DEPARTMENT OF HUMAN SERVICES
(Executive Director's Office, Office of Information Technology Services, Office of Operations, and Mental Health and Alcohol and Drug Abuse Services)
FY 2013-14 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, November 27, 2012
9:00 am – 10:30 am

9:00-9:20 INTRODUCTIONS AND OPENING COMMENTS

9:20-9:25 UTILITIES FUNDING REQUEST

1. What measures has the Department taken to control utility costs (e.g. weatherization)? Is there anything else that can be done to offset increased costs for electricity, water, coal/ash, and natural gas?

9:25-9:45 INCREASING ACCESS TO MENTAL HEALTH INSTITUTE CIVIL BEDS

2. If the Department's request is funded, is the plan to operate the 20-bed, jail-based restoration program on a permanent basis or is this a solution envisioned to address a short-term problem?

3. If the Department's request is funded, is the plan to enter into a multi-year agreement with a contractor or go out to bid for the services each year?

4. How similar is the program proposed by the Department to the one implemented as a pilot in San Bernardino County by the State of California? Are there key differences?

5. The analysis of the program implemented by the State of California indicates that costs are kept low by allowing the contractor to use clinical resources in a more flexible and targeted way than is possible in a State hospital setting. Specifically, the contractor is able to pay its psychiatrists based on the specific number of hours of patient care they provide. Are there regulations in Colorado that prohibit the State from hiring employees on an hourly, as needed basis at the mental health institute in Pueblo?

9:45-10:05 IMPROVING MENTAL HEALTH COMMUNITY CAPACITY

6. How will the implementation of the federal Affordable Care Act impact the number of individuals who are currently considered medically indigent (citizens whose income is less than 300.0 percent of the federal poverty level, are not eligible for Medicaid, and do not receive mental health services from any other system) and in need of mental health services?

7. What programs are currently place to address the issue of medically indigent individuals cycling through emergency rooms, jails, and community mental health services? How does the request to increase mental health services in the community address this issue?

8. How did the Department arrive at 429 as the number of medically indigent individuals requested to receive expanded and new services in the community?

9. What funding and services are required to address the unmet need for behavioral health services in Colorado? How does the request to increase mental health services in the community reduce the number of individuals with an unmet need for behavioral health services?

10:05-10:30 CREATING A BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

10. Have other states implemented behavioral health crisis response systems? If so, how does the amount of moneys requested by the Department to create a foundation for a behavioral health crisis care system compare to the investment made by other states?

11. Many different entities in the state have taken steps to implement pieces of a behavioral health crisis response system. If the Department's request is funded, how do you plan to incorporate existing services and avoid duplication?

12. When designing this request, did the Department communicate with county social services offices and county public safety agencies? If so, have counties expressed any concerns in building linkages between a behavioral health crisis care system and county services, including 911?

13. The Department proposes the creation of five regional behavioral health crisis response systems. If the request is funded, will the regions mirror the geography of the Behavioral Health Organizations (BHOs)? If so, is it envisioned that BHOs would play a role in the regional behavioral health crisis response systems?

14. The Department's request includes 24-hour, seven day-a-week call centers. If the request is funded, will there be multiple phone numbers (e.g. one for each of the five regions) or one statewide phone number?

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. The Joint Budget Committee has recently reviewed the State Auditor's Office *Annual Report of Audit Recommendations Not Fully Implemented* (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that fall within the following categories, please provide an update on the implementation status and the reason for any delay.

    a. Financial audit recommendations classified as material weaknesses or significant deficiencies;
    b. Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.

Colorado Department of Human Services

people who help people

Department of Human Services

Joint Budget Committee (JBC) Hearing Responses

November 27, 2012

DEPARTMENT OF HUMAN SERVICES
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9:20-9:25 UTILITIES FUNDING REQUEST

1. What measures has the Department taken to control utility costs (e.g. weatherization)? Is there anything else that can be done to offset increased costs for electricity, water, coal/ash, and natural gas?

   DHS Response: The Department has undertaken numerous initiatives to reduce the consumption of commodities. The average age of DHS buildings is 57.2 years, and many have outdated components. Beginning in 2005, the Department conducted energy audits of all major facilities and systems. These audits helped facilitate the Department to begin a series of energy performance contract projects installing energy-saving components in DHS buildings. These contracts have had the desired outcome of reducing commodity consumption, and provide essential infrastructure upgrades without the need for upfront State funding. The result of these efforts has been a reduction in consumption of electricity, natural gas, and water. Two examples of reduced electric (kWh) and natural gas (Dth) consumption are listed below.

   - 10% reduction in electric use from FY 2007 to FY 2012. (FY 2007 = 40.3 million kWh used, compared to 36.1 million kWh used in FY 2012.)
   - 12% reduction in natural gas use from FY 2007 to FY 2012. (FY 2007 = 189,992 (Dth) used compared to 166,856 in FY 2012.)

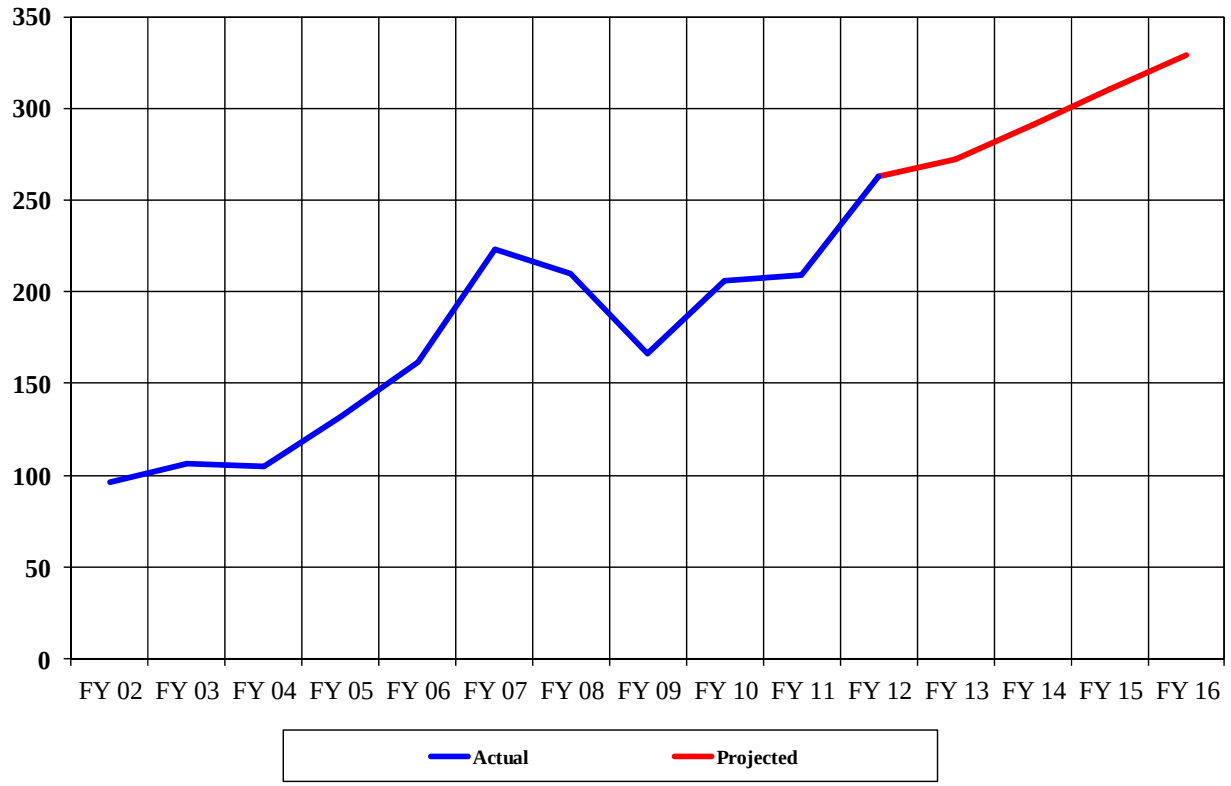
9:25-9:45 INCREASING ACCESS TO MENTAL HEALTH INSTITUTE CIVIL BEDS

2. If the Department's request is funded, is the plan to operate the 20-bed, jail-based restoration program on a permanent basis or is this a solution envisioned to address a short-term problem?

