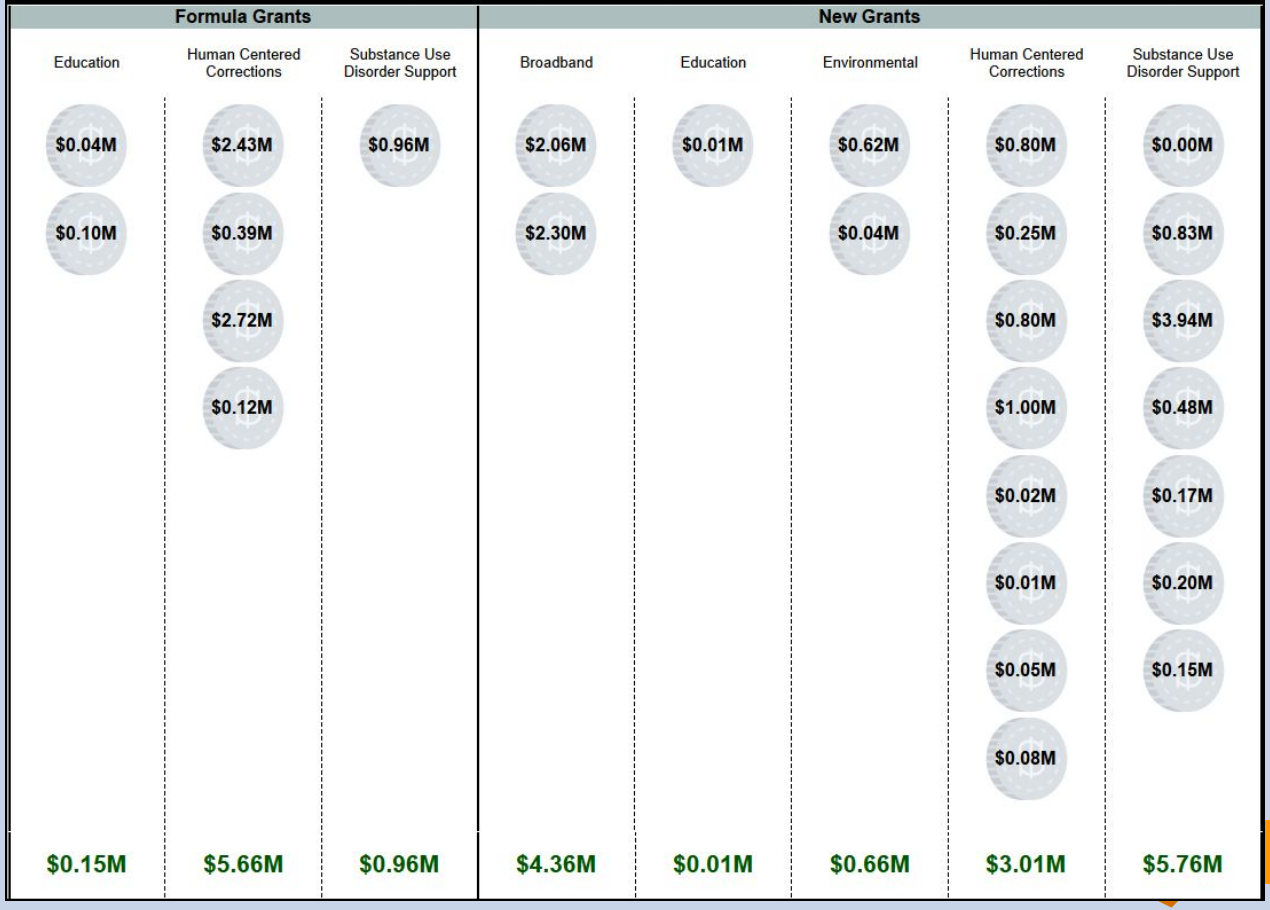


Total Job-Protected Leave Hours Used

FML, FAMLI, Short-Term Disability, Workers' Compensation, and Sick Leave (HFWA)



