COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

July 1, 2019

The Honorable Susan Lontine, Chair
Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

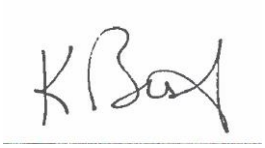
Dear Representative Lontine:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Cross-system Response Pilot Program for persons with Intellectual and Developmental Disabilities to the House Health and Insurance Committee.

Section 25.5-6-412, C.R.S. requires the Department to conduct a cost analysis of the services that would need to be added to eliminate gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system and are supported in the Colorado behavioral health crisis response system. The Department shall provide the results of the cost analyses in an annual written report on the pilot program, as well as recommendations related to closing service gaps, on or before July 1, 2017 and each July 1 thereafter.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303.866.6912.

Sincerely,



Kim Bimestefer
Executive Director

KB/cgh

Enclosure(s): 2019 Cross-System Crisis Response Pilot Program Report

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet P. Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Sonya Jaquez Lewis, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

July 1, 2019

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Cross-system Response Pilot Program for persons with Intellectual and Developmental Disabilities to the House Public Health Care and Human Services Committee.

Section 25.5-6-412, C.R.S. requires the Department to conduct a cost analysis of the services that would need to be added to eliminate gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system and are supported in the Colorado behavioral health crisis response system. The Department shall provide the results of the cost analyses in an annual written report on the pilot program, as well as recommendations related to closing service gaps, on or before July 1, 2017 and each July 1 thereafter.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303.866.6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/cgh

Enclosure(s): 2019 Cross-System Crisis Response Pilot Program Report

Cc: Representative Dafna Michaelson Jenet, Vice-Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Cathy Kipp, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
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David DeNovellis, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

July 1, 2019

The Honorable Rhonda Fields, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed please find the Department of Health Care Policy and Financing's legislative report on the Cross-system Response Pilot Program for persons with Intellectual and Developmental Disabilities to the Senate Health and Human Services Committee.

Section 25.5-6-412, C.R.S. requires the Department to conduct a cost analysis of the services that would need to be added to eliminate gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system and are supported in the Colorado behavioral health crisis response system. The Department shall provide the results of the cost analyses in an annual written report on the pilot program, as well as recommendations related to closing service gaps, on or before July 1, 2017 and each July 1 thereafter.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at David.DeNovellis@state.co.us or 303.866.6912.

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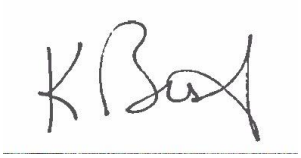

Kim Bimestefer
Executive Director

KB/cgh

Enclosure(s): 2019 Cross-System Crisis Response Pilot Program Report

Cc: Senator Brittany Pettersen, Vice-Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Faith Winter, Health and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

Fiscal Year 2018-19 Cross-System Crisis Response Pilot Report (House Bill 15-1368)

Date: July 1, 2019

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Health Care Policy and Financing
FY 2018-19 Cross-System Crisis Response Pilot Report

Annual Cross-System Crisis Response Pilot Legislative Report | July 1, 2019

This report is the final legislative report, required under Colorado Revised Statues (C.R.S.) 25.5-6-412, and builds off prior annual legislative reports.[1]

Overview

In 2014, the University Center of Excellence on Developmental Disabilities at the University Of Colorado School Of Medicine, known as JFK Partners, completed a statewide study that identified gaps in services for individuals with an intellectual or developmental disability (I/DD) who experience a behavioral health issue (Gap Analysis).[2] House Bill (HB) 15-1368 was passed into law, per section of the Colorado Revised Statutes (C.R.S.) section 25.5-6-412, which established the Cross-System Response for Behavioral Health Crises Pilot Program (CSCR Pilot) to help address the gaps in services identified in the Gap Analysis and serve people with an I/DD and a mental health disorder experiencing a behavioral health crisis.[3] C.R.S. 25.5-6-412 also directs the Department of Health Care Policy and Financing (the Department) to conduct a series of cost analyses, including an actuarial study of the services that would need to be added to Medicaid to eliminate service gaps and ensure that individuals with I/DD are fully included in the Colorado behavioral health system and are supported in the Colorado Crisis Services.[4]

Timeline

The Department of Health Care Policy and Financing (Department) entered into a contract with Rocky Mountain Health Plans (RMHP) in May 2016, and began the operational phase of the CSCR Pilot in August 2016, operating in two regions: Western Slope, and Front Range. The operational phase ended June 30, 2018, and the closeout phase began July 1, 2018, running

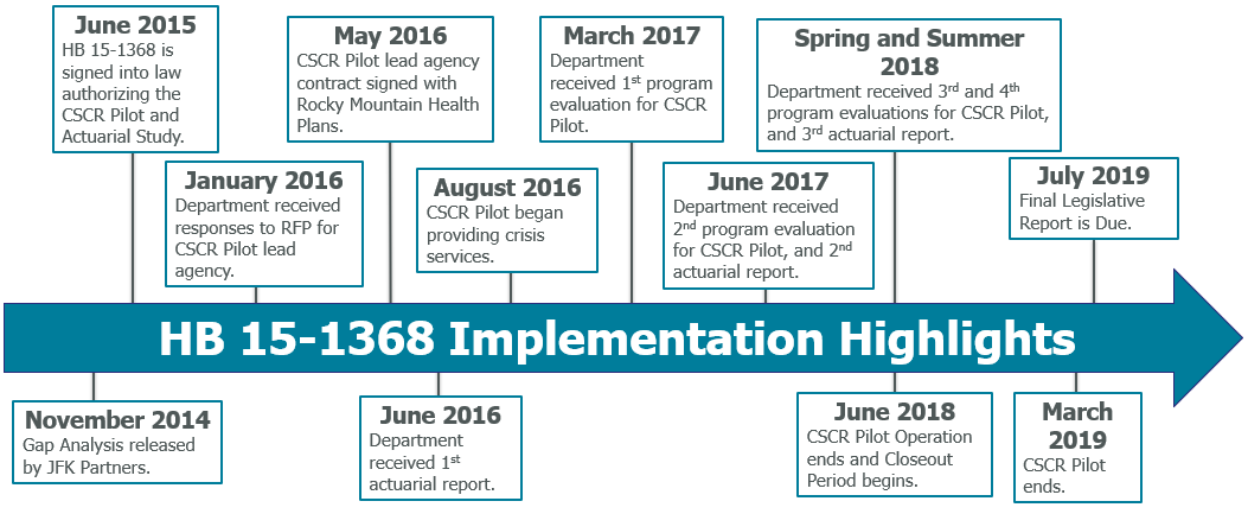
[1] July 2017 Report: https://www.colorado.gov/pacific/sites/default/files/2017%20Cross%20System%20Response%20Pilot%20IDD%20Report.pdf; July2018 Report: https://www.colorado.gov/pacific/sites/default/files/2018%20HCPF%20Cross-System%20Reponse%20Pilot%20Annual%20Report%20-%20July%202018.pdf

[2] Robinson Rosenberg, Cordelia. "Analysis of Access to Mental Health Services for Individuals who have Dual Diagnoses of Intellectual and/or Developmental Disabilities (I/DD) and Mental and/or Behavioral Health Disorders." ucdenver.edu. http://www.ucdenver.edu/academics/colleges/medicalschool/programs/JFKPartners/projects/Documents/Gap%20report%2012-3-14%20Revised.pdf (accessed May 11, 2017).

[3] HB 15-1368, 70th G.A., 1st Sess. (2015); *incorporated into* C.R.S. §25.5-6-412.

[4] Pursuant to C.R.S. §25.5-6-412, the CSCR Pilot must "compliment and expand…" Senate Bill 13-266, incorporated into C.R.S. §27-60-103, concerning a request for proposals process to create a coordinated Behavioral Health Crisis Response System for communities throughout the State, and, in connection therewith, making appropriation.

until the statutory end-date for all CSCR Pilot work, on March 1, 2019. During that period, information and data from the operational phase was compiled and analyzed through a continued Contract with RMHP, and best practices and recommendations were identified, for inclusion in this final report.



Participant DATA

During the operational phase (August 2016 – June 2018), there were 283 unique individuals seen in the CSCR Pilot, across both regions. Many of the individuals were seen in multiple months, with some seen multiple times in the same month, resulting in multiple crisis "events." The below chart captures CSCR Pilot participation during the operational phase across both regions, and splits the members by gender and age.[5]

CSCR Pilot Operational Phase Participation (August 2016 – June 2018)	
Number of crisis events	1131
Total individuals served	283
Male	164
Female	119
Adult	174
Child	109

[5] Cost associated with participation is provided below in the *Actuarial/Cost Analysis* section, and in greater detail in "SFY 2018-19 Actuarial CSCR Pilot Report," *attached*.

Barriers, Best Practices, and Recommendations

During the course of the CSCR Pilot, barriers to mental/behavioral health services for persons with I/DD emerged within five general categories: diagnosis, training, crisis stabilization, care coordination, and collaboration. Below is a brief discussion of these gaps within their respective categories, along with best practices learned during the course of the CSCR Pilot, and recommendations for addressing barriers. Unless otherwise cited, these barriers, best practices, and recommendations are derived from the operational phase of the CSCR Pilot.

Diagnosis

Barrier: Failure to accurately diagnosis mental illness in persons with an I/DD

In Colorado (and globally) mental and behavioral health professionals have a difficult time diagnosing mental illness in persons with an I/DD.[6] The Department conducted a survey of various community mental health clinics (CMHCs) as part of its SFY 2017-18 HB 15-1368 Actuarial/Cost analyses, and the top self-reported barrier to providing mental/behavioral health services and supports to persons with I/DD was diagnosing mental illness in persons with I/DD, and further, understanding eligibility for services.[7]

Diagnosing mental/behavioral needs in persons with an I/DD is necessary for two essential reasons: (1) establishing a plan of services and supports for an individual, and (2) establishing eligibility for those services and support through waivers, behavioral health, and physical health benefits. Due to the difficulty in diagnosing mental/behavioral health needs, this often results in inaccurate diagnoses, and sometimes, a complete inability to diagnose. This leads to the individual receiving inadequate supports, as well as denial of services, due to support requests that are not accurately linked back to the diagnosis. Correct diagnosis is crucial to establish eligibility for those services.

Additionally, denials based on lack of "primary diagnosis," are common for persons with an I/DD, and reflect a scenario wherein a person is denied mental/behavioral health services due to a lack of primary psychiatric diagnosis. However, through the CSCR Pilot, the Department has observed that these denials are due to an inability to justify the services requested, based upon the diagnoses listed on the service claim: the mental/behavioral health treatment must be associated to a corresponding mental/behavioral health diagnosis.[8]

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[6] *See* Fletcher, Robert J. *et al*, *Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* (2nd Edition), NADD PRESS (2016), Chapter 2 "Assessment and Diagnostic Procedures."

[7] *See* "SFY 2017-18 Actuarial CMHC Survey Report," *attached*.

[8] Exhibit H of the RAE contracts explicitly prohibits denying mental/behavioral health services based on the lack of a primary psychiatric diagnosis.

Best Practice: Use of the DM-ID-2 when diagnosing mental/behavioral health disorders in persons with I/DD

The Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5) is currently required as a basis for diagnosing mental illness persons with an I/DD, through Exhibit H of the contracts between the Regional Accountable Entities (RAEs) and the Department.[9] However, the DSM-5 is not designed, nor appropriate, for diagnosing mental illness in persons with an I/DD, without the use of an adaptive tool, such as the Diagnostic Manual – Intellectual Disabilities, Second Edition (DM-ID-2).[10] The DM-ID-2, and related materials, adapt DSM-5 diagnostic criteria to provide detailed explanations and examples related to how persons with an I/DD may present their mental illness differently than general populations, which enables a mental/behavioral health professional to arrive at a diagnosis that is consistent with the DSM-5. Further, because the DM-ID-2 is inclusive of DMS-5 standards and criteria, it may be used as a stand-alone tool. Lastly, the DM-ID-2 is recognized by the National Association for the Dually Diagnosed (NADD) as the validated best practice for diagnosing mental/behavioral health disorders in persons with I/DD, rather than using the DSM-5 alone.[11]

Recommendation: Using the DM-ID-2 when diagnosing mental illness in persons with I/DD, for purposes of obtaining Health First Colorado reimbursable mental/behavioral services.

Additionally, there is a systemic and general need for training and education related to navigating eligibility, including which services are available and appropriate for each diagnosis, as well as how to correctly appeal denials. Individuals who approach a State Fair Hearing with a letter from a Doctor asserting that the psychiatric diagnosis is indeed primary are mistakenly seeking to overcome the incorrect objection, and find that the true denial was based on the fact that the services being sought are not related to the diagnosis being cited. Understanding of the role of diagnosis in establishing eligibility is a best practice that the CSCR Pilot has used to overcome barriers to mental/behavioral health services, and will help stakeholders and members alike to ensure that the correct services are being sought, and can be provided.

Training

Barrier: Lack of training related to adapted mental/behavioral health services to persons with an I/DD

The SFY 2017-18 Actuarial CMHC Survey Report also highlighted that mental/behavioral health professionals are lacking training related to serving persons with an I/DD.[12] This includes diagnosing mental/behavioral health disorders, as discussed above, as well as providing adaptive

[9] *Id.*, at "Guiding Principles for Diagnostic Formulation," Subsection 1, *et seq*.
[10] Fletcher, *infra* note 6
[11] *Id*.
[12] *See infra*, note 7

services, and understanding eligibility. Medical providers have reported similar training concerns.[13]

Best practice: Utilizing cross-systems trainings that sufficiently and practically address the training needs of clinical professionals and service providers, as well as persons with I/DD, and their families

The CSCR Pilot used cross-system training professional learning communities (PLCs), as well as collaborative relationships between mental/behavioral health professionals and I/DD support professionals, to bridge the gaps in knowledge between the two provider environments. Through the course of operation, the Department adopted the view that providing mental/behavioral services to persons with I/DD is not a clinical specialty, but rather, a cultural competency.

In April 2019, the Department collaborated with the Colorado Department of Human Services, Office of Behavioral Health, to provide a workshop related to the use of the DM-ID-2, as well as providing adaptive mental/behavioral health services to persons with I/DD. The one-day workshop was attended by approximately 130 individuals in person, as well as over 60 through an online webinar, who represented clinical professionals, direct service providers, families, and advocates, along with other interested participants. Survey responses following the workshop indicated strong support for expanding this type of training.

Recommendation: Further exploration of trainings offered by such organizations as the National Association of Dully Diagnosed (NADD), the Center for START Services, and other related resources, to determine which trainings(s) will be most appropriate and effective for the above-mentioned groups. The breadth of trainings should include, but not be limited to: general foundational knowledge related to providing health services to persons with I/DD; specific adaptive therapies; the correct use of adaptive diagnostic tools and processes (as discussed above in relation to the DM-ID-2); trauma-informed and responsive practices, and crisis supports for persons with an I/DD. There should be collaboration among State Departments, academic programs, stakeholders, and training professionals to ensure that these trainings are person-centered, both in terms of the needs of persons with I/DD and their famlies, as well as the needs of clinical professionals and service providers.

Crisis Stabilization

Barrier: Insufficient stabilization options for persons with an I/DD who have mental/behavioral health needs

It may be difficult for persons with an I/DD to use crisis stabilization units (CSUs) and related environments within the Colorado Crisis System (Crisis System) due to staff capacity and lack of expertise to support persons with an I/DD. In addition, there are different standards for services within the various CSU environments that may affect the ability to admit a person who needs assistance with activities of daily living (ADLs), which many persons with I/DD, as well as

[13] *See* https://inclusivehealth.specialolympics.org/emerging-solutions/case-study-university-of-colorado-school-of-medicine (accessed May, 2019).

individuals with complex medical needs, have. Further, the regulation that governs acute treatment facilities (ATUs), which are often used for crisis stabilization, creates conditions that may be prohibitive for many individuals with an I/DD.[14]

Emergency rooms are frequently used, yet should be seen as a last resort. However, they are designed more for medical emergencies, rather than mental/behavioral health crises: a reality that contributed to the creation the above-mentioned CSUs. Currently, persons with I/DD are often without an appropriate setting to support them through crisis stabilization.