   DHS Response: The Department plans to operate the 20-bed program on a permanent basis. By increasing bed capacity for individuals with forensic (criminal court) orders for treatment by twenty beds, the program will restore 20-beds of civil capacity at the Colorado Mental Health Institute at Pueblo. The contract 20-bed program will help meet the projected demand for criminal court orders for inpatient

restoration to competency. As the graph below indicates, Criminal court orders for inpatient restoration to competency to stand trial services at the Colorado Mental Health Institute at Pueblo (CMHIP) increased by 25 percent from FY 2007-08 (210) to FY 2011-12 (263). The number is projected to increase to 329 by FY 2015-16.

Graph 1 - Criminal Court Orders for Inpatient Restoration at CMHIP



3. If the Department's request is funded, is the plan to enter into a multi-year agreement with a contractor or go out to bid for the services each year?

   DHS Response: The Department will let an RFP to select a vendor to operate the program for five years. The selected vendor will be engaged using an annual contract, subject to annual renewal for a period of up to five years. The Department's RFP will require the vendor to select a jail based or other secure location for the program and negotiate an agreement with the jail or facility within the rate the Department pays to the vendor that is awarded the contract.

4. How similar is the program proposed by the Department to the one implemented as a pilot in San Bernardino County by the State of California? Are there key differences?

   DHS Response: The program proposed by the Department is virtually identical to the program operated in San Bernardino County. There are no key differences.

5. The analysis of the program implemented by the State of California indicates that costs are kept low by allowing the contractor to use clinical resources in a more flexible and targeted way than is possible in a State hospital setting. Specifically, the contractor is able to pay its psychiatrists based on the specific number of hours of patient care they provide. Are there regulations in Colorado that prohibit the State from hiring employees on an hourly, as needed basis at the mental health institute in Pueblo?

   DHS Response: There are no regulations in Colorado that prohibit the State from hiring employees on an hourly, as needed basis. Both institutes currently employ staff, primarily nursing staff, on a permanent, part-time basis. These staff work the number of hours per week as determined by management. In addition, the Department has an interagency agreement with the University of Colorado at Denver to provide medical staff at both institutes.

   The primary reason the San Bernardino County program is less expensive than state hospital care is because operating the jail-based program does not require licensure as an inpatient psychiatric hospital. Licensure requirements for psychiatric hospitals require minimum nursing staffing levels and compliance with other clinical standards that are not needed to provide care for many jail inmates requiring restoration to competency. Individuals requiring an inpatient psychiatric level of care in order to be restored to competency will be served at the Colorado Mental Health Institute at Pueblo.

9:45-10:05 IMPROVING MENTAL HEALTH COMMUNITY CAPACITY

6. How will the implementation of the federal Affordable Care Act impact the number of individuals who are currently considered medically indigent (citizens whose income is less than 300.0 percent of the federal poverty level, are not eligible for Medicaid, and do not receive mental health services from any other system) and in need of mental health services?

   DHS Response: Estimates of the number of medically indigent individuals in need of mental health services who will be covered under the Affordable Care Act (ACA) are not currently available from the Department of Health Care Policy and Financing (HCPF). However, assuming Colorado chooses to opt into the ACA's expanded Medicaid eligibility provisions, many Coloradans who are medically indigent will receive Medicaid mental health benefits. The overall impact depends on the benefit choices and service array that Colorado selects, should it elect to become an expansion state.

   Currently, not everyone who needs Medicaid is eligible for the program. Medicaid does not cover most single adults who do not qualify either through disability or as caretakers of children. The ACA expands Medicaid eligibility to cover this group and other low-income people who are not now eligible under their state Medicaid plan. For mental health, Medicaid covers a wide range of community services that can aid

in recovery, including skills training, employment-related services and supported housing, as well as therapy and medications. Its package of services is much broader than the typical private insurance plan. As a result, coverage under Medicaid is often a better option for people with psychiatric disabilities.

The ACA expands Medicaid coverage to everyone with income below 133% of the federal poverty level, beginning no later than 2014. Expanded Medicaid coverage will be of great benefit to all single childless adults with psychiatric disabilities. Generally, this group can qualify for Medicaid only if receiving federal Supplemental Security Income (SSI) disability benefits. However, many individuals with psychiatric disabilities either fail to qualify for SSI because the rules are so strict or choose not to apply. The law eliminates the SSI requirement for people with incomes under 133% of the federal poverty level. As this requirement often prevents people with psychiatric disabilities from receiving health care, these expansions of Medicaid are very important.

The law also allows states to set up a state plan for individuals with incomes between 133% and 200% of poverty who do not qualify for Medicaid. To help people compare plans and purchase health insurance, the law creates new entities in states called Exchanges, which will act as a broker or middleman, through which an individual or a small employer will be able to purchase a plan. The law will be of great benefit to people with psychiatric disabilities because, for the first time, consumers could be sure that any health plan they purchase (through the Exchange system) will cover mental health and substance abuse services on a par with coverage for medical/surgical services. The law also requires health plans to cover rehabilitation and habilitation services. However, this is not defined. It is therefore not yet clear whether psychiatric rehabilitation services will be included in all health plans. However, at a minimum, all plans could be expected to offer medications, therapy and inpatient hospital care.

While the Department is not able to estimate the impact of the ACA on indigent individuals with behavioral health needs, a recent study conducted by the Department in 2009 provides data about the number of individuals in Colorado with a Serious Emotional Disorder (SED); Serious Mental Illness (SMI); Substance Use Disorder (SUD); and co-occurring (mental and substance abuse) disorders. Data from the Department's 2009 Population in Needs Study[1] are provided in the following table.

[1] The 2009 Statewide Population in Need study estimates the number of youth aged 0-17 years who have a Serious Emotional Disorder (SED) and number of adults, aged 18 years and older, who have a Serious Mental Illness (SMI). The report describes the number of persons receiving publicly funded human services, including mental health services, alcohol and drug, child welfare, youth corrections, and education. It also estimates the number of youth and adults who need, but are not receiving, behavioral health services. The report is available at - http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581450628

Table 1- Prevalence of Behavioral Health Need (2009 PIN Study)

Description	SED	SMI	SUD (Adults 18 and older)	Co-occurring (Adults 18 and older)	Total
Below 100%	13,636	30,441	16,069	3,142	63,288
100%-199%	17,993	36,183	28,551	5,632	88,359
200%-299%	16,648	25,427	27,838	4,000	73,913
Total	**48,277**	**92,051**	**72,458**	**12,774**	**225,560**
SED-Serious emotional disturbance / SMI-Significant mental illness / SUD-substance use disorder / Co-occurring (both SED or SMI and SUD)					

7. What programs are currently in place to address the issue of medically indigent individuals cycling through emergency rooms, jails, and community mental health services? How does the request to increase mental health services in the community address this issue?