CDOC HAS BEEN AWARDED OVER $20M IN GRANTS SINCE FY 2023



Common Questions

ARPA Funding

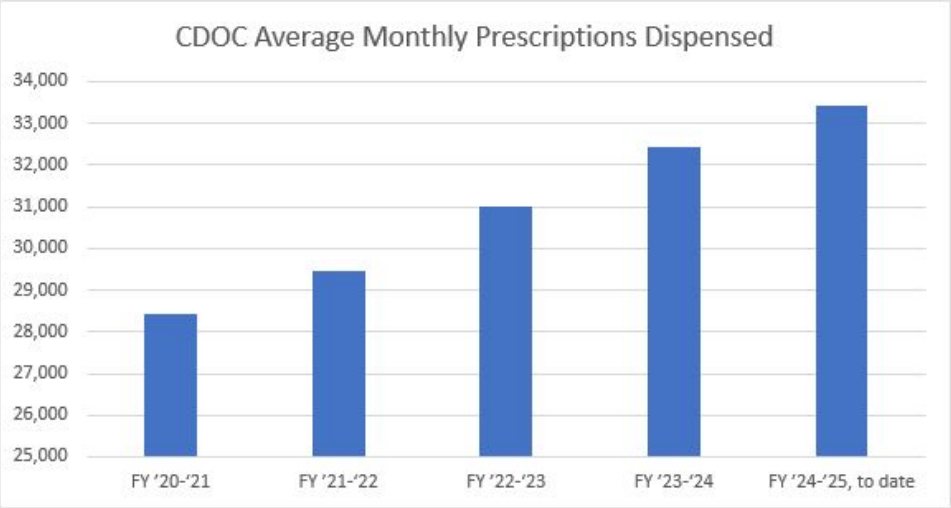
R-12 Inmate Legal Access

R-06 Recruitment and Retention

FY 2025-26 Requests

Looking forward

R-03 Pharmacy System



Fiscal Year	Annual Prescriptions Dispensed	Average Monthly Prescriptions Dispensed	% Increase, Year over Year
FY '20-'21	341,095	28,425	---
FY '21-'22	353,389	29,449	3.60%
FY '22-'23	371,952	30,996	5.25%
FY '23-'24	389,331	32,444	4.67%
FY '24-'25, to date	400,000+ projected	33,441	3.07%

- Average Prescriptions dispensed have increased by 17.65% since FY '20-'21, while staffing levels have remained consistent.

R-03 Pharmacy System

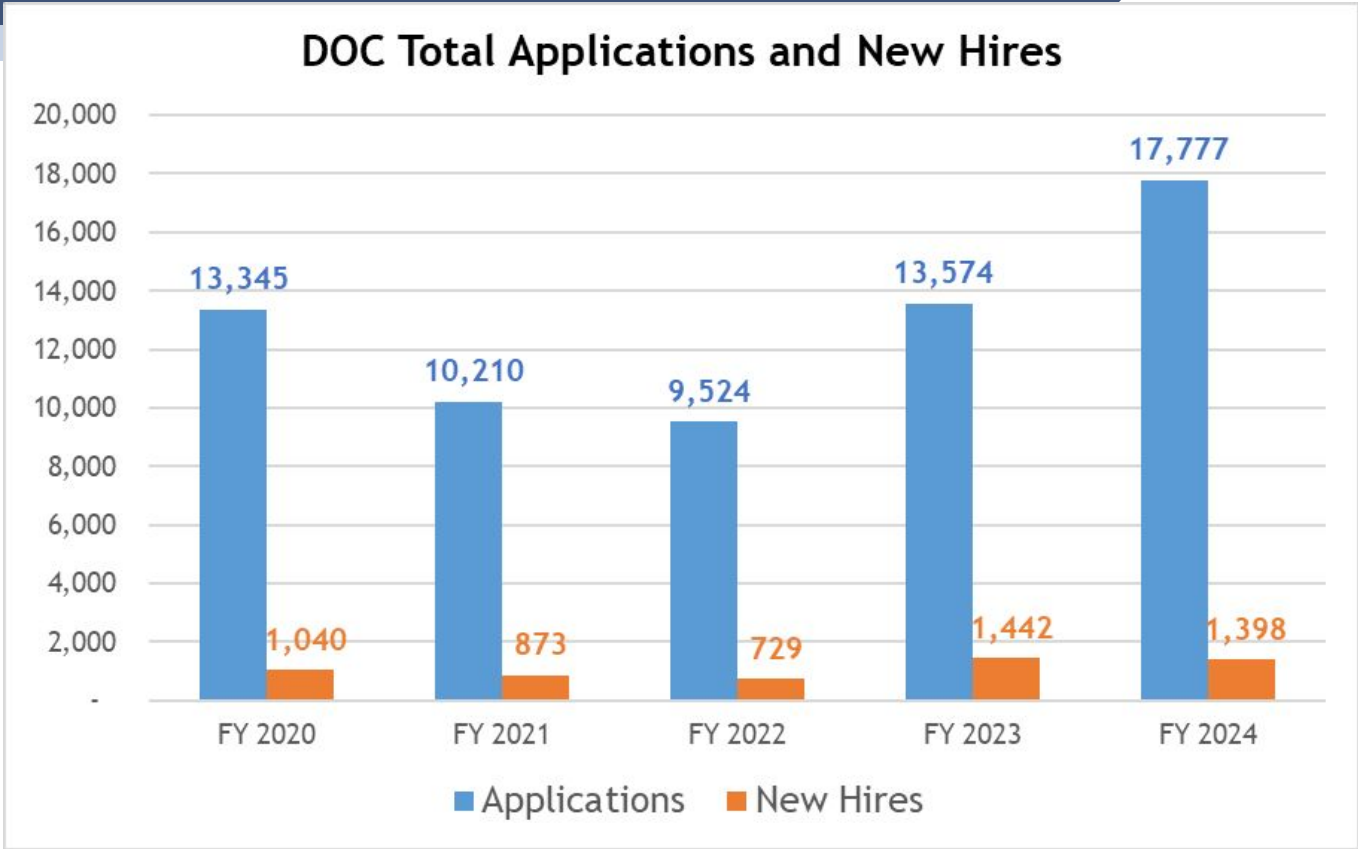
- Pharmacy upgrade is critical to the Department's ongoing **technical debt remediation** efforts and necessary to facilitate any shuttering of legacy software and systems.