Best practice: Partnering with I/DD support professionals to create stabilization environments to support individuals with I/DD

The CSCR Pilot used site based therapeutic stabilization homes that were located in the community. These stabilization environments were able to accommodate an individual's acuity of needs, and provided short term step-down stabilization when the CSU, an Inpatient Psychiatric facility, or return to home are their previous environment was not an appropriate option. These homes also provided a place for planned therapeutic support for individuals when the need arose. These person-centered stabilization environments (one in each CSCR Pilot region for adults and one for children) permitted longer lengths of stay of up to 30 days, which allowed the CSCR Pilot team to work with individuals on their assessments, as well as to work with the individuals, their families, and providers, on improving skills for supporting, and even preventing, crisis events.

Recommendation: Collaboration between the Crisis System and local I/DD professionals and service providers who have environments that are, or can be, equipped and staffed for providing stabilization and Respite services for persons with I/DD who are experiencing, or may experience, a mental/behavioral health crisis.

Barrier: Limited planned Respite options for persons with I/DD in advance of a mental/behavioral health crisis

There is a void in services to support individuals, as well as their parents/caregivers, through short term planned Respite, in advance of anticipated crisis events. Respite is available in various HCBS waivers. However, it may be difficult to find Respite providers who are able to provide these services to persons with I/DD with higher acuity needs.

Related, some communities have limited summertime day programs for children, especially adolescents ages 12-18. Once these individuals are out of school they may receive the structure, programming, or daily behavior support necessary to support them and their families.

Planned Respite is available for individuals who identify an anticipated crisis event, through the Crisis System,[15] but may be inacessible for the capacity and acuity reasons mentioned above.

[14] 2 C.C.R. §502-1/21.290.51(F).
[15] C.R.S. §27-60-103(b)(IV).

Best practice: Use of planned Respite was a benefit for both the individual and their family.
During the CSCR Pilot, planned Respite gave individuals and their families the time and space to de-escalate potential crisis events, as well as to learn new skills to help with crisis support needs.

Recommendation: The Crisis System should explore increasing the capacity, and availability, of planned Respite for persons with I/DD.

Barrier: Limited mobile supports for persons with I/DD who are experiencing mental/behavioral health needs
The Crisis System may not typically have staff who are sufficiently training in supporting persons with an I/DD included in their mobile support teams to assist during response to crisis events.

Best practice: Collaborate with local providers of I/DD supports who can work on-call to respond to mobile response when necessary; stabilize persons with I/DD where they are, when possible and reasonable
During the CSCR Pilot, staff who were trained in supporing persons with an I/DD were paid to be on call (24/7/365) and were reimbursed for their travel and time when they responded in person to support individuals with an I/DD who were experiencing a mental/behavioral health crisis. This practice resulted in more successful stabilization through a person-centered approach of meeting the person where they are and having the expertise on hand to understand the individual's needs.

Recommendation: Collaboration between the Crisis System and local I/DD professionals and service providers to create linkages for on-call mobile response within their respective geographic areas.

Wraparound

Barrier: Lack of intensive Wraparound to help adults and children with an I/DD navigate their crises; knit together their various health needs through coordination with providers; and receive appropriate follow-up supports after crisis events
There is currently no reimbursable Wraparound[16] available for persons with I/DD. Wraparound is a process through which an individual with complex needs can work with a facilitator to evaluate and identify what programs and services can or are meeting their health care needs. This is in an effort to develop a single care plan that supports the individual's ability to live in a home and community setting.

[16] Wraparound provides a comprehensive, holistic, way of responding when individuals experience serious mental health or behavioral challenges. Wraparound puts the individual at the center. With support from a team of professionals and natural supports, the individual's and perspectives about what they need and what will be helpful drive all of the work in Wraparound. *Definition adapted* to be inclusive of child, youth, and adults. *See* https://nwi.pdx.edu/wraparound-basics/ (accessed June, 2019).

Best practice: Wraparound, beginning when an individual enters a crisis event, or sooner when possible, and continued follow-up supports after stabilization

The important role Wraparound plays in an individual's continuum of care is a well-established best practice.[17] For persons with an I/DD who have co-occurring mental/behavioral health care needs, as well as their families, and providers, Wraparound is vital in preventing escalation of needs. The CSCR Pilot demonstrated that, without this support, individuals with an I/DD, their families, and providers, are often constructively pushed toward escalated needs, and crisis events.

Intensive Wraparound was an integral part of the CSCR Pilot. Through training and consultation with the Center for START Services, the CSCR Pilot provided Wraparound to all its participants, with more intense supports given to those who had a higher acuity of needs. This reduced emergency room visits, connected individuals to preventative supports and services, and helped families, providers, and community professionals, through trainings, as well as availing wraparound staff to provide guidance when needed.[18]

Recommendation: Explore ways to develop wraparound as an available service for persons with I/DD, regardless of payer type.

Collaboration

Barrier: Limited or inconsistent collaboration between agencies, providers, and health professionals when supporting persons with I/DD who have mental/behavioral health needs

Collaboration between mental/behavioral health professionals, I/DD service and support professionals, and other health related providers, is limited, yet necessary in order to ensure an individual's holistic continuum of care.

Best practice: Supporting linkages and collaborative opportunities with the various providers, systems, agencies, and stakeholders who contribute to the supports and services for persons with I/DD

During the CSCR Pilot, mental/behavioral health professionals and I/DD professionals worked closely to support persons with I/DD throughout the course of their mental/behavioral health needs. In addition, they worked with community partners, such as schools, hospitals, first-responders, and families, to provide training, support, and resources. The CSCR Pilot regions have become leaders in collaborating to serve and support persons with I/DD, and they have continued their close-knit work beyond the end of the CSCR Pilot.

[17] *See* Galbreath, Laura, MPP, "Care Coordination: The Heart of Integration," available at: https://www.integration.samhsa.gov/about-us/esolutions-newsletter/july-2012 (accessed May, 2019).
[18] *See* "Colorado START Pilot Initial Report," November 28, 2018, located at: http://www.ucdenver.edu/academics/colleges/medicalschool/programs/JFKPartners/projects/Documents/1b%20-%20Initial_Report_Colorado_FINAL_12.6.2018.pdf (accessed May, 2019).

Recommendation: Collaboration between systems, agencies, providers, and other stakeholders, to foster and ensure a continuum of care for persons with I/DD.

Actuarial/Cost Analysis

The SFY 2018-19 Actuarial/Cost Analysis was a comprehensive audit of the operational phase of the CSCR Pilot.[19] Below are some key findings.

In the below table, the total amount of $2,494,009 (rounded), is summarized further in the categories of Capital, Personnel, Supplies & Equipment, Operating, Client Services, Occupancy, Indirect, and Revenue Offsets.

Expense Category	SFY 2016 Total	SFY 2017 Total	SFY 2018 Total	Grand Total
Capital	355,086	2,004	544	357,634
Personnel	72,658	961,939	676,431	1,711,028
Supplies & Equipment	49,885	19,191	8,847	77,923
Operating	309,806	10,730	65,614	386,151
Client Services	0	31,144	35,762	66,906
Occupancy	29,063	50,628	21,532	101,223
Indirect	0	(58,232)	11,395	(46,837)
Revenue Offsets	0	(92,441)	(67,578)	(160,019)
Grand Total	816,498	924,963	752,547	$2,494,009

A summary of encounters by region and state fiscal year are available. However, a summary of individuals broken out by these categories is not possible as some individuals span more than one state fiscal year. Cost per unique individual served and per encounter were calculated in total rather than state fiscal year due to the imbalance of high start-up costs and low utilization in the first fiscal year end.

For the below tables, the expense associated with Rocky Mountain Health Plans is allocated amongst Region 1 and Region 2 based on unique individuals served by each region. Note that an allocation based on expense incurred would shift this allocation of expense slightly more to Region 2.

[19] *See* "SFY 2018-19 Actuarial CSCR Pilot Report," *attached*.

Region 1				
Expense	SFY 2016	SFY 2017	SFY 2018	Total
RMHP Share	72,525	41,798	41,940	156,263
Foothills Gateway	155,190	163,759	153,870	472,819
Summit Stone	11,498	16,955	22,834	51,287
Total Expense	239,213	222,512	218,644	680,369
Unique Individuals Served				86
Cost per Individual				$7,911.27
Encounters				434
Cost per Encounter				$1,567.67

Region 2				
Expense	SFY 2016	SFY 2017	SFY 2018	Total
RMHP Share	166,134	95,746	96,071	357,951
STRiVE	406,988	497,038	403,336	1,307,362
Mountain Valley	725	33,549	18,871	53,145
Community Options	1,063	34,706	4,631	40,400
Mind Springs	2,375	41,412	10,993	54,780
Total Expense	577,285	702,451	533,902	1,813,638
Unique Individuals Served				197
Cost per Individual				$9,206.28
Encounters				697
Cost per Encounter				$2,602.06

The total cost per individual across both regions equals $8,812.74 while the total cost per encounter equals $2,205.13.

Note, the costs associated with the CSCR Pilot program do not necessarily reflect the true cost of Statewide implementation of best practices and recommendations gathered through the course of operation. Implementation and integration of best practices will include much more collaboration and adapted utilization of already existing services and supports. The cost of this is as yet unknown, in light of the fact that true utilization of these services and supports relies on implementation of the CSCR Pilot best practices in order to overcome barriers to access. Future studies will need to be conducted in order to more accurately understand the cost impact related to the respective systems the best practices effect.

Conclusion

The CSCR Pilot identified that there is need for planned Respite, stabilization environments, and Wraparound services. In addition, the CSCR Pilot established the need to improve access to current services within five general categories: diagnosis, training, crisis stabilization, care coordination, and collaboration. Implementation of best practices learned through the CSCR Pilot will improve access to mental/behavioral health services for persons with I/DD and help ensure that their needs are being met.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Cross-System Crisis Response (CSCR) Pilot Program

Final Report

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Cross-System Crisis Response (CSCR) Pilot Program Final Report

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Consulting Report

Colorado Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

We were engaged to perform consulting services to compile total expenditures of the Cross-System Crisis Response (CSCR) Pilot Program for the period July 1, 2015 through June 30, 2018. In addition, when relevant and where data was reasonably available, we were also engaged to identify gaps in reimbursement, identify potential reimbursement sources, and project the fiscal impact of state-wide application of the CSCR Pilot Program.

Our consulting engagement was conducted in accordance with consulting standards established by the American Institute of Certified Public Accountants. We were not engaged to and did not conduct an examination or review, the objective of which would be the expression of an opinion or conclusion, respectively, on the CSCR pilot program expenditures, gaps in reimbursement, potential reimbursement sources and the projected fiscal impact of a state-wide CSCR program. Accordingly, we do not express such an opinion or conclusion.

The results of this consulting engagement are contained in the pages that follow. The expenditures presented therein were compiled from information obtained from a Regional Accountable Entity and two Community Centered Boards, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

This report is intended solely for the information and use of the Department is not intended to be and should not be used by anyone other than this specified party.

Myers and Stauffer LC
Denver, CO
May 17, 2019

Report Overview

Myers and Stauffer values the afforded opportunity to complete a cost accounting of the Cross-System Crisis Response (CSCR) Pilot Program. The CSCR Pilot Program was required under HB 15-1368.

The CSCR Pilot Program was a collaborative effort between the Department of Health Care Policy & Financing (the Department, or HCPF), the Colorado Department of Human Services (CDHS)-Office of Behavioral Health (OBH), who manages the Colorado Crisis Services, Community Mental Health Centers (CMHCs), and community-based I/DD service providers. Through a procurement process, Rocky Mountain Health Plans (RMHP) was selected to serve as the lead agency and coordinate the core services in the CSCR Pilot. RMHP is a Regional Care Collaborative Organization (RCCO) that specializes in cross-system approaches through care coordination.[1]

Per our contract[2] with the Department, our report includes:

- A detailed accounting of total CSCR Pilot expenditures, organized by services, staff, operational costs (rent, utilities, and other recurring costs), goods, including food and supplies, and administrative costs organized by state fiscal year and geographic CSCR Pilot region
- Where reasonably available, identification and accounting of potential reimbursement sources for services and supports provided throughout the CSCR Pilot
- Where relevant, and reasonably available, detailed accounting of gaps in reimbursement, and recommended remedies that may include suggested changes to the current system, or suggested alternatives not currently part of the various systems that support and overlap with the Colorado Crisis System.
- Where reasonably available, projected fiscal impact for state-wide application of CSCR Pilot, based on average per-member, per-day cost for operation, with adjustments for activities of daily living (ADL) supports or Level of Care needs

The following records were requested and reviewed as necessary in relation to the results discussed in this report:

- Invoices
- Claims information from claims databases (MMIS, Bridge, etc.)
- Claims and reimbursement through the Colorado Crisis System, if applicable and reasonably obtained
- Intake forms
- Monthly reports
- Notes and receipts
- Support and Follow-up Plans

Our contract also specifies that a labeled and paginated copy of all source documents collected and used must be submitted as an attachment. Since several file names contain Protected

[1] House Bill 15-1368 – Cross System Response to Behavioral Health Crises Pilot Program (CSCR Pilot), July 1, 2017
[2] Contract Order Number: PO, UHAA, 201900009726, Description: UHAA, 7310, Myers and Stauffer LC

Health Information (PHI), this portion of the report will be relayed via a secure File Transfer Protocol (FTP) account established with Department personnel.

The lead agency, RMHP, is a Regional Care Collaborative Organization[3]. Along with RMHP, two of the community-based I/DD service providers, or Community Centered Boards (CCBs), incurred the majority of the expense associated with the pilot program. These two entities are Foothills Gateway, Inc. and STRiVE Colorado. On-site visits for these three organizations were performed on the dates indicated to gather and clarify the documentation requested.

March 28-29, 2019 – Foothills Gateway, Inc.
April 2-3, 2019 – Rocky Mountain Health Plans (RMHP)
April 4-5, 2019 – STRiVE Colorado

A cost accounting process was completed in order to verify and reconcile supporting documentation such as receipts, invoices and personnel calculations to the invoices submitted to RMHP, and in turn, to the Department for expense reimbursement. Expenses are presented by major category and state fiscal year, with presentation becoming more detailed throughout the report. In addition, patient records such as intake forms, progress notes and other patient file documentation was utilized to verify the reasonable accuracy of participating individuals and total encounters. Recommendations were made by two of the participating organizations pertaining to existing gaps in reimbursement. Lastly, a projected state-wide cost is calculated related to the continuance of the Crisis Program.

[3] Regional Care Collaborative Organization (RCCO) equals Regional Accountable Entity (RAE) as of July 1, 2018.