   DHS Response: Both the Department and community providers (typically community mental health centers) offer a limited array of programs that target medically indigent individuals that "cycle" through emergency departments, jails, and community mental health services. Programs provided without Department support vary and have not been inventoried by the Department. Some communities have developed and funded programs to address specific priorities, including mobile crisis; acute residential transition services; and mental health courts.

   The Department funds a limited number of programs targeted at reducing inappropriate hospitalizations involvement with the jails and criminal justice system. However, these programs are not provided consistently across the State. For example, the Department provides funding to some community mental health centers to serve individuals at risk of inpatient hospitalization at the Colorado Mental Health Institutes. (These funds were appropriated in conjunction with the closure of Institute beds in 2002 and 2003.) The Department also funds approximately 1,000 Assertive Community Treatment (ACT) placements for indigent individuals; however, 874 of these placements are limited to Denver County (as a result of a 1990's federal class action lawsuit settlement against the Department). In addition, the "Offender Mental Health Services Initiative" serves approximately 1,600 adults and juveniles to reduce recidivism. The attached table (Exhibit 1) illustrates the limited array of programs funded by the Department targeted at specific populations.

This request, in conjunction with the Crisis Services request, provides funds to improve the array of community services available to help individuals avoid inappropriate hospitalizations; criminal justice encounters, and repeated "cycling" between agencies unable to provide the right care at the right time. However, this request addresses a small portion of the indigent population (429 estimated individuals) identified in the Department's 2009 Population In Need study by providing:

- Additional ACT placements;
- Two (2) 15-bed residential programs targeted for individuals needing longer term residential stabilization after inpatient hospitalization;
- Housing subsidies to provide stability for positive treatment outcomes;
- Transition specialists to provide intensive case management and link clients with health care, benefits acquisition, criminal justice, and other needed services; and,
- Increased use of adult foster care

8. How did the Department arrive at 429 as the number of medically indigent individuals requested to receive expanded and new services in the community?

DHS Response: The Department arrived at 429 as the number of medically indigent individuals to receive expanded services by looking at available Colorado data and comparing it to data from a Washington state study.

First, the Department looked at economic data supplied by the Colorado Health Access Survey[2]. This study indicated that 16% of Colorado's population is uninsured. The Department then applied this percentage to the total number of individuals placed on mental health holds in FY 2011-12. The Department then assumed that 20% of this population would be appropriate for expanded services. The Department then assumed that indigent patients that demonstrated need for intensive community based services would be at least 20% of the uninsured mental health hold group. With these two assumptions the Department derived a target population of 429 annually. (13,418 (total mental health holds) X 16% (uninsured rate) X 20% (targeted group) =429)

9. What funding and services are required to address the unmet need for behavioral health services in Colorado? How does the request to increase mental health services in the community reduce the number of individuals with an unmet need for behavioral health services?

DHS Response: The Department does not have the necessary information to estimate the funding required to meet the unmet need for indigent Colorado

[2] Report from the Colorado Trust and Colorado Health Institute (http://www.healthpolicysolutions.org/2011/11/16/uninsured-rate-jumps-as-colorado-employers-cut-health-benefits/)

individuals requiring behavioral health services. As detailed in the response to Question #6, the Department's most recent Population In Need study estimates there are 225,560 indigent individuals with behavioral health needs. As detailed in the response to Question #8, the Department is requesting funding to provide community services to 429 indigent individuals (not including those individuals that would be served by the Department's Crisis Response request). Furthermore, the uncertainty surrounding ACA and the State's decision to opt-in to expanded Medicaid benefits for behavioral health, and the lack of identification as to what behavioral health services will be part of the benefit package should Colorado choose to participate in this provision of the ACA, make estimating the cost to meet the unmet need for indigent services not possible at this time.

10:05-10:30 CREATING A BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

10. Have other states implemented behavioral health crisis response systems? If so, how does the amount of moneys requested by the Department to create a foundation for a behavioral health crisis care system compare to the investment made by other states?

DHS Response: Several other states have implemented behavioral health crisis response systems. As part of the Department's implementation of House Bill 10 – 1032, the Department reviewed several other states for best practices related to crisis response services. HB 1032 requires the Department to review current behavioral health crisis response services in Colorado and provide a plan to address the lack of coordinated crisis response in the State. (The bill requires the Department present the study findings to a joint meeting of the Health and Human Services Committees of the House of Representatives and the Senate on or before January 30 2013).

The HB 1032 study did not include an evaluation of the financial investments made by other states to develop crisis response systems. Information about other state investment costs is not available at this time. In addition, differences in management (state vs. county based) and the scope of services provided make comparisons difficult. The basis for the overall system design and financing of the request is based on the model developed and reported in the 2005 Technical Assistance Collaborative, Inc. (TAC) report[3].

11. Many different entities in the state have taken steps to implement pieces of a behavioral health crisis response system. If the Department's request is funded, how do you plan to incorporate existing services and avoid duplication?

DHS Response: As detailed in the HB 1032 study, crisis services currently exist in some form or another in many areas of the State. However, the existence of a

[3] *Practice Guidelines: Core Elements for Responding to Mental Health Crises*. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. • Funding was adjusted from the 2005 amounts in the TAC report to 2012 values using a cumulative 17.4% CPI-U adjustment factor.

service in no way means it is accessible or sufficient to meet the needs of those in crisis. Specifically, several themes related to service gaps are identified in the Department's study, including:

- utilization of 911, answering services, or national hotlines to meet the 24/7 telephonic access requirement;
- lack of coordination of care and follow-up;
- limited access to community diversion resources resulting in the use of more restrictive services to resolve the crisis such as avoided involuntary commitments;
- underutilization of peer services as a resource for crisis intervention opportunities;
- lack of uniform training requirements for crisis intervention staff, and;
- inadequate funding to support quality crisis intervention services.

The Department's request will build on existing programs and services to create the foundation for a comprehensive statewide community-based crisis service system by establishing two of the four key components of a comprehensive crisis response system, 24-hour crisis telephone line statewide and walk-in crisis stabilization/triage units. The two additional components not included in the Department request that would establish a comprehensive crisis system include: Mobile crisis units with the ability to respond within one hour to a behavioral health crisis in the community (e.g., homes, schools, or hospital emergency rooms); and a range of short-term crisis residential/respite services (e.g., supervised apartments/houses, foster homes, and crisis stabilization services).

12. When designing this request, did the Department communicate with county social services offices and county public safety agencies? If so, have counties expressed any concerns in building linkages between a behavioral health crisis care system and county services, including 911?

DHS Response: As part of the Department's HB 1032 study, various stakeholder groups, including county social services offices and county peace officers, were invited to participate in the study and provide input during a series of regional meetings. Other stakeholders invited to participate included managed service organizations; behavioral health organizations; mental health centers; Metro Crisis Services; hospitals; advocacy organizations; and other entities impacting behavioral health crisis response.

The stakeholders provided consistent input about the need for a comprehensive crisis response system that served all Colorado citizens regardless of payer source and linked closely with local services and providers. Participants were in agreement to this approach, as long as it provides continuity of care and decreased law enforcement calls and unnecessary emergency room visits. The majority of stakeholders agreed that one statewide telephone hotline number was preferred, as

long as it linked the individual to local services, similar to the way the 911 system works.