- **340B Drug Pricing Program** - Significant cost avoidance has occurred due to 340B implementation. Unfortunately, this has been counterbalanced by increasing costs in other pharmaceutical lines, such as Hep C.

- The current legacy system does not allow full compliance with **regulatory requirements** for controlled substance and other reporting.

- The new system is also necessary for **future integrations** with pharmacy technology upgrades, including pill packing and dispensing machines.

R-06 Recruitment and Retention



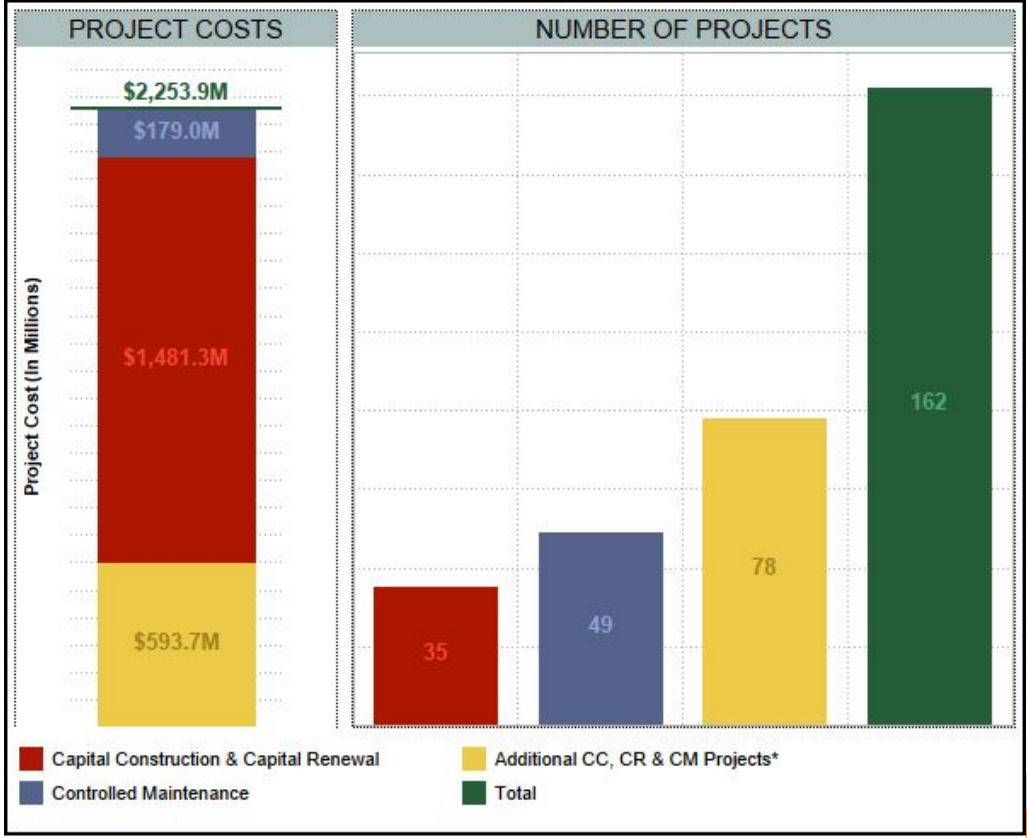
R-08 Broadband

"In this age of medical staffing shortages, clinical services need to leverage our clinical staff and consulting staff as much as possible. Telemedicine is the answer to that need. We require, however, impactful and meaningful encounters with which to provide accurate diagnoses. Through the broadband initiative, we have been able to transmit the amount of data necessary to meet that requirement. We can transmit still photos, videos through specialized optic devices and heart, lung, and abdominal sounds through the use of specialized stethoscopes. The backbone of this amount of information transmission is the broadband initiative."
-Dr. Randolph Maul, Chief Medical Officer