Cross-System Crisis Response (CSCR) Pilot Program Summary

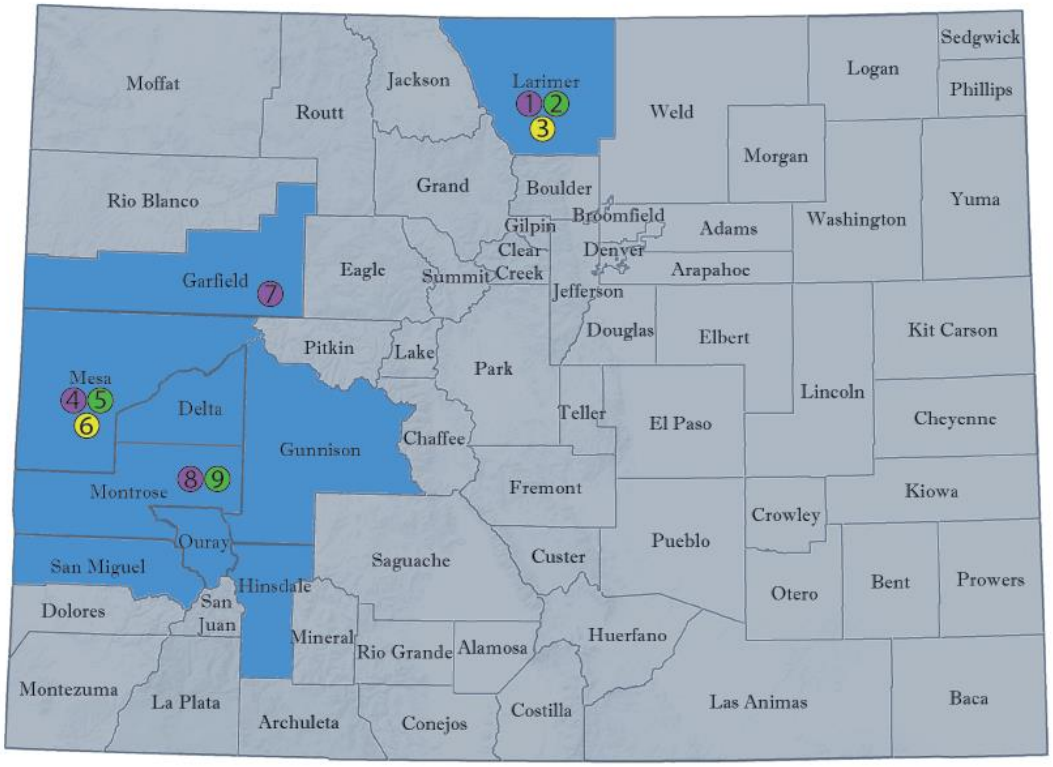
House Bill (HB) 15-1368, signed into law on June 5, 2015, created a cross-system response for behavioral health crises pilot program to serve individuals with intellectual or developmental disabilities due to the following factors based on the House Bill language:

- Limited access to appropriate treatment in the behavioral health system, including crisis intervention, stabilization, and prevention, for individuals with intellectual and developmental disabilities
- Inadequate reimbursement and inappropriate service limits and definitions in the behavioral health capitated system as well as medical mental health benefits in the Colorado fee-for service Medicaid state plan for individuals with intellectual and developmental disabilities
- Conflicting requirements and confusion about diagnosis-based requirements that limit access to assessments as well as treatment
- Lack of professional expertise and workforce capacity
- Need for a systematic and strategic approach to increase capacity among licensed medical professionals, credentialed service providers, and direct service personnel to help provide medical and behavioral health services for individuals with intellectual and developmental disabilities

Per HB 15-1368, the goal of the pilot program, "is to provide crisis intervention, stabilization, and follow-up services to individuals who have both and intellectual or developmental disability and a mental health or behavioral disorder and who also require services not available through an existing home-or community-based services waiver or covered under the Colorado behavioral health care system. The pilot program was required to have, "locations at multiple sites that represent different geographic regions of the state." Per the bill, the pilot program was to begin on or before March 1, 2016 and operate until March 1, 2019.

The map[4] located on the next page illustrates the CSCR Pilot Regions and Partners.

[4] House Bill 15-1368 – Cross System Response to Behavioral Health Crises Pilot Program (CSCR Pilot), July 1, 2017



1- Foothills Gateway, Inc. — I/DD Services
2 - SummitStone Health Partners — Mental and Behavioral Health Services
3 - Community Crisis Services Center — Front Range - walk-in center
4 - STRiVE — I/DD Services
5 - Mind Springs Health — Mental and Behavioral Health Services
6 - Transitions at West Springs — Western Slope - walk-in center
7 - Mountain Valley Developmental Services — I/DD Services
8 - Community Options, Inc. — I/DD Services
9 - The Center for Mental Health — Mental and Behavioral Health Services

- Mental and Behavioral Health Services
- I/DD Services
- Walk-in Center

For the purposes of this report, Regions 1 and 2 consist of the following organizations per the map above:

Region 1 (Front Range)	Region 2 (Western Slope)
I/DD Services	***I/DD Services***
Foothills Gateway	STRiVE
	Mountain Valley Developmental Services
	Community Options, Inc.
Mental and Behavioral Health Services	***Mental and Behavioral Health Services***
SummitStone Health Partners	Mind Springs Health
	The Center for Mental Health*
Walk-in Center	***Walk-in Center***
Community Crisis Services Center*	Transitions at West Springs*

*In the Cost Accounting section presented next, no expenses were noted separately for the Walk-in Centers for either Region or for The Center for Mental Health in Region 2.

The CSCR Pilot Program provided the below four core services[5]. The Operational Phase of the CSCR Pilot ended on June 30, 2018. The Closeout Phase ended on February 28, 2019, with the official end of the CSCR Pilot, pursuant to C.R.S. 25.5-6-412.

- Community-based mobile supports
- In-home therapeutic supports
- Site-based therapeutic supports
- Follow-up supports

Community-based mobile supports: Including the Colorado Crisis Services Hotline and Community-Based Mobile Support Team for stabilization, evaluation and treatment plan development.

In-home therapeutic supports: Designed to assist individuals in crisis within their natural living environment by coordinating with and training the individual's current services providers and natural supports and assessment team.

Site-based therapeutic supports: Two therapeutic stabilization homes were established in each region by Foothills Gateway and STRiVE, one to serve adult individuals and one to serve children. This site-based therapeutic support allowed for a 24 hour therapeutically planned and professionally staffed environment. The homes supported those requiring a higher level of care, though, not an in-patient hospital based level of care. Crisis management, stabilization and transition were the main goals. The establishment of such homes required specific structural modifications such as:

- Bolted down toilet tank lids
- Solid core hand rails
- Ligature preventive shower heads and controls
- Ligature preventive faucets and plumbing covers for sinks

[5] Presentation: Cross-System Crisis Response Pilot Program: Behavioral Health and I/DD Professionals working together, Colorado Department of Health Care Policy & Financing, June 2017

- Bolted down mirrors made from polished metal rather than glass
- Ligature resistant door knobs and locks on interior doors
- Door hinges that allow dual direction opening to prevent blocking
- Electrical outlets that prevent object insertion
- Recessed ceiling lighting made of non-glass material, including bulbs
- Furniture design that allowed for being bolted to the floor
- Lexan safety glass windows throughout
- Window panes with internal blinds

Follow-up supports: Designed to locate, coordinate and facilitate enrollment in community services as well as monitor ongoing community services.

Cost Accounting

In order to gather the necessary documentation, site visits were conducted at Rocky Mountain Health Plans (RMHP), a Regional Care Collaborative Organization (RCCO) as well as two Community Centered Boards (CCBs) involved in the CSCR Pilot Program. The Department chose RMHP, "to serve as the lead agency and coordinate the core services in the CSCR Pilot." The on-site visits performed at RMHP along with CCBs Foothills Gateway, Inc. and STRiVE were essential to our understanding of the Pilot Program.

Myers and Stauffer reconciled the invoices with the supporting source documentation submitted by RMHP. The invoices support the total expenditures listed by state fiscal year end indicated below under the "M&S Total Expense" column. The figures in the "HB 15-1368 Budget Tracking Actual" and "HB 15-1368 Budget Tracking Budgeted" columns in both charts below were obtained via a budget tracking summary document provided by the Department. Overall variances per state fiscal year, netting $260.56 are immaterial.

State Fiscal Year	M&S Total Expense	HB 15-1368 Budget Tracking Actual	Immaterial Variance
July 1, 2015 through June 30, 2016	$816,497.18	$816,384.79	$112.39
July 1, 2016 through June 30, 2017	$924,961.80	$925,215.00	($253.20)
July 1, 2017 through June 30, 2018	$752,545.92	$752,144.55	$401.37
M&S Sub-Total	**$2,494,004.90**	**$2,493,744.34**	**$260.56**
Close-out Period: July 1, 2018 through February 28, 2019		*$119,776.34*	
Operating Total		**$2,613,520.68**	
Actuarial Analyses		*$245,769.00*	
Program Evaluations		*$82,717.01*	
Grand Total		**$2,942,006.69**	

Myers and Stauffer was responsible for covering the period of July 1, 2015 through June 30, 2018. The close-out period of July 1, 2018 through February 28, 2019 is still being processed by the Department. Comparing budgeted to actual produces the following results:

State Fiscal Year	HB 15-1368 Budget Tracking *Budgeted*	HB 15-1368 Budget Tracking *Actual*	Budget Over (Under)
July 1, 2015 through June 30, 2016	$1,550,110.00	$854,954.79	($695,155.21)
July 1, 2016 through June 30, 2017	$1,050,215.00	$1,039,666.01	($10,548.99)
July 1, 2017 through June 30, 2018	$1,075,776.00	$847,609.55	($228,166.45)
Close-out Period: July 1, 2018 through February 28, 2019	$428,740.00	$119,776.34	($228,963.66)
Grand Total	**$4,104,841.00**	**$2,942,006.69**	($1,162,834.31)[6]

[6] Spending under budget was a result of a delayed initial start to the CSCR Pilot during SFY 2015-16, as well as changes to the operation/closeout of the CSCR Pilot that aligned with lessons learned, as well as fluid implementation of best-practices.

The total amount of $2,494,009 (rounded), is summarized further in the categories of Capital, Personnel, Supplies & Equipment, Operating, Client Services, Occupancy, Indirect, and Revenue Offsets. Further descriptions of each expense category follow the table.

Expense Category	*SFY 2016 Total*	*SFY 2017 Total*	*SFY 2018 Total*	Grand Total
Capital	355,086	2,004	544	357,634
Personnel	72,658	961,939	676,431	1,711,028
Supplies & Equipment	49,885	19,191	8,847	77,923
Operating	309,806	10,730	65,614	386,151
Client Services	0	31,144	35,762	66,906
Occupancy	29,063	50,628	21,532	101,223
Indirect	0	(58,232)	11,395	(46,837)
Revenue Offsets	0	(92,441)	(67,578)	(160,019)
Grand Total	816,498	924,963	752,547	2,494,009

It is important to note that expenses were reimbursed on the cash versus accrual basis of accounting. As a result, timing of expenses is not easily discernable in the cost accounting tables presented throughout the report. Under a cash basis, expenses are reimbursed when invoices are produced without consideration for when the expense was actually incurred. For example, in the discussion of Capital expense below, lease expense was paid in advance for the entire Pilot Program and reimbursed in full during SFY 2016. However, the expense applies to SFY 2017 and SFY 2018 as well.

Capital: Lease expense associated with the therapeutic stabilization homes was paid in advance for the entire operational period. In addition, capital improvements were made to ensure the safety of the individuals served. As a result, 99%, or $355,086, of the total **$357,634** in capital costs were incurred during State Fiscal Year 2016.

Personnel: Several categories of personnel expenses were noted totaling **$1,711,028**:

- Steering
- Planning
- Committee Planning
- Staff Training
- Marketing
- Residential Manager
- Staff
- Behavioral Specialist Staff
- Behavioral Specialist Training Staff
- Case Management
- Audit/Reporting
- Consulting
- On-Call Week
- On-Call Weekend
- Crisis
- Clinical Personnel
- EHR Personnel
- Other

The five categories responsible for the largest portion of personnel expense are indicated in the following chart:

Personnel Category	Amount	% of Total Personnel Expense
Staff	783,201	45.77%
Residential Manager	167,313	9.78%
On-Call Week	128,821	7.53%
Case Management	117,971	6.89%
Behavioral Specialist Staff	112,592	6.58%

Supplies & Equipment: This category, totaling **$77,923** is comprised of the following rounded subcategories:

- Computer
- Medical
- Office
- Program

Operating: This category, totaling **$386,151** is comprised of the following subcategories:

- Training Materials
- Cirrus MD
- Recruiting
- Auto Leases/Insurance/Other
- Mileage
- Other

Client Services: This category, totaling **$66,906** is comprised of the following subcategories:

- Psych Services
- Staff Support
- Translation
- Other

Occupancy: This category, totaling **$101,223** is comprised of the following subcategories of expense related to therapeutic stabilization homes:

- Home Insurance
- Repairs
- Utilities
- Internet
- Phone
- Lawn Care/Snow Removal
- Other

Indirect: This category, totaling **($46,837)** is comprised of the following subcategories:

- Lodging & Employee Food
- In-Kind
- Miscellaneous

In-Kind revenue includes a budgeted donation of $30,600 by RMHP to cover expenses exceeding expected amounts. In addition, STRiVE contributed $30,360.99 in personnel expense for "Uncompensated Care due to Budget Overages".

Revenue Offsets: This category, totaling **($160,019)** is comprised of the following subcategories:

- Medicaid Waiver Revenue
- Variance from Support to Expense Tracker

State Fiscal Year July 1, 2015 through June 30, 2016 – By Organization

Expense Category	*RMHP*	*Community Options*	*Foothills Gateway*	*Mind Springs*	*Mountain Valley*	*STRiVE*	*Summit Stone*	*SFY 2016 Total*
Capital	-	-	92,735	-	-	259,364	2,987	355,086
Personnel	24,475	1,063	10,599	2,375	725	24,910	8,511	72,658
Supplies & Equipment	-	-	8,695	-	-	41,190	-	49,885
Operating	214,184	-	38,794	-	-	56,828	-	309,806
Client Services	-	-	-	-	-	-	-	0
Occupancy	-	-	4,367	-	-	24,696	-	29,063
Indirect	-	-	-	-	-	-	-	0
Revenue Offsets	-	-	-	-	-	-	-	0
SFY 2016 Total	238,659	1,063	155,190	2,375	725	406,988	11,498	816,498

Expenses included in the start-up period incurred during state fiscal year 2015-16 for the CSCR Pilot Program are listed below. Note that only expense amounts of $20,000 and above are detailed as separate line items.

Rocky Mountain Health Plans

Vendor	$ Amount	Description
CirrusMD, Inc.	125,000	Telemedicine - Easy Care Colorado Dev. and Implementation
Institute on Disability/UCED	89,184	START Services Training and Consultation
Steadman Group, LLC	24,475	Consulting, project mgmt., implementation, report production
	238,659	

The CirrusMD, Inc. invoice contains expense for implementation of Easy Care Colorado, an electronic telemedicine system. A description provided per their website states that as a patient you will have, "access to your doctors and other members of your health care team through your computer and mobile device. Now, you can skip the drive to the clinic and meet with your healthcare team from your computer or mobile device at no extra cost to you."

RMHP incurred $89,184 of expense for, "START Services Training and Consultation, as contracted" supplied by the Institute on Disability/University Center for Excellence and Disability (UCED), University of New Hampshire. The invoice does not provide more detail pertaining to time span, services provided, or organizations serviced.

The Steadman Group, LLC was contracted by RMHP at $110 per hour to, "perform as contractor to support the implementation activities of RMHP and the Intellectual and Developmental Disabilities (IDD) Crisis Pilot project." Total expense equals $24,475 and

consulting services include; project management and implementation activities, meeting facilitation, and report production for RMHP's IDD crisis pilot project. An additional $32,258 was incurred for this vendor in state fiscal year 2017.