13. The Department proposes the creation of five regional behavioral health crisis response systems. If the request is funded, will the regions mirror the geography of the Behavioral Health Organizations (BHOs)? If so, is it envisioned that BHOs would play a role in the regional behavioral health crisis response systems?

    DHS Response: The Department worked to align the request for a statewide approach based on five regions aligned with population density (1 million people per region) and along the Accountable Care Collaborative program and the Regional Care Collaborative Organizations (RCCO). Crisis services, as modeled in most other state approaches, integrate services and have a strong collaborative partnership with local communities and alignment with behavioral health and physical health care integration.

    As the RCCOs and Health Care Policy and Financing currently contract with the Behavioral Health Organizations (BHOs) to provide mental health services (including emergency mental health services), it is assumed that they will apply through the request for proposal (RFP) process that the Department will administer to identify entities to perform/provide the required services.

14. The Department's request includes 24-hour, seven day-a-week call centers. If the request is funded, will there be multiple phone numbers (e.g. one for each of the five regions) or one statewide phone number?

    DHS Response: Based on the results of stakeholder feedback and a review of other state systems, the Department recommends a statewide crisis telephone system with one statewide telephone number. The Department would, through a competitive bid process, identify a service provider to develop and manage a statewide toll-free crisis line. Crisis line staff would:

    - conduct screenings to quickly assess callers' needs and risks, while engaging them, offering them choices, and using the least invasive interventions possible; and,

    - link callers, in real time, 24 hours per day, seven days per week, to routine services or crisis services (including mobile crisis response, when required). Callers would be scheduled with an appointment date and time at community mental health providers across the state, based on a schedule of routine and "emergent" appointments supplied in advance by the provider location.

    This recommendation is modeled on the notably effective Georgia Crisis and Access line (GCAL). In 2006 Georgia contracted to develop and manage a statewide toll-free

crisis and access line, now called the Georgia Crisis and Access Line.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. The Joint Budget Committee has recently reviewed the State Auditor's Office *Annual Report of Audit Recommendations Not Fully Implemented* (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that fall within the following categories, please provide an update on the implementation status and the reason for any delay.

   a. Financial audit recommendations classified as material weaknesses or significant deficiencies;
   b. Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.

DHS Response: In order to compile the all necessary information, the Department will respond to this question at the December 13th JBC hearing.

Office of Behavioral Health
Joint Budget Committee Hearing Agenda 11/27/2012
Question #7

Exhibit 1

Long Bill Line Item	Description of Services & Population	FY 2011-12 Served	FY 2012-13 Total	FY 2012-13 GF	FY 2012-13 CF	FY 2012-13 Re-appropriated	FY 2012-13 Federal
Services for Indigent Mentally Ill Clients	Metro Crisis Services is a 24 hour behavioral health crisis telephone hotline that provides the general public access to licensed behavioral health clinicians. This service is available across the 7 county (Adams, Boulder, Broomfield, Denver, Douglas, and Jefferson) metro area. The Division provides a cost share of the total operations.	28,724	$190,000	$0	$0	$0	$190,000
Services for Indigent Mentally Ill Clients	The Assertive Community Treatment Intensive Case Management program (AIM) provides intensive outpatient services to adult mental health clients with severe and persistent mental illness. This funding originated through the settlement of the Goebel Lawsuit in FY 2005-06. This program is only available through the Mental Health Center of Denver. There is limited mobile crisis services provided through this funding.	874	$6,849,388	$6,849,388	$0	$0	$0
Services for Indigent Mentally Ill Clients	Capacity for the Colorado West Stabilization Unit (Grand Junction) and Axis Health (Durango) Acute Treatment Unit (ATU). These dollars are used for adult and adolescent medically indigent capacity/uncompensated care in these high-intensity inpatient care settings.	816	$1,227,158	$1,227,158	$0	$0	$0
Assertive Community Treatment (ACT)	ACT programs serve adults whose symptoms of mental illness result in serious functioning difficulties that may affect areas of everyday life including work; social relationships; residential independence; money management; hospitalizations; criminal justice involvement; and physical health and wellness. This service is limited to three areas served by the Mental Health Center of Denver, Mental Health Partners (Boulder/Broomfield) and the San Luis Valley Community Mental Health Center (CMHC).	145	$1,290,200	$645,200	$0	$645,000	$0
Alternatives to Inpatient Hospitalization at a Mental Health Institute	Colorado mental health institute hospital alternative programs are intended to provide limited local area capacity in 12 CMHCs . These dollars cover a portion of community mental health center costs for non-Medicaid individuals and uncompensated care associated with ATUs, inpatient care, therapeutic 24-hour group homes, intensive outpatient based treatment such as ACT, and Wrap-around services. These services are for adults and some adolescents.The average funding is $261,551 per CMHC/year, with the lowest at $57,635 (Arapahoe Douglas) and the highest at $837,530 (Mental Health Center of Denver).	1,835	$3,138,615	$3,138,615	$0	$0	$0
Mental Health Services for Juvenile and Adult Offenders	The Offender Mental Health Services Initiative is intended to reduce recidivism of juveniles and adults with mental illness involved in the juvenile and criminal justice system. The program is administered in collaboration with criminal and juvenile justice agencies, Community Mental Health Centers, and associated community resources. This service is available in 11 CMHCs mostly along the front range.	1,616	$3,308,768	$0	$3,308,768	$0	$0
Residential Treatment for Youth (H.B 99-1116)	The "Child Mental Health Treatment Act" (C.R.S 27-67-101 et. seq., 2012) provides mental health treatment to children and adolescents, including community-based and therapeutic residential services, to eligible children and their families when a dependency and neglect action is neither warranted nor necessary. Some of the children served are in need of intensive levels of care that may include hospitalization and/or have been involved with the criminal justice system.	50	$976,994	$560,154	$300,000	$116,840	$0
Total		**34,060**	**$16,981,123**	**$12,420,515**	**$3,608,768**	**$761,840**	**$190,000**

Colorado Department of Human Services
people who help people

Joint Budget Committee Hearing

Colorado Department of Human Services

Executive Director's Office
Office of Administrative Solutions
Office of Behavioral Health

Mission, Vision and Values

Vision

The people of Colorado are safe, healthy and are prepared to achieve their greatest aspirations.

Mission

Collaborating with our partners, our mission is to design and deliver high quality human and health services that improve the safety, independence and well-being of the people of Colorado.

Values

The Colorado Department of Human Services will:

- Make decisions with and act in the best interests of the people we serve because Colorado's success depends on their well-being.
- Share information, seek input, and explain our actions because we value accountability and transparency.
- Manage our resources efficiently because we value responsible stewardship.
- Promote a positive work environment, and support and develop employees, because their performance is essential to Colorado's success.
- Meaningfully engage our partners and the people we serve because we must work together to achieve the best outcomes.
- Commit to continuous learning because Coloradans deserve effective solutions today and forward-looking innovation for tomorrow.