Infrastructure and Population

Looking forward

DOC HAS ONE OF THE LARGEST DEFERRED MAINTENANCE AND CAPITAL NEEDS



*Does not include deferred maintenance below $500k

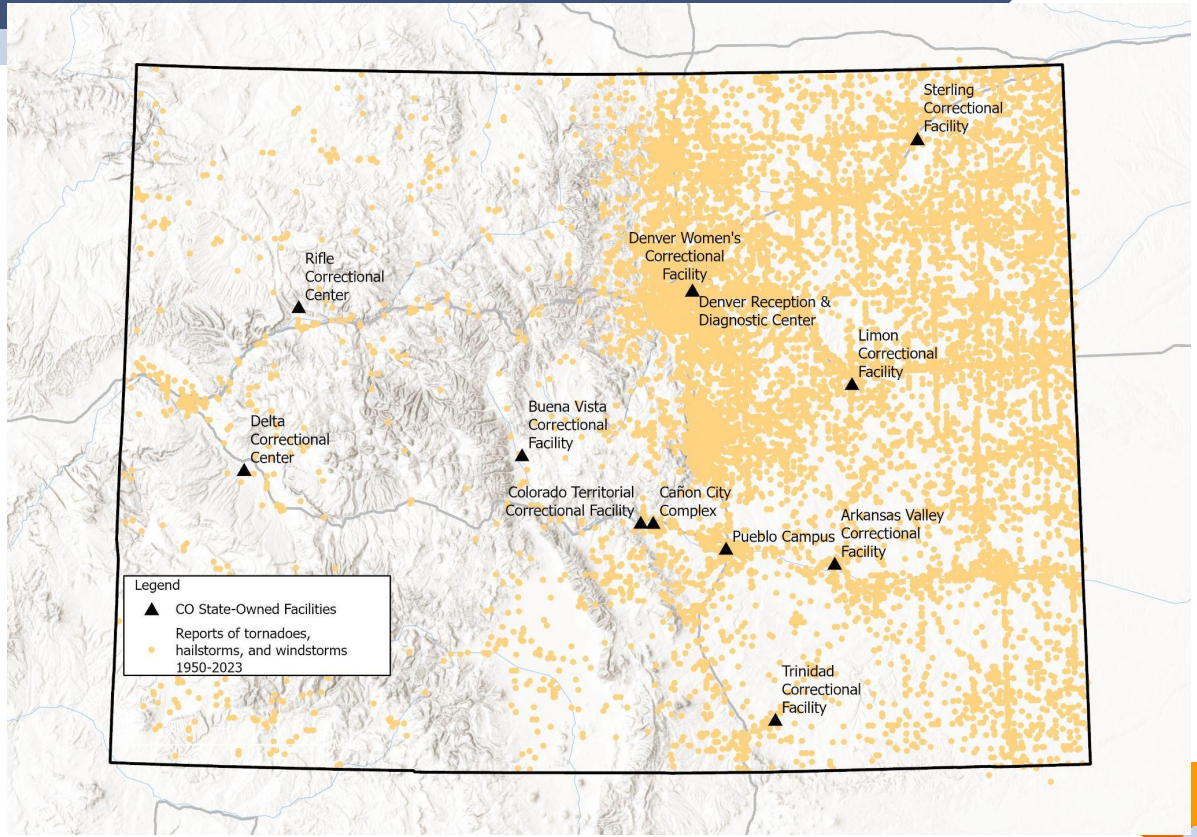
Recent CR & CM Project Appropriations

FY 24|25 Funded Projects		Facts	
Project Type	Project	Funding	Project Status
Capital Renewal	SCF Access Controls - Phase 2 of 2	$33,317,516.00	Bidding
Capital Renewal	SCF Steam Condensate Replacement - Phase 2 of 2	$16,367,112.00	Construction
Controlled Maintenance	FCF Replace Kitchen Refrigeration System	$1,440,092.00	Design
Controlled Maintenance	DCC Replace Living Unit & Support Building Roofs - Phase 3 of 3	$1,923,384.00	Design
Controlled Maintenance	SCF Security Perimeter Improvements	$1,417,984.00	Design
	Total FY 24|25 Project Impacts	$54,466,088.00	
FY 23|24 Funded Projects		Facts	
Project Type	Project	Funding	Project Status
Capital Renewal	SCF Access Controls Phase 1 of 2	$9,396,262.00	Bidding
Capital Renewal	SCF Kitchen Renovation - Phase 2 of 2	$48,525,082.00	Construction
Controlled Maintenance	DCC Replace Living Unit & Support Building Roofs - Phase 2 of 3	$1,421,711.00	Construction
Controlled Maintenance	SCF Replace Minimum Center Roof - Phase 2 of 2	$1,631,181.00	Construction
Controlled Maintenance	LCF Central Warehouse Freezer/Cooler Components	$1,163,986.00	Construction
Controlled Maintenance	Denver Complex Central Warehouse Freezer/Cooler Components	$761,391.00	Close Out
Controlled Maintenance	SCF Central Warehouse Freezer/Coolerl Components	$852,240.00	Close Out
	Total FY 23|24 Project Impacts	$63,751,853.00	
FY 22|23 Funded Projects		Facts	
Project Type	Project	Funding	Project Status
Capital Renewal	AVCF Utility Water Line Replacement	$9,539,209.00	Construction
Capital Renewal	SCF Kitchen Renovation - Phase 1 of 2	$2,800,000.00	Construction
Capital Renewal	ECCPC Water Tank Repair & Replacement	$5,349,710.00	Construction
Capital Renewal	BVCF Sanitary Sewer Line Replacement	$2,324,904.00	Construction
Capital Renewal	AVCF Critical Living Unit Shower/Drain & Toilet Room Improvements - Phase 1 of 2	$12,402,937.00	Construction
Controlled Maintenance	BVCC Critical Security Improvements to Segregation Units - Phase 2 of 4	$1,768,537.00	Construction
Controlled Maintenance	DCC Replace Living Unit & Support Building Roofs - Phase 1 of 3	$1,689,002.00	Construction
Controlled Maintenance	RCC Replace Roofs	$1,492,686.00	Close Out
Controlled Maintenance	TCF Replace Program & Support Building Roof	$1,991,473.00	Close Out
Controlled Maintenance	SCF Replace Minimum Center Roof - Phase 1 of 2	$1,109,909.00	Construction
	Total FY 22|23 Project Impacts	$40,468,367.00	