Foothills Gateway

Vendor	$ Amount	Description
SummitStone Health Partners	45,900	Stabilization Home Rent Expense (Adult 24.5 months + deposit)
Mountain -n- Plains, Inc.	37,023	Stabilization Home Rent Expense (Child 24.5 months + deposit)
Centennial Leasing, Inc.	38,000	Auto Leases (25 months: two minivans, one SUV)
Various	34,267	Other Expense
	155,190	

STRiVE

Vendor	$ Amount	Description
STRiVE (Mesa Develop. Services)	108,000	Stabilization Home Rent/Utilities/Repairs Exp. (Adult 24 months)
Unknown	107,860	Stabilization Home Property Upgrades (Adult)
High Desert Realty, LLC	42,500	Stabilization Home Rent Expense (Child 24 months)
Enterprise Fleet Management	36,828	Auto Leases (24 months: two minivans, one SUV)
CDW Sales	21,061	Computers
Alpha Medical Group	20,000	Recruiting Fee - Clinical Psychologist
Various	70,738	Other Expense
	406,988	

The lease agreement expense associated with the adult stabilization home at 181 Elm Avenue, Grand Junction, CO states that Mesa Developmental Services dba STRiVE is the landlord. Monthly rent expense of $3,471.00 plus an established monthly fee for electrical ($376.00), Gas/Water/Sewer/Trash ($398.00), and Maintenance/Repairs ($255.00) totals $4,500 per month, or the $108,000 total noted above.

Expenses of $107,860 were incurred at the same property for upgrades. The documentation submitted in support of this expense appears to be internal and an estimate rather than an invoice for work completed. The vendor completing the work is not documented on the invoice and a 13% overhead and profit margin line item of $12,408.83 is included in the total. No indication of the cost of materials or the number of labor hours that are estimated for the different parts of the project are listed.

CDW Sales in the amount of $21,061 is comprised of two invoices. One invoice for $14,608.69 contains computers (laptops and desk tops), tablets, monitors, and a firewall router, etc. Another invoice for $6,452.71 contains expense for four Verizon cell phones with 12GB of data.

State Fiscal Year July 1, 2016 through June 30, 2017 – By Organization

Expense Category	*RMHP*	*Community Options*	*Foothills Gateway*	*Mind Springs*	*Mountain Valley*	*STRiVE*	*Summit Stone*	*SFY 2017 Total*
Capital	-	-	-	-	-	2,004	-	2,004
Personnel	166,362	35,830	165,762	41,412	33,078	502,540	16,955	961,939
Supplies & Equipment	-	-	1,753	-	-	17,438	-	19,191
Operating	479	82	4,456	-	472	5,241	-	10,730
Client Services	-	-	2,108	-	-	29,036	-	31,144
Occupancy	-	-	5,659	-	-	44,969	-	50,628
Indirect	(29,297)	-	1,146	-	-	(30,081)	-	(58,232)
Revenue Offsets	-	(1,206)	(17,125)	-	-	(74,110)	-	(92,441)
SFY 2017 Total	137,544	34,706	163,759	41,412	33,550	497,037	16,955	924,963

State fiscal year 2016-17 includes one month of start-up period expense (July 2017). August 1, 2017 marks the beginning of the operational period for the pilot program. Only expense amounts of $20,000 and above are detailed as separate line items.

Rocky Mountain Health Plans

Vendor	Amount	Description
Salaried Personnel	131,129	Reference *Overall Personnel Expense* section
Steadman Group, LLC	32,258	Consulting, project mgmt., implementation, report production
Rocky Mountain Heath Plans	(30,600)	Donation
Various	4,757	Other Expense
	137,544	

Similar to state fiscal year 2016, the Steadman Group, LLC was contracted by RMHP at $110 per hour. Consulting services include, "supporting RMHP IDD crisis project manager and transitioning activities."

Foothills Gateway

Vendor	Amount	Description
Salaried Personnel	165,762	Reference *Overall Personnel Expense* section
Various	(2,003)	Other Expense
	163,759	

STRiVE

Vendor	Amount	Description
Salaried Personnel	502,540	Reference *Overall Personnel Expense* section
Salaried Personnel	25,425	Pro Bono and Management Expense Catch Up
14 Total Vendors	32,671	Stabilization Home Repairs and Maintenance
STRiVE	(30,361)	In-Kind Donation
CO Department of HCPF	(74,144)	Medicaid Waiver Revenue
Various	47,894	Other Expense
	497,038	

In April of 2017, $24,425 in Pro Bono and Management Expense Catch Up was included. The expense equals the sum of two separate calculations. The first calculation was based on one employee at 0.9 FTE for February through March 2017 to calculate the amount of hours worked during this period. The provider identified that 1 FTE is equivalent to 160 hours. It is unclear how the 0.9 FTE was determined. The calculated hours were multiplied by $24.16, the staff hourly rate, to calculate the expense. The second calculation equals the hours worked over five months covering August 2016 through December 2016 for 12 employees multiplied by their various hourly rates (Staff $24.16, Management $45.00, & Planning $75.00). These totals were then divided by the total amount of workdays for the 5 months to get an average personnel cost of $168.53. Number of workdays was determined by a simple count of the working days (Monday-Friday) in each month. The average personnel cost was then applied to the working days for January 2017 through April 2017 to get the expense amount.

The majority of the expense for repairs and maintenance to the stabilization homes for $32,671 includes $9,292 (flooded basement, anti-ligature plumbing installation, demolition, etc.), $8,231 (remove support bars, bedroom deadbolts), and $7,498 (lighting/service upgrades, cabinet installation).

Mountain Valley Developmental Services

Vendor	Amount	Description
Salaried Personnel	33,078	Reference *Overall Personnel Expense* section
Various	12,578	Other Expense
	33,549	

Mind Springs Health

Vendor	Amount	Description
Salaried Personnel	41,412	Reference *Overall Personnel Expense* section
	41,412	

State Fiscal Year July 1, 2017 through June 30, 2018 – By Organization

Expense Category	*RMHP*	*Community Options*	*Foothills Gateway*	*Mind Springs*	*Mountain Valley*	*STRiVE*	*Summit Stone*	*SFY 2018 Total*
Capital	-	-	-	-	-	544	-	544
Personnel	129,965	4,460	154,876	10,993	18,871	334,602	22,664	676,431
Supplies & Equipment	-	-	783	-	-	8,064	-	8,847
Operating	291	83	3,373	-	-	61,697	170	65,614
Client Services	-	-	3,618	-	-	32,144	-	35,762
Occupancy	-	-	5,095	-	-	16,437	-	21,532
Indirect	7,754	89	2,525	-	-	1,027	-	11,395
Revenue Offsets	-	-	(16,399)	-	-	(51,179)	-	(67,578)
SFY 2018 Total	138,010	4,632	153,871	10,993	18,871	403,336	22,834	752,547

Rocky Mountain Health Plans

Vendor	Amount	Description
Salaried Personnel	129,965	Reference *Overall Personnel Expense* section
Various	8,046	Other Expense
	138,011	

Foothills Gateway

Vendor	Amount	Description
Salaried Personnel	154,876	Reference *Overall Personnel Expense* section
Various	(1,005)	Other Expense
	153,870	

STRiVE

Vendor	Amount	Description
Salaried Personnel	334,602	Reference *Overall Personnel Expense* section
Institute on Disability/UCED	52,998	START Services Training and Technical Assistance
Citadel Security USA, LLC	26,268	24 Hour Security July/Aug 2017
CO Department of HCPF	(51,187)	Medicaid Waiver Revenue
Various	40,654	Other Expense
	403,336	

START Services Training was billed in March 2018 related to services provided for a six month period of July 2017 through December 2017. The monthly amount of $8,833 for training and technical assistance multiplied by six equals $52,998. Note that RMHP incurred $89,184 of expense for START Services Training and Consultation in state fiscal year 2016.

Private round the clock security for $576.00 per day was provided on a short term basis by Citadel Security USA, LLC. Security was required to ensure the safety of the staff at one of the site based therapeutic homes due to violent outbursts of one particular high need individual.

Overall Personnel Expense

Personnel expense at Foothills Gateway and STRiVE accounts for 69.74% of total personnel expense incurred, or $1,193,289 of $1,711,026. Case Management and Non-Case Management comprise 19.16% and 80.84% respectively of the $1,193,289 summarized in the chart below.

	SFY 2016	SFY 2017	SFY 2018	Total Cost	%
Case Management Personnel					
Case Management Foothills	$ -	$ 42,819	$ 22,147		
Case Management STRiVE	$ -	$ 83,044	$ 80,643		
Total Case Management	**$ -**	**$125,863**	**$102,790**	**$ 228,653**	**19.16%**
Non-Case Management Personnel					
Non-Case Management Foothills	$ 10,599	$122,943	$132,729		
Non-Case Management STRiVE	$ 24,910	$419,496	$253,959		
Total Non-Case Management	**$ 35,509**	**$542,439**	**$386,688**	**$ 964,636**	**80.84%**
Total Personnel Expense	**$ 35,509**	**$668,302**	**$489,478**	**$1,193,289**	

Case Management vs. Non-Case Management: The review of invoice detail identified that employee personnel costs were classified into the categories of support staff, training staff, administrative staff, case management staff and professional services staff. These categories were summarized on the invoice cover sheet into the more general categories of Case Management (Non-Site Based) and Non-Case Management (Site-Based). The personnel expense relating to Case Management includes the employees noted as such on each invoice. The personnel expense relating to Non-Case Management includes support staff, training staff, administrative staff and professional services staff. The Case Management staff at STRiVE performed multiple roles relating to crisis. As a result, the Case Management costs for this entity include some Non-Case management expenses due to the cross-utilization of staff in both Case Management and Non-Case Management roles.

Personnel Hours: Hours were compiled based from the submitted invoices and are summarized below. Full Time Equivalent (FTE) calculations are based on an individual working 2,080 hours annually.

	SFY 2016	SFY 2017	SFY 2018	Total Hours	%
Case Management Hours					
Case Management Foothills	0	542	197		
Case Management STRiVE	0	2,305	3,846		
Total Case Management	**0**	**2,847**	**4,043**	**6,890**	**11.38%**
Non-Case Management Hours					
Non-Case Management Foothills	250	11,441	13,263		
Non-Case Management STRiVE	157	15,848	12,722		
Total Non-Case Management	**407**	**27,289**	**25,985**	**53,681**	**88.62%**
Total Hours	**407**	**30,136**	**30,028**	**60,571**	
Total FTEs (2,080 Hours)	***0.20***	***14.49***	***14.44***	***29.12***	

Hourly rates: Hourly rates for each personnel category are detailed below. Note that some of the hourly rates for Foothills Gateway are calculated based on the invoices provided to Rocky Mountain Health Plans. In addition, the rate structure for STRiVE was revised in September 2017.

Hourly Rate Breakdown	***Foothills***
Steering Group Calls	$ 125.00
Planning Calls	$ 75.00
Committee Planning	$ 39.92
Behavioral Specialist Training Staff	$ 35.00
Residential Manager	$ 25.73
Case Mgmt Coord. Not Targeted Case Management	$ 21.02
START Training	$ 20.00
Staff Training	$ 20.00
Marketing Staff	$ 20.00
Case Mgmt Coord. Targeted Case Management	$ 18.85
DSP Training	$ 12.00
Behavioral Specialist Staff	$ 9.29
On-Call	$ 3.00

Hourly Rate Breakdown	*STRiVE*
Rate Structure June 2016 - August 2017	
Leadership Day Rate	$ 168.53
Steering SJ	$ 125.00
Planning SJ	$ 75.00
Management	$ 45.00
Case Management	$ 35.52
Staff	$ 24.16
Rate Structure September 2017 - June 2018	
Psychiatrist	$ 200.00
Primary Care Physician	$ 150.00
Professional Services	$ 101.16
Psychologist	$ 45.08
Program Director	$ 45.08
Behavioral Assessor	$ 30.05
Behavior Specialist	$ 28.85
Start Coordinators	$ 27.50
Line Staff	$ 26.88
On Call - Called out	$ 25.00
Res Supervisor	$ 25.00
Site-Based Staff	$ 18.75
On Call	$ 4.16

Unsupported Expense

Supporting documentation was not submitted to Myers and Stauffer for all expenses listed on the monthly invoices submitted to Rocky Mountain Health Plans. In total, $53,163, or 2.13% of $2,494,009 in total expense is unsupported by source documentation such as invoices, receipts, etc.

Organization	Expense Category	Amount
Foothills Gateway	Capital	$ 4,577
Foothills Gateway	Occupancy	$ 1,200
	Sub-total	$ 5,777
STRiVE	Capital	$ 6,855
STRiVE	Personnel	$ 14,855
STRiVE	Supplies & Equipment	$ 846
STRiVE	Supplies & Equipment	$ 5,226
	Sub-total	$ 27,782
Summit Stone	Personnel	$ 6,730
SFY 2016 Total		**$ 40,289**

SFY 2017 Total		**$**	**0**
Mind Springs	Personnel	$	751
Mountain Valley	Personnel	$	4,585
STRiVE	Operating	$	1,879
STRiVE	Client Services	$	2,630
STRiVE	Occupancy	$	789
	Sub-total	$	5,298
Summit Stone	Personnel	$	2,240
SFY 2018 Total		**$**	**12,874**
Grand Total		**$**	**53,163**

An organizational breakdown indicates that STRiVE comprises $33,080, or 62.22% of the unsupported expense total. Summit Stone in the amount of $8,970 accounts for the second largest portion at 16.87%. Six insignificant transactions of less than $100 are not included in this analysis.

Unsupported Expense			
Organization		**Amount**	**% to Total**
Foothills Gateway	$	5,777	10.87%
STRiVE	$	33,080	62.22%
Summit Stone	$	8,970	16.87%
Mind Springs	$	751	1.41%
Mountain Valley	$	4,585	8.62%
	$	53,163	100.00%

Further detail of the expenses by state fiscal year as well as region are included in Exhibits A through C.

Individuals & Encounters

A summary of encounters by region and state fiscal year are available. However, a summary of individuals broken out by these categories is not possible as some individuals span more than one state fiscal year. Cost per unique individual served and per encounter were calculated in total rather than state fiscal year due to the imbalance of high start-up costs and low utilization in the first fiscal year end.

The expense associated with Rocky Mountain Health Plans is allocated amongst Region 1 and Region 2 based on unique individuals served by each region. Note that an allocation based on expense incurred would shift this allocation of expense slightly more to Region 2.

	Region 1			
Expense	***SFY 2016***	***SFY 2017***	***SFY 2018***	***Total***
RMHP Share	72,525	41,798	41,940	156,263
Foothills Gateway	155,190	163,759	153,870	472,819
Summit Stone	11,498	16,955	22,834	51,287
Total Expense	239,213	222,512	218,644	680,369
Unique Individuals Served				86
Cost per Individual				$7,911.27
Encounters				434
Cost per Encounter				$1,567.67

The cost per individual is $1,295.01 less in Region 1 than in Region 2 while the cost per encounter is $1,034.39 less.

	Region 2			
Expense	***SFY 2016***	***SFY 2017***	***SFY 2018***	***Total***
RMHP Share	166,134	95,746	96,071	357,951
STRiVE	406,988	497,038	403,336	1,307,362
Mountain Valley	725	33,549	18,871	53,145
Community Options	1,063	34,706	4,631	40,400
Mind Springs	2,375	41,412	10,993	54,780
Total Expense	577,285	702,451	533,902	1,813,638
Unique Individuals Served				197
Cost per Individual				$9,206.28
Encounters				697
Cost per Encounter				$2,602.06

The total cost per individual across both regions equals $8,812.74 while the total cost per encounter equals $2,205.13.

The number of patients served by the Crisis Program equals 1,047. This represents the cumulative count of how many times the participating individuals were present in the program.

For example, if individual A was present in the program in January and February of 2017, they are counted in January as a patient and February as a patient.

The number of encounters represents how many times an individual client was serviced by the Crisis Program. Several encounters could occur within a given month and could include multiple therapy visits, etc.

Source documents including Intake forms, Crisis Pilot Face Sheets, Crisis Management Follow-Up Plans, 60-Day Plans, Discharge Plans, Fact Sheets, etc. were reviewed. The number of encounters were substantiated through the review of these documents.