2012 Recap

- C-Stat performance management strategy
  - Using real-time data to drive outcomes
  - 96 department-wide measures reviewed monthly
  - County auditors, county C-Stat analysts, county liaisons
- Rules review, reduction and revision
  - 20% (843) rules repealed - 7/1/11 – 6/30/12
  - 49% (2,000+) undergoing revision - completed by 12/31/13
- Governor's Child Welfare Plan
  - Common Practice Model
  - C-Stat
  - Training Academy
  - Increased transparency
  - Funding

2012 Recap (continued)

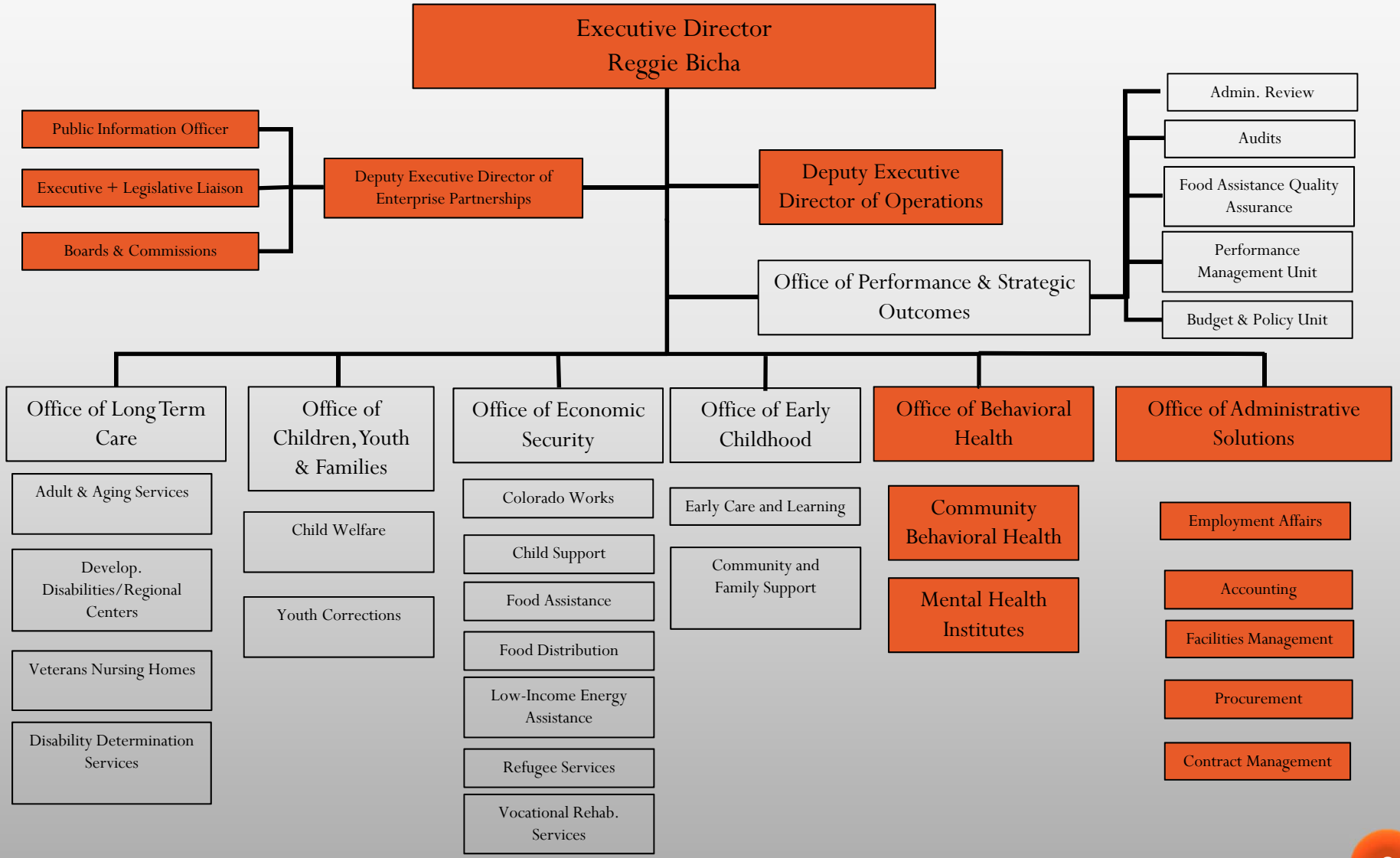
- Timeliness
  - Processing regular Food Assistance applications today at 97.49% timely - the highest historical level of achievement
  - Processing regular TANF applications today at 99.08% timely
  - CBMS Rebuild

- Established Office of Early Childhood
  - Early Care and Learning
  - Community and Family Support

2013 CDHS Strategic Plan

- Consolidate state Early Childhood Services and funding within CDHS
- Reduce the wait list for services for individuals with developmental disabilities
- Establish a strategy to align employment and training services with the Governor's Economic Development Plan
- Implementation of the Governor's Child Welfare Plan "Keeping Kids Safe and Families Healthy"
- Redesign and re-tool Colorado Behavioral Healthcare System

Colorado Department of Human Services



Colorado Department of Human Services
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Office of Administrative Solutions

Utility Performance Contracts

- Beginning in 2005, the Department implemented projects to increase energy efficiency
  - Weatherization
  - Energy efficient lighting
  - Conservation of electricity, natural gas, water and coal
- Electrical use saw a **10% reduction** from FY 2007 to FY 2012
  - FY 2007 = 40.3 million kWh; FY 2012 36.1 million kWh
- Natural gas use saw a **12% reduction** from FY 2007 to FY 2012
  - FY 2007 =189,992 Dth; FY 2012 166,856 Dth
- Cost vs. Consumption
  - While consumption decreased across the Department, retail costs have continued to rise

Colorado Department of Human Services
people who help people

Office of Behavioral Health

Redesign Behavioral Health Care

- Provide the right services for the right people at the right time
- Establish crisis response and services
- Expand inpatient capacity
- Enhance community care
- Build trauma informed approaches

Establish Crisis Response and Services

The Department's budget request - *$10,272,874 GF* - establishes a base for a statewide crisis response system

- Five regions aligned with population density and RCCO regions, which includes the BHOs
- 24-hour statewide crisis hotline
  - One number for all of Colorado which links to local service area
  - Conducts screening, brief assessments and options counseling
  - Links caller to counseling services, crisis supports and emergency services
  - Statewide marketing and communications campaign to create public awareness
  - Built on the Georgia model
- Walk-in crisis stabilization units providing immediate clinical intervention
  - 24/7 availability
  - Assessment, counseling, stabilization and referrals

Establish Crisis Response and Services

- Proposal builds on analysis and recommendations from the Behavioral Health Crisis Response Services Study (HB10-1032)
  - Reviewed several other states for best practices
  - Final report due to Legislature January 30, 2013
- Early findings:
  - Use of 911 may result in inappropriate or ineffective response to those in crisis
  - Lack of coordination of care and follow-up – system fragmentation
  - Limited access to community diversion resources resulting in the use of more restrictive services to resolve the crisis, i.e. emergency rooms and jails
  - Underutilization of peer services as a resource for crisis intervention
  - Lack of funding for statewide system
- Partner input
  - County human services departments, law enforcement, managed service organizations, behavioral health organizations, mental health centers, Metro Crisis Services, advocacy organizations

