V. Key Trends and Other Background Information

A. Changes in State Statutes

Bill/State Statute	Title	Program	Description
HB 07-1005 / 24-33.5-415.8	CONCERNING AN ALERT PROGRAM FOR MISSING PERSONS WITH DEVELOPMENTAL DISABILITIES	Developmental Disabilities	Expands the missing senior citizen alert program to include persons with developmental disabilities. Requires local law enforcement agencies to assist in the recovery of such missing persons.
HB 07-1025	CONCERNING THE FUNDING OF CHILD WELFARE SERVICES AND IN CONNECTION THEREWITH REQUIRING THE STATE DEPARTMENT OF HUMAN SERVICES TO REVIEW RATES, SERVICES, AND OUTCOMES NEGOTIATED BY COUNTIES AND PROVIDERS.	Child Welfare	Requires the Department to promulgate rules regarding out-of-home provider rate-setting methodologies and to periodically review methodologies.
HB 07-1057	CONCERNING DEMONSTRATION PROGRAMS FOR INTEGRATED SYSTEMS OF CARE FAMILY ADVOCACY PROGRAMS FOR MENTAL HEALTH JUVENILE JUSTICE POPULATIONS.	Child Welfare Mental Health	Creates demonstration programs for system of care family advocates for mental health juvenile justice populations that are implemented and monitored by the Division of Mental Health in the Department of Human Services, with input, cooperation, and support services from the Division of Criminal Justice and in the Department of Public Safety, family advocacy coalitions, and the task force for the continuing examination of the treatment of persons with mental illness who are involved in the criminal and juvenile justice systems in Colorado.
HB 07-1062	CONCERNING THE CREATION OF A STATEWIDE SYSTEM OF EARLY CHILDHOOD COUNCILS	Child Care	The bill creates the Early Childhood (EC) Cash Fund. All monies are first appropriated to the Colorado Department of Human Services (CDHS) because it has governance over the councils. Under HB07-1062, new costs are incurred in CDHS to provide general oversight and support to the EC Councils and ensure each council develops and executes strategic plans to respond to local needs and conditions. These costs are identified at $51,743 in year one and $48,738 in year two. The department will require 1.0 FTE in both fiscal years.

Bill/State Statute	Title	Program	Description
HB 07-1064 / 24-33.5-415.9	CONCERNING GRANTS TO ENCOURAGE THE USE OF TRACKING TECHNOLOGY BY COUNTIES TO LOCATE PEOPLE WHO BECOME LOST AS A RESULT OF A COGNITIVE IMPAIRMENT.	Developmental Disabilities	Provides incentives to counties to develop Lifesaver Programs for people with medical conditions, such as Alzheimer's disease, autism, down syndrome, and other mental impairments that cause wandering.
HB 07-1100 / 39-26-123	CONCERNING AN INCREASE IN THE FUNDING TO THE OLDER COLORADANS CASH FUND FROM THE RECEIPTS COLLECTED FROM THE STATE SALES AND USE TAX, AND MAKING AN APPROPROPRIATION THEREEFOR.	Older Adult and Aging Programs	Increases funding to the Older Coloradoans Cash Fund in all future state fiscal years.
HB 07-1106	CONCERNING THE INCOME THRESHOLDS USED TO DETERMINE ASSITANCE GRANTS FOR ELDERLY AND DISABLED PERSONS	Aging	The legislation will increase property tax and heat rebate payments to eligible recipients by adjusting the amounts grant payments are reduced for recipient income. This increase in payments has the potential to increase or significantly impact the Department's Maintenance of Effort agreement with the Social Security Administration.
HB 07- 1117	CONCERNING THE REQUIREMENT THAT A PROTECTIVE HELMET BE WORN BY A PERSON UNDER EIGHTEEN YEARS OF AGE DURING THE OPERATION OF CERTAIN VEHICLES	Traumatic Brain Injury Program	Requires use of a helmet for both operators and passengers less than 18 years on motorcycle or motorized bicycle. Penalty and surcharge are $100 and $15, respectively. An additional surcharge of $10 to be deposited in the TBI Trust Fund per violation.
HB 07-1161	CONCERNING THE DEVELOPMENT OF JUVENILE SECREENING ASSESSMENT GUIDELINES FOR THE RELEASE OF JUVENILES FROM DETENTION	Youth Corrections	Requires that each Juvenile District Screening Team (22 judicial districts) be trained by the Division of Youth Corrections (DYC) to use the DYC risk assessment tool for use in determining which juveniles shall be recommended to the court for release from detention.
HB 07-1211 26-12-401	CONCERNING THE CREATION OF THE BOARD OF COMMISSIONERS OF STATE AND VETERANS NURSING HOMES IN THE DEPARTMENT OF HUMAN SERVICES.	State and Veterans Nursing Homes	Establishes an advisory board for the Office of State and Veterans Nursing Homes.

Bill/State Statute	Title	Program	Description
HB 07-1212	CONCERNING THE CREATION OF LOCAL ADVISORY BOARDS FOR STATE AND VETERANS NURSING HOMES IN THE DEPARTMENT OF HUMAN SERVICES.	State and Veterans Nursing Homes	Establishes a local advisory board for each home.
HB 07-1274	CONCERNING THE CREATION OF A COMMISSION FOR THE VISUALLY IMPAIRED, AND MAKING AN APPROPRIATION THEREFOR	Vocational Rehabilitation	Creates the Colorado Commission for Individuals who are Blind or Visually Impaired that shall serve as an advisory committee.
HB 07-1324 / 26-11-205.5	CONCERNING THE USE OF INTEREST EARNED ON THE OLDER COLORADANS CASH FUND FOR OLDER AMERICANS ACT PROGRAMS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.	Older Adult and Aging Programs	Allows for appropriations from the Older Coloradoans fund of accumulated interest to not be subject to the restriction that requires allocations as a whole.
HB 07-1349	CONCERNING CHILD SUPPORT OBLIGATIONS	Child Support Enforcement	This legislation implemented provisions of the federal Deficit Reduction Act (DRA) of 2005, assessing a $25 fee on custodial parents who have never received TANF once they receive $500 in annual collections, and requiring the review of child support orders of TANF recipients every 3 years. It also established the Gambling Payment Intercept Act, allowing for the intercept of casino and race track winnings to pay for child support arrearages; streamlined the process for reviewing child support orders; made changes to the child support guidelines to give credit for existing children regardless of birth order and credit for medical support when provided by a spouse; and a number of technical changes.

Bill/State Statute	Title	Program	Description
HB 07-1358	CONCERNING THE STUDY OF THE CRIMINAL JUSTICE SYSTEM, AND, IN CONNECTION THEREWITH, CREATING THE COLORADO CRIMINAL AND JUVENILE JUSTICE COMMISSION AND MAKING AN APPROPRIATION	Youth Corrections	Creates the Colorado Criminal and Juvenile Justice Commission. The mission of this Commission is to enhance public safety, ensure safety, protect the rights of victims, and ensure cost-effective use of public resources. The Commission consists of 24 voting members and housed within the Department of Public Safety. The Division of Criminal Justice is directed to provide staff assistance.
SB 07-002	CONCERNING EXTENDING MEDICAID ELIGIBILITY FOR PERSONS WHO ARE IN THE FOSTER CARE SYSTEM IMMEDIATELY PRIOR EMANCIPATION.	Child Welfare	Provides that the Health Care Expansion Fund can be used to provide Medicaid eligibility for persons who are in the foster care system immediately prior to emancipation.
SB 07-003	CONCERNING THE CREATION OF AN ADVISORY BOARD TO MAKE RECOMMENDATIONS CONCERNING COMPETENCY EVALUATIONS IN ADULT CRIMINAL CASES	Mental Health	Creates an advisory board to study and recommend standards regarding the level of training, education, and experience that a psychiatrist or psychologist shall have to be qualified to perform competency evaluations in criminal cases.
SB 07-004 / 27-10.5-701, 25.5-1-124 and 10-16-104	CONCERNING A COORDINATED SYSTEM OF PAYMENT FOR EARLY INTERVENTION SERVICES FOR CHILDREN ELIGIBLE FOR BENEFITS UNDER PART C OF THE FEDERAL "INDIVIDUALS WITH DISABILITIES EDUCATION ACT", AND, IN CONNECTION THEREWITH, REQUIRING THE DEPARTMENT OF HUMAN SERVICES TO DEVELOP A COORDINATED PAYMENT SYSTEM, REQUIRING COVERAGE OF EARLY INTERVENTION SERVICES BY PUBLIC MEDICAL ASSISTANCE AND PRIVATE HEALTH INSURANCE, AND MAKING AN APPROPRIATION.	Division for Developmental Disabilities	Requires the Department of Human Services to develop and implement, in coordination with the Departments of Education, Health Care Policy and Financing and Public Health and Environment, Division of Insurance, private health insurance carriers and Community Centered Boards, a coordinated system of payment for early intervention services using public and private funds. Requires group health plans to provide coverage for early intervention services for infants and toddlers with significant developmental delays or disabilities.
SB 07-14 26-12-108	CONCERNING THE APPROPRIATION OF FUNDS TO THE CENTRAL FUND FOR STATE NURSING HOMES.	State and Veterans Nursing Homes	Allows the General Assembly to give up to 10% of the 505 Fund in general fund dollars towards the operations and capital improvements of the state and veterans nursing homes.

Bill/State Statute	Title	Program	Description
SB 07-033	CONCERNING ADOPTION OF HIGH RISK CHILDREN	Child Welfare	Families who have adopted a child with emotional or mental health issues and have placed the child voluntarily through the Child Welfare system will not have to have a Dependency and Neglect Petition filed against them when the voluntary placement agreement expires.
SB 07-036	CONCERNING THE INCLUSION OF CERTAIN ADDITIONAL MENTAL DISORDERS IN THE MANDATORY HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS	Mental Health	Expands mandatory health insurance coverage to require coverage for mental disorders as defined in the 9th revision of the International Classification of Diseases (ICD-9).
SB 07-064	CONCERNING CREATION OF A TASK FORCE TO EXAMINE THE STATE'S SYSTEM OF CARE OF CHILDREN WHO ARE REMONVED FROM THEIR BIOLOGICAL PARENTS	Mental Health	Establishes a task force to address problems in the State's child foster care and adoption systems. Specifies the issues the task force shall consider. Directs the task force to report to the governor the chief justice of the Colorado Supreme Court and the judiciary and health and human services committees by 12/31/2007.
SB 07-096 / 18-4-401	CONCERNING THEFT FROM AT-RISK INDIVIDUALS	Developmental Disabilities	Expands the missing senior citizen alert program to include persons with developmental disabilities. Requires local law enforcement agencies to assist in the recovery of such missing persons.
SB07-097 – HB07-1359	CONCERNING THE ALLOCATION OF TOBACCO LITIGATION SETTLEMENT MONEYS THAT ARE NOT CURRENTLY REQUIRED TO BE ALLOCATED TO EXISTING TOBACCO SETTLEMENT PROGRAMS TO HEALTH-CARE RELATED PROGRAMS THAT, EXCEPT FOR THE CHILDREN'S BASIC HEALTH PLAN, DO NOT CURRENTLY RECEIVE TOBACCO LITIGATION	Alcohol and Drug Abuse Division Mental Health	Allocates 3% of 2nd Tier program funds to be allocated for the restoration and enhancement of community substance abuse prevention and treatment services. Requires tobacco litigation settlement moneys that are currently required to be credited to the general fund or the tobacco litigation settlement case fund to be allocated to healthcare related programs, entities, and funds that except for the children's basic health plan, do not currently receive tobacco litigation settlement monies.

Bill/State Statute	Title	Program	Description
SB 07-146	CONCERNING THE CREATION OF A PILOT PROGRAM TO PROVIDE MENTAL HEALTH SERVICES TO FAMILIES OF RECENTLY DISCHARGED VETERANS	Mental Health	Creates a 3-year mental health services pilot program for spouses and dependent children of discharged veterans of operation enduring freedom and operation Iraqi freedom. Authorizes the Department of Human Services to purchase mental health services from community mental health centers in Colorado Springs area for families of recently discharged veterans.
SB07-213	CONCERNING THE CONTINUATION OF THE LICENSING OF ADDICTION TREATMENT PROGRAMS BY THE DEPARTMENT OF HUMAN SERVICES	Alcohol and Drug Abuse Division	Continues the licensing of addiction treatment programs under the "Colorado Licensing of Controlled Substances Act" until 7/1/14. Requires existing rules to be updated by 9/1/07 and that rules be available to the public on its website.
SB 07-224 / 26-3.1-102	CONCERNING AT-RISK ADULT PROTECTION TEAMS.	Older Adult and Aging Programs and Developmental Disabilities	Changes statute to require counties with a minimum number of reports of at-risk adult mistreatment or self-neglect to create an adult protection team.
SB 07-225	CONCERNING STRATEGIES INCLUDING THE EARNINGS INCOME DISREGARD FOR INCREASING THE WORK PARTICIPATION RATES FOR PERSONS PARTICIPATING IN THE COLORADO WORKS PROGRAM	Colorado Works	This legislation requires the Dept to submit an annual report to the Legislature regarding what the State and counties are doing to increase work participation rates.
SB 07-226	CONCERNING NECESSARY CHANGES TO STATUTES TO COMPLY WITH FEDERAL LAW REGARDING PLACEMENT OF A CHILD OUTSIDE OF THE HOME.	Child Welfare	This legislation requires more stringent and longer-term background checks on prospective foster, kin and adoptive parents as well as any adults who reside in their homes; requires the court to consult with a child in an age-appropriate manner regarding the child's permanency plan; gives provider's right to be heard during court proceedings; and provides Title IV-E incentive funding to Colorado for timely completion of interstate home studies.
SB 07-230	CONCERNING REVISIONS TO THE CHILDREN'S MENTAL HEALTH TREATMENT ACT	Mental Health	Authorizes mental health agencies to coordinate mental health care and services for children from assessment to discharge, clarifies agency reporting requirements including treatment outcomes, expands rights of families, and allows for payment of room and board costs associated with residential treatment for eligible children.

Bill/State Statute	Title	Program	Description
SB 07-255 / 27-10.5-140 and 22-20-118	CONCERNING THE DISTRIBUTION OF CHILD FIND RESPONSIBILITIES UNDER THE FEDERAL "INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT OF 2004", AND MAKING AN APPROPRIATION THEREFOR.	Developmental Disabilities	Distributes responsibilities for child find activities between Community Centered Boards and local education agencies. Specifically requires local education agencies to perform screening and evaluations for infants and toddlers who may need early intervention services.

B. Changes in Federal Laws and Funding

Mental Health

Mental Health Block Grant. The Division of Mental Health (DMH) is a recipient of the federal Community Mental Health Services Block Grant (Block Grant) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, to enhance community mental health services to people with serious mental illness. Colorado's Mental Health Block Grant allocation increased from $5.7 million to $6.2 million during FY 2006-07, of which over $5 million is spent on direct services through contracts with community mental health providers and organizations. In accordance to the Block Grant award, the Colorado Mental Health Planning and Advisory Council, comprised of consumers, family members, advocates, community providers, and State representatives, assists the State with planning, monitoring and advocating regarding the Block Grant award. The Senate Appropriations Committee recently recommended flat funding for the Mental Health Block Grant for federal FY 2007-08. Final action is not expected for several months.

Alcohol and Drug Abuse. A Senate Appropriations Subcommittee approved a bill that recommends flat funding of the Substance Abuse Prevention and Treatment Block Grant (SAPT), administered by the Substance Abuse Mental Health Services Administration (SAMHSA), for federal FY 2007-08. In an effort to further develop common performance measures nationwide, the federal Substance Abuse Prevention and Treatment Block Grant program will incorporate a select set of outcomes or measures of success called National Outcomes Measures (NOMS). State agencies administering the SAPT Block Grants will work closely with the Substance Abuse Mental Health Services Administration (SAMHSA) to revise their technology and reporting systems to collect NOMS within required timeframes, a process SAMHSA refers to as State Measurement and Management Systems (SOMMS). SOMMS includes a major change in federal funding practices. SAMHSA will only pay states after states have proven they can consistently report accurate NOMS with federal timeframes. The outcome reporting changes have impacted the Alcohol and Drug Abuse Division's (ADAD) block grant process, data collection and reporting. ADAD is currently in compliance with NOMS outcome reporting; however not all federal NOMS have been finalized and further changes to data collection and reporting are anticipated.

Screening, Brief Intervention and Referral to Treatment (SBIRT). As part of its continuing efforts to bridge the gap between prevention and treatment, and to improve Colorado's Prevention-Treatment continuum, ADAD was awarded a five-year Screening, Brief Intervention and Referral to Treatment grant from SAMSHA/CSAT. Colorado is now one of eleven such projects around the country. The grant awards $2.8 million per year directed at fostering the establishment of a statewide SBIRT infrastructure, specifically in primary healthcare settings. The project is charged with informing Colorado about SBIRT and its efficacy in reducing

the progression of substance use disorders and reducing costs in other areas, demonstrating the benefits of the SBIRT process through implementation, and establishing sustainable alliances with primary healthcare providers throughout the state.

The Colorado SBIRT Project began its screening in Women, Infants, and Children (WIC) medical clinics in March 2007. Implementation of the project at the Denver Health Medical Center's Emergency Department and Women's Health Clinic is currently in process. Hospitals in Colorado's mountain community (Vail) and western region (Grand Junction) are being prepared to begin operating SBIRT programs within the first quarter of FY 2007-08. In subsequent years, SBIRT program projects will be implemented around the state and efforts will move towards sustainability.

Supportive Housing and Homeless. On May 24, 2007, Senator Reed (D-RI), Senator Allard (R-CO), and 11 other Senators introduced the Community Partnership to End Homelessness Act of 2007 (S. 1518). This legislation has the potential to make the McKinney program a more effective tool to prevent and end homelessness. Key provisions of the legislation would:

- Establish a new prevention program to serve people who have moved frequently for economic reasons, are doubled up, are about to be evicted, live in severely overcrowded housing, or otherwise live in an unstable situation that puts them at risk of homelessness;
- Encourage programs that move families into permanent housing;
- Enable rural communities to use funds for homeless prevention and stabilization with an application process tailored to rural communities;
- Renew permanent housing programs non-competitively; and
- Reward communities based on positive program outcomes.

Child Support Enforcement

The Deficit Reduction Act of 2005 passed by Congress and signed by President Bush will have a negative fiscal impact on the child support enforcement program in Colorado. Beginning October 1, 2007, county child support offices will no longer be able to receive federal financial participation on child support incentives dollars they earn that are required to be re-invested in the child support program. This will result in an estimated loss of $3.1 million in revenue to the counties.

Child Welfare

The Safe and Timely Interstate Placement of Foster Children Act of 2006 seeks to: expand the requirements for placement options considered and identified for a child who will not be returned to a parent; clarify that it is the court's responsibility to make a judicial determination about the appropriateness of the out-of-state placement; specifies that the foster parent, pre-adoptive parent, or relative

providing care to a child, has a right to be heard in any court proceeding; establishes an orderly and timely process for the placement of children in out-of-state foster care placements including a timeline for the completion of home studies requested by other states through the Interstate Compact on the Placement of Children (ICPC) program; and establishes a monetary incentive payment for States that complete homestudies within the specified timeframe. This legislation is expected to facilitate timely placements in other states where appropriate.

The Adam Walsh Child Protection and Safety Act of 2006 allows county access to the National Crime Databases via an agreement with local law enforcement; requires FBI fingerprint-based criminal history background check for all foster, adoption and kinship foster care applicants and any other adult(s) living in the home of the applicant before a child may be finally approved for placement; and requires that any child abuse and neglect registry be checked for all adoptive, foster care and kinship foster care applicants and any other adult(s) living in the home of the applicant from the date of the application and five years previous, regardless of the state of residence before they may be approved for the placement of a child.

The Child and Family Services Improvement Act of 2006 reauthorizes the Court Improvement Program, the Promoting Safe and Stable Families program, and the Program for Mentoring Children of Prisoners for five years through 2011; enhances reporting and evaluation under Title IV-B; enhances PSSF funding for Tribes; requires the courts in conduction permanency hearings to consult with the child in an age-appropriate manner, regarding the child's permanency plan; and requires States to develop a Disaster Response Plan.

C. Current Lawsuits and Court Orders

The department has been involved in litigation related to services provided. The following are the most noteworthy:

COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO LAWSUIT - CIVIL ACTION NO. 99-B-1120, IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLORADO, JAMES NEIBERGER, DANFORD ELDRIDGE, PAUL GARDNER, TERENCE JACOBS, BRADLEY GLENNIE, DAVID SNYDERS, LAWRENCE EUBANK, AND ALLEN HALL, Plaintiffs v. STEPHEN SCHOENMAKERS in his official capacity as Superintendent of Colorado Mental Health Institute at Pueblo; ELIZABETH STILLMAN in her official capacity as Director of Hospital Services, Colorado Department of Human Services; COLORADO DEPARTMENT OF HUMAN SERVICES; and COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO, Defendants

On January 24, 2003, the court approved a settlement agreement, which was subsequently amended on September 22, 2004. The parties agreed to certain improvements in patient care, such as additional staff, additional training for some staff, additional recreation activities for patients, a limit on census, and some physical plant modifications, in addition to construction of a new High Security Forensic Institute for the medium and maximum security forensics program. One of the plaintiffs' expert witnesses and two of the state's expert witnesses will monitor compliance with these conditions. The Department of Human Services will pay the costs of the monitoring. The agreement terminated on December 31, 2006. All settlement agreement obligations have been fulfilled.

ZUNIGA v COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO

Defendant Zuniga was charged in Denver criminal courts with theft of a bicycle. On June 13, 2006, he was found incompetent to proceed, and the court ordered him transported to the Mental Health Institute at Pueblo. CMHIP did not have an open bed. On September 7, 2006, the court issued a contempt citation when the judge learned that Mr. Zuniga had not yet left the jail, due to the lack of a CMHIP bed. The contempt citation was directed to the Superintendent of the Mental Health Institute at Pueblo (as described above). The Superintendent responded that the number of jail inmates ordered to CMHIP by the courts throughout the State had approximately doubled over the previous five-year period, with no increase in funding to the Institute. This dramatic increase in the need for CMHIP services had produced a waiting list of jail inmates. The court appointed a private law firm to serve as special prosecutor, and set the case for trial to begin February 26, 2007. The court added the Executive Director of the Department as a second alleged contemnor, and expanded the citation to include the cases of two additional defendants who also could not obtain timely services from CMHIP.

On December 15, 2006, the Department of Human Services appeared before the Joint Budget Committee and requested funding for staff and equipment so that CMHIP could open an additional 20-bed unit. The funding request was approved. On January 8, 2007, the new unit opened. By February 2, 2007, all inmates on the December waiting list had been served.

Because of these additional resources, which facilitated management of the waiting list, the Department was able to settle the pending contempt case without a finding of contempt being issued. With the assistance of the Judicial Arbiter Group, the parties agreed that the case would be dismissed; that the Department would file reports with the prosecutors on a monthly and quarterly basis showing the length of time that jail inmates, ordered to CMHIP for competency evaluation or treatment, were waiting for admission; and that the Department would use as a goal certain timeframes (no more than a 28 day maximum wait for admission for any single inmate, and no more than a 24 day wait, averaged over the quarter, for all inmates included in the agreement). If the Department is unable to meet these timeframe goals, the case will be returned to the court system which will determine the cause of the Department's inability to comply with the goals and issue a public document that explains the causes. A fine may be levied not to exceed $1000 per patient per quarter, for an unjustified failure to meet the timeframe goals. The Department also agreed to provide, if requested, training on competency law and practices for the Judicial Branch and the Colorado District Attorneys Council. The Department paid the legal fees of the prosecutors in the agreed amount of $20,000. The prosecutors donated this money to the Colorado Coalition for the Homeless.

The Department's first quarterly report is due on or about July 31, 2007. The Department has filed the required informal monthly reports starting in February 2007, after the settlement agreement was approved. The Department has met all timeframe goals.

WAITING LIST LAWSUIT – CIVIL ACTION NO. 00 M 1609 - (MANDY R. ET AL. V OWENS ET AL). (ADRS – DDD)

This lawsuit was filed in Colorado on August 14, 2000, on behalf of persons with developmental disabilities who are waiting for Comprehensive Services (24-hour care and rehabilitation). The lawsuit alleged that the State had violated the U.S. Constitution, Title XIX of the federal Social Security Act, the due process clause of the 14th Amendment and Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). The plaintiffs cited several court precedents upholding federal guidelines of 90 days or less as reasonable promptness for providing services, such as ICF/MR (Intermediate Care Facilities) available under the Medicaid State Plan. The relief sought by the plaintiffs and the intervener in the Mandy R. lawsuit was denied in a ruling in February 2005. In March 2005, the Mandy R. plaintiffs and Colorado Association of Community Centered Boards (CACCB) appealed the dismissal to the 10th Circuit (05-1150 and 05-1148, respectively). In September 2006, the Circuit Court affirmed the District Court decision and dismissed the appeal. In January 2007, the plaintiffs petitioned the U.S. Supreme Court to take up the case. The court denied this petition on March 26, 2007.

CBMS LAWSUIT - HAWTHORNE -BEY ET AL V. REINERTSON AND HAMMONS, CIVIL ACTION NO. 04 CV 7059, DENVER DISTRICT COURT

The plaintiffs filed this lawsuit in August 2004 in an attempt to stop the implementation of the Colorado Benefits Management System (CBMS). After a hearing in September 2004, the Judge denied plaintiffs' request to stop implementation of CBMS. Plaintiffs then amended their complaint to seek different relief. After a seven-day hearing in December 2004, the Judge entered a preliminary injunction, requiring the Department of Human Services and the Department of Health Care Policy and Financing to:

- Establish an emergency processing unit to resolve situations in five days when an application was not processed according to statutory guidelines or a recipient's benefits were improperly reduced, terminated or suspended AND the applicant or recipient faced imminent peril of physical injury, harm or extreme hardship;
- Reduce the backlog of applications not meeting statutory processing guidelines by 40% in 60-day periods of time and to report to the court;
- Substantially correct problems with notices, and
- Not seek recovery of any overpayment caused by CBMS.