	Region 1	Region 2	Total
Encounters	434	697	1,131
% of Total	***38.37%***	***61.63%***	***100.00%***
Patients Served	380	667	1,047
% of Total	***36.29%***	***63.71%***	***100.00%***
Individuals	86	197	283
% of Total	***30.39%***	***69.61%***	***100.00%***

Demographics related to the 1,047 patients served are indicated in the chart below:

	Patients Served	Male	Female	Adults	Children
Region 1	380	224	156	280	100
		58.95%	***41.05%***	***73.68%***	***26.32%***
Region 2	667	352	315	466	201
		52.77%	***47.23%***	***69.87%***	***30.13%***
Total	1,047	576	471	746	301
		55.01%	***44.99%***	***71.25%***	***28.75%***

Recommendations

Reimbursement Gap Analysis

Myers and Stauffer requested a reimbursement gap analysis from Rocky Mountain Health Plans in addition to the two most prominent CCBs involved in the Pilot Program, Foothills Gateway, Inc. and STRiVE.

Rocky Mountain Health Plans

The following program improvement recommendations were made by Louisa Wren, RAE Health Neighborhood and Community Programs Manager at Rocky Mountain Health Plans:

Overall: *With appropriately funded staffing, expanded training and commitment to inpatient and outpatient resources, these communities would be better equipped to meet the long term crisis needs of this population as well as develop support systems of care that reduce frequency and acuity of crisis events.*

Issue: The absence of continued funding for the CSCR Pilot Program removes two crucial supports listed below.

- 24-hour, seven days a week, 365 days per year, on-call and mobile I/DD experts are not available to respond to behavioral health crisis events in the community.
- Stabilization homes are not operational and therefore not available

Recommendation: Fund a crisis system state-wide in order to make these services available indefinitely.

Issue: High needs individuals experiencing an ongoing crisis or crises lose funding dollars when they are not in crisis because their Supports Intensity Scale (SIS) level is reduced.

Recommendation: Higher need individuals with a dual diagnosis need support on an on-going basis. As additional follow-up services and assessments post crisis are required, implement a mechanism for these individuals to retain the necessary support level under the HCBS – SLS/DD programs in order to prevent funding support reductions when they are not in crisis.

Issue: High needs individuals experiencing an ongoing crisis or crises have a set number of TCM and Behavioral Service Units per service plan year and extinguish these units earlier in their service plan than those individuals without a dual diagnosis.

Recommendation: Create a mechanism that would allow individuals to receive more TCM units when they have run out during crisis events, or an alternate form of case management for crisis events. In addition, develop a process for requesting additional Behavioral Services Units during a service plan year for individuals who have repeated crisis events.

Issue: Caregiver families lose HCBS-DD waiver funding during the time a child with I/DD is in a therapeutic stabilization home receiving services.

Recommendation: A policy change is required to retain waiver funding in order to remove the disincentive for a family to place and support a child in the therapeutic stabilization home for the time and services needed.

Issue: In general, planned respite care for individuals and their families is a scarce resource.

Recommendation: If the Crisis Program is funded in the future, therapeutic stabilization homes provide the valuable service of structured respite for short stay individuals. In addition, creating evidence-based person-centered training for respite providers is essential for success.

Issue: Training for families with an individual with I/DD in order to give them tools for managing behavior and crises is currently not funded.

Recommendation: If the Crisis Program is funded in the future, create and offer training programs for families and caregivers on trauma informed parenting and Applied Behavior Analysis. This training will provide support by supplying the necessary tools and strategies to utilize de-escalation techniques and reinforcement of specific, positive alternative behaviors. The added benefit of proactively preventing crisis events will exist as a result.

Foothills Gateway and STRiVE

Recommendations made by Foothills Gateway, Inc. are included as **Appendix D**. Foothills Gateway recommendations were submitted by Erin Eulenfeld, M.S., CRC, Chief Operating Officer, Services. Recommendations requested from STRiVE were not submitted.

Myers & Stauffer Observations and Recommendations

Observation #1: Establishing Standards for Cost Finding

The CSCR Pilot program was designed to reimburse participating entities for the cost of providing program services. During our engagement, we noted that the documentation in support of costs was inconsistent and in some cases lacked sufficient detail to fully understand the nature of the expenditure. In addition, there was not clear guidance given defining what expenses should be included, how they should be determined, and what should be excluded. For example, support provided for a capital improvement expenditure looked like an invoice but it did not identify a vendor and it was also identified as an estimate. This raises questions as to whether the actual cost was the same as the estimate and if the vendor was a related party.

Observation #1: Myers and Stauffer Recommendation

We recommend that the Department develop tools and guidance designed to ensure costs are consistently reported and allow for effective program oversight. These tools and guidance will also ensure that only costs related to the provision of CSCR services are included. These can include:

- Establishing a standardized cost reporting template along with guidance on what costs should be included, how costs should be determined, and what costs must be excluded.
- Establishing minimum standards regarding the type and quality of documentation that must be maintained in support of reported costs.
- Establishing a verification process to ensure accurate reporting, and the existence of adequate supporting information through the review of source documentation such as accounting ledgers, third party invoices, payroll records, etc.

Observation #2: Establishing Standards for Patient Encounter Documentation

During the course of our engagement, we noted that patient encounter data was not summarized in a consistent and complete manner, making identification of participants in the program difficult. We were also unable to determine the date an individual received CSCR services unless we compiled them from each participant's patient file.

Observation #2: Myers and Stauffer Recommendation

We recommend that the Department develop tools and guidance designed to ensure encounters are consistently reported, in requisite detail, and be readily available to allow for effective program oversight. This can include:

- Establishing a standardized encounter reporting template that captures at a minimum dates of service and the service type rendered.
- Establishing minimum standards regarding the type and quality of documentation that must be maintained in support of an encounter.

- Establishing a verification process to ensure accurate reporting, and the existence of adequate supporting information through the review of patient records.

Observation #3: Reimbursement Gap Analysis

Recommendations concerning reimbursement gaps and other issues noted during the operation of the CSCR Pilot Program were provided by Rocky Mountain Health Plans and Foothills Gateway in the preceding section.

Observation #3: Myers and Stauffer Recommendation

We recommend that a committee comprised of Department policy staff and stakeholders should be formed to identify and address gaps in funding concurrently with a state-wide roll-out of crisis related services.

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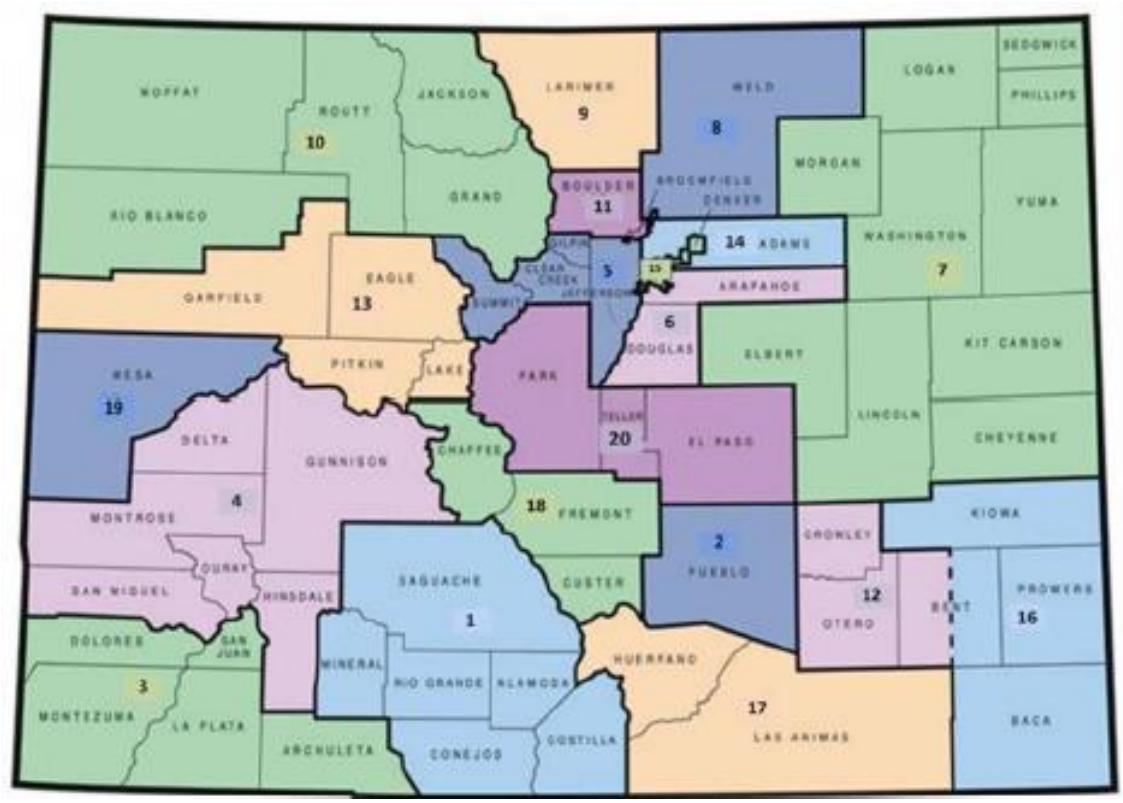
Continuance of the Crisis Program

There are 20 Community Centered Boards (CCBs) in Colorado. A map of the respective areas covered by each CCB is located below and was extracted from the Department's website.



The following table projects the annual state-wide cost of implementing the Crisis Program Note the following in reference to data in this table:

- ***Total Average IDD Individuals Served*** represents those served by each CCB for *all available* IDD services, including the Crisis Program during the operational period of the Crisis Program, or August 1, 2016 through June 30, 2018.

- ***Projected IDD Crisis Individuals*** represents a calculated number of expected Crisis Program participants based on the percentage of actual Crisis Program individuals served in Region 1 and Region 2 during the operational phase.

- ***Projected State-wide Cost Operating Period*** figures are based on the total cost per individual served of $8,812.74.

Information regarding activities of daily living (ADL) supports and Level of Care needs were not reasonably available and were not considered in the projection of this program statewide.

Community Centered Board	Map No.	Total Average IDD Individuals Served[7]	Projected IDD Crisis Individuals[8]	Projected State-wide Cost Operating Period	Projected State-wide Cost Annual Basis
Blue Peaks Developmental Services	1	78	15	127,871	66,867
Colorado Bluesky Enterprises	2	583	108	952,666	498,171
Community Connections	3	104	19	169,774	88,779
Community Options	4	181	0	0	0
Developmental Disabilities Resource Center	5	1,190	221	1,945,662	1,017,431
Developmental Pathways	6	1,946	361	3,183,223	1,664,580
Eastern Colorado Services	7	261	49	427,467	223,532
Envision	8	427	79	698,300	365,157
Foothills Gateway	9	668	86	757,896	396,321
Horizons Specialized Services	10	74	14	121,825	63,705
Imagine!	11	1,041	193	1,702,310	890,176
Inspiration Field	12	93	17	151,604	79,277
Mountain Valley Developmental Services	13	147	14	123,378	64,517
North Metro Community Services	14	909	169	1,486,024	777,076
Rocky Mountain Human Services	15	1,256	233	2,054,768	1,074,485
Southern Colorado Developmental Services	16	90	17	147,453	77,107
Southeastern Developmental Services	17	56	10	90,980	47,575
Starpoint	18	174	32	285,094	149,082
STRiVE	19	529	183	1,612,731	843,334
The Resource Exchange	20	1,731	321	2,830,716	1,480,245
Total		11,538	2,141	18,869,742	9,867,417

Using a rounded per-member, per-day figure of $12.63 yields an annual projected state-wide cost of $9,869,903, an immaterial difference of $2,486 from the previous table. The projections for Region 1 and Region 2 using their respective cost per individual are stated in the chart below:

	Cost Per Individual	Per-Member/ Per Day	Projected State-wide Cost Annual Basis
Region 1	$7,911.27	$11.33	$8,858,060
Region 2	$9,206.28	$13.19	$10,308,052

[7] Long Term Services and Supports Medicaid Funding Enrollment Report, Data from Colorado Medicaid Decision Support System (MMIS)
[8] Projected number based on 283 individuals served divided by total average individuals served of 1,525 in Regions 1 and 2. Actual numbers are stated for CCBs located in Regions 1 and 2.

Other Reports and Resources

Several reports related to the CSCR Pilot Program as well as reports not related but touching on shared aspects of the program are listed below.

House Bill 15-1368 – Cross System Response to Behavioral Health Crises Pilot Program (CSCR Pilot)
Colorado Department of Health Care Policy & Financing
July 1, 2017 and July 1, 2018

Colorado Department of Health Care Policy and Financing
Division for Intellectual and Developmental Disabilities
2017 Dually Diagnosed I/DD Actuarial Analysis on Gaps in Services
Optumas
June 30, 2017

Cross-System Crises Response Pilot Program Evaluation Site Visit Reports
Larimer County and Western Slope
TriWest
June 30, 2017 and January 31, 2018

Expansion of the Colorado Crisis System Report (C.R.S. 27-60-103 (6) (c))
Colorado Department of Human Services, Office of Behavioral Health
May 1, 2018

Survey of Community Mental Health Centers in Colorado Regarding Mental Health Services for Individuals with Intellectual or Developmental Disabilities
Center for Research Strategies
May 2018

State of Colorado Analysis of Services Utilized by Individuals with Intellectual and Developmental Disabilities
Optumas
April 2019

State Fiscal Year July 1, 2015 through June 30, 2016

		Region 1			*Region 2*			
	RMHP	Foothills Gateway	Summit Stone	STRiVE	Mountain Valley	Comm. Options	Mind Springs	Total
Capital								
Lease-Homes								
Adult - Promise House		45,900						45,900
Child - Clearview		37,023						37,023
Adult- 181 Elm				83,304				83,304
Child - 2206/2204 N. 6th				42,500				42,500
Furnishings								
Promise House/Clearview		5,235						5,235
181 Elm/2204-2206 6th				18,845				18,845
Property Upgrades								
Clearview		4,577						4,577
Adult- 181 Elm				107,860				107,860
Child - 2206/2204 N. 6th				6,855				6,855
Painting			2,987					2,987
Personnel								
Steering		1,520	375	688	125	125	875	3,708
Planning		1,560	1,406	600	600	938	1,500	6,604
Committee Planning		2,438		5,775				8,213
Staff Training		3,489	6,730					10,219
Residential Manager		1,457		2,993				4,450
Behavioral Specialist Training Staff		134						134
Consulting	24,475							24,475
Other				14,855				14,855
Supplies & Equipment								
Computer		4,862		21,061				25,923
Medical		1,341		5,441				6,782
Office		647		3,708				4,355
Program		1,845		10,980				12,825
Operating								
Training Materials	89,184	525						89,709
Cirrus MD	125,000							125,000
Recruiting				20,000				20,000
Auto Leases		38,000		36,828				74,828
Auto Insurance		269						269
Occupancy								
Home Insurance		24						24
Repairs				6,120				6,120
Utilities		90		18,576				18,666
Lawn Care/Snow Removal		4,253						4,253
Rounding		1		(1)				
Grand Total	238,659	155,190	11,498	406,988	725	1,063	2,375	816,498