Construction Beds: Process, Requests and Bed Planning

Develop Needs	Project Plan & Studies	CDC Request Process	Long Bill Approval	Year One	Year Two and Project Length
Work with plant managers, wardens, executive leadership, and others, FMS develops a master list. List ranked in order of priority for the facility and then for the Department. Priority given to project that result in loss of use and maintaining staff and inmate safety.	Project planning begins to identify scope, impact and costs. This includes professional studies by third parties.	DOC annually submits the highest needs to OSA & OSPB for review and consideration. Priority is given to projects that would result in the loss of use of a facility and the safety/security of staff and inmates. OSA & OSPB share submittals with CDC members and staff. CDC members and staff tour DOC facilities to see first hand the project need.	Through the approval process, CDC ranks and prioritize the list of CC, CR, CM projects with all state agencies and institutions of higher education. Approved list added to the Long Bill.	Once the project is approved in the Long Bill, OSA requires professional service contracts within six months. Year one focuses on design, permits, bidding, project schedule, and identifying out-year bed impacts, if required. This results in no bed impacts in year one for projects, unless they are phased projects.	In year two and beyond, projects are completed based on size and scope. If current beds are impacted for the projects year two and beyond, additional beds are addressed in the yearly bed caseload process.

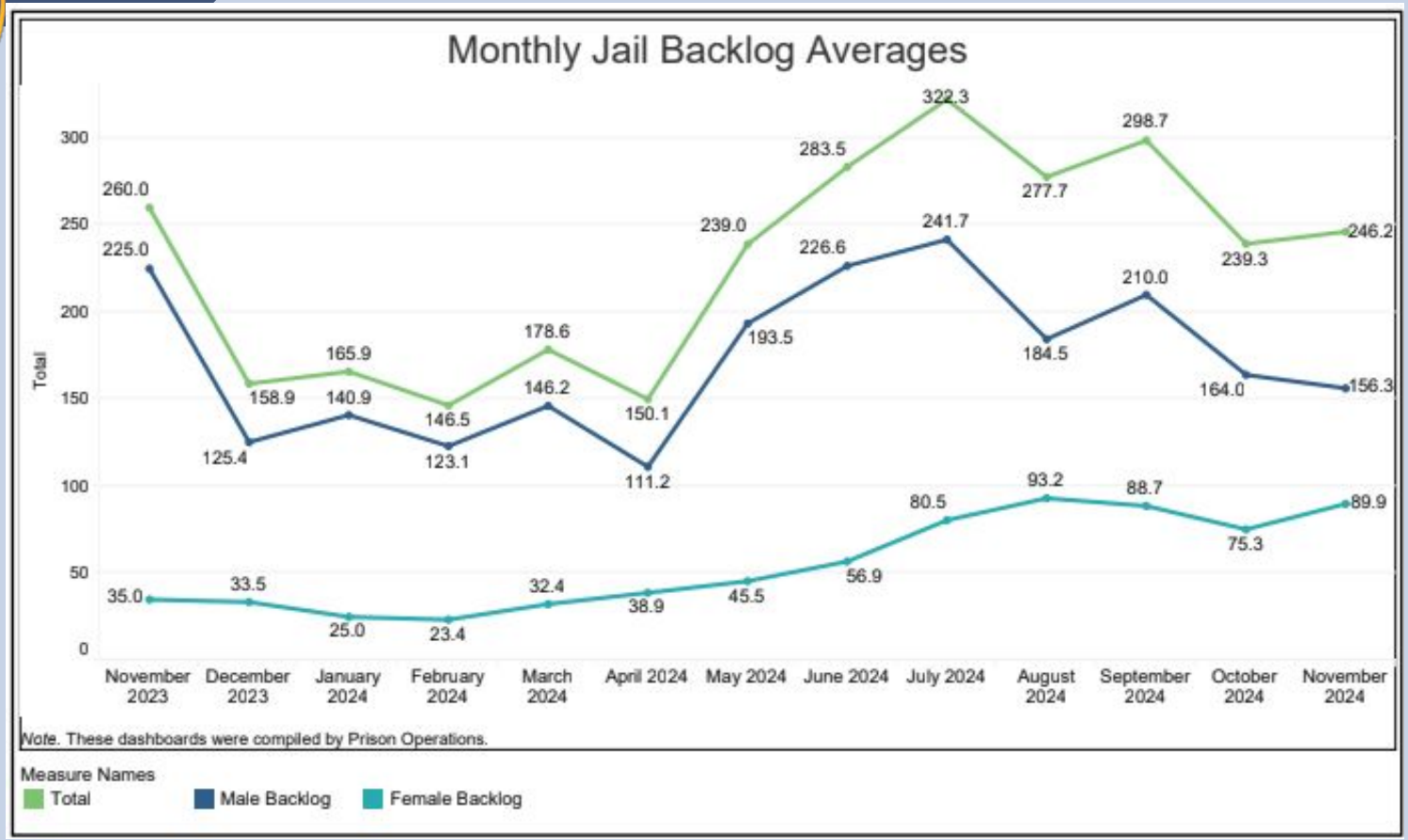
Climate Change



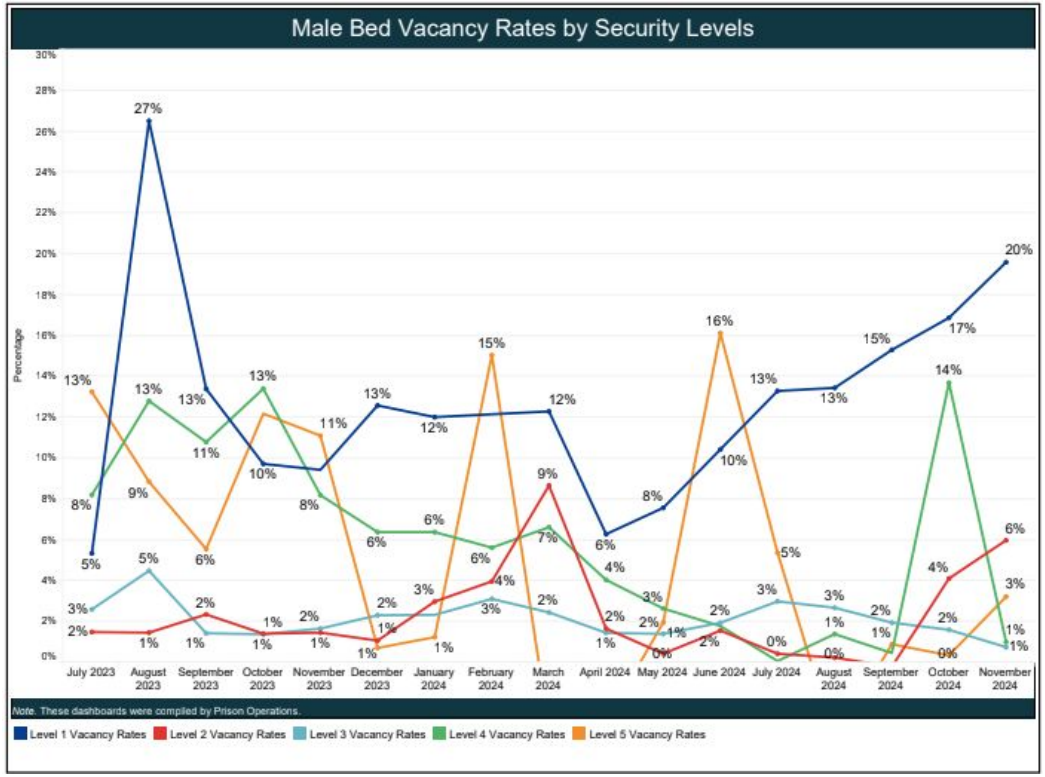
Remaining Unfunded Bed Capacity

Facility (Security Level)	Custody Level	Remaining Unfunded Beds
Centennial Correctional Facility (Level V)	Level V	316*
Private Facilities (Level III)	Level III	227
Buena Vista Correctional Complex (Level III)	Level II	200
Sterling Correctional Facility (Level V)	Level II	200
Delta Correctional Facility (Level I)	Level I	86
Total		**1,029**

*Would require legislation to utilize


Monthly Jail Backlog Averages
Total
300
250
200
150
100
50
0
260.0
225.0
158.9
125.4
165.9
140.9
146.5
123.1
178.6
146.2
150.1
111.2
239.0
193.5
283.5
226.6
322.3
241.7
277.7
184.5
298.7
210.0
239.3
164.0
246.2
156.3
35.0
33.5
25.0
23.4
32.4
38.9
45.5
56.9
80.5
93.2
88.7
75.3
89.9
November 2023
December 2023
January 2024
February 2024
March 2024
April 2024
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
Note. These dashboards were compiled by Prison Operations.
Measure Names
Total
Male Backlog
Female Backlog