The Departments have worked diligently and in good faith to comply with the court's order. Plaintiffs and the Departments agreed to a stipulation regarding the preliminary injunction that

- Eliminates the requirement for an emergency processing unit after June 30, 2006,
- Eliminates the need to further reduce the backlog in pending applications below current levels,
- Eliminates the requirement to make any improvements to notices beyond those already accomplished, and
- Allows all overpayments made after June 1, 2006 to be collected in accordance with applicable law. Plaintiffs and the Departments are currently in negotiations to attempt to resolve the remaining issues raised by this litigation.

As of July 1, 2007, there is no change in this status and the departments continue to work toward a final resolution.

POSSIBLE LEGAL ACTION AGAINST THE ALCOHOL AND DRUG ABUSE DIVISION (ADAD) (NOTICE OF INTENT TO FILE A LAWSUIT)

The Boulder Clinic notified the Colorado Attorney General's Office of its intent to file a lawsuit against Marva Hammons (CDHS, Executive Director), Janet Wood (ADAD, Director) and Daria Leslea (ADAD, Controlled Substance Administrator) because ADAD denied the clinic's treatment license due to multiple ongoing quality of care problems. The provider appealed ADAD's denial for licensure and an administrative law judge ruled in ADAD's favor, but raised statutory ambiguities. This ruling led to legislation being introduced during the 2006 legislative session to clarify and strengthen the statutory language regarding ADAD's authority to license treatment agencies that dispense controlled substances, primarily methadone.

The Alcohol and Drug Abuse Division (ADAD) was notified in April 2007 by the Colorado Attorney General's Office that Comprehensive Addiction Treatment Services (CATS) had filed a formal appeal of ADAD's denial of their controlled substance license. ADAD denied the renewal of their controlled substance license in March 2007 due to numerous issues of substandard care and jeopardizing the health and safety of the patients they serve. This appeal is on-going as of November 1, 2007.

The Alcohol and Drug Abuse Division is still pursuing litigation with the Adolescent Family Institute of Colorado (AFIC) as of November 1, 2007. The litigation will decide if AFIC must submit DACODS (Drug and Alcohol Coordinated Data System) data to the state. The Adolescent Family Institute of Colorado is licensed by the Alcohol and Drug Abuse Division to provide adolescent alcohol and other drug services. Adolescent Family Institute of Colorado, which is not state funded (receives no General Fund), requested a waiver on July 27, 2006, regarding submitting DACODS data to ADAD, and both ADAD and the Attorney Generals Office denied their request on August 15, 2006. All agencies licensed by ADAD, regardless of whether they receive state funds or not, are required by state statute (25-1-1102(4), C.R.S. (2006) to report data directly to ADAD.

D. Demographic and Societal Trends in Colorado

State Population Growth

The population of Colorado continues to grow. Although the relationship is not a linear one, in general there is a greater demand for services as the population increases. The challenges for the Department are to be able to develop more products and deliver more services in the organizational context of FTE caps and budget reductions.

As the population increases, the number of youth and children in the Colorado population also increases. Persons under the age of 21 commit a very significant percentage of all crimes. An effect has been that the Division of Youth Correction continues to experience increases in client populations. In addition, the demographic profile of juveniles committed to DYC has changed. Committed youth increasingly have more serious substance abuse histories and significant mental health treatment needs. The percentage of committed youth with moderate to severe mental health concerns increased from 227 youth in FY 1998-99 to 861 youth in FY 2005-06, equating to a 279% increase over the previous eight years. In an effort to mitigate a portion of this need, the division opened the 20-bed Sol Vista Youth Services Center for violent committed male juveniles with severe mental illness in November 2006 and is requesting to expand the facility to its full design capacity of 40 beds.

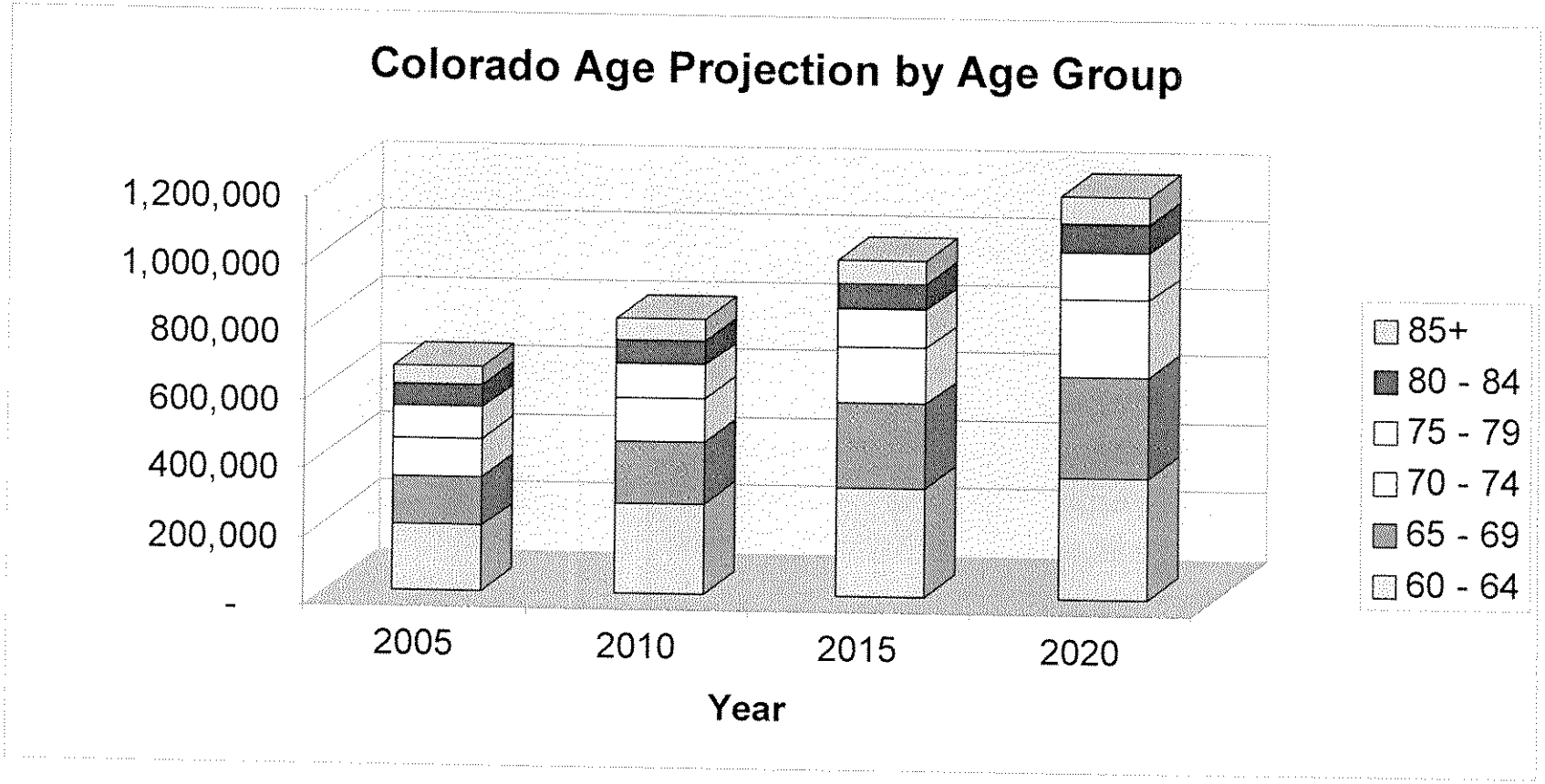
Growth in Aging Population

According to the Demography Office of the Colorado Department of Local Affairs, the state's older adult population is projected to grow from 741,319 in 2008 to 851,000 in 2011, an increase of 15% in just three years. By contrast, the remainder of the population (age 0 to 59) is expected to grow by 5%. Much of the growth of the total older adult population will be due to a surge in the number of young-old (60-74).

Colorado's "middle-age bulge" reflects past demographic events—both the post-World War II baby boom and past migration trends. People born during the baby boom—conventionally dated from 1946 to 1964 – began turning 60 in 2006, though those born at the peak of the baby boom (1954) will not turn 60 until 2014. Thus, the full impact of the aging of the baby boom on the size of Colorado's older adult population will not occur for another 15 or 20 years.

More immediate is the impact of past migration trends on the state's age distribution. Many Coloradoans who are in their 50s and 60s today were part of the wave of younger adult migrants who moved to Colorado in the 1970s and after. These past in-migrants will contribute to the surge in the numbers of young-old in the next decade.

Year	Total Population of Colorado	Percent Increase Total Population (from 2008)	Number of Persons ages 60+	Percent Increase 60+ (from 2008)	Number of Persons ages 0-59	Percent Increase ages 0-59 (from 2008)
2008	5,004,990		741,319		4,263,671	
2011	5,311,455	6%	851,054	15%	4,460,401	5%
2018	6,047,354	21%	1,145,932	54%	4,901,422	15%
2028	7,097,682	42%	1,509,952	104%	5,587,730	31%



With the demographic boom, the need for in-home assistance will dramatically increase. Relatively low cost assistance can be provided to seniors that allow them to remain in their communities. Service provision failure may result in staggering increases in the societal economic cost of institutional care. Just as life insurance is cheaper the younger a person buys it, the costs of strengthening senior support systems will be more inexpensive now than later.

The growth of the aging population is impacting the *Older Americans Act* programs' service delivery network. The most important issues facing older adults and persons with disabilities in Colorado are affordable transportation, housing and health care. With the expected growth in the aging population, additional resources will be needed to meet the already growing demand for services. For example, there is a growing demand for ombudsman services in the state's 222 nursing homes and 479 assisted living residences. Additionally, an increased need for adult protective services is anticipated, as persons age 60 and over are most often targets of abuse, neglect, and exploitation.

A similar impact will affect aging parents of adults with developmental disabilities who are living at home and are on waiting lists for services or who are receiving minimal supported living services. The average life expectancy for persons with developmental disabilities has increased dramatically in the last 20 years (e.g., life expectancy for persons with Down syndrome in 1983 was 25 years and was 57 years in 2003). As the primary caregivers age and are unable to continue to provide needed supports, the criticality of the demand for state funded adult services will increase. The waiting list for developmental disabilities adult services has grown from 2,623 in 1997 to 3,146 in 2007.

Growing misuse of alcohol, prescription drugs and over-the-counter medications in older adults aged 60 and above is considered to be a "silent epidemic" that will grow in significance as the first baby boomer cohorts reach age 60. Some medications are addictive, while others cause dangerous sedation leading to increased accidents. There are also drug-to-drug and/or drug-to-alcohol related adverse reactions, as well as decreased capacity to absorb or clear medications from the body. There is some expectation of increased demand for prevention, intervention and treatment services for this age group, and Colorado has noted an increase in the proportion of treatment admissions for persons 45 and over from 11.2% in 2000 to 17.0% in 2006). The proportion of persons 45 and over entering treatment for the first time also increased from 8.2% in 2000 to 13.1% in 2006. However, increases were most prominent and consistent for alcohol.

Child Care

As more families continue to transition from welfare to employment, and as the maternal work force continues to increase, the demand for child care will continue to increase. Families are also demanding more affordable, safe and available child care. The requirement for quality child care is also increasing – parents want their children to be ready to learn when they enter school. There is also an expectation on the part of schools that child care providers will send children to school ready to learn and succeed, but there is no shift in funding to equip child care providers for their increased role in a child's cognitive learning.

Substance Abuse

Substance Abuse Treatment Clients in calendar year (CY) 2006 were most commonly single, white male adults between the ages of 18 and 44 years old with a median age of 31 years of age. Nearly 70% achieved a 12th grade education or higher and more than a third worked full-time. The highest proportions of the treatment population were in treatment for alcohol, followed by marijuana. Sixty-one percent started using their primary drug before the age of 18 years and had been using for an average of 14.5 years. These clients tended to be daily users of tobacco, had one or more prior treatment episodes, did not support children and were treated in ADAD - contracted outpatient treatment services.

In CY2006, the largest proportions of clients in treatment, DUI and detox were Caucasian. However, compared with the 2000 census figures for Colorado, Hispanics were over-represented in all three of these substance abuse service types. While Hispanics represent 17% of Colorado's general population, they comprised 24%, 27% and 29% of treatment, DUI, and detox, respectively. Moreover, American Indians comprised 7% of the detox clientele, but only represent 1% of Colorado's general population.

Treatment proportions by age groups have remained relatively stable. Current drug trend data indicate:

1) high levels of marijuana use and related problems (e.g., emergency room episodes, treatment admissions), especially among adolescents and young adults;
2) continued high levels of some cocaine problem indicators (e.g., deaths, emergency room episodes, quantities seized by law enforcement) as well as an increase in treatment admissions for the first time since 2001;
3) a decrease in most methamphetamine indicators (e.g., treatment admits, death) for the first time in years; and
4) an increase in the amount of law enforcement seizures of MDMA (i.e. Ecstacy), believed to be trafficked into Colorado by Asian gangs with sources in Canada and California.

Employment of Persons with Disabilities

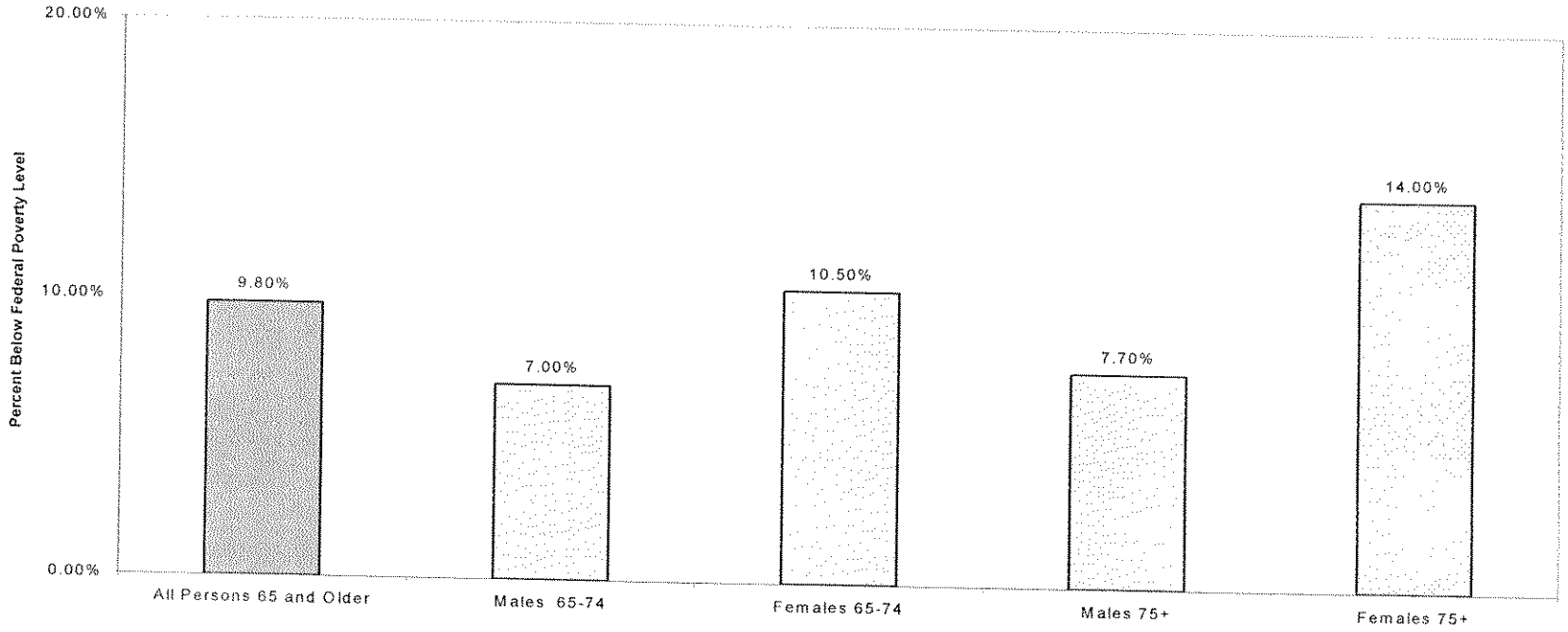
Issues affecting the success of people with disabilities in their employment endeavors include concerns about losing financial and medical public benefits if they begin or return to work full time, the lack of reliable public transportation in remote areas of the state, the availability of affordable housing, and the misperceptions held by employers about hiring persons with disabilities. At present, people with disabilities represent the most unemployed or underemployed group in America at approximately 70%. These issues will be compounded in coming years by the upsurge in older adults either staying in the workforce longer or returning to it. After age 60, adults are far more likely to have a disability of some kind, often more than one. The need for services designed to help older adults get into and keep good jobs will grow exponentially as Baby Boomers age.

Aging Trends

Short Term Trends

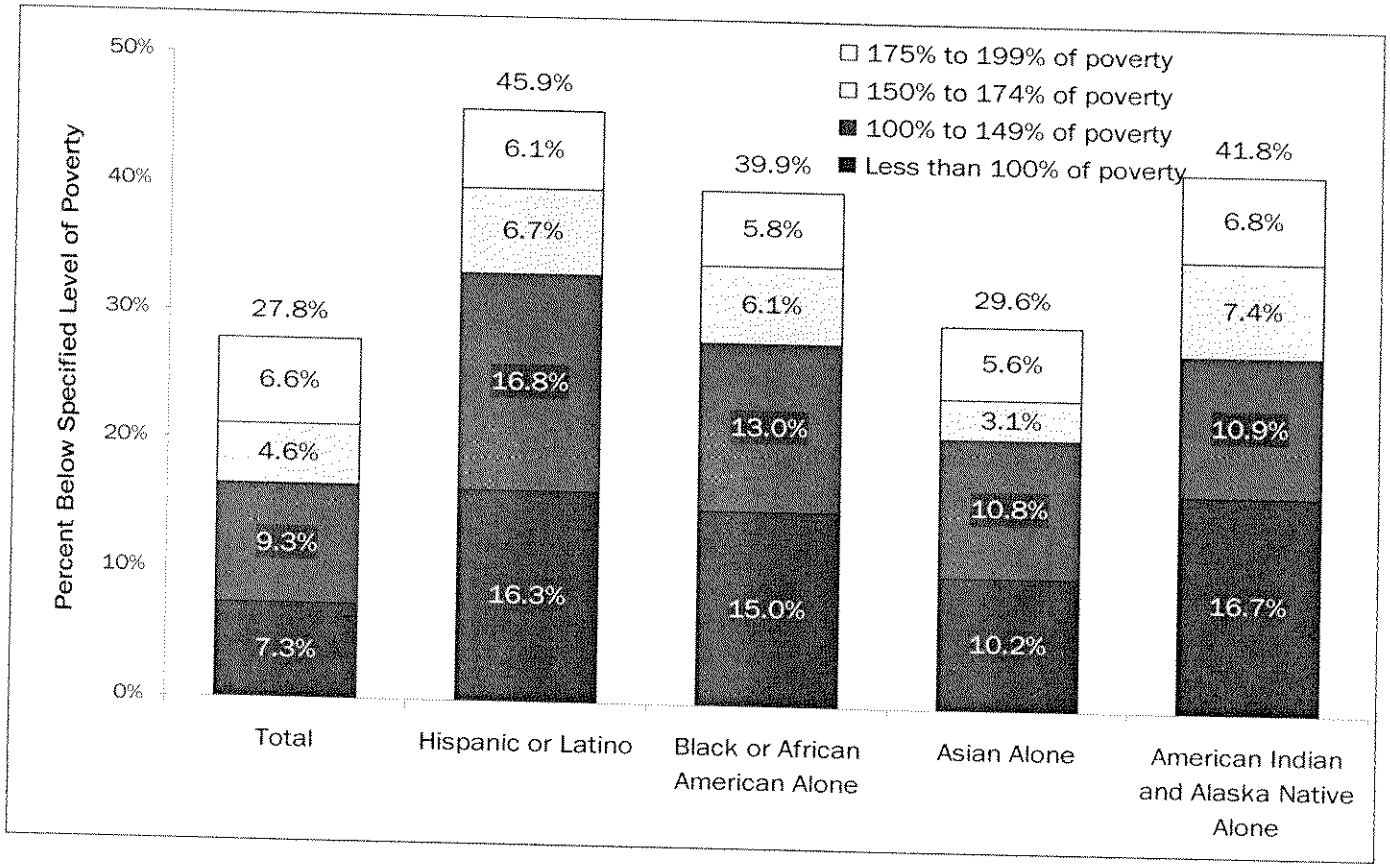
Because women outlive men, older age groups have higher proportions of women. Poverty rates are substantially higher for older women than men, and these differentials increase with age. In 2006, over 45,900 seniors in Colorado were living on income below the federal poverty level. Fourteen percent of women 75 years and older (over 18,000 individuals in Colorado) were below the federal poverty level.

Percent of Older Adults (65+) Below Federal Poverty Levels



Poverty rates are substantially higher for minority adults 65 years and older. In 2004, 16.3% of Hispanic elders (8,135 individuals) were at or below the federal poverty level, 15% of African American elders (2,187 individuals) were at or below the federal poverty level, 10.2% of Asian elders (893 individuals) were at or below the federal poverty level, and 16.7% of Native American elders (478 individuals) were at or below the federal poverty level. Resources must be targeted to these groups.

Poverty Rates for Minority Older Adults (65+)



More women work outside the home; therefore, they will be less available to assume traditional caregiving roles at home and will require a variety of in-home services as well as elder care services in the workplace. Caregiver respite is an increasing unfilled need throughout the state.

The use of service coordinators is likely to expand as mobility continues to separate the generation needing care from the generation able to provide care.

Dramatic increase in the number of seniors in Colorado whose incomes are at or below poverty will require an intensive diversion of resources to meet their needs.

As programs at state, county and local levels are reduced because of funding difficulties, the composition of congregate meal sites may change. More homeless and desperately poor persons may avail themselves of nutrition programs at the congregate meal sites.

Successful recruitment will become an increasingly important cornerstone of service provision. Volunteer outreach efforts will be increased to meet the growing need of service provision and counter the effects of reductions in funding. The use of volunteers results in significant cost savings to programs.

Placing Senior Community Service Employment Program (SCSEP) workers is becoming increasingly difficult. Increased competition for available positions exists because of higher unemployment rates and the slow growth of the economy. Veterans often decline to participate in SCSEP when they learn that SCSEP income will be deducted from their veterans' benefits.

Long Term Trends

Since elders choose to remain in their homes longer, the gap between in-home service programs and in-home unmet service needs will continue to grow. The importance and use of preventative nutritional programs that improve health, prevent more costly interventions, and allow the elderly population to remain independent longer, will increase with the percentage of the aging population. People of all ages prefer to receive care at home. In the next 40 years, the number of people 85 and older is expected to quadruple. Since this group generally has a high need for services, there will be a concomitant increase in the use of in-home services.

Medical costs at the Mental Health Institutes have increased significantly in recent years, partially due to regulatory changes and partially due to their aging population.

Transportation services for the elderly will continue to be an issue, especially in rural communities. Improved and increased access to transportation is essential to improve mobility, employment opportunities, and access to community, health, and dental services for persons who are transportation-disadvantaged.

E. Economic Conditions Affecting Programs

1. *High Staff Turnover and Low Wages*

High turnover and low wages continue to exist in the child care industry, Colorado State and Veterans Nursing Homes, residential care facilities, and in nursing and physician positions at both the Fort Logan and Pueblo Colorado Mental Health Institutes. Nursing home facilities are still significantly impacted despite the slump in the state's economy and are in a chronic crisis state, especially for nursing and certified nursing assistant positions. Significant problems in recruitment are related to current compensation levels. The information technologies classifications for Information Technology Professional V, VI, and VII have compressed to the same compensation limit. This compression will increase turnover and/or personal services costs as new recruits cause compression on current staff. Skilled nursing facilities are not able to compete with higher paying service jobs. The fact that we have to pay a higher salary in order to recruit entry level staff causes moral issues with current staff whose salary is below that of the new hire. Inability to recruit qualified staff has negative impacts on the quality of care for clients.

This difficulty is compounded by the levels of pay and benefits that can be offered to direct care and other program support entry-level staff. The state has trouble competing with other private sector jobs outside of the human service field, where the pay and benefits are more attractive.

The department continues to have problems finding job applicants willing to accept entry-level support positions such as custodial positions. The department is currently in direct competition for workers with fast food chains and warehouse type facilities. Both low wages due to salary freezes during the recession and the high cost of health insurance to state staff are issues.

2. *Staff Recruitment and Retention*

Direct Care Agencies

Significant staff recruitment and retention issues remain for the department, particularly for those programs that provide direct services to clients as well as allied support functions such as facilities management. In order to be effective and safely provide services, agencies need to maintain staffing at adequate levels, especially in 24-hour care facilities such as the Regional Centers, the Mental Health Institutes, State and Veterans Nursing Homes, and the Division of Youth Corrections.

Adequate staff-to-patient ratios are necessary to ensure the safety and health of patients and clients and to provide a clean, safe, sanitary and reliably functioning workspace. Direct client care and allied support positions in these facilities deal with challenging

client populations, making it difficult for the department to recruit and retain staff in these positions. For example, the turnover rate for developmental disability technicians is about 100% annually.

Low salaries in comparison to the general health care community impact the department's ability to staff the Mental Health Institutes with adequate numbers of direct care staff, including nurses and psychiatrists. It creates retention problems and reduces staff morale. While CDHS has been successful in working with the Department of Personnel and Administration to address some concerns (e.g., Nurse Anesthetist salary adjustments, shift differential pay for nurses, etc.), much work remains to get direct care staff salaries to a competitive level.

The department continues to have problems finding qualified job applicants for direct health care positions. Competing employers are in a position to hire at higher salary rates and offer higher signing bonuses, making it extremely difficult for CDHS to compete. Unemployment surges have also resulted in an increased number of applicants, many of whom are not qualified for the jobs for which they applied. Processing these applications taxes an already under-resourced HR department. The Office of State and Veterans Nursing Homes has had to apply for out-of-state hiring waivers for top nursing home management positions.