State Fiscal Year July 1, 2016 through June 30, 2017

		Region 1			*Region 2*			
	RMHP	Foothills Gateway	Summit Stone	STRiVE	Mountain Valley	Comm. Options	Mind Springs	Total
Capital								
Furnishings								
181 Elm/2204-2206 6th				2,004				2,004
Personnel								
Steering		8,520	1,925	4,450	1,625	725	1,813	19,058
Planning		13,848	12,069	1,538	3,458	10,313	5,317	46,543
Committee Planning		19,407						19,407
Staff Training		11,940	2,740		4,369	1,782	117	20,948
Marketing		583						583
Residential Manager		13,281		43,087				56,368
Staff	108,665			371,389				480,054
Behavioral Specialist Staff		58,853						58,853
Behavioral Specialist Training Staff		749						749
Case Management		13,347		82,077		42		95,466
Audit/Reporting		802			255	21		1,078
Consulting	35,233							35,233
On-Call Week		25,211			20,971	13,224		59,406
On-Call Weekend						8,832		8,832
Crisis					2,400	892		3,292
Clinical Personnel			221				12,347	12,568
EHR Personnel							21,818	21,818
Other	22,464	(779)						21,685
Supplies & Equipment								
Computer				1,498				1,498
Medical		6		200				206
Office		154		294				448
Program		1,593		15,446				17,039
Operating								
Training Materials	61	138		47		82		328
Auto Insurance		3,399		4,137				7,536
Auto Other		798		1,057				1,855
Mileage	419	122			472			1,013
Client Services								
Psych Services		1,838		884				2,722
Staff Support				3,728				3,728
Other		270		24,425				24,695
Occupancy								
Home Insurance		498		627				1,125
Repairs		257		32,671				32,928
Utilities		1,930		3,181				5,111
Internet/Phone		2,974		5,669				8,643
Lawn Care/Snow Removal				2,821				2,821
Indirect								
Lodging & Employee Food	1,303	1,146		478				2,927
In-Kind	(30,600)			(30,361)				(60,961)
Miscellaneous				(198)				(198)
Revenue Offsets								
Medicaid Waiver Revenue		(17,125)		(74,144)		(1,206)		(92,475)
Variance from Support to Expense Tracker				34				34
Rounding	(1)	(1)		(2)	1	(1)		(5)
Grand Total	137,544	163,759	16,955	497,037	33,550	34,706	41,412	924,963

State Fiscal Year July 1, 2017 through June 30, 2018

		Region 1			*Region 2*			
	RMHP	Foothills Gateway	Summit Stone	STRiVE	Mountain Valley	Comm. Options	Mind Springs	Total
Capital								
Furnishings								
181 Elm/2204-2206 6th				544				544
Personnel								
Steering	1,493	3,000			263	57	250	5,063
Planning		6,024	3,131		450	563	113	10,280
Committee Planning		8,483						8,483
Staff Training		70,516					448	70,964
Residential Manager		2,343		104,153				106,496
Staff	126,600		17,293	159,255				303,148
Behavioral Specialist Staff		15,823		37,916				53,739
Case Management		5,456		17,050				22,506
Audit/Reporting		4,133						4,133
On-Call Week		39,097		16,229	12,074	2,016		69,416
On-Call Weekend						1,824		1,824
Crisis					1,500			1,500
Clinical Personnel							6,840	6,840
EHR Personnel							2,591	2,591
Other	1,872		2,240		4,585		751	9,448
Supplies & Equipment								
Computer				2,084				2,084
Medical		12		82				94
Office		104		163				267
Program		667		5,735				6,402
Operating								
Training Materials		130		53,553				53,683
Auto Insurance		2,013		4,298				6,311
Auto Other		737		1,967				2,704
Mileage	291	493	170			83		1,037
Other				1,879				1,879
Client Services								
Psych Services		864		3,246				4,110
Staff Support		2,754		26,268				29,022
Other				2,630				2,630
Occupancy								
Home Insurance		360		569				929
Repairs				4,323				4,323
Utilities		2,055		3,218				5,273
Internet/Phone		2,680		5,335				8,015
Lawn care/Snow removal				2,203				2,203
Other				789				789
Indirect								
Lodging & Employee Food	1,939	3,076		1,027		89		6,131
In-Kind		(11,612)						(11,612)
Miscellaneous	5,815	11,061						16,876
Revenue Offsets								
Medicaid Waiver Revenue		(16,399)		(51,187)				(67,586)
Variance from Support to Expense Tracker				8				8
Rounding	(1)	1		(1)	(1)	1		
Grand Total	138,010	153,871	22,834	403,336	18,871	4,631	10,993	752,547

Current service under CSCR Pilot and/or available through the state Crisis System	Is there funding to provide services post 6/30/2018? Barriers?	Possible Solutions
SummitStone (SHP), Community Crisis Center (CCC) or ER staff call Foothills Gateway (FGI) Agency On-Call after hours.	FGI currently provides after hours on call for emergency situations. This is an administrative function and required as part of our HCPF contract, but there is no state funding to cover this expense of Agency On-call.	State general funds allocated to Community Centered Boards (CCBs) to fund after-hours on call responsibilities to help defray the cost of after-hours emergency calls and emergency response for individuals in crisis.
FGI Agency On-Call contacts START Coordination/Residential Manager to dispatch FGI Direct Support Professionals (DSPs) to the CCC or ER for assessment and support.	There is currently no funding available to pay for FGI staff to support clinicians at the CCC or ER and to also support individuals with IDD in crisis at the CCC or ER.	Add a billing category through either State General Funds or HCBS that would pay for IDD staff support at the CCC/ERs for emergency situations (allowing HCBS PARs to be backdated since the PAR would have to be developed after the emergency situation is over). There is reimbursement from BHO Medicaid Crisis funding for a clinician's services for a person in crisis, but there is no reimbursement for the support services of an IDD professional at the CCC.
Adults with IDD can be admitted to the Crisis Stabilization Unit (CSU) for up to a 5 day stay.	There is no State General funding or HCBS funding available for IDD staff support of a person with IDD at the CSU.	Add a billing category option for State General funds or for HCBS funding that would pay for IDD staff support at the CSU for emergency CSU stay (allowing HCBS PARs to be backdated since the PAR would have to be developed either during or after the emergency situation – since crisis events can't be predicted).
Adults/children with IDD need step-down stabilization services for up to 30 days at a separate facility with trained IDD staff.	**CES/SLS** – Children can receive up to 30 full days of 'respite' per Service Plan year. However, families who have already utilized respite during the year, wouldn't have the full 30 days available to them. The hourly rate for respite services is $21.60 (daily rate of $215.86) which does not cover the cost of specialized staffing to provide the crisis stabilization services (which can be 2:1 staffing). **HCBS-DD** – There is no respite funding available for individuals receiving DD services. **Adults/Children not eligible for HCBS** – These individuals have no funding available to pay for stabilization services.	CES/SLS: Additional units for 'respite' (stabilization services or therapeutic respite) should be available to individuals who have been in crisis. These units would not be capped, and, for SLS, the SPAL shouldn't limit/restrict the option to receive more stabilization services. Increase the unit rate for crisis related 'respite' (for CES/SLS HCBS) to help cover the cost of the additional, specialized staffing. DD: There is no 'respite' billing category in DD. If step down stabilization services are needed for someone receiving DD, the agency providing the step down stabilization has to take the residential daily rate from the Program Approved Service Agency and the Host Home Provider to receive reimbursement for the step down stabilization (respite) services. Adults/Children not eligible for HCBS: Allocate state general funding that could be used to support individuals during crisis events in the IDD system and that would pay for step down stabilization services.
Funding is needed to pay for staffed settings that are utilized by individuals in crisis.	Funding is only available for specific services and the rate for specific services is based on the person's SIS Level.	For individuals in crisis who need stabilization services in a residential setting, provide a way for the CCB to request a SIS Level increase to a Level 7 for a 90 day to 6 month period of time. By allocating a higher level of funding the CCB or PASA will be able to provide the additional staffing needed and the additional supports that are needed to help the person stabilize from the crisis event.

Current service under CSCR Pilot and/or available through the state Crisis System	Is there funding to provide services post 6/30/2018? Barriers?	Possible Solutions
Person with IDD needs Behavioral Assessment, Consultation, and Counseling Services.	**CES** – Behavioral Services have to be set up for the child through the Medicaid State Plan (not available through HCBS). Families need support to get the order from the PCP, choose a Behavioral Services provider, set up appointments for assessment/consultation/counseling. **HCBS SLS/DD** - For individuals (SLS) in crisis, they either run into issues with not having room in their plan (due to the SPAL) for Behavioral Services or respite services, so the family/person either has to reduce other needed services to make room in the plan or go without the needed support services. Also, for individuals in SLS/DD who are frequently in crisis, Behavioral Services and very limited and units have usually been expended well before the end of the Service Plan. Once the Behavior Services units are expended, there is no current mechanism to add units until the beginning of the next Service Plan year.	**CES** – Add TCM units so case managers can support families in arranging for these services for a person who has been in crisis. Create an HCBS service option under the CES waiver that would allow for specialized IDD staff to support the family and the child during the Behavioral Services assessment phase for children who have been in crisis. **HCBS SLS/DD** – Create the option to increase Behavior Services if the person is either in crisis or is at risk of being in crisis. In crisis cases, allow flexibility in going over the SPAL amount for someone in SLS to make sure that needed services can be available. **Not eligible for HCBS/Medicaid:** Create a state general fund mechanism that could cover this cost for individuals who do not have/are not eligible for Medicaid/HCBS.
START Coordination	START Coordination provides intensive care management, assessment, resources and support.	Fund START Coordination and an Intensive Case/Care Management service through the IDD HCBS waivers. BHO Medicaid and the CMHS waiver have the option for TCM **and** also "Intensive Case Management" services: Intensive Case Management services are described as: Community-based services averaging more than one hour per week, provided to adults (children can receive this through EPSDT) with serious behavioral health disorders who are at risk of more intensive 24-hour placement and who need extra support to live in the community. Services are assessment, care plan development, multi-system referrals, and assistance with wraparound and supportive living services, monitoring and follow-up (language is from the BHO Uniform Service Coding Manual). The IDD system would also benefit from this additional level of service for individuals with IDD who have been in crisis. CCBs/IDD providers cannot provide or bill for the Intensive Case Management services since it's a unique service component **only** through the BHO Medicaid system.

Current service under CSCR Pilot and/or available through the state Crisis System	Is there funding to provide services post 6/30/2018? Barriers?	Possible Solutions
Crisis Stabilization for Children	Crisis stabilization services (for children) have been provided at the houses operated by Strive/Foothills Gateway. There are no other options for children's stabilization services other than to go to a higher level of care.	Children do have the option of inpatient hospitalization funded through Medicaid, however, there are no inpatient hospitals in Larimer County for children and they must go to Denver. Ideally, having a Crisis Stabilization Unit or setting available for children would reduce the incidences of referrals to higher levels of care when that level of care may not be needed (also, it's more cost effective than hospitalization and would keep children in their home communities).
FGI Case Management and Crisis Staff attend discharge meetings from Crisis Stabilization Units or other interdisciplinary meetings at the hospital or inpatient facility.	The FGI Case Manager can bill TCM for these meetings (if there are TCM units available under the 240 unit annual cap). However, other crisis staff cannot bill for meeting attendance under any Medicaid/HCBS option.	Add an option to the waivers to allow for billing meeting attendance during crisis situations.
Ongoing psychotherapy services for individuals who have been in crisis, but have stabilized are not available to individuals with IDD who do not have a 'covered diagnosis'.	No. Per the Uniform Coding Standards Manual for billing BHO services, a 'covered diagnosis is required for reimbursement' once the person is no longer in crisis.	Add the option of Medicaid State Plan paying for ongoing psychotherapy services for a person with IDD, regardless of diagnosis, who had previously been in crisis.
Children with more complex and intensive support needs who are applying for or already enrolled with in CES receive supports/behavior interventions from CSCR Pilot trained Direct Support Professionals.	The rates for respite in CES and SLS are all set rates, and for SLS, not impacted by a person's SIS Level and support needs. The current hourly rate for CES/SLS respite is $21.60/hour. That rate does not cover the cost of 1:1 specialized staffing, and often, individuals who have been in crisis need 2:1 specialized staffing. There are currently children wanting CES who have higher levels of behavioral health support needs and cannot find agencies to provide their services.	Create a "Crisis Respite" or "Specialized Respite" rate category that would provide the funding necessary for providers to offer up to 2:1 specialized staffing to provide these much needed respite services.

SURVEY OF COMMUNITY MENTAL HEALTH CENTERS IN COLORADO REGARDING MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Improving Behavioral Health Services for Individuals With a Co-Occurring Intellectual or Developmental Disability And a Behavioral Health Condition

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SURVEY OF COMMUNITY MENTAL HEALTH CENTERS IN COLORADO REGARDING MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

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SURVEY OF COMMUNITY MENTAL HEALTH CENTERS IN COLORADO REGARDING MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Executive Summary

This report summarizes responses received from staff members in community mental health centers (CMHCs) in Colorado in response to a survey request that focused on challenges related to the delivery of mental health services, particularly for clients with intellectual or developmental disabilities (I/DD). The CMHC survey respondents highlighted factors that limit access to mental health services such as transportation, the ability to pay for services, and language barriers. A particular difficulty faced by Individuals with I/DD relates to their need to establish a covered diagnosis in order to receive services.

CMCHs have worked to enhance the availability of services by lengthening the times when services are available, expanding service locations and diversifying their staff. The continuity of mental health service delivery has been improved through strategies such as case management, peer support, drop-in engagement groups and same day access to services. CMHCs also work in partnership with local service agencies such as jails, crisis centers, hospitals and Community Center Boards in order to respond effectively to the needs of those seeking mental health services.

Clients whom CMHCs describe as the most challenging to stabilize during a mental health crisis include those with co-occurring substance abuse issues, the homeless, clients without a support network, adolescents and those who are not ready to engage in their recovery. According to the survey respondents, the ability of CMHCs to stabilize clients in crisis would be improved if a broader array of service facilities were locally available including agencies offering detox and inpatient services, respite providers and those managing transitional housing options. CMHC representatives also suggested that their agencies could benefit from being able to hire more clinicians and to cover medication assistance during crises. With respect to clients with I/DD, CMHC survey respondents acknowledged that placement entities and psychiatric facilities can be hesitant to accept those who are perceived as being difficult in particular clients with chronic or acute medical conditions and those with lower IQs or functional impairments.

The proportion of overall CMHC clients with I/DD is estimated to be less than 10 percent, although one CMHC that is participating in the Crisis Pilot program has seen the number of clients with I/DD increase after a staff member was embedded at the local Community Center Board. Challenges identified in serving clients with I/DD relate to establishing eligibility, coordinating care delivery and finding long-term treatment options. Access to mental health services for clients with I/DD is also impacted by the lack of specialized providers, limited numbers of residential facilities and restrictions related to the coverage for services. Other issues specific to the delivery of services to clients with I/DD include the need to confirm the presence of a diagnosis covered by the CMHC and the interface between developmental disabilities and a client's presentation of mental health symptoms.

Assessment protocols tailored to clients with I/DD vary. While some CMHC survey respondents indicated their assessment, protocols were the same for all clients, others seek additional information

from medical records, interview caregivers and utilize protocols established in conjunction with Community Center Boards to assess and diagnosis mental health conditions in clients with I/DD.

To be able to better respond to clients with I/DD who are in crisis, CMHC survey respondents recommended that additional resources be allocated to continue work that is already underway and potentially expand these services to more locations. Other suggestions focused on training, referral resources and expanding the ability of CMHCs to cover medication services within walk-in centers.

According to the survey respondents, clients with I/DD who are seeking mental health services would benefit from having access to clinicians with specialized training as well as an I/DD specific array of services. Barriers to improved service for clients with I/DD include cost, a lack of community resources and a lack of trained providers with specialized credentials. Other challenges relate to the lack of covered diagnoses and the difficulty of setting up programming for a limited number of clients with I/DD who live in rural/frontier settings. Increased funding and reimbursement reforms related to I/DD diagnoses, capitated rates and additional support for specialized positions were recommended.

All of the CMHCs agreed that their staff members would benefit from training particularly related to the diagnosis and assessment of mental health issues in clients with I/DD. Relative to possible reforms that would improve access to mental health services for clients with I/DD, CMHC survey respondents favored waiver initiatives, enhanced capitation rates and specialized service delivery programs tailored to clients with I/DD.