Expand Inpatient Capacity

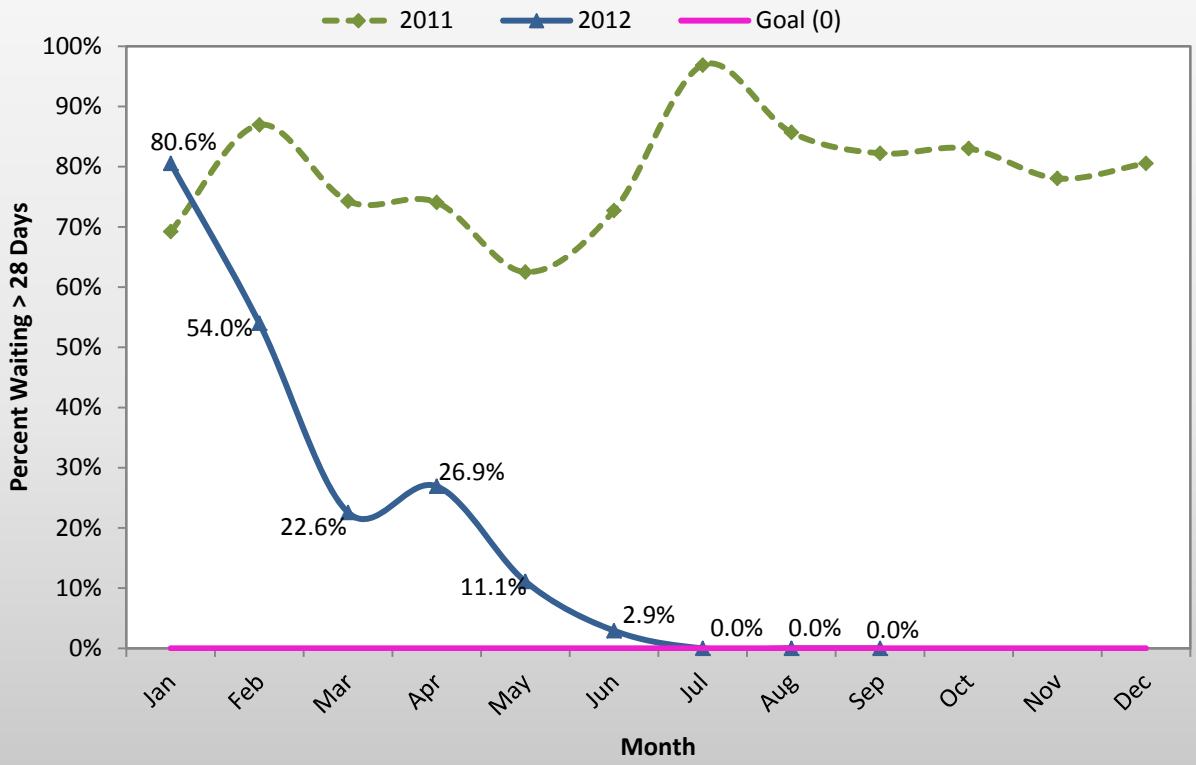
- Colorado's "safety net" civil bed capacity has been diminished over the last several years
  - Program closures have outpaced openings
- Waitlist at CMHIP
  - Currently an average of 19 civil patients per day are awaiting services at CMHIP
- Colorado ranks 48th in total public and private psychiatric beds per 100,000 adults (SAMHSA)
- 2012 Federal lawsuit settlement – no patient waits more than 28 days for competency evaluation
  - 22 civil beds now used for criminally court ordered patients at CMHIP
  - Repurposed 16 of 24 forensic beds from the Department of Corrections

Percentage of Patients with Wait Times over 28 Days - CMHIP

Description of Trend: Steadily declining since January 2012 to 0% in July 2012. Has remained at 0%.

Numerator: # of all ITP and Comp Exam Patients who Waited over 28 Days for admission, September = 0

Denominator: # of People who Ended their Wait in the Month; September Denominator: 34



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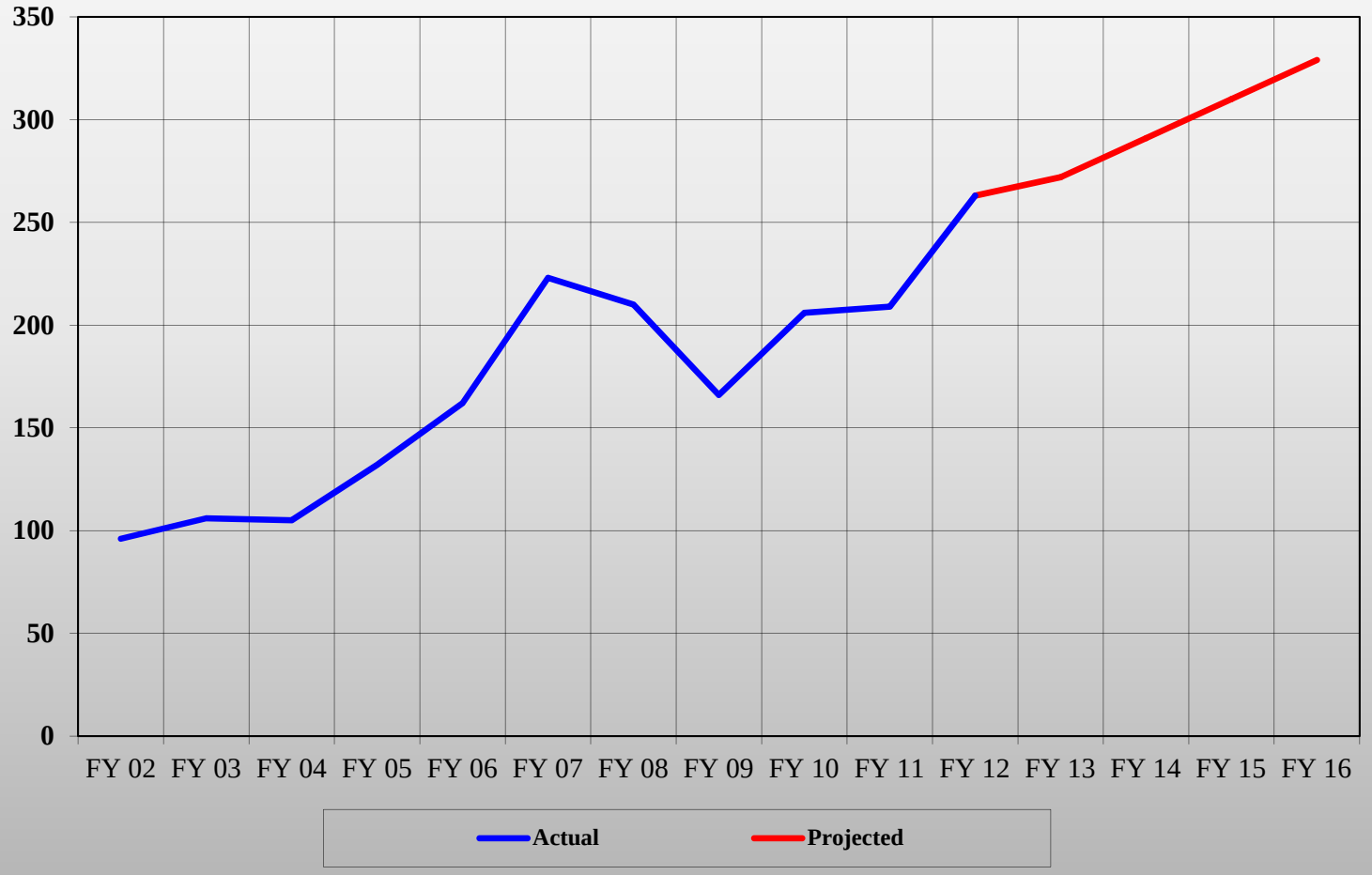
Criminal Court Orders for Inpatient Restoration at CMHIP



Expand Inpatient Capacity

- The Department's budget request - *$2,063,438 GF* – increases community mental health center access to civil beds