A three-year analysis of staff hours available to cover critical posts at DYC state-operated facilities identified a need for additional critical post staff across the Division. In FY 2004-05 alone, DYC experienced over 11,400 shifts, Division-wide, that would have gone uncovered because of staff shortages – which equates to approximately 44.0 FTE (assuming the Division would realize the full 2,080 hours per FTE – no annual, sick leave, or training hours taken). In order to ensure that these shifts were covered, the Division took numerous actions, including:

- Calling in staff on their days off
- Asking staff to work a double shift (back to back)
- Collapsing posts to ensure youth are minimally supervised
- Canceling group treatment sessions to ensure youth are supervised

When the Division's facilities are not adequately staffed to ensure coverage for all critical posts, there is an increased likelihood that critical incidents can occur, significantly endangering both staff and youth. These issues are also prevalent in Mental Health Institutes, which are constantly needing to juggle staffing levels with staff schedules with patient acuity in order to ensure appropriate coverage on all units.

Over the past four years the Regional Centers have been serving a more severe clientele, largely due to new admissions criteria that were fully implemented in April 2003 and were established to meet the high demand for Regional Center services. These individuals

require enhanced staffing for monitoring of safety and provision of necessary treatment. During this time period the state faced budgetary crisis and funds appropriated for personal services have not kept pace with costs. The staffing pressures associated with a more severe clientele and funding constraints have been identified by the Colorado Department of Public Health and Environment (CDPHE) during surveys, and all three Centers have been cited for inadequate staffing with plans of correction requiring additional staff. Continued certification by CDPHE is at risk if adequate staff are not obtained. As a result of the above circumstances, the Office of Adult, Disability, and Rehabilitation Services undertook a comprehensive study of the staff of the Regional Centers. The study identified two models for staffing: minimum and appropriate. The minimum additional staff necessary to continue operating at current bed capacity (403) is 259.2 FTE. The number of FTE necessary to provide the services outlined in the Appropriate Model is 656.9. Given the very large number in the Appropriate Model, the Department is pursuing funding of the Minimum Model.

Information Technology

The Office of Information Technology Services (OITS) has been affected similarly to other offices where a convergence of statewide budget issues continues to clash with the loss of key personnel due to high levels of retirements and through normal attrition. Recruiting efforts continue to challenge the OITS as the Denver area continues a modest recovery in the high-tech labor market. Recent job postings are attracting fewer qualified applicants, and contractors that are currently filling temporary positions have been leaving for better paying full-time positions. The combination of lower staffing levels, attrition, and longer than normal time to fill open positions has created periodic skill shortages. These shortages continue to impact the OITS in its efforts to provide expected service levels.

Other indicators of the improving high-tech labor environment for the Denver area are the increase in the cost to fill temporary positions with contractors from the state procurement price agreements.

Nursing Shortage

The growing nursing shortage is impacting the Colorado Department of Human Services' ability to recruit and retain nurses to staff its health care facilities. A number of factors are contributing to the nursing shortage. These factors include: increases in nurse turnover rates, younger nurses leaving the field due to burnout, a decline in the number of younger persons choosing nursing as a career, and a projected increase in nurse retirement rates in the next four years.

The grim statistics regarding the nursing shortage make recruitment and retention of nursing personnel a pressing issue for CDHS. CDHS has responded by paying premium wages to recruit and retain nurses, obtained residency waivers to attract out-of-state applicants and significantly increased recruitment through a strategic plan, posting jobs on web sites and trade journals, etc. However,

these tactics are only marginally effective, particularly when higher wages must be paid out of "vacancy savings", thus reducing the numbers of staff that can be hired. Recruitment and retention of frontline nursing staff is further limited by challenging clinical populations producing, at times, dangerous situations.

County Private Direct Care Services, Community Mental Health Services, Community Substance Abuse Services

These issues affect not only the programs operated directly by the state, but also county departments of human services, private direct care agencies, community centered boards, and community mental health centers that provide services to department clients through contractual arrangements. In these agencies, even though the unemployment rate in Colorado has increased, there still continues to be demands for higher salaries, difficulty attracting and retaining staff, and delays in filling vacancies. This impacts the stability and profitability of these providers, whose salaries have historically been relatively low. As a result, it is more difficult to keep or recruit new contract providers.

3. *Cost of Medical Services and Pharmaceuticals*

Increasing costs of contractual medical services and medications have had significant budget impacts for the Division of Youth Corrections, the Mental Health Institutes, the Division of Mental Health programs, the Division for Developmental Disabilities, the Regional Centers for persons with developmental disabilities, and the Colorado State and Veterans Nursing Homes. For example, the emergence of highly effective new generation anti-psychotic medications has increased the Institutes' medical expenses and there is an unabated and dramatic increase in medical services expenses for psychiatric patients as a result of regulatory changes and an aging population.

From FY 2000 to FY 2005, Mental Health Institute pharmaceutical costs increased 31.2% or an average of 10.7% annually. Extrapolating from 9 months of data, FY 2006-07 is projected to have an increased medication expenditure of 11.6%; FY 2005-06 expenditures of $2.9 million versus a projected $3.3 million for FY 2006-07. This increase occurred despite active efforts to limit pharmaceutical expenditures (e.g., clinical medication case review, formulary restrictions). Based on the American Journal of Health System Pharmacy (AJHP) article dated January 15, 2005 titled *Projecting Future Drug Expenditures-2005*, the Mental Health Institutes anticipate an average increase in the cost of pharmaceuticals of 21% for both FY 2005-06 and FY 2006-07. The February 15, 2007 AJHP article *Projecting Future Drug Expenditures-2007* projects an increase of 4-6% for hospitals (2-3% related to price, 3-4% related to volume and mix, and 1% related to new drugs).

The Division of Youth Corrections is spending approximately 50% of its medical services operating budget on medications in SFY 2005-06 (predominantly psychotropic medications), and is anticipating increased medical operating costs as a result of medical inflation rates that far exceed overall inflation rates.

The vast majority of physicians working at the Mental Health Institutes provide contractual medical services through an agreement with the University of Colorado Health Sciences Center (UCHSC). The Mental Health Institutes have difficulty recruiting and retaining psychiatrists and other physicians due to a relatively low salary paid by the institutes in comparison with other opportunities for employment. Institute physicians receive base salaries between $138,000 and $168,000 annually, while other psychiatrists and physicians along the Front Range with comparable certifications and experience generally earn between $150,000 and $220,000 annually. Some child psychiatrists in the community earn well over $200,000 annually.

The discrepancy between Institute salaries and community salaries makes it difficult to recruit new physicians to work at the Institutes and to retain those already employed at the Institutes. Often, the most qualified candidates do not apply for vacancies at the Institutes and/or accept positions elsewhere, and vacancies go unfilled for long periods. The department also had to shift funds from other direct care positions to fund psychiatrists working at the Institute of Forensic Psychiatry at CMHIP to comply with the terms of the Neiberger lawsuit settlement agreement, exacerbating nursing staff shortages.

During FY 2005-06, the Mental Health Institutes received funding from the legislature to provide a physician salary stipend for the remainder of the FY 2005-06 in order to assist in recruitment and retention. This funding was annualized and approved as part of the base budgets for the Institutes beginning in FY 2006-07.

The recent loss of the last remaining Medicaid HMO (Colorado Access) will require significant numbers of Medicaid recipients (low income or those with disabilities) to have to find new primary care physicians (PCPs). Increasingly physicians in private practice are reluctant to take new Medicaid patients due to low Medicaid reimbursement rates and this will jeopardize the availability of health services for this population.

4. *Affordable Low Income Housing*

Supportive Housing and Homeless Programs (SHHP) maintains a closed wait list for the subsidized housing that it provides to persons with disabilities and the homeless. The wait list is only opened for new applications when the number of persons on the waiting list falls below the number of persons who can be served in a two-year period. There are currently 358 family and individual households remaining on the wait list, after accepting over 1,400 new applications on one day in November 2005. In recent years, U.S. Department of Housing and Urban Development (HUD) policy changes and lack of new appropriations has leveled the number of

families SHHP can serve, while the need for subsidized housing continues to increase. Each year, HUD issues a competitive notice of funding availability for homeless housing and services. However, SHHP is restricted in its ability to apply for these federal funds due to a lack of state matching dollars. In addition, SHHP receives no state funds, further limiting SHHP's ability to provide rental assistance to persons with disabilities and persons who are homeless. Historically, all of SHHP's staff salaries and benefits have been funded from Section 8 administrative funds. Prior to January 2004, homeless and resource development activities were supplemented using Section 8 administrative funds. After January 2004, Congress re-categorized the use of Section 8 administrative dollars, resulting in denial of funding for homelessness initiatives. SHHP is currently using Section 8 reserves that accumulated prior to the regulation change to fund salaries of staff working on homeless initiatives, but these reserve funds will be depleted in approximately 2 years. If SHHP's homelessness activities are to continue, SHHP will require state support for functions once the reserves are depleted.

F. Information Technology Industry Trends Affecting Programs

1. Aging Technology

Continued issues exist with regard to old technology systems and applications. As these legacy environments enter into an age where they are no longer cost effective and are difficult or impossible to maintain, the Department is exposed to a much higher risk of system/application failure, resulting in adverse impacts to the Department's business. Additionally, these outdated technologies, systems and applications prevent the Department from taking advantage of statewide economies of scale that are available via consolidating applications and systems with other state departments. Normally these aging systems/applications would have been updated or replaced except that the tight fiscal environment of the state in recent years has prevented these areas to be addressed in the timely manner needed. Although the Department has had some success in the replacement of old technology, there still exists key system applications that have reached a critical point due to their age and need to be addressed. Currently (July 2007), the Department maintains 26 key system applications. Twelve of these system applications have been in service six years or longer and seven have been in service ten years or longer.

The Department will be reviewing where the use of newer technologies, i.e., Service Oriented Architecture, Web Services and web-oriented development tools (Java, etc.) can be utilized in moving the legacy systems from the old technologies. Additionally, where applicable, the Department will evaluate where these technologies can be applied to systems where the legacy technologies have been replaced.

2. Technology – Information Security

A disturbing trend in the realm of technology is the continual increase in the types of threats and attacks on computer users and associated data, both personal and business. Today the three main areas of concern are viruses, spam, and spyware.

A virus is a self-replicating program that spreads by inserting copies of itself into other executable code or documents. Viruses are one of the several types of malware (malicious software). The threat of a virus attack causes information technology resources to be consumed in either a protection mode or in a recovery mode. The protection mode uses resources to defend the system infrastructure from these attacks and can easily require a daily approach to applying filters that detect each and every virus known. The recovery mode, when needed, can consume many hundreds of hours in the repair and restoration of critical data. In the interim, computer users can be left with severely degraded service, or in worst-case scenarios, no service at all.

Spam involves sending identical or nearly identical messages to thousands or millions of recipients. Addresses of recipients are often harvested from Internet postings or web pages, obtained from databases, or simply guessed by using common names and domains. By definition, spam is sent without the permission of the recipients. The continuing escalation and proliferation of spam in the business environment has become a major worldwide problem. According to the European Commission, the costs of spam to businesses and consumers have been estimated at eight billion dollars per year. If only 1% of the 24 million small businesses in America were to send only one piece of spam, the average computer user would receive 657 spam emails a day. The resources required to effectively combat this issue continue to rise, resulting in fewer resources to be used for proactive support and implementation of technology overall.

Lastly, spyware has become the newest threat to computer users around the world. Spyware consists of computer software that gathers and reports information about a computer user without the user's knowledge or consent. These products perform many different functions, including delivering unrequested advertising (pop-up ads in particular), harvesting private information, re-routing page requests to fraudulently claim commercial site referral fees, and installing stealth phone dialers. The mitigation of spyware also consumes many hours of staff support, thus contributing to the problem of diverting reosurces from their primary job responsibilities and thus adversely impacting the Department's computer users.

These three types of malware, in conjunction with the growing problem of identity theft, are all contributors to making computer security the overall number one priority goal throughout the world. Without the continued concentrated approach to mitigating and elimating these types of threats and attacks, all computer users in all societies of the world are in danger of losing their ability to operate securely in an electronic age.

3. Disaster Recovery / Business Continuity

The natural and man-made disasters that occur underscores the importance of disaster recovery planning (DRP). In addition to a general emergency plan, computer contingency plans to protect critical information from loss, destruction, theft and other risks must be in place. An effective DRP provides for the recovery of vital records, alternative telecommunication systems, evacuation of employees, housing arrangements for the recovery team, food service and alternate sources of supplies. A computer contingency plan, on the other hand, should have emergency, back-up, recovery, test and maintenance plans. The issue is not just keeping the computers running, but how to communicate with customers, employees, and others who interact with an enterprise that suddenly has to vacate its premises. Although the DHS has made great strides in accomplishing this goal, much still needs to be accomplished to have a fully developed and tested plan in place. Once the plan is in place, annual review and testing will need to occur to keep the plan operational in the future.

4. System and Data Security

The Colorado Information Security Act ("ISA") consists of Colorado Revised Statute (C.R.S.) 24-37.5-401 through 406 and was enacted by the legislature (House Bill 06-1157) and signed into law by the Governor on June 6, 2006. The Colorado ISA recognized the importance of information security to the economic and security interests of the State of Colorado. The Colorado ISA requires each public agency to develop, document, and implement a plan to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source. It also requires public agencies to protect data that could impact citizen privacy and security. In addition, the ISA provides each agency a three-year phase-in period to achieve complete compliance with the controls and the minimum provisions established in the Colorado Cyber Security Policies. Another requirement is that an annual risk assessment be conducted annually to guide security planning. During FY2006-07 the risk assessment was integrated into the policy gap analysis process to help accelerate the initial Agency Cyber Security Plan (ACSP) development. In FY2007-08, and for each year thereafter, an enterprise self risk assessment will be required. Considerable effort and resources will be required to enable the Department to meet the requirements of the Colorado Revised Statute mentioned above and will be a major component of the technology environment in the foreseeable future.

G. Issues and Policy Changes

A. Mental Health/Substance Abuse Prevention and Treatment of Clients in Other CDHS Systems

There is increasing recognition of the need for mental health and/or substance abuse prevention and treatment in clients originating in the child welfare, TANF, and juvenile and adult criminal justice systems, leading to increased demand for services from these systems. These needs are being supported by policy and funding changes that support pilot programs and collaborative efforts across systems. Similar collaborative efforts between the Division of Vocational Rehabilitation and county departments of human services are addressing needs for vocational services for TANF recipients who have disabilities.

Youth Corrections

The Division of Youth Corrections reports significant increases in the number of youth with mental illness and substance abuse problems. Eighty-three percent of the DYC population has substance abuse treatment/intervention needs. The Division of Youth Corrections has identified the prevalence of mental health problems among committed youth at nearly two to four times the rate of problems among general population children and adolescents. In response to the need for additional mental health services for youth and a shortage of residential capacity, the Department constructed the Sol Vista Youth Services Center on the CMHIP campus. The Division is requesting to expand this 20-bed facility to the full design capacity of 40 beds, to provide additional capacity to meet the increasing need for a secure environment with mental health, substance abuse, and sex offender treatment services.

Department of Corrections

The Department of Corrections also reports significant increases in the proportions of incarcerated adults who have major mental illnesses and substance abuse problems. Seventy-five percent of the adult offender population in the Department of Corrections has substance abuse treatment/intervention needs. In a November 1998 report to the legislature, the Department of Corrections stated that almost 10 percent of its adult correctional population now meets the diagnostic criteria for major mental illnesses. This is twice the number identified in 1996, and five to six times the number identified ten years ago.

Residential Child Mental Health Programs

As a result of change in policy guidance by the federal Center for Medicare and Medicaid Services, Colorado redesigned the Residential Child Mental Health Program, formerly known as the Residential Treatment Center (RTC) Program. As a part of the redesign, Colorado developed a higher level of care Psychiatric Residential Treatment Facility, and a comparable level of care

Therapeutic Residential Child Care Facility (TRCCF) to replace the RTC program. Redesign of the program resulted in a net loss of federal funding to the state for which general fund was appropriated. The change was implemented July 1, 2007. Colorado is monitoring the program utilization for the coming years as the system transitions to the new models to assure that children continue to receive appropriate residential mental health services.

Behavioral Health Services

Individuals and families continue to identify problems accessing comprehensive services for persons with co-occurring disorders, current resources are inadequate to treat the number of persons needing such services, and the current service delivery systems are not intervening early enough to impact positive future outcomes for this population. Untreated substance use or mental health disorders are expensive and impact a variety of other systems (schools, hospitals, juvenile and criminal justice, health, child welfare, etc.); therefore it is in the state's best interests to intervene early, provide necessary services in a comprehensive way in order to avoid the high costs of untreated substance use or mental health disorders. The Alcohol and Drug Abuse Division and the Division of Mental Health have combined to form the CDHS Behavioral Health Services unit in order to improve services to the population of persons with either a substance use or mental health disorder or both. Behavioral Health Services (BHS) will promote early identification and improved outcomes for persons with substance use and/or mental health disorders while preventing or reducing the social and economic consequences of untreated substance use and/or mental health disorders.

The Legislature also recognized the importance of behavioral health services and their impact on other programs and passed House Joint Resolution 07-1050 creating a task force for the study of behavioral health funding and treatment, whose duty shall be to study mental health and substance abuse services in Colorado. The intent is to coordinate the efforts of state agencies, streamline the services provided, and to maximize federal and other funding resources.

Criminal Justice and Behavioral Health

As part of the Governor's FY 2007-2008 Recidivism Reduction Package, the Department, working with the Interagency Advisory Committee on Adult and Juvenile Correctional Treatment (IAC), will receive an increase in funding (General and Cash Funds Exempt) for an expansion of the Short-term Intensive Residential Remediation Treatment (STIRRT) program. This program focuses on reducing recidivism among adult offenders, age 18 years or older, who have been unsuccessful in community treatment for drug and alcohol abuse, who continue to commit offenses and who have been recommended to a level 4 or higher level of treatment (intensive outpatient). The STIRRT program includes a two-week intensive inpatient (residential) treatment component followed by an eight-month outpatient (continuing care) component. The expansion includes the addition of 2 residential programs (increase to a total of 4 programs) and the funding of the continuing care services. The outcome of the expansion of services and funding is an expected cost avoidance to the State, specifically in the Department of Corrections and the Judicial Department.

Community Offender Mental Health Programs

With the passing of Senate Bill 07-97, a portion of State tobacco settlement dollars is earmarked for community-based mental health programs for offenders. DMH is working with community mental health centers to develop innovative, promising practices to positively impact the early intervention, diversion, and transitional needs of juvenile and adult offenders with mental illness and substance abuse problems.

Child Mental Health

The Child Mental Health Treatment Act (CRS 27-10.3-101, et seq.) was enacted into Colorado law in 1999 through House Bill 99-1116. The Act provided access to residential treatment for children with a mental illness requiring that level of care, when a dependency and neglect action is neither appropriate nor necessary. Additionally, the Act included an appropriation to support services for children not categorically eligible for Medicaid, granted local and State-level appeal rights to families when services are denied, and a dispute resolution process when mental health agencies and county departments disagree on responsibility for providing care. More recently, the General Assembly allocated additional funding for transition services to improve post-discharge outcomes non-Medicaid children and their families.

Recognizing that additional program improvements for non-Medicaid children were necessary, the General Assembly enacted SB 07-230. Among the reforms included in this bill are expanding services to include community-based alternatives, defining the care management responsibilities of Community Mental Health Centers, extending family appeal rights to cover discharge decisions, and

enhancing data collection. These changes better align the Act and DMH with the values and principles of a system of care, a nationally recognized standard for children's mental health services.

Child Welfare

Services to pregnant women, women with dependent children, and families referred by the Child Welfare system have continued, with 11,876, or 26% of children with families involved in the Core Services Program receiving substance abuse treatment services, either for the child or for the parent/caregivers in FY 2006. This is a 25% increase from FY 2005 in which 9,499 children and families were served. Estimated prevalence of substance abuse among the child welfare population ranges between 40 – 80% in the child welfare literature.

B. Emphasis on Child Safety

The next federal Child and Family Services Review (CFSR) is expected to occur in June 2008. The emphasis of the CFSR is on child safety, permanency, and child and family well-being. The Department has begun efforts to involve counties and community stakeholders in the self-assessment phase of the review. The Department is expecting federal sanctions in FY 2008 related to unmet goals of a Program Improvement Plan related to the 2002 CFSR.

C. Integrated Care Management Program

In an effort to control costs and improve access to and effectiveness of services, many programs in the Colorado Department of Human Services have instituted some type of integrated care management approach to service delivery. Legislation was passed during the 2004 legislative session HB04-1451, "Concerning the Collaborative Management of Multi-Agency Services." This legislation authorizes county departments of human services and local representatives of the judicial districts, health departments, school districts, and community mental health agencies to enter into a Memorandum Of Understanding (MOU) to promote a collaborative system of local-level services to children and families. The legislation also creates the performance-based collaborative management incentive cash fund and requires allocation of the monies in the fund to provide incentives to parties to the MOU that have agreed to performance-based collaborative management, have met or exceeded performance-based performance measures specified by the state department of human services, and have successfully implemented elements of collaborative management as specified by the state board of human services. This legislation became effective July 1, 2005, and repeals the integrated care management program.

D. *Services for Persons With Developmental Disabilities*

During FY 2003-04, the federal Centers for Medicare and Medicaid Services (CMS) reviewed Colorado's home and community-based services Medicaid waivers for persons with developmental disabilities. The final CMS audit report on the Comprehensive Waiver program was issued in April 2004 and a renewal of the waiver was approved September 24, 2004. The renewal was conditioned on various changes, including (1) the removal of certain program costs from the waiver program and their transition to the Medicaid State Plan, and (2) steps to increase financial oversight and accountability for the program, including steps to "unbundle" services and costs in the comprehensive waiver program.

In FY 2004-05, Colorado unbundled the collection of service encounter data and differentiated costs through Community Centered Board (CCB) audits, but the billings were still bundled in a single rate. In addition, the CCBs continued to negotiate rates as the Organized Health Care Delivery System (OHCDS). CMS has since stated that billings must be unbundled, all providers must have the choice to bill directly to the state through the Medicaid Management Information System (MMIS) or to use CCBs as the OHCDS, and that there must be a uniform rate setting methodology.

Effective July 2006, the State established and implemented interim statewide uniform rates based on analysis of existing rates. Providers were given the option to enroll as Medicaid providers and to bill directly through the Medicaid Management Information System. In addition, the State implemented procedures to collect detailed "prior authorization request" data on each client, and converted claims processing from a single bundled service to nine discreet services under the waiver to improve fiscal accountability. With the short-term solution in place, the State moved forward on the long-term solution for FY 2007-08, including a selection of an assessment tool to place individuals into rate levels (Supports Intensity Scale) and awarding a contract to identify how the Waivers should be changed to ensure that they align with federal requirements, restructure rates based on individual support needs as identified by the Supports Intensity Scale; and, assisting state officials to prepare federal Waiver applications to incorporate required changes and the new rate structure. CMS is requiring Colorado make similar changes to the HCBS-SLS (Home and Community Based Services - Supported Living Services) and HCBS-CES (Home and Community Based Services - Children's Extensive Supports) Waivers in FY 2009-10. The requirement to change to a standard fee for service system resulted in the State not being able to utilize certified local match funds to enhance rates for specific people and services. The State can only use standardized State set rates. This change reduced the amount of certified local funds being allowable for federal matching funds from approximately $8,201,522 to $984,540.

A June 1999 decision by the United States Supreme Court directly impacts programs serving persons with disabilities. In Olmstead v. L.C., the United States Supreme Court ruled that unjustified institutionalization of people with disabilities is prohibited under the Americans with Disabilities Act (ADA). In its ruling, the court said that institutionalizing a person with a disability who can benefit

from living in a community, and who wishes to do so, severely limits the individual's ability to interact with others, and thus constitutes discrimination. The court suggested that states could demonstrate compliance with the ADA by showing that they have effective plans for placing qualified persons with disabilities in less restrictive settings, and that they have waiting lists for community placement that move at a reasonable pace. Colorado is in compliance with the provisions of Olmstead. The Supreme Court's ruling provides an additional incentive for these plans to be implemented, and for these and other systems to assure that people with disabilities live in the most integrated setting possible.

E. Employment Services for Persons with Disabilities

The verification process imposed by the passage of HB06S 1023 has impacted legally residing citizens with disabilities seeking services from DVR, especially those from out of state, who do not have identification at all or who do not have the type that is required by the new law.

F. Waiting Lists for State Services

Mental Health

In many parts of the state, the public mental health system has waiting lists for initial routine, non-emergency access and evaluation. In the third quarter of FY 2004, the waiting lists included 240 persons during one month. There were over 850 other persons who chose not to be placed on a wait list or were referred to other resources. The average statewide wait time for persons on the wait lists is approximately three to four weeks. Additionally, the community mental health centers have had waiting lists for specific services for several years. The Division of Mental Health contracted for a population-in-need study in 2001 that estimated the number of severely ill individuals across the state who need access to public mental health services and would seek or accept it if offered. Unmet need figures suggest that there are 36,412 adult Coloradoans with serious mental illnesses and an additional 30,041 children with serious emotional disturbances who are not receiving needed services.

A waiting list for individuals ordered by the courts to receive competency restorations at CMHIP Institute for Forensic Psychiatry has developed gradually since the December 2002 federal court settlement agreement in Neiberger v. Schoenmakers. CMHIP has experienced a dramatic increase in adult competency evaluation referrals for county jail inmates. In FY 2001-02, the hospital conducted 433 evaluations and in FY 2005-06 the Institute conducted 815 evaluations; this represents an increase of 88 percent. The CMHIP is expected to see a steady increase in demand for competency evaluations and restoration treatment in coming years, as indicated by trends during the first half of the decade.

In addition to the increase in competency orders, the department's federal court settlement agreement in Neiberger v. Schoenmakers mandates the CMHIP Institute for Forensic Psychiatry to comply with a number of requirements, including a staff-to-patient ratio (based in national averages, adequacy of programming, and staff and patient safety) and a census limit in certain clinical areas.