SURVEY OF COMMUNITY MENTAL HEALTH CENTERS IN COLORADO REGARDING MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Background and Methods

In response to identified gaps in the availability of mental health services for individuals with intellectual or developmental disabilities (I/DD), the Colorado legislature passed HB 15:1368 in June 2015. As part of this legislation, the Colorado Department of Health Care Policy and Financing (HCPF) was directed to gather information regarding the structural changes that would help remove barriers limiting the ability of individuals with I/DD to access mental health services. Potential changes to be considered included possible reforms within the Medicaid state plan, home- and community-based service Medicaid waivers, the capitated mental health care system, and the Colorado behavioral health crisis response system.

In January 2018 in response to this directive, HCPF contracted with the Center for Research Strategies (CRS) to gather information from a number of different sources in order to identify ways in which the delivery of mental health services in Colorado could be improved for individuals with co-occurring intellectual or developmental disabilities (I/DD) and behavioral/mental health conditions.

This report details information gathered from a survey distributed to community mental health centers (CMHCs) throughout Colorado to identify factors that limit access to mental health services and to research any particular challenges faced by clients with I/DD who are seeking mental health care.

In April 2018 CRS sent out a survey request to CMHC representatives. Contacts within the CMHCs were identified with the help of the Colorado Behavioral Healthcare Council which sent out an e-blast request to its members. In addition, CRS sent individualized survey invitations to CMHC representatives identified by staff members within the Colorado Crisis Response System regional network.

Profile of Responding Community Mental Health Centers

Between April – May 2018, 13 CMHC respondents reviewed the survey and selectively answered the questions that were posed. Respondents indicated that they occupied the following varied positions within their agencies:

- Chief Operating Officers or the Deputy Director of Operations (N=4)
- Program Directors, Administrative Directors or Deputy Directors (N=4)
- Clinical Directors (N=2)
- Executive Vice President (N=1) and
- Director of Access Services (N=1).

Observations Regarding the Delivery of Mental Health Services

Challenges Faced in Accessing Mental Health Services

When asked to name the biggest challenges all clients face in accessing mental health services, respondents were able to select multiple options. The major challenges to service access that were identified were transportation, coordination with primary care providers and coordination with social service agencies, followed by payment for service and family support. Some respondents noted that continuity of services and access to individualized therapies were also difficult to access.

What would you say are the biggest challenges the clients you serve face in terms of accessing mental health services? (Select all that apply)

Challenges	# of Responses
Transportation	5
Coordinating with Primary Care Providers	5
Coordinating with Social Service Agencies	5
Paying for Services	3
Family Support	3
Continuity of Services	2
Access to Individualized Therapies	1

When provided with the opportunity to provide open-ended responses, respondents identified several other challenges including: language barriers, wait time for scheduled appointments, client ambivalence, a lack of child care and not all clients with I/DD having a covered diagnosis.

No respondents indicated that clients face challenges in accessing crisis services.

Clients Who Have the Most Difficulty Accessing Mental Health Services

When asked which groups of clients have the most difficulty accessing mental health services, 11 respondents identified the following groups as facing access challenges. Client groups who struggle to obtain mental health care tend to be those who lack transportation, face payment difficulties, are non-English speakers and individuals with intellectual or developmental disabilities. A listing of all responses to this question is provided in Appendix A.

Transportation

- *Those who can't organize well enough to utilize Medicaid transport*
- *Homeless clients with no transportation*
- *Children who may not have a support network to provide transportation*
- *Elderly clients without means of transportation;*
- *Individuals who live in more rural areas and do not have transportation.*
- *People without transportation*
- *Clients in outlying counties*

Payment and Reimbursement Issues

- *Clients who do not have the resources or cannot prioritize mental health services given other socio-economic factors*
- *We are noticing that individuals with high-deductible health plans may be staying away from services due to the significant up-front costs.*

- *People with insurance that has high deductibles and poor mental health coverage*
- *Any clients who have high deductible health insurance plans*

Language barriers

- *Clients who are not English speaking*
- *Those who speak and write other than English.*
- *Clients whose native language is other than English*
- *Second language*

Individuals with intellectual or developmental disabilities

- *I/DD clients with Medicaid without a corresponding covered diagnosis where referring party believe person would benefit from therapy. This may be true and without another payer it is difficult to access services.*
- *Those with developmental disabilities*

Organizational Changes to Improve Access to Mental Health Services

Survey Respondents pointed to a number of organizational changes that have been made to improve the ability of clients to access mental health services. The most common reforms noted related to the lengthening of hours of service (e.g., same-day services and seven-day a week access) and expanded service locations. CMCHs have also worked to increase the diversity of their staff. See Appendix A for a full listing of all organizational changes that were described.

When asked, none of the CMHCs who responded to the survey indicated that they have a waiting list for clients to be seen.

Expanded Hours of Operation

- *We offer same-day services designed to offer individualized intervention rather than focus only on administrative intake*
- *7- day access to intake services*
- *Created same day intakes*
- *Same day access, 24-hour crisis services*
- *Walk-in intakes available at three locations 6 days a week*

Expanded Community Outreach

- *Offering services in many community locations (jails, schools, primary care, human services, etc.)*
- *Work with family members when the person has difficulty keeping appointments*
- *Bringing more services into the community*
- *We do have some public transportation in our larger communities and we have purchased bus passes for clients. We are also doing more "home based services" for clients who have difficulty getting to the center.*
- *Community based services*

Improved Diversity of Staffing

- *Hiring staff from diverse backgrounds with cultural and linguistic skills*
- *Language line*
- *Utilizing language-line and bi-lingual providers when we can recruit them*
- *Differentials for Spanish-speaking clinicians*

With reference to clients with I/DD, one CMHC noted several particular challenges related to the coordination of services, access to respite services and funding limitations.

- *We've participated in the I/DD Pilot to make sure I/DD clients at least have easy access to crisis services; however, this has been somewhat compromised by a lack of participation by the local CCB as well as lack of respite services within region as well as insufficient respite services in GJ. Considering the lack of behavioral health supports in general for this population, we would like to expand services, but we need a way to fund it.*

Ability to Respond to Client Crises

On a scale between 1 = (Not Well) and 5 = (Very Well), survey respondents were asked to rate their ability to respond to client needs in a way that minimizes the chance that a crisis will occur. The seven CMHC representatives who answered this question rated their ability to prevent crises from occurring to be 4.1 with a range between 3 and 5.

Follow-up Protocols

CMCHs described a broad array of services to assure the continuity of service delivery including case management, peer support, drop-in engagement groups and same day access to services. Relative to crisis services, some CMHCs have walk-in crisis clinics that operate 24 hours a day, seven days a week with post-crisis follow-up to monitor patient safety and welfare.

- *We have our Walk in Crisis clinic open 24 hours a day, 7 days a week. Case management services, reminder calls for appointments.*
- *Follow up from crisis is a phone call/outreach within 1 business day. Follow up from intake... we schedule an appointment*
- *if the question refers to post-crisis follow up, the agency routinely contacts individuals who have encountered crisis services to assess their continued safety. Clients who are seen in crisis are routinely scheduled for follow up appointments in outpatient office within 72 hours of crisis. Case Managers and Peers are often used to do outreach to these individuals.*

One CMHC respondent noted that the agency collaborates with the local Community Center Board, but the array of services that are available in the region is limited.

Coordination with Other Agencies

Each of the CMHC representatives described an array of community partnerships established through their case managers and care navigators with schools, jails, crisis centers and hospitals. Several CMHCs highlighted their collaborations with their local Community Center Board with one respondent commenting on the limited availability of services in rural/frontier communities.

- *Our case management services spend a great deal of their time connecting clients to agencies in the community.*
- *Our agency is located in rural/frontier communities where very few, if any community settings exist. When needed, the agency coordinates or assists community partners with placement of individuals in facilities outside of our geographic region*
- *Embedded staff in other agencies such as Community Center Board agency, homeless services, primary care, schools, etc.*

Populations Most Challenging to Stabilize During a Mental Health Crisis

Clients whom CMHC representatives describe as the most challenging to stabilize during a mental health crisis are those with co-occurring substance abuse issues and the homeless. Others include those without a support network, adolescents and clients who are not ready to engage in their recovery.

Several CMHCs referenced specific challenges related to individuals with I/DD.

- *Clients with chronic/acute medical conditions or I/DD clients with low IQ/functional impairments (when an inpatient treatment facility is required)*
- *I/DD, while rare for us, is the most difficult due to lack of resources in region and the difficulty it is to get this client type placed.*

Factors that make stabilizing these clients challenging relate to insufficient regional resources, limited qualified providers and difficulties securing living situations. Clients without a support network have difficulty being able to stabilize after a crisis. Even when facilities are available, some are reluctant to accept clients who are perceived as difficult.

- *Most psychiatric facilities are hesitant to accept clients with those impairments/conditions (Clients with chronic/acute medical conditions or I/DD clients with low IQ/functional impairments)*
- *Insufficient resources in region and out along with many of the possible placement entities being unwilling to take this client type. (I.e., clients with I/DD)*

Resources to Help CMHCs Respond to Clients in Crisis

CMHC representatives suggested that their ability to respond to clients in crisis would be improved if a broader array of service facilities were available including agencies offering detox and inpatient services, respite providers and those managing transitional housing options. They also noted that their agencies could benefit from being able to hire more clinicians and to cover medication assistance during crises.

- *Our community is in need of local detox services, and CSU level of care for adolescents (we have an adult CSU).*
- *More respite providers, higher level of care facility that will receive this client type, and funding to support treatment services around some of the social supports that community members often want addressed even when a covered diagnosis doesn't exist.*
- *There is no financially sustainable system in place for medication assistance during crisis.*
- *A more robust workforce to meet the needs of the community. Colorado unemployment coupled with all other centers hiring for the same positions leaves too many open positions at the Center.*

Patterns of Mental Health Service Delivery

CMHC representatives estimated that the proportion of clients with I/DD seen in the last year was less than 10 percent, with one respondent saying that he/she did not know. One agency noted that the volume of clients with I/DD seen in the most recent year was changing because of a staff member embedded at the local Community Center Board.

In serving clients with I/DD, CHMCs face particular challenges related to establishing eligibility, coordinating care delivery with other agencies and caregivers and finding long-term treatment options. Fewer CMHC survey respondents identified clinical challenges such as assessment, diagnosis or treatment planning as complicating the delivery of mental health services to clients with I/DD. No respondents indicated that they had difficulties integrating the delivery of mental health care with primary health care services.

What particular challenges does your CMHC face in serving individuals with I/DD who also have mental health problems? (Select all that apply.)

Challenges Serving Individuals with I/DD and Mental Health Problems	# of Responses
Establishing eligibility for services	5
Coordination of services with other agencies	4
Coordination of services with caregivers	4
Identifying long-term treatment options	4
Assessment/diagnosis	2
Treatment	2
Creating individualized treatment plans	1
Integrating the delivery of mental health care with primary health care services	0

Other challenges identified were:

- *Coverage for services*
- *Lack of host-homes or residential facilities; lack of ABA-trained staff*
- *Having qualified providers with training in caring for I/DD issues*
- *Staff with knowledge and experience with the population*

Several factors were identified by the survey respondents as complicating the delivery of services to clients with I/DD including the need to confirm the presence of a diagnosis covered by the CMHC and clarification regarding the interface between developmental disabilities and a client's presentation of mental health symptoms. Other issues involve confirming a client's eligibility for CMHC services, involving caregivers and family members in the provision of therapeutic supports and determining the most appropriate treatment options.

Relative to service reimbursement, which of the following factors complicate the delivery of services to clients with an intellectual or developmental disability? (Select all that apply.)

Factors that Complicate the Delivery of Services to Clients with I/DD	# of Responses
Confirming the presence of a diagnosis covered by the CMHC	7
Clarifying the role of an I/DD vis-à-vis mental health symptoms	6
Clarifying eligibility for CMHC services	4
Providing therapeutic supports to caregivers and family members	4
Determining appropriate treatment options	3
Addressing possible drug interactions	2
Determining the appropriate length of treatment	1
Confirming the stabilization of a mental health problem	1
Enabling the I/DD client to receive services in the least restrictive setting	1

Protocols for Assessing Client Needs

Details regarding the assessment protocols used by individual CMHCs when a client is first seen are provided in Appendix A. In general, the intake process addresses the client's history, presenting issue, screening results and based on this information a treatment plan is developed and an appointment is made with an appropriate clinician.

Some CHMCs have specialized teams to deal with clients with I/DD, the homeless and clients who are home-based.

A typical first interview averages 90 minutes with a range between 60 minutes to two hours. One CMHC representative reported that an interview typically takes one hour while another hour is required to write-up the results. Another commented that interviews take longer with specialized client groups.

Of the seven CMHC respondents, four indicated that their agency has staff members trained to assess clients who have language difficulties while three others said this is not the case.

Respondents were provided with a series of strategies designed to assist clients with language difficulties including: translation services, specialized training to assist clients with speech difficulties, specialized assessment tools for clients with language impediments and customized assessment protocols for clients with I/DD.

- Seven CHMCs offer translation services.
- One CMHC employs specialized assessment tools for clients with language impediments.
- One CMHC uses customized assessment protocols for clients with I/DD.

Other methods available to address clients with speech and language difficulties include the use of Contigo for the hard of hearing.

Assessment Protocols for Clients with I/DD

When asked about the protocols that clinicians use when interviewing clients with I/DD, two CMHCs indicated that the assessment protocols were the same as those used for other clients. Two of the CMHCs reported that they have staff embedded at the local Community Center Boards (CCB) and work in conjunction with the CCB to coordinate the delivery of services. Other CMHCs seek additional information from the client's medical records and from caregivers.

- *Comprehensive clinical assessment which relies heavily on information provided by collateral sources; we typically seek medical/clinical/academic records from other providers to better ascertain client's level of functioning and treatment history*
- *Determine whether there is a mental health diagnosis that is co-occurring with the developmental disability. Determine who are the caregivers, and how we can most effectively provide coordination with them. Develop individualized treatment plan.*
- *We have staff embedded at CCB so the case manager at CCB contacts therapist to set up assessment. Clients identified through Crisis are referred to CCB and the two agencies work jointly to assure client receives services.*
- *Many come in through the same access system that other clients do. However, many are referred through the Community Center Board to our embedded staff member(s) in their programs.*

Of the seven CHMC respondents, three indicated that diagnosing mental health problems in individuals with I/DD is difficult with one reporting that it is very difficult. By contrast, four others described this process as being "neither easy nor difficult."

Several CMHC representatives commented on communication challenges relative to the ability of a client with /DD to describe his/her symptoms. One respondent pointed out that making a differential diagnosis for clients with more severe I/DD requires particular skills. Another noted that when clients must rely on family members to communicate their needs, their voices are sometimes not heard.

- *Lack of skill in differential diagnosis, particularly if the I/DD diagnosis is severe.*
- *The person can have a limited speech, impaired ability to communicate, or difficulty describing or verbalizing symptoms. It is difficult to discern whether or not the symptoms endorsed are indicative of DD or an actual SPMI diagnosis.*
- *Most recently, we had a client who relied on his family for communication. We often see caregivers/parents who explain the need for MH services. The client's voice is often lost or difficult to hear.*

When asked what resources, if any, would help the CMHCs to be able to better respond to clients in crisis, several respondents recommended that additional resources be allocated to continue work that is underway and potentially expand these services to more locations. Other suggestions focused on training, referral resources and an expanded ability to cover medication services within walk-in centers.

- *Our center has been involved in the pilot matching CCBs and Crisis which has been tremendously helpful in combining forces to best serve this population. We would encourage resources to continue.*
- *Additional resources to offer walk-in services in more locations and/or add mobile crisis teams to address people in outlying parts of our very large county.*

- *Training, additional referral resources for respite and higher LOC providers*
- *I think it would be nice to have a crisis clinic that can also prescribe medications that way people who run out of meds don't decomp.*
- *In general-- centers would benefit from funds to provide medication services in the walk-in crisis centers.*

Patterns of Mental Health Care for Clients With I/DD

Most CMHC representatives (four out of six) believe it is either likely or very likely that clients with I/DD will experience mental health problems compared to the general population. Two responded that it was neither likely nor unlikely.