Vacancy and Security Level

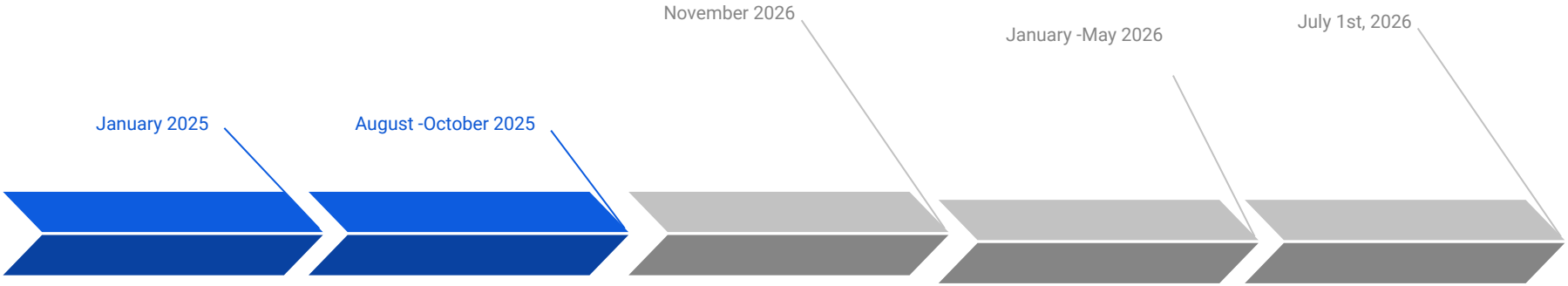


- DOC tracks and monitors vacancy rates at all level daily. This is to accommodate intake, release, and inmate movement.
- DOC uses historical information when evaluating bed caseload requests to help accommodate low vacancy security levels as well as future project requests.
- Bed Caseload requests are being evaluated as part of the Performance Audit requests, will need JBC approval

Private Prisons

Our Facility partners

Private Prisons



Procurement Process Starts
Following state procurement process DOC will begin the procurement process. Extra time is needed because of the size and complexity of the contract.

Setting of Per Diem Rate
Through the procurement process DOC will be able to identify a new per diem rate with a vendor. While the contract will still be worked on, the rate should be known.

FY 2026-27 Budget

DOC will work with OSPB to include the change in Per Diem rate in the FY 2026-27 budget requests

JBC Discussion on Long Bill

New Contract Begins
Based on the contract and what is approved by JBC new rates will start July 2026, FY 2026-27

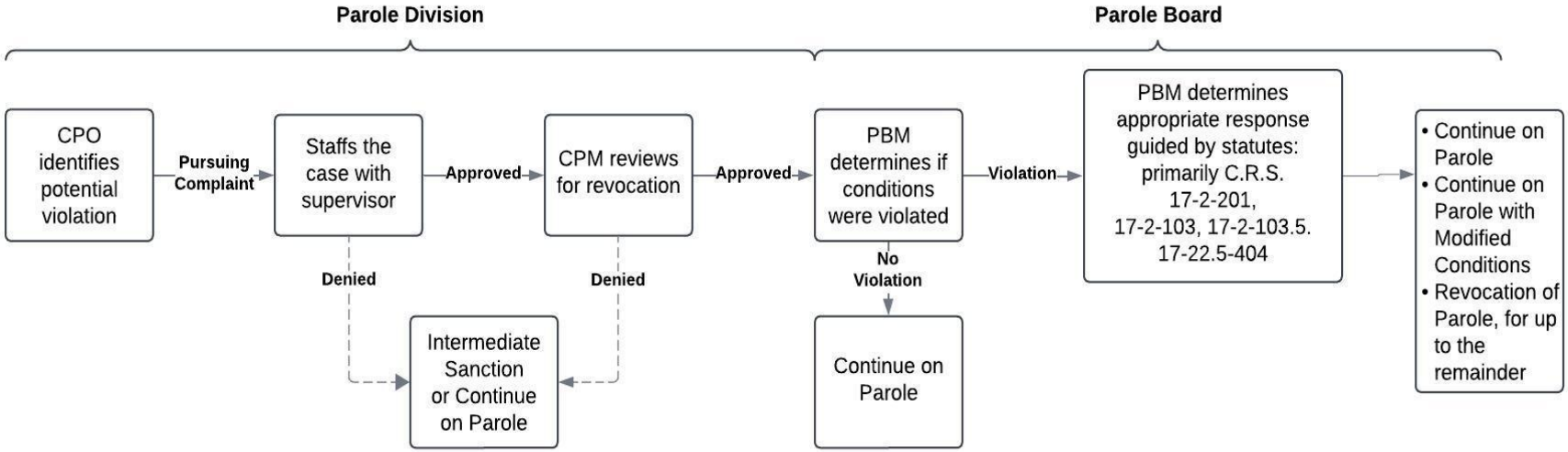
Community Reintegration

Engaging partners to ensure success

Technical Parole Violations

- Technical Parole Violations (TPV) are violations of parole conditions where the Parole Board revokes parole after a complaint is filed
- TPV can also include felony convictions that did not result in a new DOC sentence by the courts, but do result in revocation to DOC
- Criminal returns are new convictions resulting in a parolee being sentenced to DOC by the courts