These factors resulted in a waiting list that ran as high as 83 in December 2006. The length of wait for admission was approximately one month and often longer. The waiting list grew despite efforts to reduce it by treating restoration patients with less violent offenses to the General Adult and Adolescent Services (i.e. civil units), which now averages a daily census of 15 competency restorations. The long waiting list precipitated a contempt of court citation against the Superintendent of CMHIP; this court action lead to the Zuniga settlement agreement (see Lawsuit and Court Orders section).

Developmental Disabilities

Waiting lists for developmental disabilities services remain large as demand for services continues to increase steadily with the population growth in Colorado. In addition, Colorado's rate of furnishing comprehensive 24-hour residential supports to its citizens with developmental disabilities is low compared to the national average.

There has been increasing need to use cost-effective support services to delay the need for more costly residential placements of people with developmental disabilities. Supported Living Services (SLS) augment whatever natural supports the adult has while he/she is waiting for comprehensive services. SLS, however, is only a temporary solution in most cases, since parents and other caregivers are unable to provide support indefinitely.

House Joint Resolution (HJR) 07-1043 establishes a legislative Interim Committee to solicit and accept reports and public testimony and consider ways to improve the developmental disabilities system, including: ways to create more transparency, reliability, efficiency, and accountability, innovative options, recommendations for new funding, and eliminate all waiting lists. At the same time, the demand for services continues to increase. One indicator is the 2007 Centers for Disease Control report that found that one in 150 children have an autism spectrum disorder (ASD). For decades, the best estimate for the prevalence of autism was four to five per 10,000 children.

Child Care

Waiting lists for the Child Care Assistance Program (CCAP) are in place in five counties, with over 1,277 affected children statewide. In SFY 2006, Denver County was able to eliminate its waiting list. Arapahoe County has over 300 on its list; Pueblo and Jefferson Counties each have over 400 on its wait list. As counties change their eligibility criteria to manage their budgets, resulting in fewer

children being eligible for the program, counties will experience waiting lists for CCAP. However, additional funds were added to the CCCAP allocation for SFY2007, which will mitigate this issue to some extent.

G. Federal Safety Standards

Public Law 109-248 (The Adam Walsh Act) implements a higher level of scrutiny that will be placed on foster and adoptive families to more thoroughly address safety issues. A more stringent background check is required, including FBI checks for all adults in the foster home and an increased demand for checks of state child abuse and neglect reports is required. Currently, Colorado's foster parents are required to have FBI-level of background when they have lived in Colorado for less than two years. This additional check will add to the amount of time that it takes to approve a foster or adoptive home because of the response time for receiving the results from the FBI. The statute also requires the creation of a national child abuse registry. Legislation is required to implement the federal statutory changes in Colorado. These requirements may have a negative impact to the Department's Title IV-E funding related to loss of administrative costs associated with children placed in unlicensed foster care. The new requirement also creates workload issues for the counties and for the Department.

H. Mental Health Institute Direct Care Staffing Requirements

Managed care systems are now in place statewide for Medicaid mental health services. As more and more clients are being treated in the least restrictive setting appropriate to their needs, the state-run Institutes increasingly provide services to persons who demonstrate the most severe and challenging behaviors. The concentration of persons with the highest level of treatment and security needs in theses facilities presents constant challenges to the staff and programs of the Institutes.

Both the Centers for Medicare and Medicaid Services and the Joint Commission on Accreditation of Healthcare Organizations have increased emphasis on active treatment, reducing the use of seclusion and restraint, and requiring that staff be available for regular treatment, programming and individual patient intervention. The Department studied the level of direct care staff at the Mental Health Institutes and determined additional direct care staff is needed. A multi-year phase-in approach was adopted and the Institutes received funding for additional direct care staff in FY 2002, FY 2003, and FY 2004. All funding for direct care staff in FY 2003 and FY 2004 was for direct care staff for the Forensics Division at CMHIP. The civil treatment units of the Mental Health Institutes, continues to need additional direct care staff to meet the staff-to-patient ratios identified in the direct care staffing study. There is ongoing discrepancy in staffing levels between civil and forensic units at CMHIP despite equivalent patient acuity levels, producing significant treatment challenges on civil units.

I. Prevention and Detection of Fraud and Abuse

The CDHS Audit Division installed a toll free fraud hotline in June of 2004 to be used by anyone wishing to report fraud related to the Department, agencies, or clients we serve. The division received 56 calls in SFY 2005, and 36 in SFY 2006, and 52 in SFY 2007. Most of the allegations involve clients who are reportedly not eligible for benefits, and those calls are referred to county investigators whenever possible. In addition to the toll free fraud hotline, the Audit Division continues to conduct *extensive* training around fraud prevention and detection to a wide variety of stakeholders, and will continue to make this a priority.

The detection of human services state and county employees perpetrating fraudulent activity has increased at least four-fold since SFY 2003-04. This trend might be attributed to improvements in technology, the use of data mining software to find the activity, increased awareness around fraud prevention and detection, and the complex environment of numerous computer system changes that have occurred over the past few years. Two of the four county frauds that were discovered pre-date CBMS, so not all of the fraudulent activity that is occurring can be attributed to new systems. Improved auditing techniques have resulted in the discovery of some of the activity. The CDHS Audit Division plans to continue to make advancements in the sophistication of error profiles and methodologies used to discover unusual activities. For example, the Audit Division currently obtains and reviews a variety of daily report in CBMS that identifies unusual transactions, and follows up on that information with the appropriate county. Two months into SFY 08, the Audit Division has recognized in $52,796 in savings (cash taken off EBT client benefit cards) from this effort. Data mining provides more than just a fraud tool, the data can be used to make improvements in processes and procedures, and can also identify or target training opportunities.

Another focus area for the Audit Division is to research and implement advancements in the use of data interfaces to prevent and detect fraud. Two years ago, the Department received a grant to implement a data matching initiative called PARIS – Public Assistance Reporting Information System. PARIS is an information exchange system designed by the Administration for Children and Families to provide State Public Assistance Agencies with appropriate data as a result of a Federal computer matching initiative. The data will allow workers to cut down on public assistance errors, fraud, and abuse by providing them with information about potential dual participation in multiple states, as well as VA and Federal income or benefits. Workers will be able to recover or prevent issuance of benefits to clients who are otherwise not eligible for public assistance. Currently 44 states and territories participate in this data-matching initiative, and Colorado savings already exceed $250,000. The Division also worked hard to implement the provisions of HB 06-1266 that allows counties to garnish workers compensation benefits for clients who have public assistance judgments/debts. The Audit Division implemented this effort with the assistance of CDOLE outside of our systems because there was no funding attached to the initiative. The hope is to continue this matching effort and document the cost/benefit of efforts so that funding can be requested to automate this in the future.

J. *Methamphetamine*

Methamphetamine use and manufacture continue to be critical issues for rural and urban communities and counties across the state. It impacts human services, public health, law enforcement, mental health, and judicial systems. Consequently, efforts to combat this problem involve cross-program, cross-system, and cross-discipline collaboration. State representatives have advocated for a comprehensive response to the problem of methamphetamine use and manufacture including, but not limited to, public health, prevention, intervention and treatment, law enforcement, the business community, social services, first responders, and the criminal justice system. In FY 2006-07, the Statewide Methamphetamine Task Force, authorized by HB06-1145, was formed to determine how best to respond to and support local communities in reducing the impact of methamphetamine use. The Methamphetamine Task Force is chaired by the Attorney General's Office and includes participation from many public and private entities, including ADAD. The Task Force has completed its first full year of work, resulting in a strategic plan and a Blueprint For Action with which to move forward and carry out its mission. Promising information for the task force is that in CY 2006, several methamphetamine indicators declined for the first time in recent years.

K. *Increased Oversight/Monitoring*

The State submitted a Plan of Correction to the Centers for Medicare and Medicaid Services in May 2006, which included a commitment that the Department of Health Care Policy and Financing and the Department of Human Services will improve oversight of the Developmental Disability Waiver program.

L. *Needs of Veterans*

What was once thought of as an appropriate setting for long term care needs, is now out dated. No longer are residents moving into a nursing home with the thought they would live there 5, 10, even 15 years. With home health and assisted living options, clients are coming to the homes sicker and for shorter time periods. In order to be a national leader in the industry, the Department recognizes the need to address the following issues:

- How to make the physical plant of nursing homes the best possible place to reside
- How to remain respectful to the culture of the WW II and Korean veteran while meeting the cultural needs of the Vietnam era veteran
- How to serve the short term, but intense needs of the Iraq/Afghanistan veteran
- How to address the needs of the 2,430 homeless veterans who may not need the intensive 24 hour skilled nursing facility level of care.

The Colorado Department of Human Service's Veterans Nursing Home Program is exploring options to fund a study to analyze the needs and wants of the veterans in Colorado in order to match the needs of the physical setting to the buildings to the appropriate care settings 5, 10, 15 and 20 years in the future. At a minimum, the study would consist of demographic analysis, key person interviews, veteran organizations focus groups, consumer focus groups, existing resident surveys, comparative analysis, determination of need and a summary of findings.

The study will assist the Department in designing the homes to match the cultural wants and needs of the changing demographic. The study may show the need for niche facilities, such as changing a home to be completely focused on dementia or Alzheimer's care. The study may show the need for an additional assisted living facility (domiciliary) at the Fitzsimons campus to serve homeless veterans and/or younger veterans coming out of Iraq/Afghanistan who need shorter-term intensive rehabilitation services wrapped around them and their families in order to return to the community. Colorado is eligible from the Veterans Administration for an additional 87 beds. The use of the beds are not limited to straight nursing home care, but can and should be used to provide a full range of continuing care.

H. Capital Construction Issues

Department of Human Services – Capital Construction and Controlled Maintenance Need

The Colorado Department of Human Services (CDHS) has a significant unmet capital construction need. CDHS facility-based programs, the Division of Youth Corrections (DYC), the Mental Health Institutes (MHI), the Regional Centers (RC) for the Developmentally Disabled and the State and Veterans Nursing Homes (SVNH), operate in older buildings lacking technically modern building systems, designed for populations different than those they currently serve, and that do not recognize the needs of programs employing current therapeutic methods for treatment. The average age of buildings, derived from the 2002 CDHS Building Physical Condition Audit, for these programs are as follows:

DYC = 29.1 years
MHI = 51.6 years
RC = 36.7 years
SVNH (general funded buildings) = 79.2 years
All CDHS Buildings = 56.0 years

The negative implications of older buildings range from facilities that are difficult to maintain due to aging building systems, to facilities designed for populations that were not as acute as those now occupying them, to facilities lacking in modern systems that support programs. CDHS facilities suffer from all of these. The advanced age of buildings is indicative of the lack of investment in replacing facilities once they have served their useful life. The buildings in the DYC system are the newest in the Department, due primarily to the expansion of bed capacity that occurred during the last decade. But many older DYC buildings also exist, such as the Adams Youth Services Center in Brighton which is functionally obsolete, while others lack space for program activities, such as individual counseling and group sessions. Outside of the new Forensic Replacement project at the Colorado Mental Health Institute at Pueblo (CMHIP), there has not been any new construction in the MHI system for over 30 years. The Colorado Mental Health Institute at Fort Logan (CMHIFL) was opened 45 years ago and has not been substantially modified since. The 35 group homes for the developmentally disabled, which make up the primary residential component of the RC system, were all constructed in the early 80's. While a number of the SVNH facilities were constructed in the late 80's to early 90's, the nursing care buildings at the Trinidad State Nursing Home date from the 50's and 60's and are in dire need of either significant renovation or replacement. It is essential that a systematic approach for replacement of aging buildings be developed and implemented or there may be dire consequences, such as recent lawsuits.

Programs and treatments have evolved to meet the needs of changing populations, but facility replacements have not kept pace. Youth committed to DYC are increasingly more sophisticated in their criminal involvement and require a wider and more comprehensive range of services and treatments. A significant portion of these youth have severe behavioral, mental health and addiction issues. Committed juveniles who were victims of past abuse, both physical and sexual, are increasing in numbers. Eight in ten committed juveniles require substance abuse treatment or intervention. Half of DYC youth have high moderate or severe mental health needs that require treatment and counseling. All of these functions require adequate space, generally not available in existing facilities, but planned for in the requested **Northeast Region Youth Services Center**. In addition, DYC's capacity to treat juveniles with mental health needs will be enhanced by the requested **Expansion of Sol Vista Youth Services Center**. The MHI facilities, particularly those in Pueblo, were designed for warehousing patients, rather than for active treatment; many of them date from the 1930's or 1950's prior to the advent of modern medications and treatment approaches. These facilities are woefully lacking in program space so critical to effective treatment. In addition, buildings at both institutes are in need of modifications as proposed in the **Suicide Risk Mitigation** project to increase the safety of patients and improvement of the patient environment as proposed with the **F Cottage Air Conditioning** project. The RC group homes were designed for a largely ambulatory population of individuals requiring rehabilitation and training, and now struggle to meet the needs of the most profoundly effected 1% of the developmentally developed population of the State. These clients can often be difficult to control and harm themselves or others during out-bursts. Much of the RC system is in need of renovation to serve these clients, similar to the improvements proposed in the **Kipling Village Remodel** project. In the SVNH system, the incidence of residents with dementia is increasing. These individuals require specialized care and unique facilities. Improvements have been made at several facilities, but to better accommodate residents needs additional improvements, such as the **CSVC McCandless Renovation** project need general fund support.

The full extent of capital need is difficult to quantify, as a critical element to establishing the big picture is the completion of a **Department Operational Master Plan**. The current Five-Year Capital Construction Plan identifies a need for nearly $200 million in capital projects. This is unquestionably only the tip of the iceberg for CHDS; the Current Replacement Value (the value to replace buildings as is without improvement) of existing buildings exceeds half a billion dollars. The full cost remains to be quantified, but if buildings were replaced only once every half-century, the majority of CDHS buildings would require immediate replacement based on age alone. The current CDHS inventory of buildings exceeds 3,250,000 gross square feet; at current institutional construction costs, the cost to replace all buildings with modern structures would be $975,000,000.

The backlog of Controlled Maintenance need is also a significant issue for the Department. Due to the advanced age of facilities, many building operating systems are in need of substantial repair or complete replacement due to obsolescence. The 2002 Building Physical Condition Audit (Audit) established a Department-wide Facility Condition Index (FCI) of 65.6 on a scale of 100. FCI is a measure of the cost of remedying building deficiencies compared to building replacement value. This value is one of the lowest FCI ratings of any agency in State government. The condition of infrastructure on CDHS campuses is no better, and an audit underway

confirms, in all likelihood, is worse than that of buildings. When complete, this Infrastructure Condition Audit will establish an Infrastructure Condition Index (ICI), similar to the FCI for buildings; which will quantify infrastructure replacement cost.

The CDHS FY 08-09 Controlled Maintenance Request (Request) will identify 16 specific projects totaling approximately $9,000,000 for funding during the next budget cycle. This amount would address immediate needs for repair and replacement, but realistically do little to impact the overall backlog of deferred maintenance needs. The Request will identify a total of about $80,000,000 of projects in a five year planning window. The backlog of controlled maintenance for buildings and infrastructure was estimated at over $140 million in 2002, it has continued to grow. The Audit projected that to make substantive progress in reducing the backlog and to eliminate it in 20 years, the Department would need $17 million in Controlled Maintenance funds annually. In recent years, CDHS has received about $5 million a year, when funds were available for the Controlled Maintenance program. CDHS has been consistently losing ground and the backlog has been increasing as a result.

A fundamental problem, in addressing the Department's capital need, is the inability to replace worn-out buildings due in part to a lack of a variety of revenue sources. Only the SVNH system has some access to Federal Grants and as pressure has mounted on the Federal budget, this source is not reliable. Instead, the Department is highly dependent on the general fund with little opportunity for the generation of funds through gifts, bequests, foundations and benefactors. This situation is compounded by the rather static population in three of the CDHS program systems (MHI, RC and SVNH). When growth in populations occur, and capacity is created through the construction of new buildings, the average age of buildings drops and older buildings are either replaced or at least make-up a smaller proportion of building inventory. When populations are not on the increase, capacity is not expanded and older buildings continue to be used, despite becoming programmatically obsolete.

Summary of Capital Need by Program

(a) Division of Youth Corrections

The DYC committed population has become increasingly complex. Juveniles entering the DYC system present a variety of specialized and intensive needs, including mental health counseling, addiction treatment, and sex offense issues, along with increasing criminal sophistication and gang involvement. These youth will continue to press the system for delivery of services. New facilities must accommodate these services and older facilities will need to be modified to accommodate treatment activities, and to ensure an appropriate level of safety and security for youth, staff and the general public. DYC's facilities should be periodically evaluated to determine what improvements may be required.

The Department has included, in its Five Year Capital Construction Plan, a Year 2 Request for funds to prepare a facility program plan for a centralized Assessment, Classification and Diagnostic Center (ADCC) to improve the Division's assessment and classification functions for newly committed youth. Additionally, the Five Year Plan includes a Year 3 request to replace obsolete bed capacity at the existing Lookout Mountain Youth Services Center in Golden.

(b) Mental Health Institutes

Changes in the state's mental health system continue to place pressure on the existing facilities that house programs to treat persons with mental illnesses. Services for the mentally ill have shifted from simply housing persons with mental illness to "active treatment" such that these individuals can manage their illnesses and be effectively and safely integrated into society. Existing buildings often do not contain adequate treatment space to progress patients to the community, which extends the average length of stay for these patients, and significantly increases costs to the state. Also, the acuity of those in need of mental health treatment remains high in the State's residential facilities increasing the wear and tear on these State facilities. Driven by the Nieberger lawsuit settlement agreement, the Department has a new Institute of Forensic Psychiatry facility for the maximum and medium security levels under construction. This new facility, when complete in 2009, will address a portion of the need for the Forensics program; a new Transitional Forensic Institute remains part of the current CDHS 5 Year Capital Construction Plan. Also, the need for improved facilities for the civil side of the mental health population at both institutes must be addressed in the future. Until this portion of the mental health system can be studied in a comprehensive manner as part of the CDHS Operational Master Planning process, it will be necessary to fund capital improvements to the existing buildings in order to ensure the treatment of patients in these facilities meets certification requirements in humane settings.

(c) Regional Centers for the Developmentally Disabled

Along with an increase in the Colorado population has been an increase in the number of persons with developmental disabilities who, because of physically aggressive behaviors, sexual offenses, medical conditions or co-occurring diagnosis of developmental disability and mental illness, pose highly complicated challenges for safe and appropriate services in community settings. Generally, the state operated system for persons with developmental disabilities has been able to address the needs of persons with significant medical and behavioral conditions. However, there is a lack of state facilities specifically designed to accommodate individuals who may pose a danger to others or who are considered a public safety risk.

The department has included, in its Five Year Capital Construction Plan, a Year 2 Request for funds to prepare a facility program plan for a cluster unit facility at the Grand Junction Regional Center specifically for these individuals. This facility would be tailored to those individuals who present a public safety risk and cannot be safely placed in the satellite group homes or with community providers. The facility would be durably constructed with a level of safety, security and program support that can only

be provided in a setting separate from the community/neighborhood, while at the same time maintaining a residential home-like living environment.

(d) State and Veterans Nursing Homes

The Office of State and Veterans Nursing Homes (OSVNH) has realized considerable success in obtaining grant monies from various sources to make improvements to several of its facilities. The Colorado State Veterans Center at Homelake, the McCandless Colorado State Veterans Center in Florence and the State and Veterans Nursing Home at Fitzsimons have all benefited from grant monies. In addition, the Department has invested significant amounts of enterprise funds to upgrading facilities. However, the monies invested have been unable to meet all the needs of aging facilities. Currently, Colorado devotes less funding to the support of state and veterans nursing homes than most other states. The passage of Senate Bill 07-014 was a step forward. While no monies were included with this bill, it will allow the OSVNH to compete with other agencies for general fund support. The Office of State and Veterans Nursing Homes is also in the process of updating its five-year capital needs plan in order to assure its buildings serve veterans in the most appropriate settings in the future. Issues of current concern including the role of each facility in a strategy for the system as a whole, also how best to pursue funding of improvements will be explored. The results of this plan will be consolidated in the Department's Operational Master Plan.

(e) Information Technology Systems

Numerous CDHS programs depend on computer-based Information Technology (IT) systems for facilitating a wide-range of services to both the citizens of the State and Department staff. These systems have a limited life span and become obsolete. With accurate data essential to tracking information on those the Department serves, and since this information is often used for payment of benefits, accuracy and efficiency is critical. CDHS received a FY 2007-08 appropriation for the replacement of the Child Care Automated Tracking System (CHATS) which supports the Colorado Child Care Assistance Program (CCCAP). The FY 2008-09 Capital Construction Request includes a project for a feasibility study to determine how best to migrate the 20-year old ACSES System to a new platform in a cost-effective manner while maintaining all of the functionality so critical to the program, its beneficiaries, and users. This system is essential to the Child Support Enforcement Division of the Office of Self-Sufficiency. Additional IT systems will require replacement in the future to keep pace with changing Federal regulations and ensure reliability.

The Department's Request for an Operational Master Plan

Individual program groups and the Office of Operations have in recent years engaged in a number of strategic planning sessions to look at the future capital needs of the Department. Each program has developed prioritized capital construction requests that annually are included in the CDHS Capital Construction Request document. It is now timely, however, for a more comprehensive approach to planning within the Department to fully realize the ability of programs to cooperatively develop more efficient program service

delivery and more effective treatment strategies. Also, needed facility improvements to better support programs should be identified and documented. The Department's request for an Operational Master Plan (Plan) will serve as the vehicle to develop this strategy for programs and facilities. Major evaluation elements that will serve as the foundation for the Plan include:

Building and Infrastructure Physical Condition Audits (updates)
Code Compliance audits based on the International Building Code series
Program Sufficiency audits of existing facilities for the programs served
Safety & Security assessments of existing buildings
Standards Compliance evaluations

The Plan will utilize this information, along with extensive program input, to map the direction for programs, to identify required improvements to support program initiatives, and to develop implementation strategies. The Plan will form the basis for future capital construction requests and ensure capital funds are used in the most effective manner to address Department goals for meeting citizens needs.

High Performance State Buildings

The State of Colorado jumped to the forefront of the green building movement when Senate Bill 07-051 became law. The Department of Personnel and Administration, through the Office of the State Architect, is developing a High Performance Standard Certification Program. This program will influence all new construction and substantial renovations of State buildings. With a primary goal of reducing long term operating costs, while reducing the impact of State facilities on the environment, this program will shape how projects are designed and constructed. The program will be modeled after the Green Building Council's LEED (Leadership in Energy and Environmental Design) program. Some of the provisions of the program will reinforce measures prudent in any new development, while others will create new challenges. Some programmatic aspects of CDHS facilities are contrary to the objectives of the LEED program. For example, energy can be saved by changing thermostat settings to reduce energy consumption when buildings are not occupied; however, the Department's program buildings are occupied 24hours/day 365 days/year. Also, safety and security concerns preclude saving energy consumed for systems such as security lighting and surveillance systems. In addition, often the Department's buildings are sited in a manner that penalizes them when LEED certification points are tabulated. CDHS facilities are frequently separated from other uses and dense development, in non-urban areas; negative factors when certification is sought. The challenge for the Department will be achieving the highest level of certification both cost efficient and practicable, while keeping intact programmatic requirements. The Department has already made significant strides in energy conservation with an aggressive and far-reaching performance contracting program, which has become a model for State government. This program has already reduced utility costs by making improvements to buildings which have reasonable payback periods. Performance contracting will continue to be implemented in parallel with efforts to replace existing facilities with ones which are environmentally responsible.

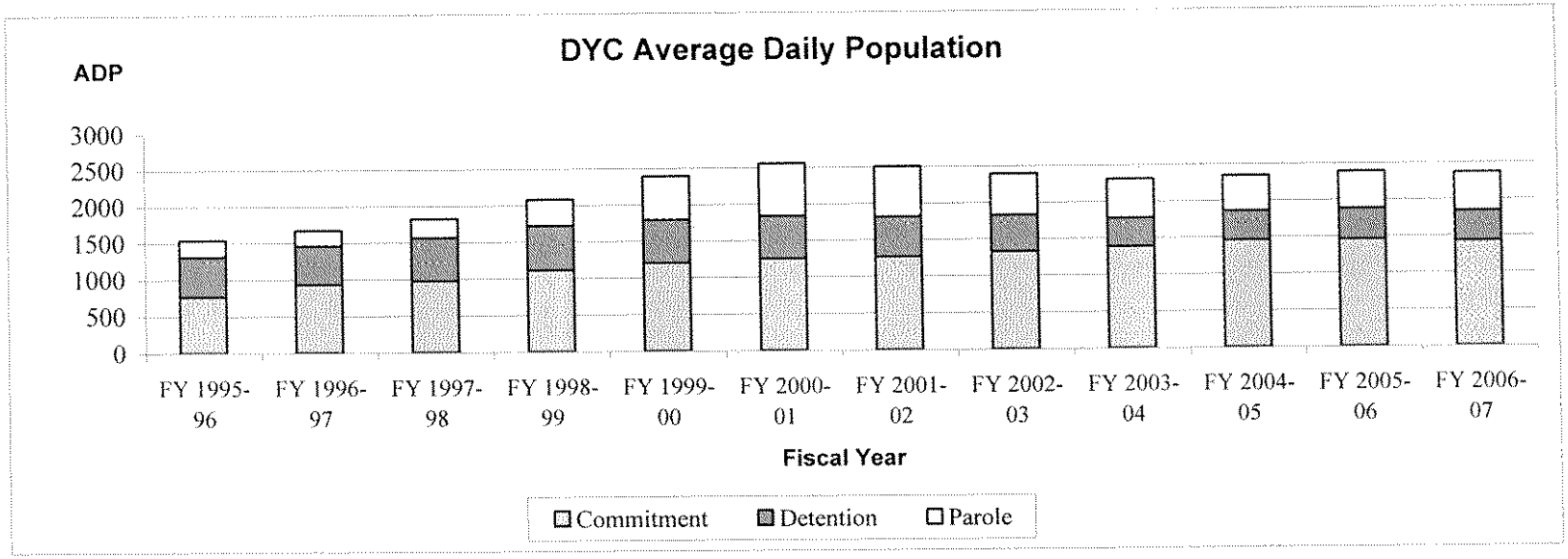
I. Program Caseloads

Office of Children, Youth and Family Services

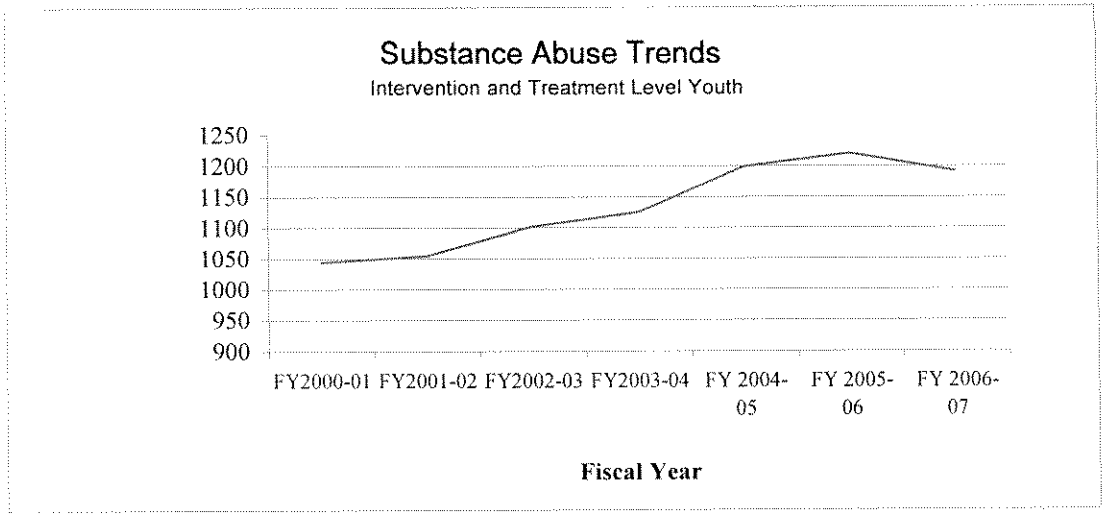
There are three divisions under the Office of Children, Youth and Family Services: 1) the Division of Youth Corrections; 2) the Division of Child Welfare; and 3) the Division of Child Care. The next section details the caseload trends for these three divisions.