- Metro area 20-bed jail-based contract operated restoration program
  - Built upon San Bernardino, CA program
  - Permanent, ongoing effort to begin to address system capacity needs
  - Operates at a lower cost per day (approx. $325) than Institutes (approx. $473)
    - Licensure requirements are different than Institutes'
  - Individuals requiring inpatient levels of care would still be served by CMHIP
  - Vendor will be selected via competitive procurement for a five-year contract

Enhance Community Care

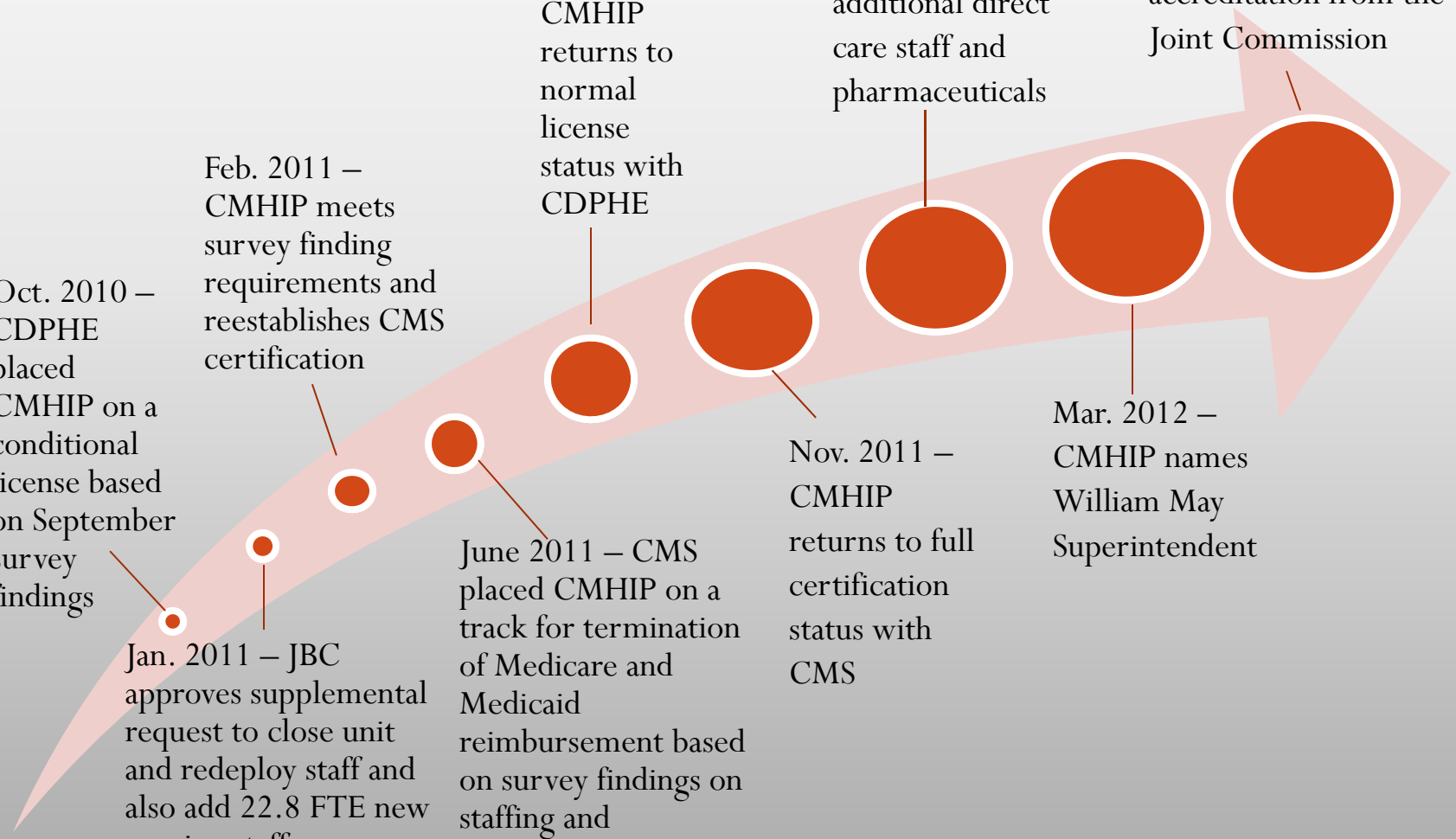
- Limited and insufficient to meet the needs of all individuals
- Too many individuals seek treatment through acute hospital emergency departments or unnecessarily become part of criminal justice system
- Individuals can linger in hospital settings
  - 20% of the civil patients at Fort Logan and 12% at CMHIP are medically ready to leave the hospital
- People have the right to live in the least restrictive, most home-like setting
  - Current service array doesn't allow for this

Enhance Community Care

- The Department's budget request - *$4,793,824 GF* – increases community services and access
- Assertive Community Treatment
  - Evidence-based model of behavioral health care for individuals with severe mental illness; effective in reducing hospitalization
  - Proven effective with individuals who have had frequent contacts with the behavioral health and/or criminal justice system
  - Intensive services including individualized clinical services; emergency rehabilitation; medication management; relationship building; outreach; in-home support and recovery
- Two15-bed residential facilities for transition from hospital to community
- Targeted housing subsidies for clients with behavioral health needs
- Transition specialists to facilitate wraparound services
- Dramatically expand utilization of adult foster care placements

Mental Health Institutes – Path to Improvement

Colorado Department of Human Services
people who help people



Establishing a New Paradigm

- Up to 2/3 of men and women in substance use disorder treatment report being the victim of childhood abuse & neglect
- 55%-99% of women with substance use disorders have a lifetime history of trauma; 50% of women in treatment have history of rape or incest
- 90% of public mental health clients have been exposed to trauma
- 70% of youth in residential placement have had some type of past trauma
- Providing Trauma Informed Care across the Department
  - Recognizes the presence of trauma experience and acknowledges the role that trauma has played in an individual's life
  - A trauma informed culture looks to assist others in identifying "What happened to me?" instead of "What's wrong with me?"