Parole Revocation Process



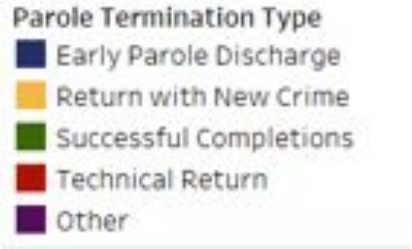
CPO: Community Parole Officer
CPM: Community Parole Manager
PBM: Parole Board Member

Reasons for Technical Violations Can Include…

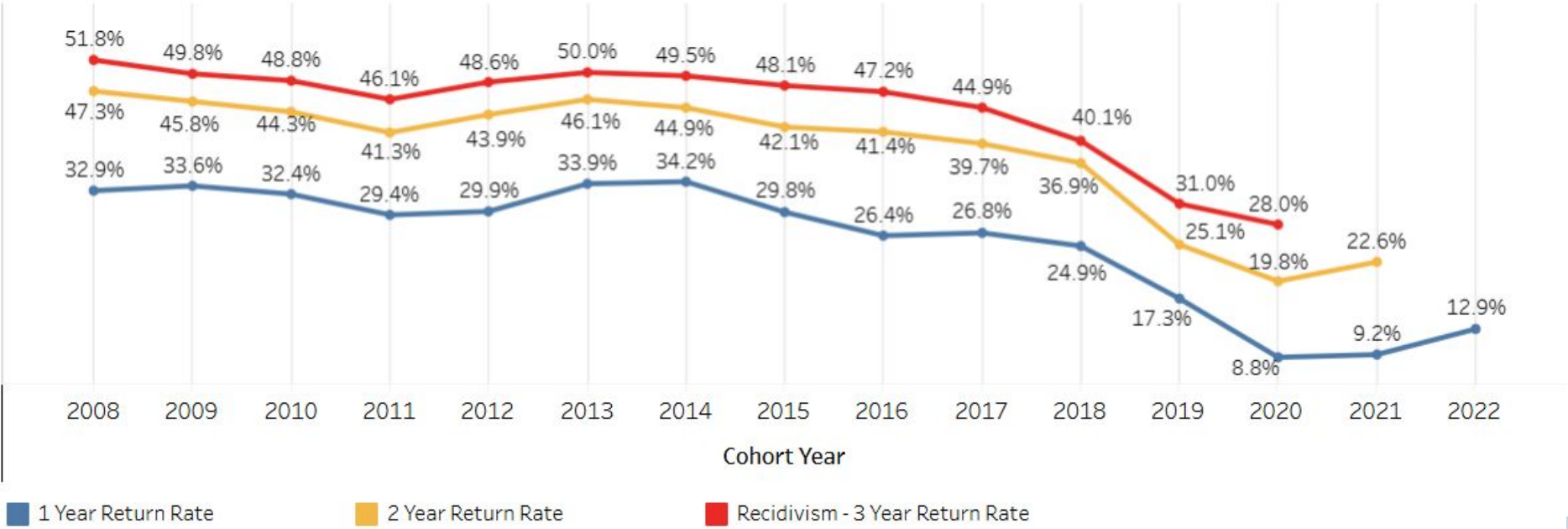
- Self-revocation requests granted by the Parole Board
- Parolees convicted of a new felony but not sentenced to prison
- Parolees convicted of a misdemeanor offense
- True TPV (no criminal convictions)
  - Absconding from parole supervision
  - Termination from sex offender treatment/noncompliance with sex offender treatment
  - Possession of a Deadly weapon
  - Willful Failure to Appear for a Summons
  - Unlawful Contact with a Victim
  - Willful Tampering or Removal of an Electronic Monitoring Device

Parole Supervision Outcomes

Key



CDOC RECIDIVISM AND RETURN RATES



Note: Please see "About Recidivism and Returns" tab for definitions and cohort information.

Clinical services

Providing the best care for those behind the walls

Clinical Care

- Medical Care
  - Dental
  - Pharmacy
  - X-ray
  - Dementia
  - Infirmary
  - Dialysis
  - End of Life care
  - Outside speciality care provided through the third party administrator, Correctional Health Partners
- Behavioral Health Care
  - General Mental Health
  - Sex Offense Treatment
  - Substance Use
  - Psychiatry
  - Community Mental Health
  - Peer Services
  - Residential Treatment Unit (RTP)
  - Medication Assisted Treatment (MAT)
  - Crisis Intervention
  - Therapeutic Communities (TC)

Medical Fees

- CRS 17-1-13 outlines medical visit charges to inmates which will not exceed $5 per visit
- $3 co-payments are charged for medical, dental, and optometry inmate initiated appointments and “no shows”
- An inmate “no shows” when they refuse to attend a scheduled appointment and sign a refusal form
- $5 co-payments can be charged for self-declared medical emergencies
- Behavioral health and psychiatry are not charged co-payments
- Care is **not** dependent upon ability to pay

Fund	Average Revenue Over Five Years (FY 2019-2023)
Medical Services—Personal Services	$102,864
Medical Services—Indirect Cost Assessment	$1,258