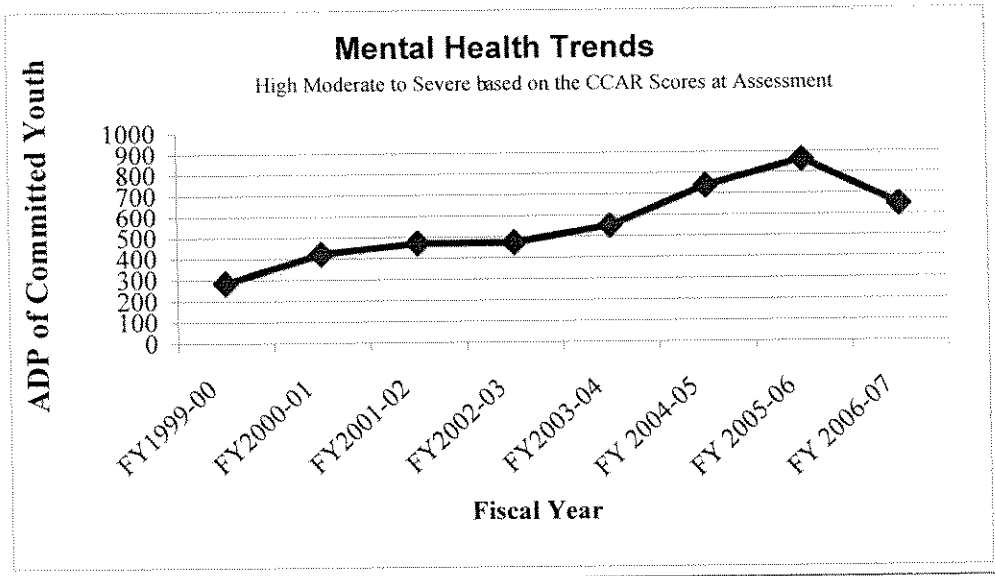
Division of Youth Corrections:

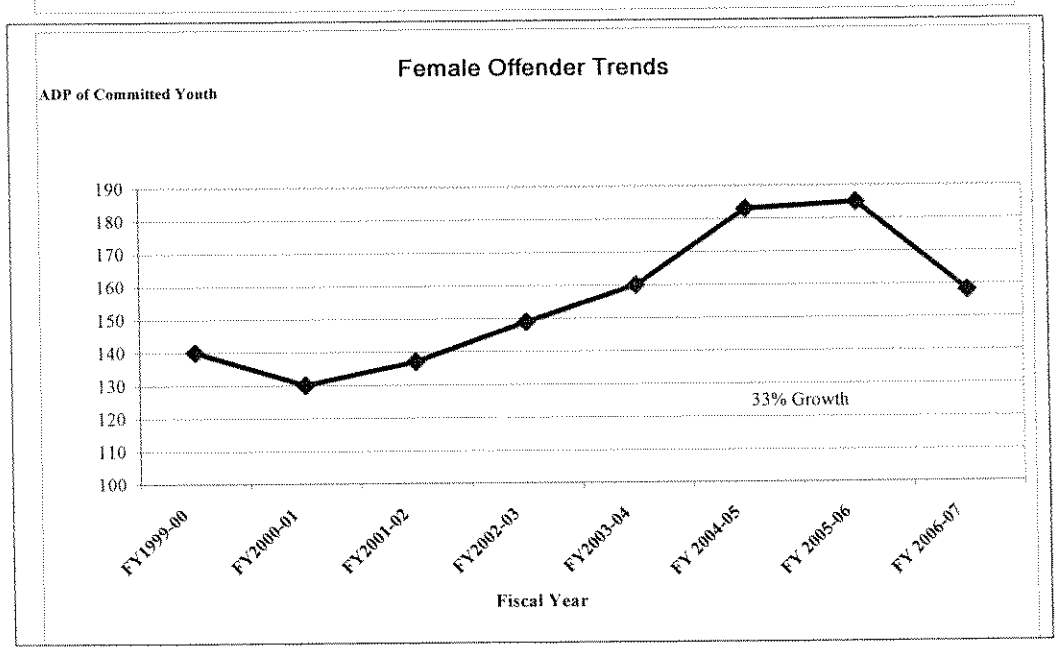
The table below details trends in the Average Daily Population (ADP) of committed, detention, and parole youth over the last several years. The December 2006 Legislative Council Staff (LCS) juvenile commitment population projections indicate that the DYC commitment population will total 1,489.4 ADP in FY 2007-08 to 1,522.1 ADP in FY 2008-09 and 1,551.0 ADP in FY 2009-10. 1,459.7 Average Daily Population (ADP) in FY 2006-07 and 1,489.4 ADP in FY 2007-08. The FY 2007-08 projection is 59.6 ADP lower, respectively, than the December 2005 LCS projections for the same fiscal year timeframe. The December 2006 LCS projection identifies the Division's Continuum of Care Initiative as a significant factor influencing commitment populations downward. LCS states *"...the on-going impact of the Continuum of Care Initiative (has) served to lower the forecast from a year ago."* The LCS document also states that *"continued and consistent funding"* of the Division's Continuum of Care Initiative *"is expected to reduce growth in commitments, particularly in the near term."* The Division believes the 0.1 percent reduction in actual FY 2005-06 commitment ADP from the prior year, and the reduction in projected commitment ADP is likely a result of the Division's Continuum of Care Initiative. FY 2005-06 represents the first year in 14 years that the Division has seen a ***decrease*** in the commitment ADP.



In addition to growth in the overall population of youth served by the Division, the following charts demonstrate the significant growth trends for youth in the Division with high risk and/or high need profiles.


Substance Abuse Trends
Intervention and Treatment Level Youth
1250
1200
1150
1100
1050
1000
950
900
FY2000-01
FY2001-02
FY2002-03
FY2003-04
FY 2004-05
FY 2005-06
FY 2006-07
Fiscal Year


Mental Health Trends
High Moderate to Severe based on the CCAR Scores at Assessment
ADP of Committed Youth
1000
900
800
700
600
500
400
300
200
100
0
FY1999-00
FY2000-01
FY2001-02
FY2002-03
FY2003-04
FY 2004-05
FY 2005-06
FY 2006-07
Fiscal Year


Female Offender Trends
ADP of Committed Youth
190
180
170
160
150
140
130
120
110
100
33% Growth
FY1999-00
FY2000-01
FY2001-02
FY2002-03
FY2003-04
FY 2004-05
FY 2005-06
FY 2006-07
Fiscal Year

Division of Child Welfare:

The following table describes the major trends that have emerged in the Child Welfare Division over the past seven years:

Trends	FY00-01	FY01-02	FY02-03	FY03-04	FY04-05	FY05-06	FY06-07**
Unduplicated Monthly Average Number of Children Served *	24,671	27,997	28,916	29,284	29,520	30,456	
% Change From Prior Yr	.78%	13.87%	3.28%	1.27%	0.81%	3.17%	
Average Number of Subsidized Adoption Placements	5,493	6,130	6,807	7,512	8,045	8,494	
% Change From Prior Yr	14.99%	11.60%	11.04%	10.36%	7.10%	5.58%	
Monthly Average Residential Mental Health Placements	1,365	1,449	1,439	1,255	1,265	1,311	
Residential Mental Health Placements as a % of all OOH	16.66%	17.92%	17.62%	16.50%	15.92%	15.97%	

*Monthly Average – The monthly average uses an unduplicated count of children per month that had a Trails assessment or an involvement open during that month. The average is calculated based on the 12 months of data.

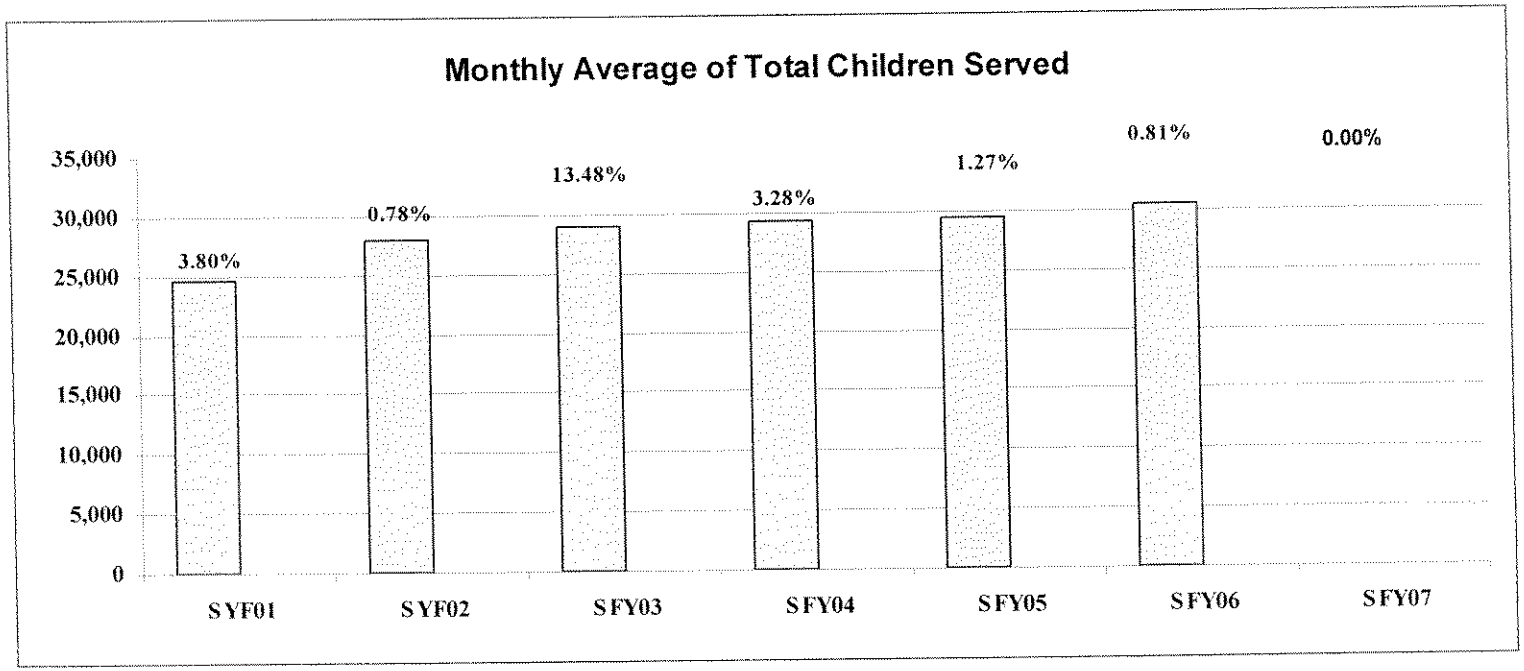
** FY06-07 data will be available in the Fall of 2007.

** Data from SFY01 through SFY06 reflect RTC placements. Data beginning in SYF07 reflects TRCCF and PRTF placements.

Monthly Average of Total Children Served:

The number of children in need of protection and families needing assistance in caring for their children continues to increase. Part of the increase is attributable to Colorado's population increase. The population for children ages 0-17 for SFY2006-007 has seen an overall increase of xx%. * FY07 data will be available in the Fall of 2007.

Additionally, during the economic downturn in Colorado's economy, counties have experienced an increase in the number of children who are being abused or neglected.



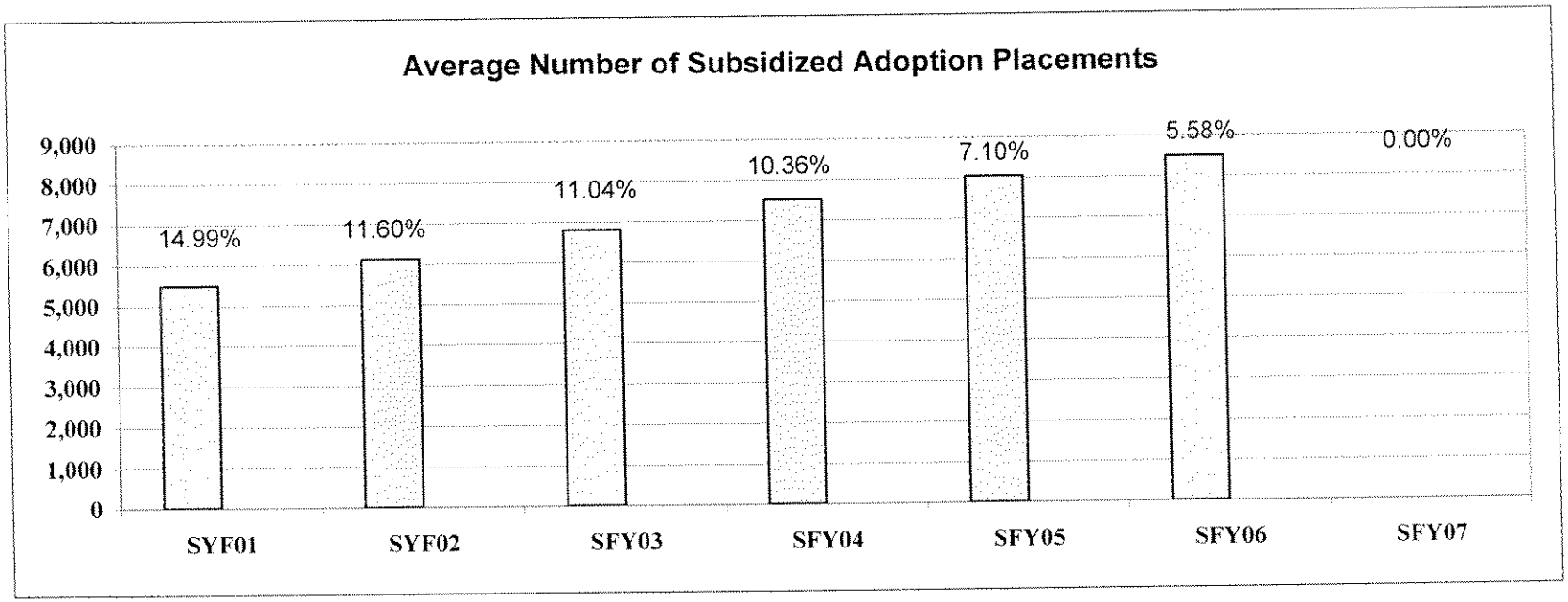
Finally, counties are intervening in families earlier to decrease penetration into higher levels of care in the system and to also try to decrease length of time the family is involved with the county. This chart reflects the increase/decrease from the previous fiscal year.

Average Number of Subsidized Adoption Placements

Colorado has seen an increase in the number of adoptions as a result of the 1997 Adoption and Safe Family Act (ASFA) that requires that permanency be achieved within 24 months of a child's last entry into foster care when the child can no longer return home and the goal becomes adoption.

ASFA also requires that the county enter into a termination hearing when a child has been in out-of-home care for 15 of the last 22 months when no compelling reasons exist to maintain the child in foster care.

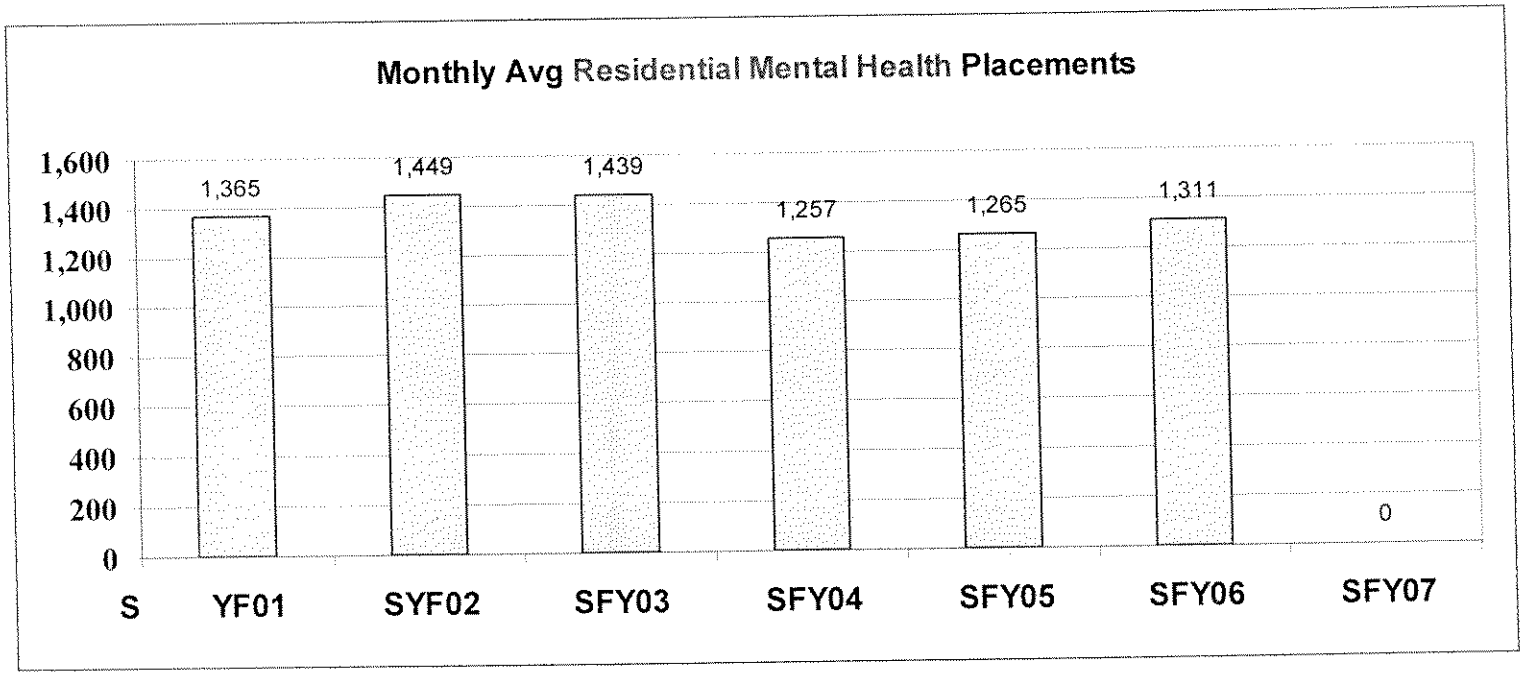
Since 1994 Colorado has been a concurrent planning state. Concurrent Planning means the simultaneous preparation of plans to: 1) assist the child's parents in completing a treatment plan that, when completed by the parents, will allow the child to safely return to the parents' home; and, 2) place the child in a setting that will become the child's permanent home if the parents are unable to successfully complete their treatment plan. This shift in practice, utilization of Expedited Permanency Planning through statute, and the use of Family Group Decision Making mediation, have all assisted in the adoption increase. The chart below reflects the increase from the previous fiscal.



Monthly Average of Residential Mental Health Placements

The census in RTCs reached their peak in FY 2002 and decreased significantly after FY 2003. This is largely a result of a shift in county practice to place children in lower levels of care, but it also reflects a decrease in the number of children in out-of-home placements from FY 2003 forward. Although RTC census and out-of-home placements show a small "bump" up for FY 2006 overall, changes in county practice and the re-design of residential care is showing a drop in residential treatment for FY 2007.

The chart below compares Residential Mental Health number of placements for each year. Data from SFY01 through SFY06 reflect RTC placements. Data beginning in SYF07 reflects TRCCF and PRTF placements.



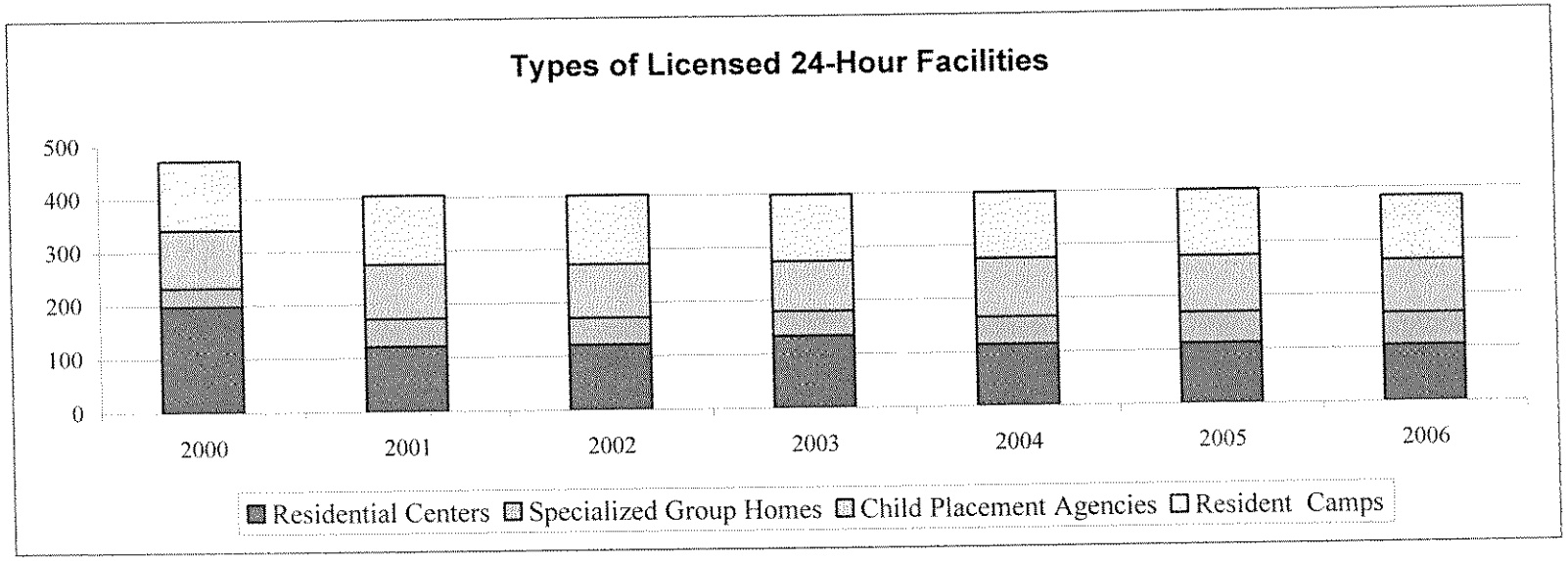
Division of Child Care:

Types of Child Care Facilities

Less than 24-hour facilities make up the bulk of the caseload of the Division of Child Care. 24-hour facilities are complex facilities that care for difficult children but are few in number. The number of 24-hour facilities has been fairly static over the last five years. Family child care homes are dropping in numbers over the last several years.

This is a trend that is not only occurring in Colorado but also happening nationally. The number of child care centers has remained stable for a number of years.

24-hour facilities have remained fairly stable over the last several years since an initial drop in residential centers in 2001.

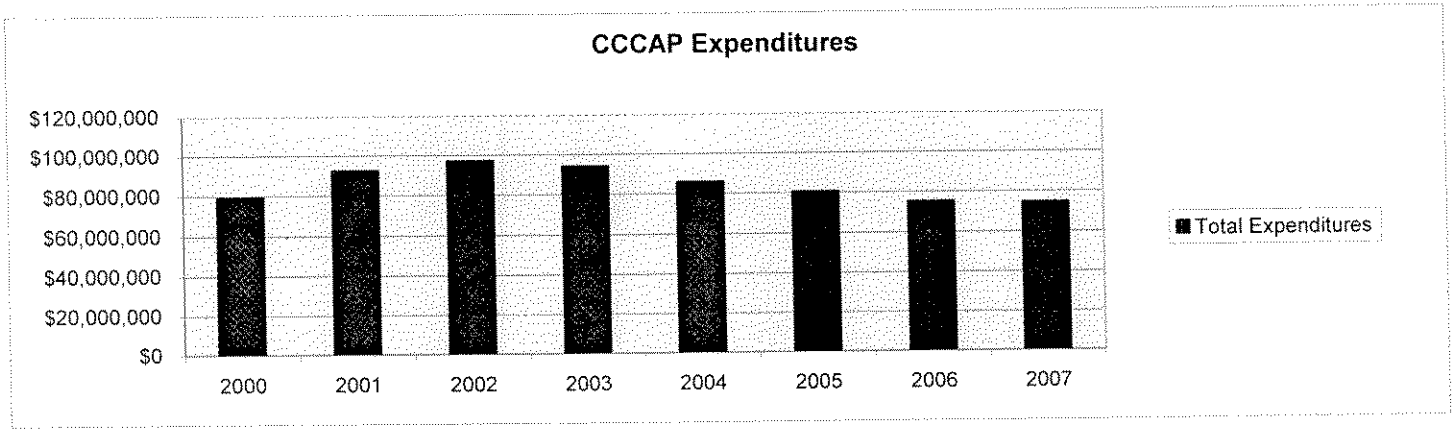


Colorado Child Care Assistance Program (CCCAP)

When this program began in July 1997, there were approximately 33,000 Colorado Child Care Assistance Program (CCCAP) children in care. By 2000, there were approximately 54,000 CCCAP children in care. Between FY 2003 and FY 2004 the number of children being served decreased by 9.4%, while total expenditures decreased by 8.7%. Between FY 2004 and FY 2005, the number of children served stayed level, while total expenditures decreased by 6.2%. Between, FY2005 and FY2006, the number of children served decreased by 11.6%, while the total expenditures decreased by 6.8%. Between, FY2006 and FY2007, the number of children served decreased by 4.5%, while the total expenditures decreased by 0.9%.