When asked what types of services are available for clients with I/DD, the most common responses were tailored medication management/evaluation and cross-system coordination of services. Two CMHCs report that they develop functional behavior plans in cooperation with caregivers and family members. No CMHCs said that they conduct augmented assessments using assessment tools tailored for clients with I/DD.

In addition to these options, one CMHC reported that they have clinical staff members embedded at the local Community Center Board. Another CMHC said that they do not provide any special services for clients with I/DD.

Which of the following services are available through your CMHC for clients with intellectual or developmental disabilities? (Select all that apply.)

Additional Service Options	# of Respondents
Tailored medication management and evaluation	5
Cross-system coordination of services	5
Development of functional behavior plans developed with caregivers and family members	2
Augmented assessment with assessment tools tailored for clients with I/DD	

Additional Mental Health Services for Clients with I/DD

CMHC representatives listed additional mental health services that they believe clients with I/DD would benefit from, but which are not typically available including specialized teams and providers with specialized training. Other suggested options include developing an I/DD specific service array, peer support and applied behavior analysis (ABA).

- *Specialized teams to provide services to this population.*
- *Specialized training for staff -- START training very beneficial but costly*
- *I think they need a person assigned to them to help them through the process of getting connected to a mental health center*
- *I/DD specific service array.*
- *Peer support from individuals with I/DD and MH issues.*
- *ABA services*

One respondent made a general observation regarding the capacity of CMHCs to serve clients with I/DD, writing: "*I do not believe our clinicians have enough training or knowledge in I/DD. There are very few providers willing to take on clients with I/DD and MH issues.*"

Barriers to improved service ability for clients with I/DD identified by the survey respondents included cost, a lack of community resources and a lack of trained providers with specialized credentials. One CMHC representative commented on the lack of covered diagnoses and the difficulty of setting up programming for a limited number of clients with I/DD who live in rural/frontier settings.

- *Cost*
- *I think the main barrier is people with ID and DD have a great deal of difficulty communicating their needs and providers in Mental Health need a lot of training to help, but usually mental health providers choose in school to serve people with mental health issues and not the DD ID community.*
- *Lack of local community resources; difficulty hiring staff with specialized credentials*
- *A lack of covered diagnosis complicates the matter due to lack of funding. In a rural and frontier setting the low number of persons in this client type also make it difficult to set up programing for so few.*

Commenting on the types of reforms that would enable these services to become more available, the CMHC survey respondents focused on increased funding and reimbursement reforms relative to I/DD diagnoses, capitated rates and additional support for specialized positions.

- *Increased financing*
- *incorporating I/DD diagnosis in covered list and add the financial resource into the RAE capitation rates.*
- *Breaking down barriers of I/DD being fee-for-service, and MH being capitated; requirements for improved coordination, task forces to create a new system of care. Funding for treatment, specialized positions.*
- *I think you need to incentivize providers to serve people with DD and ID*
- *Financial resources specific to challenges of rural/frontier communities*
- *Flexible funding regardless of covered diagnosis similar to the 6 sessions in primary care, a state-lead effort to establish a training system for an EBP for this population that is easily supported within the rural/frontier settings with low population occurrence.*
- *Mandated provider at each center to care for individuals with I/DD. Funding to staff a licensed clinician who specializes in I/DD services.*

Training for Clinicians Providing Mental Health Care to Clients with I/DD

Most CMHCs reported that they do not have any staff members with specialized experience in providing mental health services to clients with I/DD. Of the seven who responded, five indicated that their agencies did not have specialized staff or that they could not answer the question. Only two CMHC survey respondents said that their agency had staff members with specialized training or experience related to serving clients with I/DD. In one of these agencies, the local Community Center Board provides person centered training to any new employees who will be working with clients with I/DD. In the past, this training has been provided through the START program although this is no longer the case.

All of the CMHCs reported that their staff members would benefit from training that would enable them to better serve the needs of clients with I/DD. While several of the survey respondents indicated that any type of training would be beneficial, others suggested more specific training topics related to applied behavior analysis, developing behavior plans and assessing individuals with low verbal skills. One respondent suggested that the START program training could be beneficial despite its intensive time commitment.

- *Many of our providers have not received any training on working with individuals with an I/DD. I'm not sure of what to recommend for training but know that if we want to expand our services to meet the need, a formalized training across systems is needed.*
- *ANY training: Differential diagnosis, assessment, treatment planning, care coordination*
- *Traditional class room, on-line, reading, pod casts.*
- *Applied Behavioral Analysis*
- *Developing behavioral plans. Assessing individuals with low verbal skills*
- *START for some, though this is time consuming with ongoing intensive obligations.*

When offered a list of possible training topics, those identified by the CMHC survey respondents as likely to be of most benefit to their teams related to the diagnosis of mental health issues in clients with I/DD, assessment, positive behavior support and behavioral assessments, with other training topics listed within the table below also recognized as being of benefit.

Please check the types of training that you believe would benefit your team? (Select all that apply.)

Recommended Training Topics	# of Responses
Diagnosis of mental health issues in clients with I/DD	7
Assessment	6
Positive behavior support	6
Behavioral assessments	6
Psychotherapy	4
Crisis prevention and intervention	4
Bio-psycho-social approaches	3
Psychopharmacology	3
Assessment of medical conditions	3
Medication	3

CMCH survey respondents agreed that incentives would encourage their staff members to receive training including making the training easily accessible, providing on-site training, developing train the trainer options and covering training costs. One respondent suggested that it would be helpful if the agency was required to have a designated staff position devoted to clients with I/DD as part of their contract.

What resources, if any, would provide an incentive for staff members within your CMHC to receive this training? (Select all that apply.)

Training Incentives	# of Responses
Easy access to training (i.e., online)	6
On-site training	6
Train the trainer options	6
Reimbursement for cost of training	5

Suggested Reforms for Improving Mental Health Services to Clients with I/DD

Relative to possible reforms that would improve access to mental health services for clients with I/DD, CMHC survey respondents tended to prefer waiver programs, enhanced capitation rates and specialized service delivery programs tailored to clients with I/DD while half suggested that pilot programs could be instituted to fund a comprehensive array of health and social services for those with intellectual or developmental disabilities.

Given the challenges associated with providing mental health services to clients with intellectual or developmental disabilities, what are the types of reforms that would improve their access to services?

Recommended Reforms	# of Responses
Waiver programs featuring care coordinators who can facilitate access to services	6
Enhanced capitation to CMHCs to support added costs associated with serving this population	6
Specialized service delivery programs tailored to clients with I/DD	5
Pilot programs that fund a comprehensive array of health and social services	3

Additional comments provided by survey respondents regarding ways to improve mental health services for clients with I/DD are provided below.

- *We appreciate the opportunity to comment on this survey. This is an extremely important, and under/inappropriately served population in Colorado and particularly with CMHCs. We applaud your efforts.*
- *There is too small of a pool of specialty providers in this area-- numbers seeking care are small and thus, there is a need for a network of known providers in our region who can best handle referrals. I'm not sure this needs to be at the CMHC level. Knowing where to refer to a specialist would be useful.*
- *The pilot was successful.*
- *Consider similar conversations for SUD integration*

Conclusions

Among the CMHCs throughout Colorado, seven provided substantive answers and comments in response to a survey that sought to identify challenges related to the delivery of mental health services, particularly for clients with I/DD. Since the survey respondents were not asked to identify their agency affiliations, we are unable to determine how representative these responses are relative to the experience of all CMHCs across the state.

According to the survey respondents, Individuals with I/DD who have co-occurring mental health conditions are among those who face challenges in accessing mental health services. Along with difficulties related to transportation, the ability to pay for services, and language barriers, clients with I/DD find their access to mental health services is limited by their need to establish a covered diagnosis in order to receive services.

Even as CMHCs have instituted a number of strategies to improve access to mental health services, they reported that their ability to stabilize clients in crisis would be improved if a broader array of service facilities were locally available related to detox and inpatient services, respite and transitional housing. With respect to clients with I/DD, CMHC survey respondents acknowledged that placement entities and psychiatric facilities can be hesitant to accept clients who are perceived as being difficult in particular those with chronic or acute medical conditions and those with lower IQs or functional impairments.

Other challenges identified in serving clients with I/DD relate to establishing eligibility, coordinating care delivery and finding long-term treatment options. CMHC survey respondents also noted the lack of specialized providers, limited numbers of residential facilities and restrictions related to the coverage for services., as factors affecting the delivery of mental health services to clients with I/DD.

According to the survey respondents, increased funding and reimbursement reforms related to I/DD diagnoses, capitated rates and support for specialized positions would enable more clients with I/DD to have access to clinicians with specialized training as well as an I/DD specific array of services. Expanded training programs would also permit the CMHCs to improve the diagnostic and treatment options that are available to clients with I/DD and co-occurring mental health conditions.

APPENDIX A
LISTING OF ALL RESPONSES TO OPEN-ENDED QUESTIONS

Responses Regarding Which Groups of Clients have the Most Difficulty Accessing Mental Health Services

- Clients who are not English speaking and/or who do not understand how the system functions; clients who do not have the resources or cannot prioritize mental health services given other socio-economic factors
- Those with developmental disabilities, those who can't organize well enough to utilize Medicaid transport
- Homeless clients with no transportation; children who may not have a support network to provide transportation; we are noticing that individuals with high-deductible health plans may be staying away from services due to the significant up-front costs.
- People with TBI, dementia, agoraphobia. Speak and write other than English.
- Elderly clients without means of transportation; clients whose native language is other than English
- Individuals who live in more rural areas and do not have transportation.
- I/DD clients with Medicaid without a corresponding covered diagnosis where referring party believe person would benefit from therapy. This may be true and without another payer it is difficult to access services.
- Substance abuse clients and any clients who have high deductible health insurance plans
- Second language, people without transportation, people with insurance that has high deductibles and poor mental health coverage
- Clients who are court ordered, clients with dual diagnoses, clients who want evening appointments only
- Clients in outlying communities

Responses Regarding the Types of Organizational Changes the CMHC has Put into Place to Help Improve the Ability of Clients to Access Mental Health Services

- We offer same-day services designed to offer individualized intervention rather than focus only on administrative intake; offering services in many community locations (jails, schools, primary care, human services, etc.) and hiring staff from diverse backgrounds with cultural and linguistic skills.
- 7-day access to intake services. We have had a significant caseload management project at our Center in our outpatient offices in order to reduce the number of disengaged clients to allow for increased access to services for existing clients.
- Created same day intakes, language line, work with family members when the person has difficulty keeping appointments
- Bringing more services into the community; utilizing language-line and bi-lingual providers when we can recruit them
- We do have some public transportation in our larger communities and we have purchased bus passes for clients. We are also doing more "home based services" for clients who have difficulty getting to the Center.

- We've participated in the I/DD Pilot to make sure I/DD clients at least have easy access to crisis services; however, this has been somewhat compromised by a lack of participation by the local CCB as well as lack of respite services within region as well as insufficient respite services in GJ. Considering the lack of behavioral health supports in general for this population, we would like to expand services, but we need a way to fund it.
- Sliding fee changes
- Differentials for Spanish-speaking clinicians, home based team, same day access, 24-hour crisis services
- Walk-in intakes available at three locations 6 days a week
- Community Based Services

Follow-Up Services that are Available

- We have our Walk in Crisis clinic open 24 hours a day 7 days a week. Case management services, reminder calls for appointments.
- if the question refers to post-crisis follow up, the agency routinely contacts individuals who have encountered crisis services to assess their continued safety. Clients who are seen in crisis are routinely scheduled for follow up appointments in outpatient office within 72 hours of crisis. Case Managers and Peers are often used to do outreach to these individuals...
- We are able to collaborate with our CCB, however, the available services are limited within region.
- Case management, peer support, drop in engagement groups, same day access,
- I'm not sure what this question is asking. Follow up from crisis is a phone call/outreach within 1 business day. Follow up from intake... we schedule an appointment.
- Peer Support, clubhouse services, PRN (drop-in Services)

CMHC Coordination with Other Agencies to Place Clients in Appropriate Community Settings

- We have multiple community partnerships to coordinate care, including schools, jails, other crisis centers, hospitals, etc.
- Our case management services spend a great deal of their time connecting clients to agencies in the community.
- Our agency is located in rural/frontier communities where very few, if any community settings exist. When needed, the agency coordinates or assists community partners with placement of individuals in facilities outside of our geographic region
- As stated we coordinate care with our CCB.
- Embedded staff in other agencies such as Community Center Board agency, homeless services, primary care, schools, etc.
- We have case managers and care navigators who coordinate with referral sources and connect to resources.
- We collaborate with most other community agencies

Client Populations Who Are the Most Challenging When It Comes to Stabilizing a Mental Health Crisis

- Individuals without a support network. Co-occurring populations. Individuals who are not at a place in their stage of change to engage. Individuals who are homeless.

- People who are currently using illegal substances and alcohol. Homelessness
- Clients with chronic/acute medical conditions or I/DD clients with low IQ/functional impairments (when an inpatient treatment facility is required)
- I/DD, while rare for us, is the most difficult due to lack of resources in region and the difficulty it is to get this client type placed.
- Adolescents as there are few crisis stabilization units for this age group in our area.
- Clients who have a history of violence and substance use-- can be very difficult to place for services.
- Homeless

Why are Those Populations the Most Challenging to Stabilize?

- Having a support network is crucial for recovery and stabilization. Not having a place to live makes it extremely difficult to stabilize or come back from a crisis, even in the absence of mental health issues.
- Because when a person is using illegal substances they have a difficult time seeing the connections of substances creating more instability in their lives.
- Most psychiatric facilities are hesitant to accept clients with those impairments/conditions
- Insufficient resources in region and out along with many of the possible placement entities being unwilling to take this client type.
- Few CSUs
- Hard to find qualified providers who can provide quality services. Safety concerns.
- Living situations cannot be readily found.

What Resources Would Help Your CMHC to be able to Better Respond to Clients in Crisis

- A more robust workforce to meet the needs of the community. Colorado unemployment coupled with all other centers hiring for the same positions leaves too many open positions at the Center.
- More money to hire more clinicians.
- Detox and inpatient facilities within our geographic region
- More respite providers, higher level of care facility that will receive this client type, and funding to support treatment services around some of the social supports that community members often want addressed even when a covered diagnosis doesn't exist.
- Our community is in need of local detox services, and CSU level of care for adolescents (we have an adult CSU).
- There is no financially sustainable system in place for medication assistance during crisis.
- Access to transitional housing

What is the Typical Protocol for Assessing a Client's needs when a Client is First Seen at the CMHC?

- Full biopsychosocial assessment
- We do a face to face mental health assessment. Minnie Mental Status Exam, RnL, SOCRATES, Psychocl Socal, Presenting Concern, PHQ9, Previous Mental Health Treatment, Risk Assessment, Cultural, Strengths, Safety Plan, Consumer Recovery Measure, and Recovery Measure Index
- Comprehensive clinical assessment, interview of collateral sources, screening

- We typically begin with various screenings, comprehensive diagnostic eval, explore collateral information from various sources, etc.
- Most clients access services through same-day access, where an intake assesses current need and history, and the client has an appointment with an ongoing therapist made upon departure. Specialized populations such as I/DD, homeless, home-based, etc. are referred to the identified team who reaches out to set up intake appointment.
- If the client comes through our traditional intake process, the intake involves a brief screening, comprehensive assessment, and treatment planning session. Following the intake, if the person is admitted to our organization for services the client will then be scheduled for an appointment with an appropriate clinician/provider.
- Initial appointment with MA level clinician to assess history, presenting issue, etc and determining initial treatment plan.