Build Trauma Informed Approaches

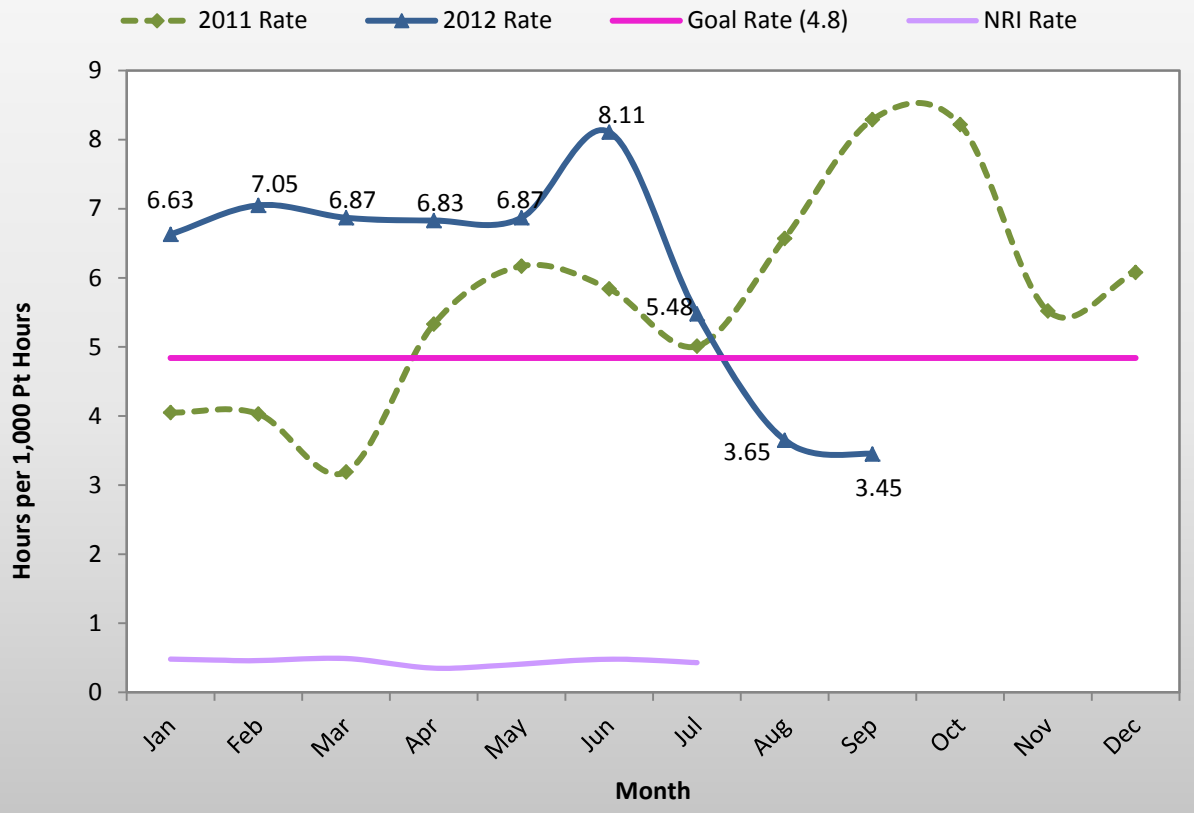
- Both Institutes, and all Offices with direct client care, have begun to implement trauma informed approaches to treatment and intervention
- These trauma informed approaches are beginning to produce positive patient outcomes
- Improving treatment services as evidenced by the declining use of seclusion and restraint

Seclusion Use - CMHIP

Description of Trend: Rates ranged from 3 to 8 in 2011. The rates reached a high of 8.11 in June 2012 and have since been falling.

Numerator: # of Hours of Seclusion; September = 998.28

Denominator: Per 1,000 patient hours; September Denominator: 289.39 thousand patient hours



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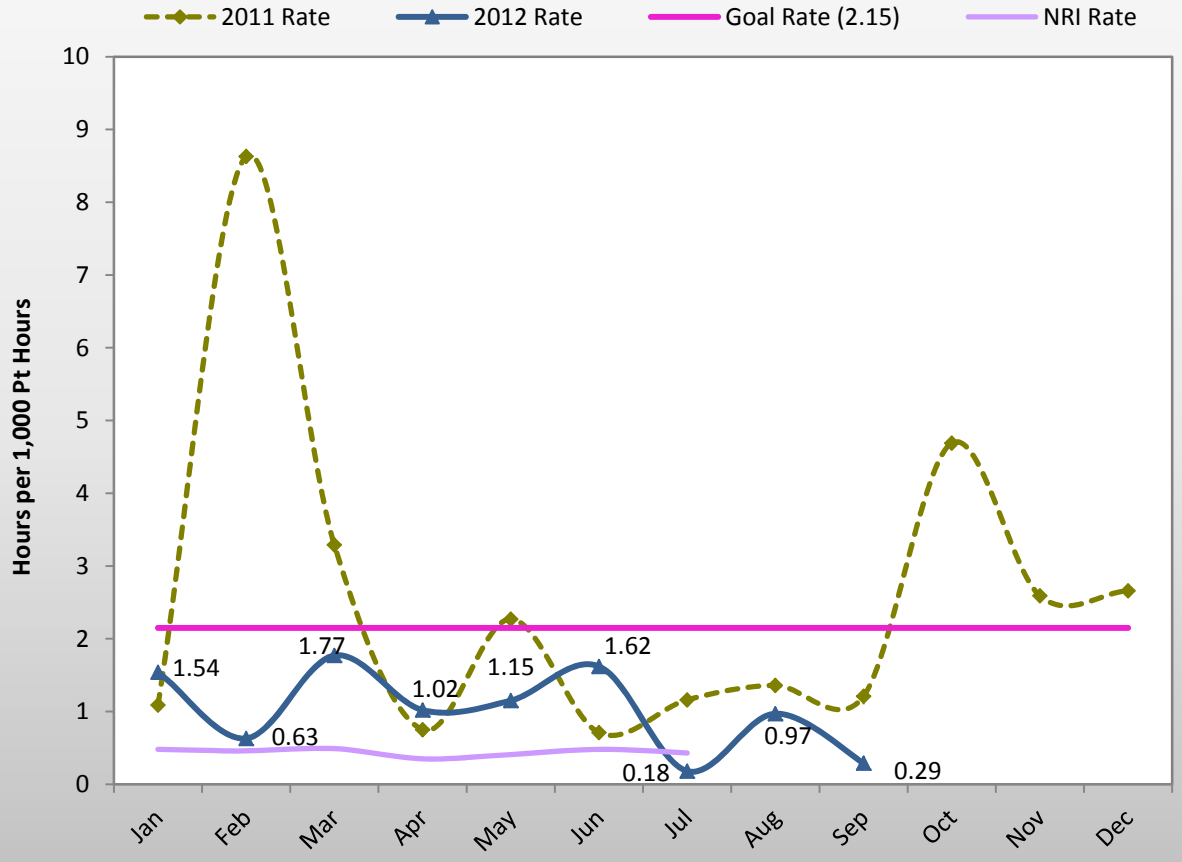
Seclusion Use - CMHIFL

Description of Trend: Rates have remained below the goal rate for the first eight months of the 2012 calendar year, and under the NRI rate in July and September 2012.

Numerator: # of Hours of Seclusion; September = 19.03 hours

Denominator: Per 1,000 Patient Hours; August Denominator: 65.35 thousand patient hours



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Build Trauma Informed Approaches

- The Department's budget request - $911,865 GF – provides the ability to implement trauma informed care throughout the Institutes

- Trauma support groups
- Peer support specialists
- De-escalation rooms
- Continued reduction and elimination of seclusion and restraint

Integrated Data Tool

- The Department's budget request - *$480,000 TF* – develops an integrated substance abuse and mental health data system.
- Current systems are outdated and stand alone
  - Burdensome to providers
- Consolidates and replaces the mental health Colorado Clinical Assessment Record (CCAR) system and the substance use disorder Drug/Alcohol Coordinated Drug System (DACODS).
  - Aligns mental health and substance abuse records
  - Creates one unique patient identifier
  - Tracks performance and patient outcomes

Thanking Our Partners

- Colorado Department of Public Health and Environment
- Colorado Department of Health Care Policy and Financing
- County Human Services Departments
- Local and Statewide Law Enforcement Agencies
- Mental Health America of Colorado
- Federation of Families for Children's Mental Health Colorado Chapter
- National Alliance for Mentally Ill
- Advocates for Recovery
- Colorado Mental Health Centers
- Colorado Substance Use Disorder Treatment and Prevention Providers
- Colorado Behavioral Health Care Council
- Colorado Department of Local Affairs
- Colorado Department of Public Safety
- Behavioral Transformation Council

Colorado Department of Human Services
people who help people

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