	2000	2001	2002	2003	2004	2005	2006	2007
Total Expenditures	$79,087,713	$92,525,940	$97,070,905	$93,915,311	$85,739,790	$80,426,556	$74,927,197	74,253,133
Appropriation	$59,957,161	$68,383,264	$65,048,303	$71,336,427	$72,376,513	$73,135,526	$75,768,237	74,739,133
TANF Transfer Spent	$19,130,552	$23,420,014	$30,634,560	$21,430,667	$12,360,250	$5,811,812	0	0
TANF Short Term Reserve		$0	$271,868	$70,346	$6,665	$884,953	0	0
Local Share in Excess of Long Bill		$722,661	$1,116,174	$1,077,872	$996,361	$145,502	0	0
County Only		$0	$0	$0	$0	$448,763	0	0
Total Number of Children Served	54,000	55,000	53,830	47,479	42,986	42,795	37,809	36,085
Expenditure Per Child	$1,465	$1,737	$1,807	$1,979	$1,997	$1,879	$1,982	$2,058

Data Source – Colorado Department of Human Services, Close Out Final, Accounting



Office of Self Sufficiency:

The programs under the Office of Self Sufficiency are as follows: Colorado Works; Disability Determination Services; Food and Energy Assistance Programs; Child Support Enforcement Program; and Colorado Refugee Services Program.

Colorado Works:

This program began July 1, 1997. The Aid to Families with Dependent Children (AFDC) caseload prior to implementation of Colorado Works reached a high point in FY 1993 of 42,449 cases. From this high point, the AFDC caseload dropped to an average monthly caseload of 31,894 - a decrease of 25% in caseload just prior to implementation of Colorado Works. With the implementation of Colorado Works, the rate of decline increased.

During the first full year of implementation, the average monthly caseload for basic cash assistance dropped from 31,894 to 22,735—a 29% decrease in one year. The caseload dropped every month from June 1998 (19,826) to October 2000 (10,471). After October 2000, however, the caseload steadily increased, reaching 14,930 during SFY 2006. During the past year, the caseload has averaged 12,344, representing a 17% decline from SFY 2006. We are currently examining the causes behind the caseload reduction.

The dynamics of the Colorado Works caseload has shifted over the years with a more apparent presentation of individuals who experience employment related barriers that cause long-term dependency on public assistance. These barriers include mental health, substance abuse, homelessness, domestic violence and a significant number of individuals with disabilities. The Colorado Works program hopes to get a better understanding of the caseload dynamics and evolution through the Colorado Works program evaluation that resulted from implementation of HB04-1030 in 2004.

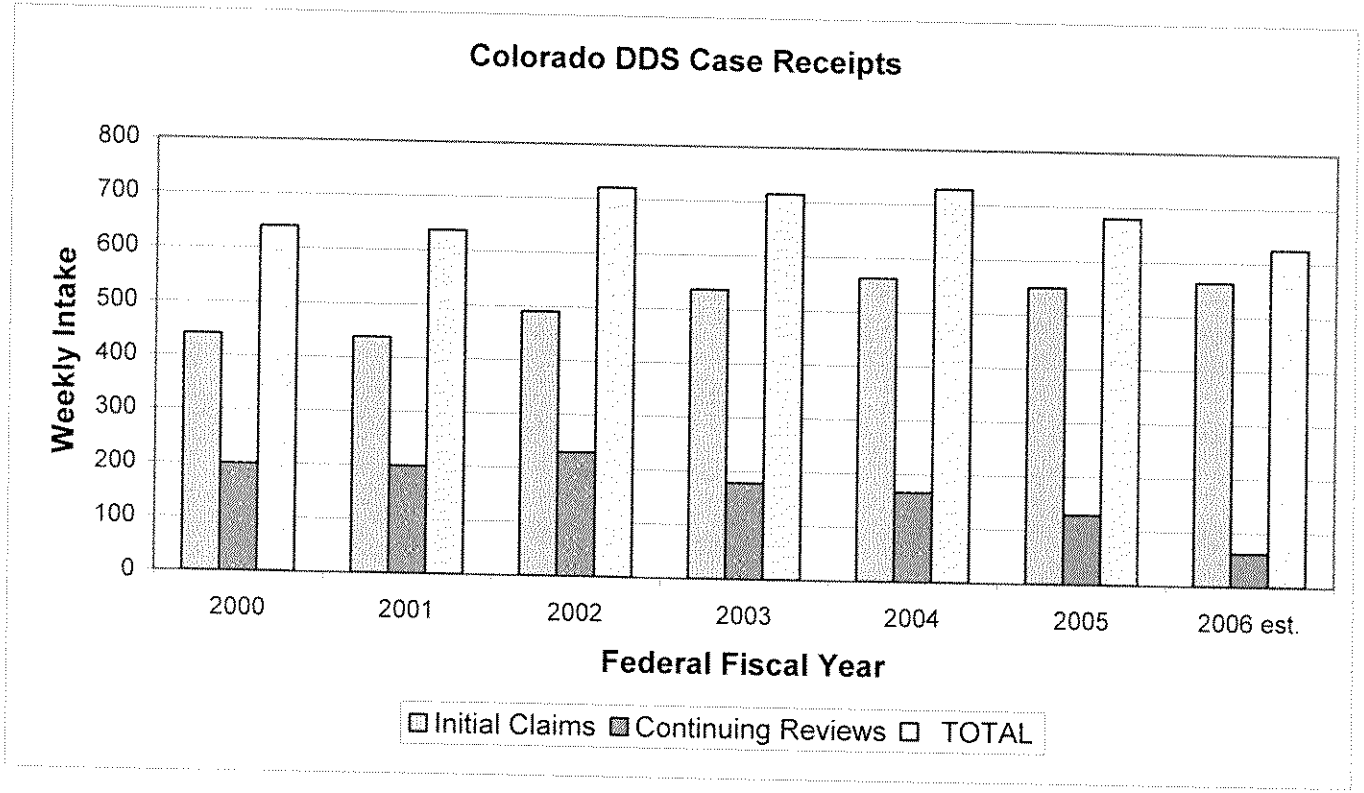
Disability Determination Services:

The Social Security Administration (SSA) and the Disability Determination Services (DDS) agencies continue to work cooperatively on redesign of the disability process. The Colorado DDS is one of 10 state agencies participating in prototype redesign that started in October 1999. The concept eliminated the reconsideration level of appeal while trying to improve the initial level of claim adjudication.

SSA announced its new approach to the disability processes in Spring 2006. Colorado will adopt the Disability Service Improvement procedures in the summer of 2007 as they are phased in across the nation. It assumes the successful implementation of a paperless (electronic) case folder. Much uncertainty exists about the impact of these changes on worker productivity, although one goal is to

reduce overall SSA processing time. The expectation from SSA is a more timely process for claimants seeking disability benefits, with awards occurring sooner in the process.

The Division anticipates growth of initial claims of 1-2% for 2008. Further, it is anticipated that the SSA will release substantially more reviews to the states, increasing workload by over 100% in that area. Staffing up to meet this increase in volume with experienced DDS adjudicators will be a challenge during 2008.



Food and Energy Assistance Programs:

Low-income Energy Assistance Program (LEAP): LEAP has more than doubled its caseload over the past six years. The program provided assistance to over 49,000 recipients in 1999-00; during the winter of 2005-06, 107,000 households received LEAP assistance. There are several reasons for this rise. First, natural gas and other heating fuel costs have risen significantly in recent years. Secondly, LEAP embarked on an aggressive outreach campaign in 2000-01, continuing every year thereafter. LEAP, in collaboration with three major utility companies, ran ads on television, radio, bus benches and billboards during the coldest winter months. The LEAP caseload decreased in 2006-07 to 93,359 households. We are currently examining the reasons for the decrease and whether any of it is due to the enactment of HB 06-1023, which added new requirements to the application process. LEAP also provides year-round furnace repair and replacement through its Crisis Intervention Program.

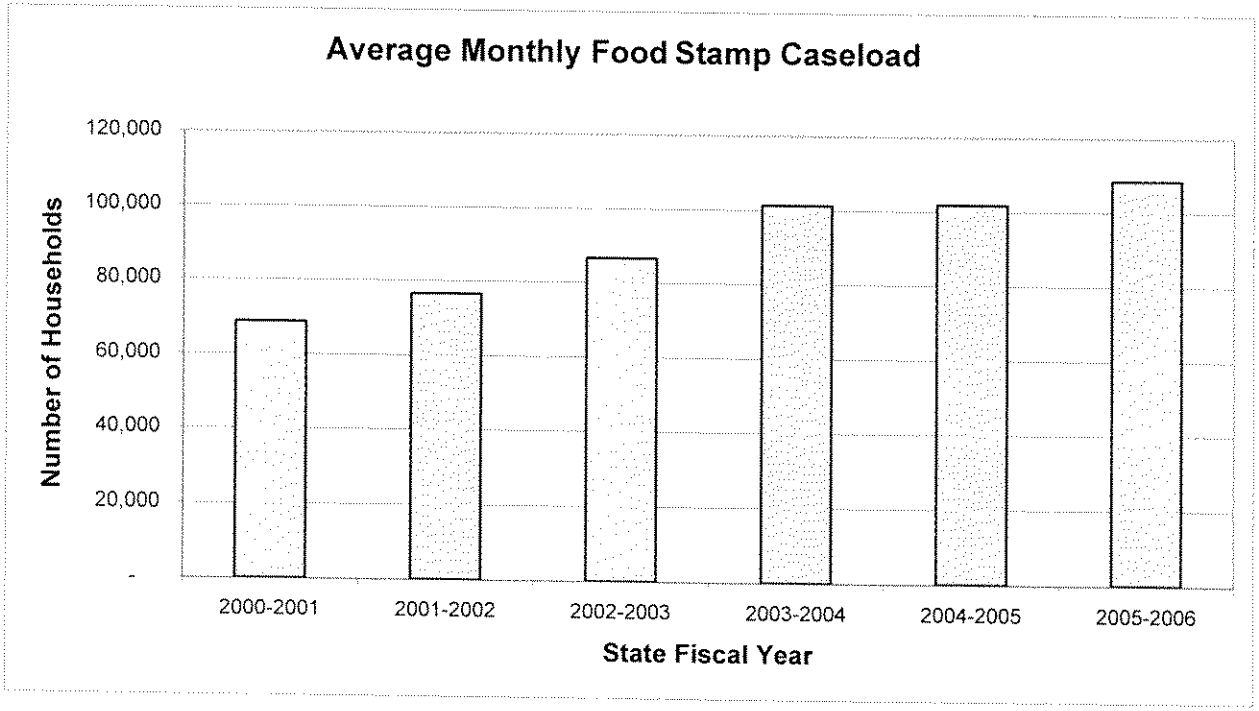
Food Distribution Programs:

The Food Distribution Program estimates that the value of commodities delivered in 2007 will be down from the value of commodities that were delivered in 2006. The amount of commodities available each year is determined by the availability of surplus commodities on the open United States market. The value of commodities from one year to the next is driven by surplus foods, which fluctuate due to weather conditions in the United States. Recruitment for the program is carried out by the seven recipient agencies, e.g., Food Bank of the Rockies. One reason for the decrease is that a number of families that had been receiving commodities are now eligible for WIC, which provides more and more-varied benefits.

State Fiscal Year	Commodities Delivered
FY 03-04	$18,594,303
FY 04-05	$18,311,493
FY 05-06	17,102,491
FY 06-07	15,487,210

Food Stamp Program:

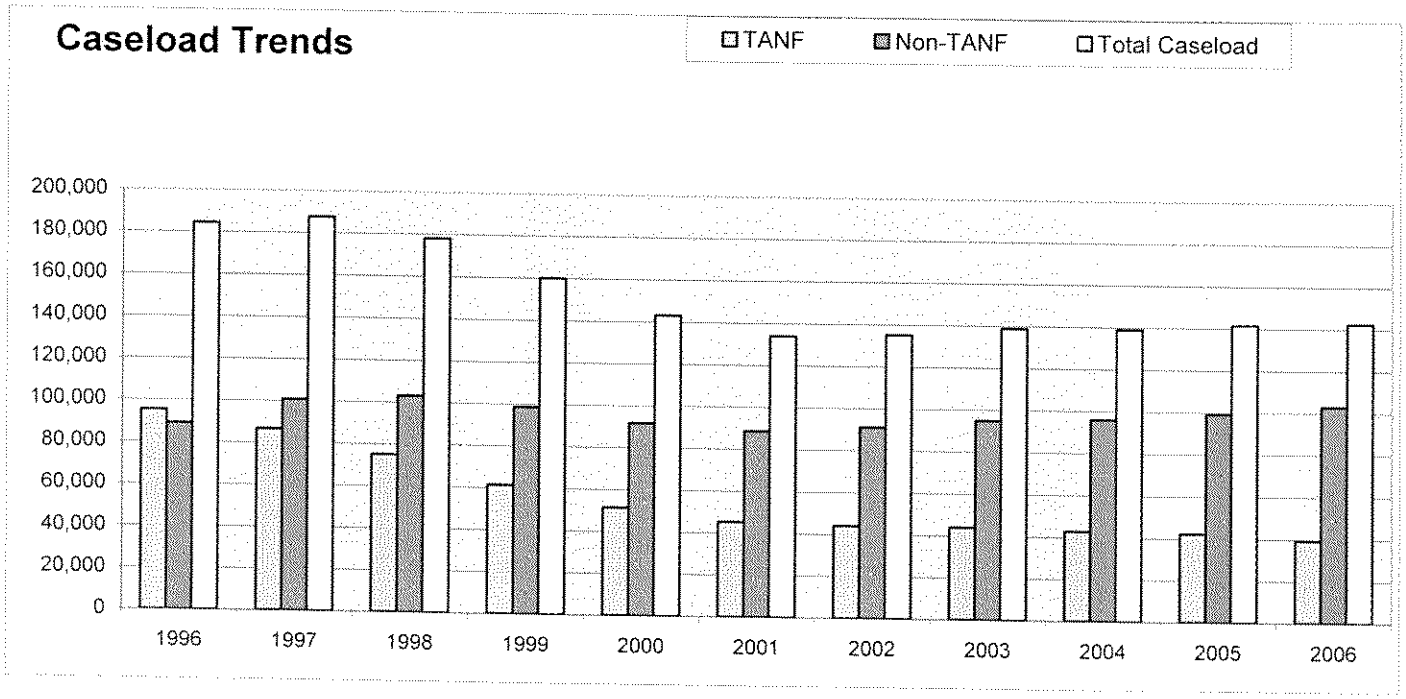
The food stamp program averaged 101,755 caseloads per month for FY 2004-05; which was the first year of CBMS implementation. Even though this represents a 5% decrease from the previous federal fiscal year, the program was soon back to and exceeding monthly caseload levels established prior to CBMS implementation. During the first 9 months of the current FY 2006-07, the average food stamp caseload was 107,000 cases per month. The continued increase in caseload impacts the program in the areas of monitoring, training, provision of technical assistance and quality assurance. An increase in caseload results in the need to strengthen program coordination, policy development and training across all programs. Food Stamp staff will also need to ensure that mandatory onsite program reviews that are imperative to effective supervision in a state supervised/county administered model of service delivery are completed timely.



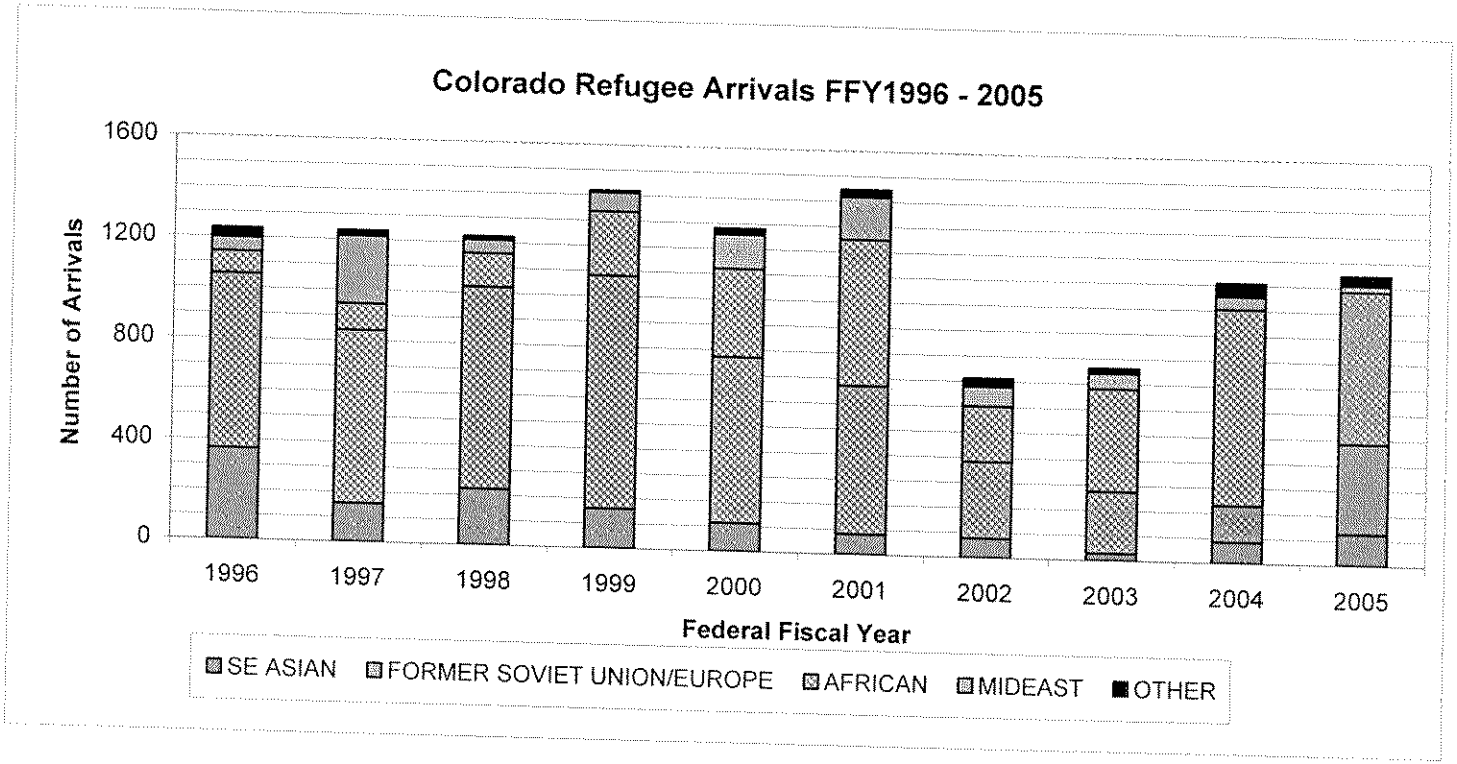
Child Support Enforcement Program:

The total caseload in this program decreased by 24% during the prior ten calendar years (1997-2006) from 187,425 to 142,489, although it has been relatively stable at around 140,000 since 2000. The composition of the caseload has changed due to the focus on family self-sufficiency that was legislated in PRWORA (The Personal Responsibility and Work Opportunity Reconciliation Act) of 1996.

Since PRWORA, the IV-A caseload has continuously declined while the non IV-A caseload has increased. The declining IV-A caseload combined with an increased national emphasis to distribute arrears collections to former TANF recipients before reimbursing IV-A arrears have resulted in more dollars being paid to families and decreased retained IV-A collections to be shared by the county, state and federal governments.



Colorado Refugee Services Program (CRSP):



There are approximately 1200 arrivals proposed for Colorado in FFY 2007. For FFY 2006, we had 1182 total arrivals. (By "arrival" we include all refugees, asylees, and secondary migrants who become eligible for services during the fiscal year.) The breakdown is as follows:

Africa	703
Europe and Central Asia	282
East Asia	117
Near East and South Asia	61
Latin America and Caribbean	19

There are three significant trends with respect to arriving populations:

First, there will continue to be a decline in the number of arrivals from the Former Soviet Union. Second, there will be a significant increase in the numbers of Burmese arrivals. The estimates are that as much as 25% of all resettlement in FFY 2008 will be Burmese. These are Burmese who have been in refugee camps on the Thai border for 10-15 years. Third, there will be a significant increase in the numbers of Iraqi arrivals. How many arrivals, and the immigration categories through which they enter the United States, remains a broadly discussed national issue. These are Iraqis who have recently fled Iraq, mostly to Syria and Jordan, because of the increasing insecurity and violence in Iraq.

Because of the changes in the arriving populations, refugee service providers are making staff changes to ensure that services continue to be provided in a linguistically and culturally appropriate manner.

FFY 2007 is the second year of a five-year Wilson-Fish cooperative agreement with the Office of Refugee Resettlement (ORR), a program under the Administration for Children and Families within the Department of Health and Human Services. The current model allows for comprehensive services, including cash assistance, from faith-based and community partners as specified in the grant. This allows the program to provide a continuum of services for up to five years after the initial date of entry by linguistically and culturally appropriate providers. CRSP anticipates increases in funding under several of its programs from ORR: Wilson-Fish, Refugee Social Services, and Cash and Medical Assistance. In addition, CRSP began receiving federal TANF funds to provide linguistically and culturally specialized employment services for refugees during 2007.

Office of Adult, Disability, and Rehabilitation Services (ADRS):

The Office of Adult, Disability, and Rehabilitation Services (ADRS) contains three Divisions, each administering a variety of programs. The programs managed by the Division of Aging and Adult Services (AAS) are: Old Age Pension (OAP), Aid to the Needy Disabled/Supplemental Security Income-Colorado Supplement (AND/SSI-CS); Aid to the Needy Disabled-State Only (AND-SO); Aid to the Blind/Supplemental Security Income-Colorado Supplement (AB/SSI-CS); Home Care Allowance; Adult Foster Care; Adult Protective Services (APS); Older Americans Act (OAA) programs; and State Funding for Senior Services (SFSS) programs. The Division for Developmental Disabilities provides: Comprehensive Residential and Day Program Services for Adults (through the community-based system and at the State Operated Regional Centers), Intermediate Care Facilities for the Mentally Retarded (ICF-MR) and Nursing Facility Services; Supported Living Services for adults, and Child and Family Services, including early intervention services, family support, and the Children's Extensive Support program. The Division of Vocational Rehabilitation operates the federal vocational rehabilitation program in Colorado and manages the federal independent living program.

Aging and Adult Services (AAS):

The Old Age Pension program, which provides financial assistance to eligible individuals age 60 and older, has three different grant payment categories (A, B and C). The grant standard for the Old Age Pension Program is currently at $648 per month, which is equivalent to 76% of the poverty level ($851 per month). There have been no measurable caseload trends in the OAP program over the last six fiscal periods. The table below contains the average monthly caseload by State Fiscal Year.

	FFY 2001-02	FFY 2002-03	FFY 2003-04	FFY 2004-05	FFY 2005-06	FFY 2006-07
OAP Caseload	24,701	25,034	24,734	24,690	24,240	24,100
Net Change		333	(300)	(44)	(450)	(140)
Percent Change		1.35%	-1.20%	-0.18%	-1.82%	-0.58%

Aid to the Needy Disabled/Supplemental Security Income-Colorado Supplement (AND/SSI-CS):

Aid to the Needy Disabled/Supplemental Security Income-Colorado Supplement (AND/SSI-CS), established in 1969, provides supplemental income to individuals receiving Supplemental Security Income (SSI) payments, up to the Colorado standard of need of $623 (effective 1/1/07). This standard of need is equivalent to 73% of the current poverty level of $851 per month. These payments are intended to assist the recipients to manage their monthly living expenses. The need standard is based on dollars appropriated to the program.

The federal SSI program is an entitlement program that provides financial assistance to persons with a disability that precludes them from securing or retaining employment for at least 12 months. Effective January 1, 2006, the maximum SSI grant is $623. The Social Security Administration decreases a SSI recipient's grant if he/she is married, lives with another person, or does not pay his or her fair share of the shelter costs. People who do not receive the full SSI grant due to being married or living with another person may qualify for the AND/SSI-CS program.

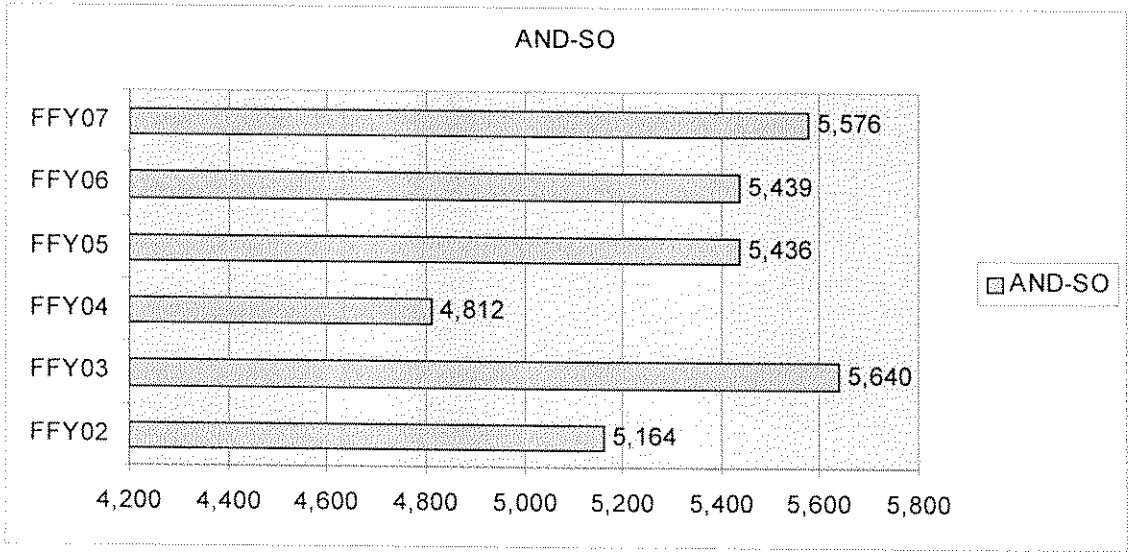
The AND/SSI-CS grant is needed as long as people have difficulty meeting shelter expenses. In SFY 2004, the grant standard was reduced and some people were no longer eligible for the grant. In SFY 2005, the implementation of CBMS ensured the placement of individuals in the proper category of assistance. This may result in a slight decrease in caseload.

The increase to the maximum grant standard increased the number of individuals eligible for AND-CS. Consequently, a new baseline has been established for trend analysis. The SFY 2006-07 average monthly caseload is approximately 978. When more yearly data is available with the $623 grant standard, trend analysis will begin.

Aid to the Needy Disabled-State Only (AND-SO):

Aid to the Needy Disabled-State Only (AND-SO), established in 1953, is the only state assistance program that provides basic financial assistance to low-income persons aged 18 to 59. To receive assistance, individuals must have a disability expected to last six months or more. Effective April 1, 2006, the maximum grant payment is $230 per month, which is only 27% of the current poverty level of $851 per month.

The AND-SO Program is linked to the federally funded and administered SSI Program. Persons who apply for AND-SO benefits must also apply for the federal program. As such, the AND-SO Program is an "interim assistance" program where state benefits are distributed pending an eligibility decision for federally funded benefits. After approval for the SSI Program is received, the state is reimbursed for payments made from the AND-SO Program fund. To qualify for Aid to the Needy Disabled-State Only benefits, a person must be certified by a physician or other designated medical practitioner as being too disabled to work at any occupation for at least six months. Applicants must meet the income limit of $230 per month, resource limit of $2,000, citizenship/legal status, and Colorado residency requirements. There may be an emerging upward trend in AND-SO clients, as can be seen in the chart below. Previous year caseload shifts were a result of changes to the grant standard; the lower the grant standard, the fewer the eligible individuals.



Aid to the Blind/Supplemental Security Income-Colorado Supplement (AB/SSI-CS):

Aid to the Blind/Supplemental Security Income-Colorado Supplement (AB/SSI-CS) was established in 1969. The purpose of this program is to supplement the recipient's income up to the current Colorado standard of need to enable recipients to meet their monthly living expenses. Effective January 1, 2006, the maximum SSI grant is $623, which is 73% of the currently poverty level of $851 per month.

The Social Security Administration decreases SSI recipients' grant if they are married, live with another person, or do not pay their fair share of the shelter costs. Those who do not receive the full SSI grant due to being married or living with another person may qualify for the AB/SSI-CS program. There are no measurable trends in the last three fiscal periods. The SFY 2006-07 average monthly caseload was approximately 1-2 individuals.

Home Care Allowance (HCA):

The Home Care Allowances (HCA) program was transferred to the CDHS from the HCPF, effective SFY 2006-07. The purpose of the program is to provide financial grants to individuals, in order for the individual to receive personal care services from informal caregivers. The intent of the program is to keep individuals independent and in their own residences. The department has only been collecting caseload data since SFY 2006-07. The estimated average caseload for HCA is 3,339. Trends will be analyzed as more fiscal year data is available.

Adult Foster Care (AFC):

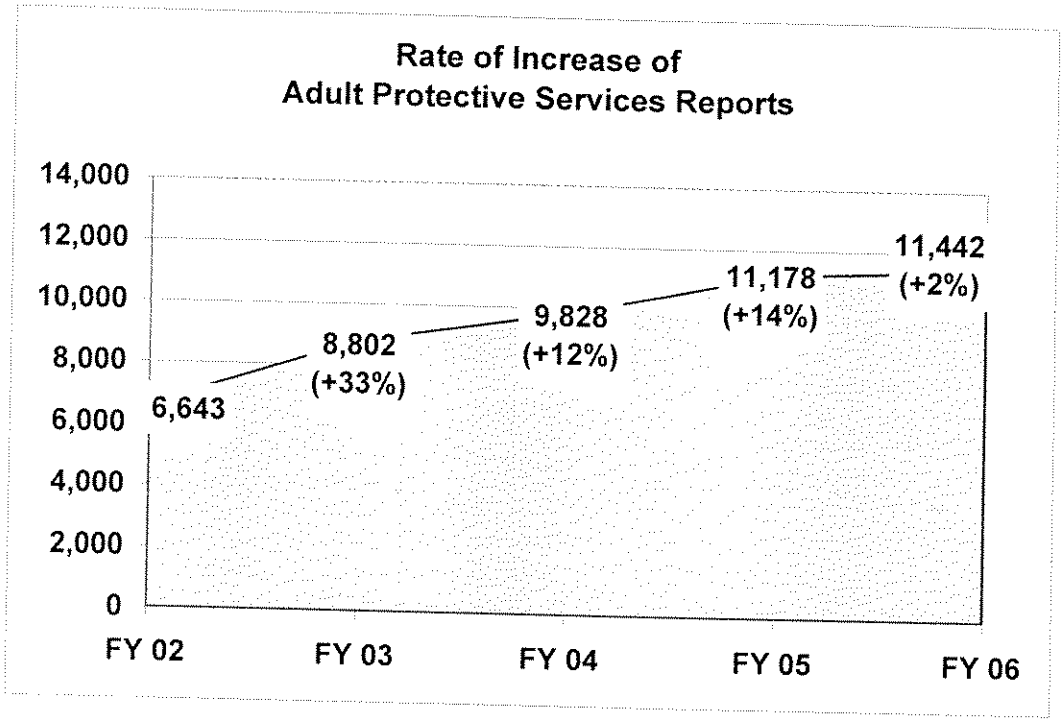
The Adult Foster Care (AFC) program was transferred to the CDHS from the HCPF, effective SFY 2006-07. The purpose of the program is to provide financial grants to individuals to be used for foster care services. Recipients give grants to the facilities and are allowed to keep fifty dollars a month for personal needs.

The department has only been collecting caseload data since SFY 2006-07. The estimated average caseload for AFC is seven. Trends will be analyzed as more fiscal year data is available.

Adult Protective Services (APS):

Reports of abuse, neglect, and exploitation of at-risk adults ages 18 and over to Adult Protective Services have steadily increased over the past decade. Reports to county Adult Protective Services programs statewide have increased by 72%, from 6,643 reports in FY 2002 to 11,442 reports in FY 2006.

The increases in reports to Adult Protective Services in Colorado are likely attributable to an increase in the population of persons over the age of 60 years (those most susceptible to adult abuse); increased reporting by the public secondary to increased education and awareness about the existence and seriousness of adult abuse; and to a lesser but notable degree, improvement in the documentation of reports across county adult protection programs.



OLDER AMERICANS ACT (OAA) AND STATE FUNDING FOR SENIOR SERVICES (SFSS):

While funding for Older Americans Act programs has remained stable since 2002, there have been dramatic changes in the funding of State Funding for Senior Services (SFSS) and the Older Coloradoans Act programs during the same time period. Over the past two State fiscal years, the amount of the SFSS has increased from three million to seven million dollars. These additional funds will allow the Area Agencies on Aging (AAA) to maintain and supplement existing services provided through the Older Americans Act programs.

The total number of services delivered to recipients of State Funding for Senior Services and the Older Coloradoans Act has decreased because of a corresponding increase in the delivery of more expensive services. These services include material aid, transportation, ombudsman, and in-home services. These services remain essential to allow seniors to live in the least restrictive (and most inexpensive) environments for longer periods of time. The number of unique individuals served in these programs has been approximately 34,000. No significant caseload shifts are expected.

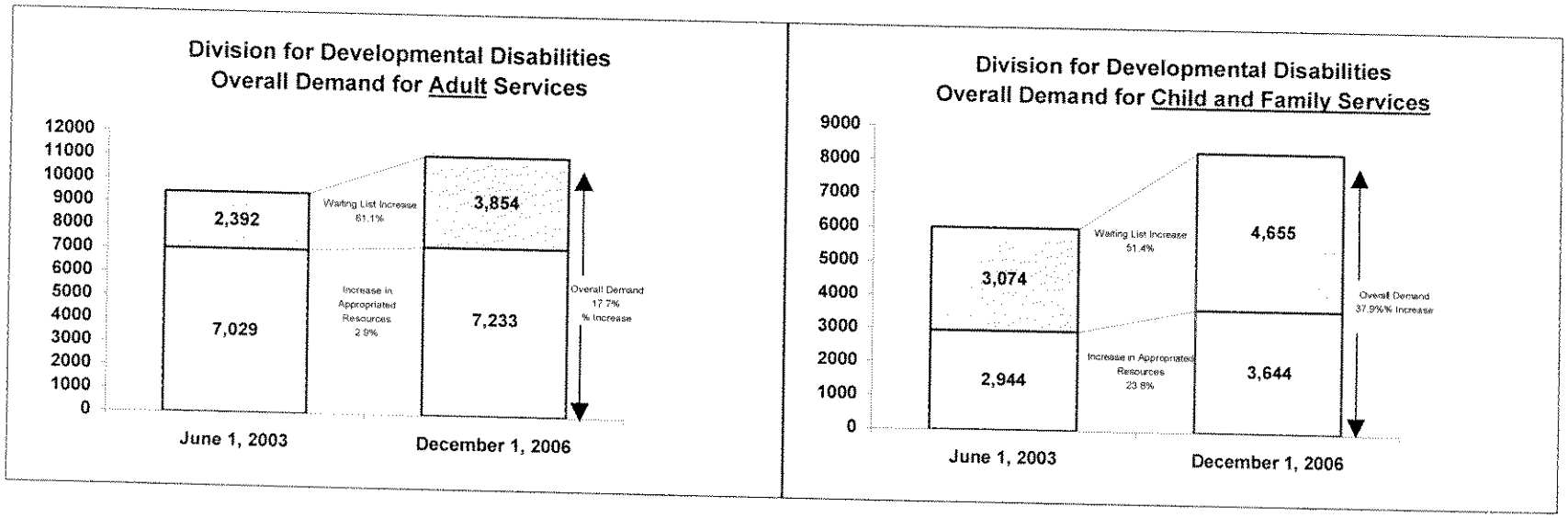
Division of Vocational Rehabilitation (DVR):

DVR operated under an order of selection from May 21, 2003, through June 30, 2006, where newly eligible individuals whose disabilities are not considered to be significant were placed on a waiting list for services. As of July 1, 2006, the wait list was lifted and DVR is currently able to serve all eligible individuals. In FY 2006-07, 2,337 DVR customers obtained suitable employment and maintained it for at least 90 days. As can be see in the table below, the division has witnessed significant improvements on this measure of production over the last three years, as well as the others by which it is evaluated. The order of selection caused a significant decline in applications for services over the past two years as referral agents were no longer referring those individuals with least significant disabilities to the program. DVR has seen a rise in the number of applicants since then and expects this to continue as a result of recent expansion efforts due to increased funding beginning in FY 2006-07.

	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Total Successful Closures	2,359	2,114	1,976	1,638	1,858	2,151	2,337
Number of New DVR Applicants	7,058	7,883	8,558	6,753	6,749	6,948	7,300
Total Clients Served by DVR	18,522	18,160	19,481	18,728	18,962	19,361	19,752

Division for Developmental Disabilities (DDD):

During the last three and one half years, the Division for Developmental Disabilities has had a 17.7% increase in its overall demand for adult services and a 37.9% increase in its overall demand for children and family services. For adult services the overall demand includes a 2.9% increase in appropriated resources from 7,029 to 7,233, and a 61.1% increase in the waiting list (those needing services within two years) from 2,392 in June 2003 to 3,854 in December 2006. For children and family services the overall demand includes a 23.8% increase in appropriated resources from 2,944 in 2003 to 3,644 in 2006, and a 51.4% increase in the waiting list (those needing services within two years) from 3,074 in June 2003 to 4,655 in December 2006.



In FY 2001, the developmental disabilities system began conducting an annual survey of individuals waiting for comprehensive (24-hour residential) services in response to Footnote 88 of the FY 2002 Appropriations Long Bill: Survey of the Waiting List for Developmental Disabilities Comprehensive Services. This survey is designed to determine actual need by date of anticipated placement. In order to complete future years surveys, additional resources will be required.

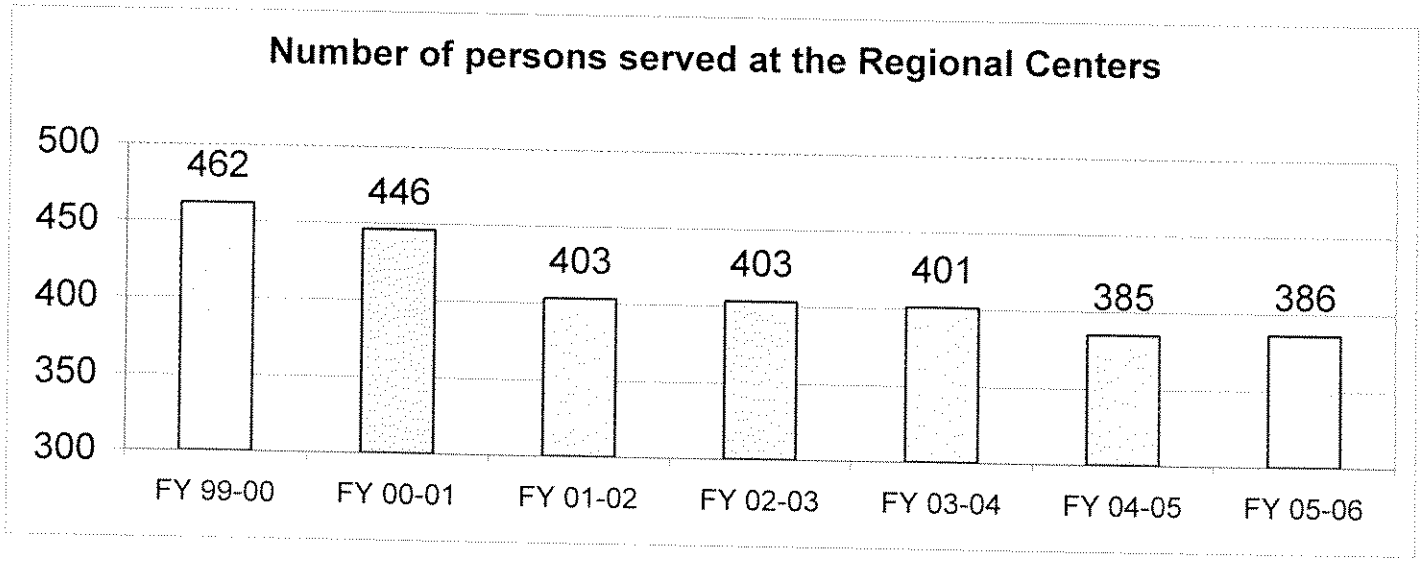
The need for comprehensive services for persons with developmental disabilities is expected to increase as parents become unable, due to their own advancing age and/or declining health, to care for their adult family members with developmental disabilities at

home. Eight percent of adults with developmental disabilities who are waiting for comprehensive services within the next two years and still living with their parents are themselves 40 years old or older, implying that their family caregivers are in their 60s or older.

Regional Centers (RC):

The role of the Regional Centers is to address the needs of the most difficult population with developmental disabilities, i.e., individuals whose needs cannot be met through the traditional community-based system. The Regional Centers continue to pursue a goal of providing services in community-based settings whenever possible. However, along with an increase in the Colorado population has been an increase in the number of persons with developmental disabilities who, because of physically aggressive behaviors, sexual offenses, medical conditions or co-occurring diagnosis of developmental disability and mental illness, pose highly complicated challenges for safe and appropriate services in community settings.

The reduction in the bed capacity of the Regional Centers from 1,310 in 1980 to 403 in FY 2002-2003 represented a decrease of 71%. Overall bed capacity remains at 403 for on-campus homes and within the local communities.



People are referred to the Regional Centers through Community Centered Boards based on their individual plan from the Mental Health Institutes, the Department of Corrections, nursing facilities and the CCB community system including persons with high needs who are waiting for services.

Regional Centers provide active treatment programs including residential services, day programs, work therapy services, and medical care, based on individual assessments and habilitation plans. These active treatment programs are intended to result in increased independence and inclusion in the community.

Office of Behavioral Health and Housing

The programs under the Office of Behavioral Health and Housing are as follows: Behavioral Health Services, including the Alcohol and Drug Abuse Division and the Division of Mental Health; the Mental Health Institutes; Supportive Housing and Homeless programs; and the Traumatic Brain Injury Program. A brief summary of General Fund dollars and numbers served by program is shown in the table below.

MH Community Program	**Community Mental Health Estimated Number Served (FY 2006-07)**	**General Fund $s (FY 2006-07)**
Indigent (LB estimate)	9,865	$30,065,061
Juvenile MH (HB 1034)	40	184,512
Assertive Comm. Treatment	160	639,051
Enhanced MH Pilot	200	493,019
Early Childhood MH Services *	376	1,135,750
Alternatives Programs*	972	2,933,815
Residential Treatment for Youth (MGF not included)	37	626,149
Total DMH	**11,650**	**$36,077,357**
Mental Health Institutes	**Duplicated number of episodes at the MHI** (FY 2005-06 Actual)**	**General Fund $s (FY 2006-07)**
CMHIFL	1,710	
CMHIP	5,471	
Total MHIs	**7,181**	**$66,659,845**
Total MHIs and DMH	**18,831**	**$102,737,202**

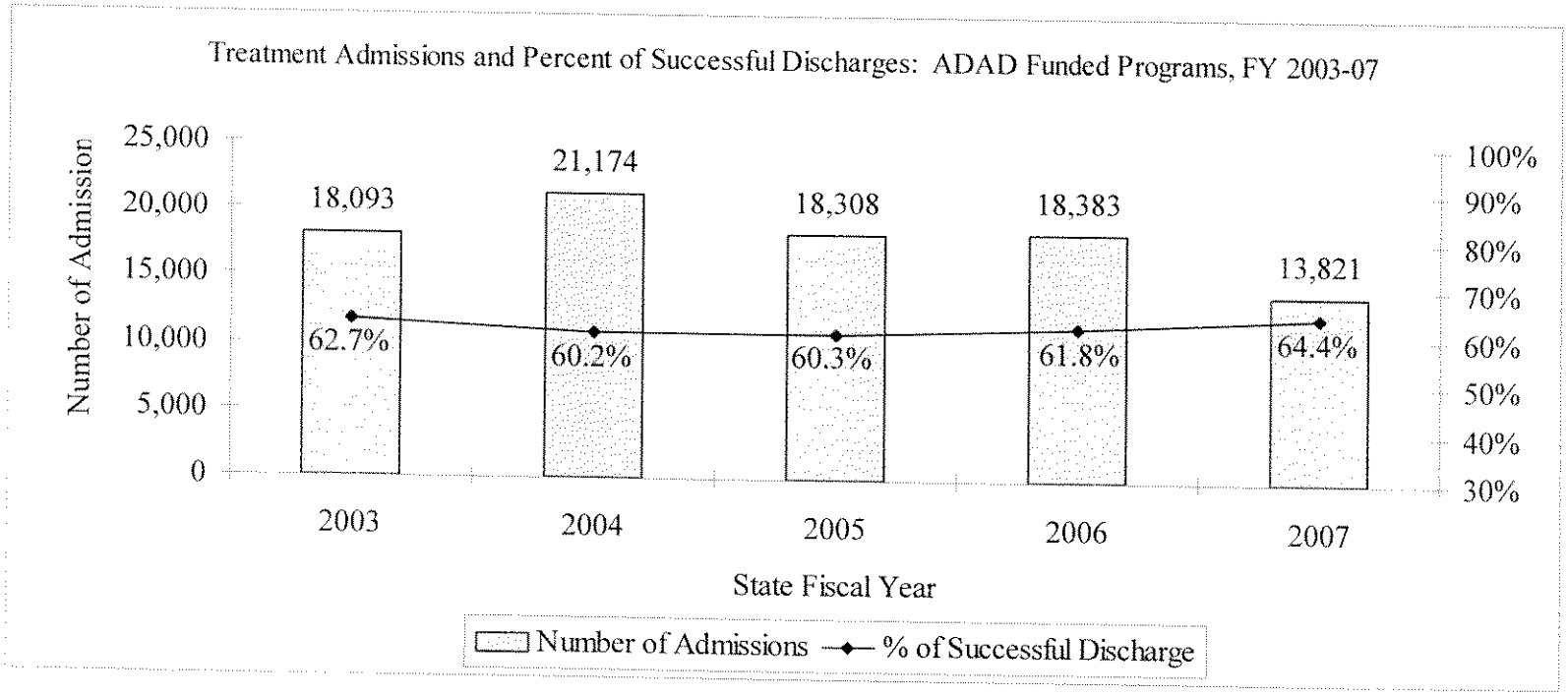
* Estimate based on total dollars divided by $3,018 average annual cost for services.

** Episodes reflect the number of existing clients on July 1, 2005, and any additional admissions throughout the year (that may have occurred for the same person), as well as ancillary services such as laboratory, radiology etc., provided to non-Fort Logan clients (e.g. DYC).

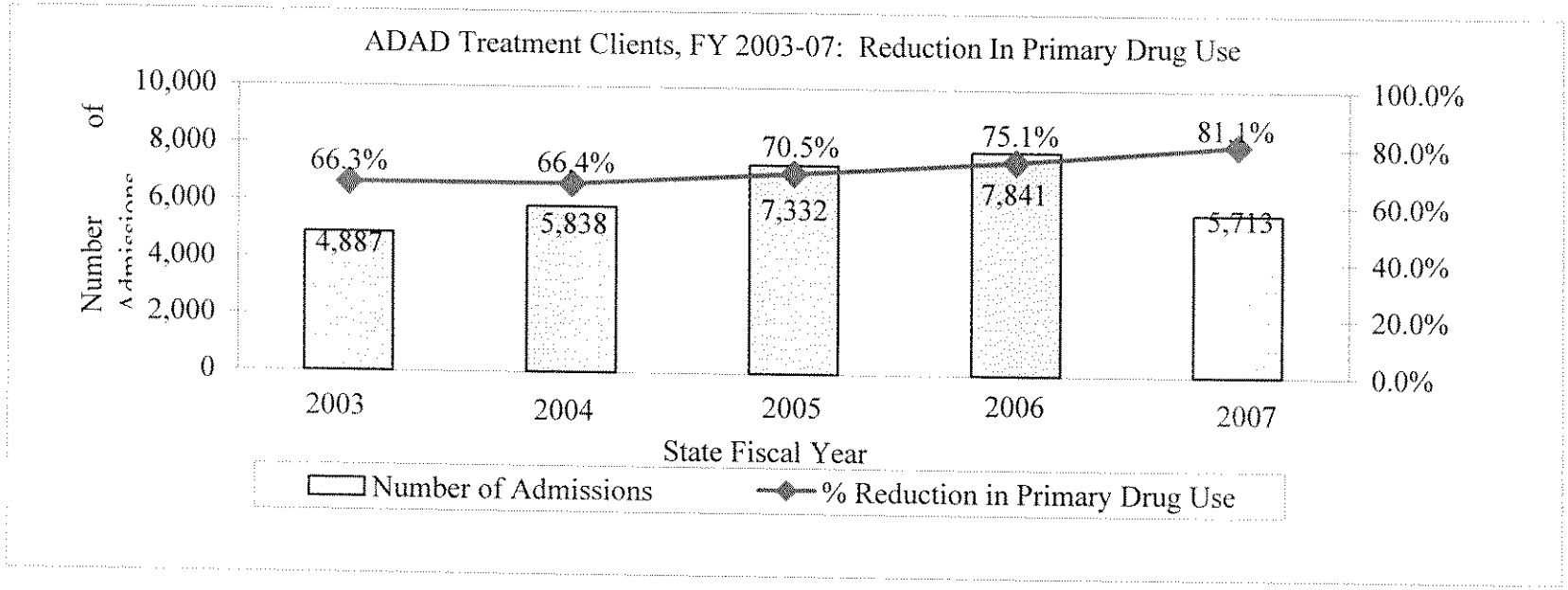
Behavioral Health Services

In FY 2006-07 the Alcohol and Drug Abuse Division and the Division of Mental Health were combined under joint administration to encourage cross system treatment of the clients served by each Division. Although it will take several years to integrate service provision, contracting and program quality activities, Behavioral Health Services is already working on administrative and data integration. The combining of these two Divisions was prompted by increasing recognition, both locally and nationally, that many clients of these two programs have co-occurring issues (e.g. substance abuse problems and mental illness) and that treatment is more effective when addressed jointly.

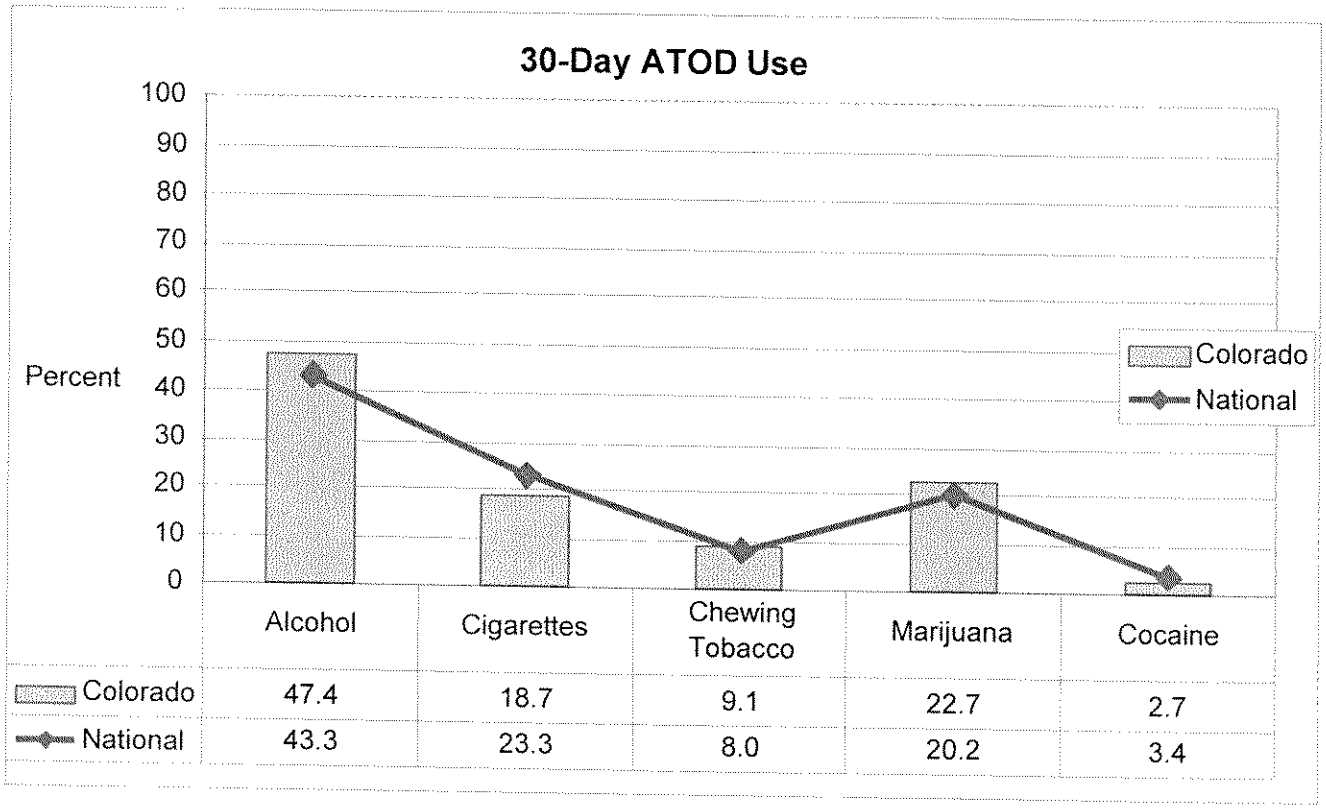
Alcohol and Drug Abuse Division



For FY 2006-07, the 33% reduction in treatment admissions is due to data reporting lags rather than a true decline in treatment admissions. The Department expects to see these figures exceed FY 2005-06 numbers when full FY 2006-07 data are available in November 2007. Also, successful discharges from treatment, or those individuals who accomplished a moderate to high achievement of their treatment goals, have increased consistently from 2004. National studies indicate that clients who complete a moderate to high percentage of their treatment plans have a more successful treatment outcome: e.g., they are not as likely to relapse as clients completing less of their treatment plans. The increase from 60.2% to 64.4% for these completions is a positive trend given those studies.



The percent of treatment clients who had a reduction in their primary drug use while in outpatient treatment has consistently increased from 66.3% in FY 2002-03 to 81.1% in FY 2006-07. This represents an overall increase in the number of clients achieving reductions in the usage of their primary drug of 22.3% within this timeframe. The Department expects to see FY 2006-07 treatment admissions increase once full FY 2006-07 data is available in November 2007.



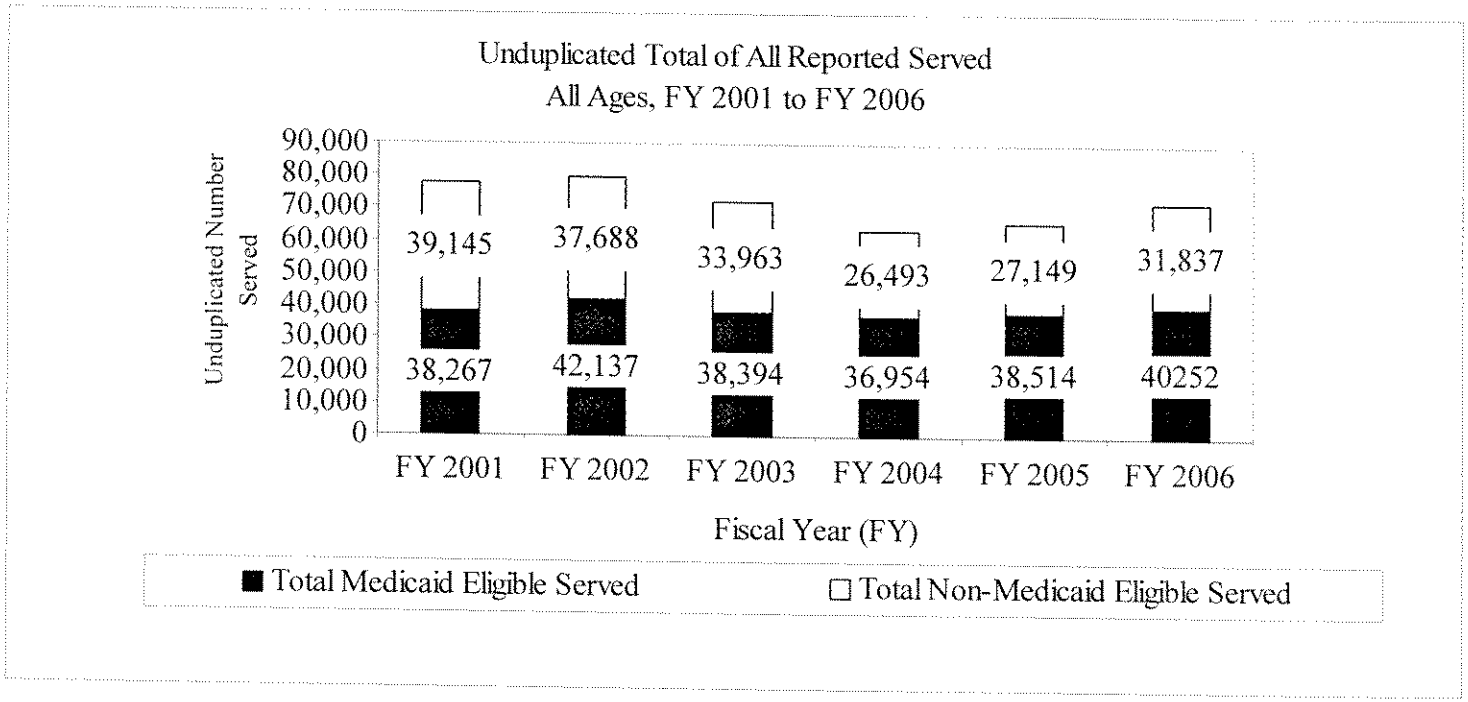
Through the administration of the *Fall 2005 Healthy Kids Colorado Survey* the state obtained Colorado representative data for high school age youth, grades nine through twelve regarding health and behavior issues, such as tobacco use, unhealthy dietary behaviors, alcohol and other drug use (ATOD) behaviors that contribute to unintentional injuries and violence, among other adverse effects. The survey results demonstrate, for most substances, Colorado is similar to the nation as a whole. Cigarette use is less prevalent while alcohol and marijuana use is more prevalent in Colorado. Colorado 30-day alcohol use for high school age youth is 47.4%, which is higher than the national rate of 43.3%. ADAD's prevention programs for youth target reducing 30-day alcohol use, which is also a National Outcome Measure (NOMs) reported to SAMHSA.

Division of Mental Health

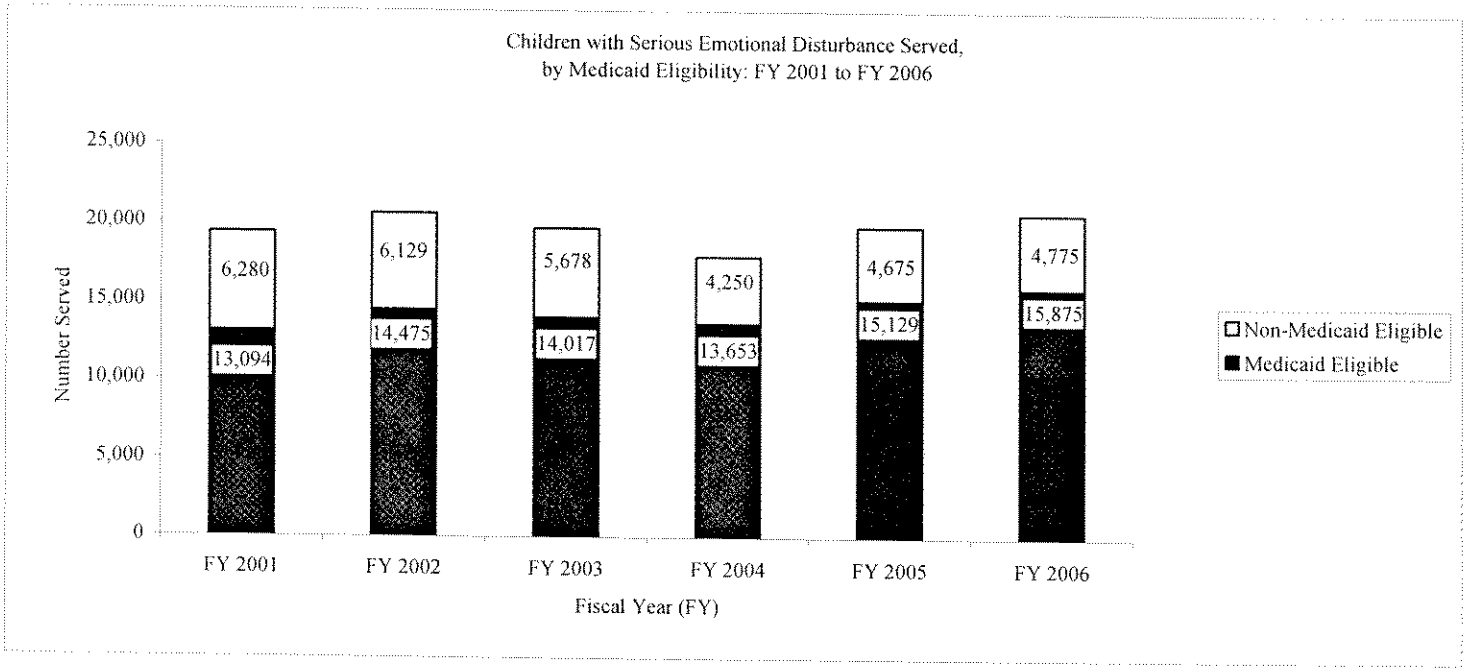
Although the Division does not provide direct services and therefore does not have a 'caseload', it does track the number of Coloradoans who receive mental health services in the state's public mental health system. The unduplicated number of persons served reflects the actual number of persons who were reported as having received any service within the fiscal year.

In FY 2000-01 there were 77,412 persons served in the public mental health system; by FY 2003-04, 63,447 persons were reported served. This represented an 18% reduction in the number of people receiving public mental health services across the State. During the same period, there was an equally significant reduction in the number of non-Medicaid eligible persons served, from 39,145 in FY 2000-01 to 26,493 in FY 2003-04. There were also 1,313 fewer Medicaid eligible persons reported served. This downward trend reversed between FY 2003-04 and FY 2005-06 with the population served increasing 12% from 63,447 to 72,089 in those years respectively. While trends fluctuated between FY 2000-01 and FY 2005-06, those not served in the public mental health system did not cease to have a serious mental illness nor need care; rather, they increasingly sought care in other systems, such as hospitals, community health clinics, and non-profit organizations; as well as, emergency rooms and criminal justice systems. The Division is addressing these trends by intensifying its collaborative and consultative efforts at both state and local levels. The intent of this collaboration is to identify ways to provide services to this population in a more efficient manner while increasing the quality of care provided across the public mental health system. The Division expects to report complete FY 2006-07 data in November 2007.

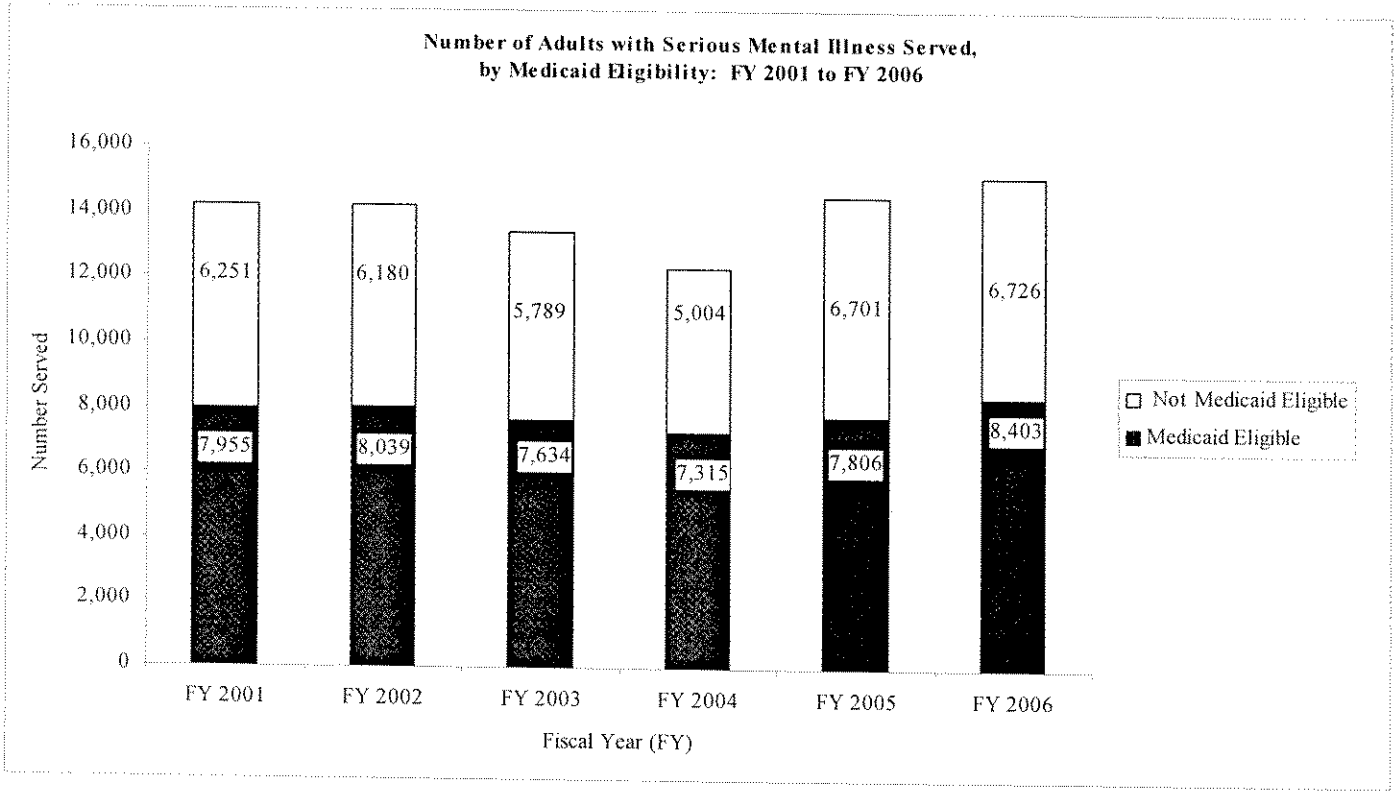
These reductions have also resulted in the public mental health system no longer serving an equal number of Medicaid and non-Medicaid eligible persons. A total of 10,461 fewer non-Medicaid eligible persons were reported served in FY 2003-04, which is a reversal of FY 2000-01 when 878 more non-Medicaid persons were reported served. However, between FY 2003-04 and FY 2005-06, Medicaid eligible persons served increased 8% and non-Medicaid eligible persons served increased 16% during the same time period. While there remains a large gap in numbers served between those who are Medicaid eligible versus those who are non-Medicaid eligible, the trend of serving fewer non-Medicaid eligible persons in the public mental health system continues and is largely due to budget reductions to general funds allocated to serve this population. As noted above, however, a number of persons with serious mental illness who are not served in the public mental health system receive some care from other, often state-funded, systems. The Division will be able to report FY 2006-07 data in November 2007.



The following two charts demonstrate trends between FY 2000-01 and FY 2005-06 in the number children with serious emotional disturbance (SED) served. The total number of children with SED served in the public mental health system has grown from 19,374 in FY 2000-01 to 20,650 in FY 2005-06. While the number of Medicaid eligible children served with SED has grown from 13,094 in FY 2000-01 to 15,875 in FY 2005-06, the number of non-Medicaid eligible children with SED declined from 6,280 in FY 2000-01 to 4,775 in FY 2005-06. The percent of children served with SED who are Medicaid eligible increased from 67.6% in FY 2000-01 to 76.9% in FY 2005-06; whereas the percent of children served with SED who are non-Medicaid eligible decreased from 32.4% in FY 2000-01 to 23.1% in FY 2005-06. The Division expects to see similar trends in children with SED served in FY 2006-07.



The total number of adults with SMI served in the public mental health system has grown from 14,206 in FY 2000-01 to 15,129 in FY 2005-06. During this period, the total number of adults with SMI served increased by 19% (FY 2003-04, 12,319 adults served to FY 2005-06, 15,129 adults served). The chart below shows the increase in the numbers served by Medicaid eligibility category. [FY 2007 data will be reported in November 2007.]



Mental Health Institutes

Caseload trends over the last five years illustrate the significant changes that have been taking place at the Mental Health Institutes and, in turn, will drive further changes in the future. These trends are:

- A shift from inpatient hospital to community treatment for civil and forensics patients
- Increased admissions and discharges, patient acuity, and staff workloads at Fort Logan and Pueblo

- Increased demand for competency restorations in forensics and civil beds at Colorado Mental Health Institute at Pueblo

These trends are discussed below.

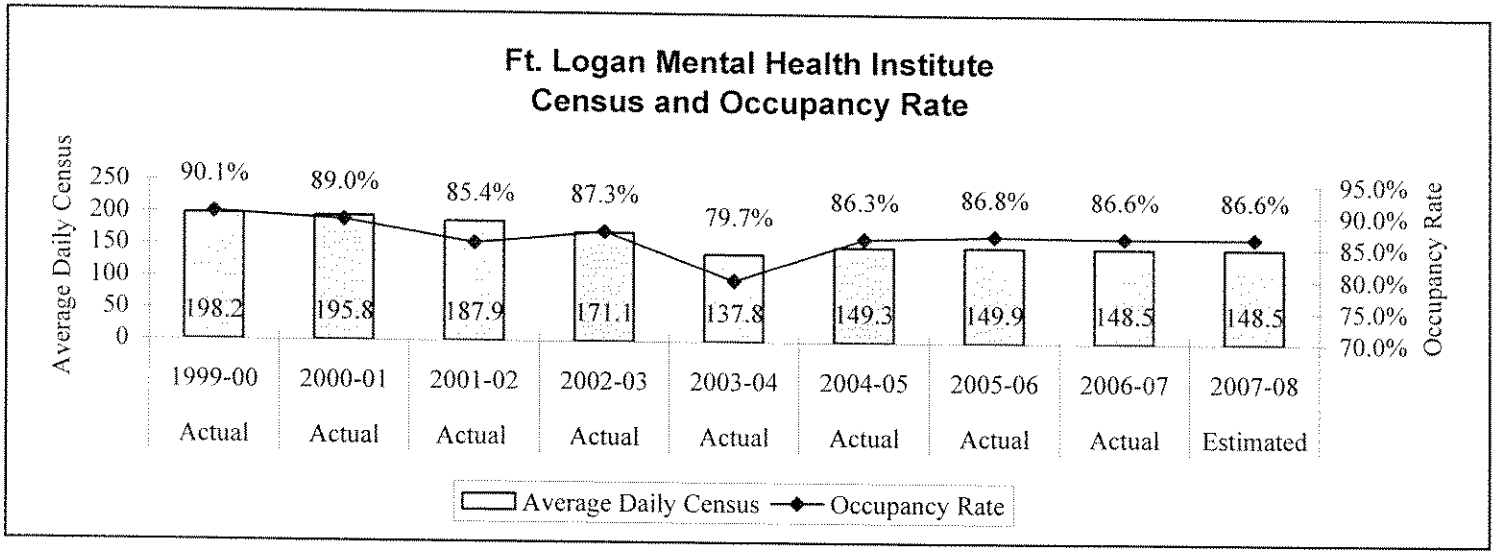
Shift from Inpatient Hospital to Community Treatment for Civil Patients

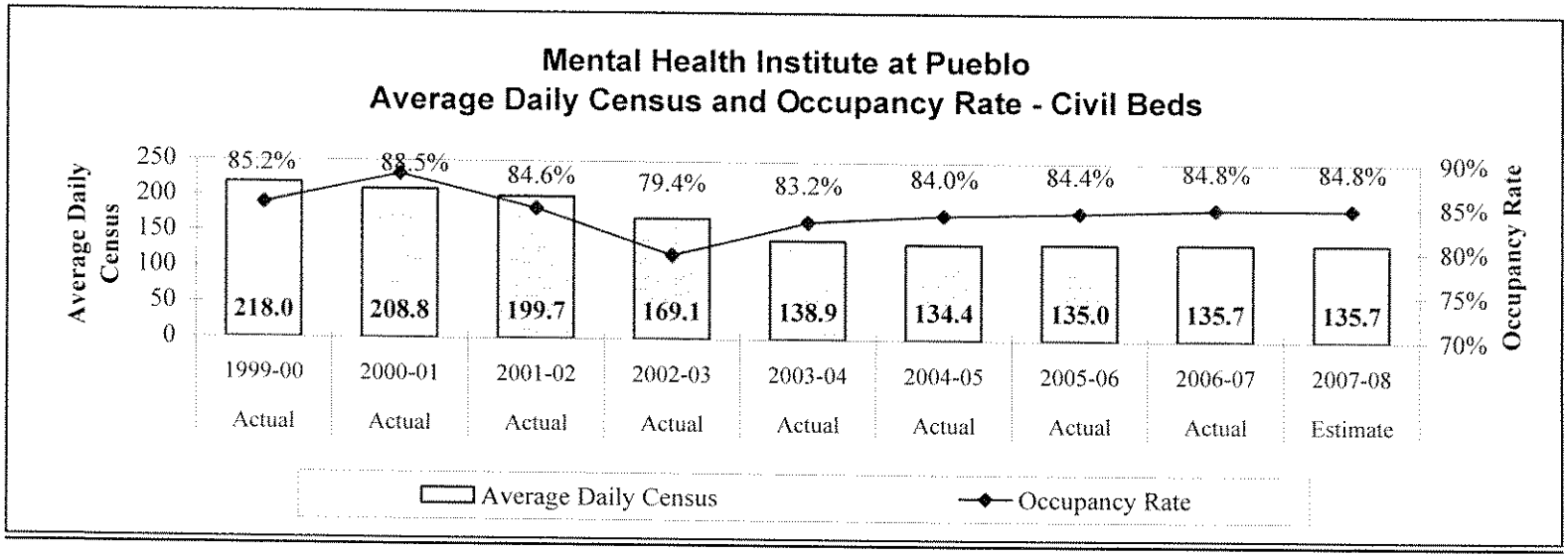
During the last five years there has been a significant decrease in the use of Institute inpatient psychiatric services and a corresponding increase in community-based services for individuals with serious mental illnesses and emotional disorders. This trend has been driven by multiple factors, including the increased use of managed care to control both treatment and costs, advances in community-based treatments that allow more people to be treated successfully in the community, inpatient bed reduction and state budget shortfalls.

In March 2001, the TriWest Group issued a comprehensive report on the Mental Health Institutes. The report recommended the development of new intensive community-based services that would allow some individuals with serious mental illnesses to be treated in the community, rather than in the Institutes. The report also recommended downsizing the Institutes and shifting funds from the Institutes to the community mental health system. In response to the TriWest report, the department developed an operational plan in February 2002 for implementing the intent of the report.

The Institutes now have a total of 631 beds, including 298 beds at the IFP at CMHIP. Over the last five years, both the total number of civil beds and the average daily census declined. The state budget shortfalls that began in FY 2002-03 accelerated the implementation of community services and reduction of Institute beds. In addition, the Department of Health Care Policy and Financing reduced the Medicaid inpatient psychiatric hospital benefit from an unlimited benefit to 45 days per state fiscal year, beginning in FY 2003-04.

The next two graphs detail the average census and occupancy percentage for each of the Institutes.


Ft. Logan Mental Health Institute
Census and Occupancy Rate
Average Daily Census
250
200
150
100
50
0
90.1%
89.0%
85.4%
87.3%
79.7%
86.3%
86.8%
86.6%
86.6%
198.2
195.8
187.9
171.1
137.8
149.3
149.9
148.5
148.5
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Occupancy Rate
1999-00 Actual
2000-01 Actual
2001-02 Actual
2002-03 Actual
2003-04 Actual
2004-05 Actual
2005-06 Actual
2006-07 Actual
2007-08 Estimated
Average Daily Census
Occupancy Rate


Mental Health Institute at Pueblo
Average Daily Census and Occupancy Rate - Civil Beds
Average Daily Census
250
200
150
100
50
0
85.2%
88.5%
84.6%
79.4%
83.2%
84.0%
84.4%
84.8%
84.8%
218.0
208.8
199.7
169.1
138.9
134.4
135.0
135.7
135.7
90%
85%
80%
75%
70%
Occupancy Rate
1999-00 Actual
2000-01 Actual
2001-02 Actual
2002-03 Actual
2003-04 Actual
2004-05 Actual
2005-06 Actual
2006-07 Actual
2007-08 Estimate
Average Daily Census
Occupancy Rate

Increased Admissions/Discharges, Patient Acuity, and Staff Workloads

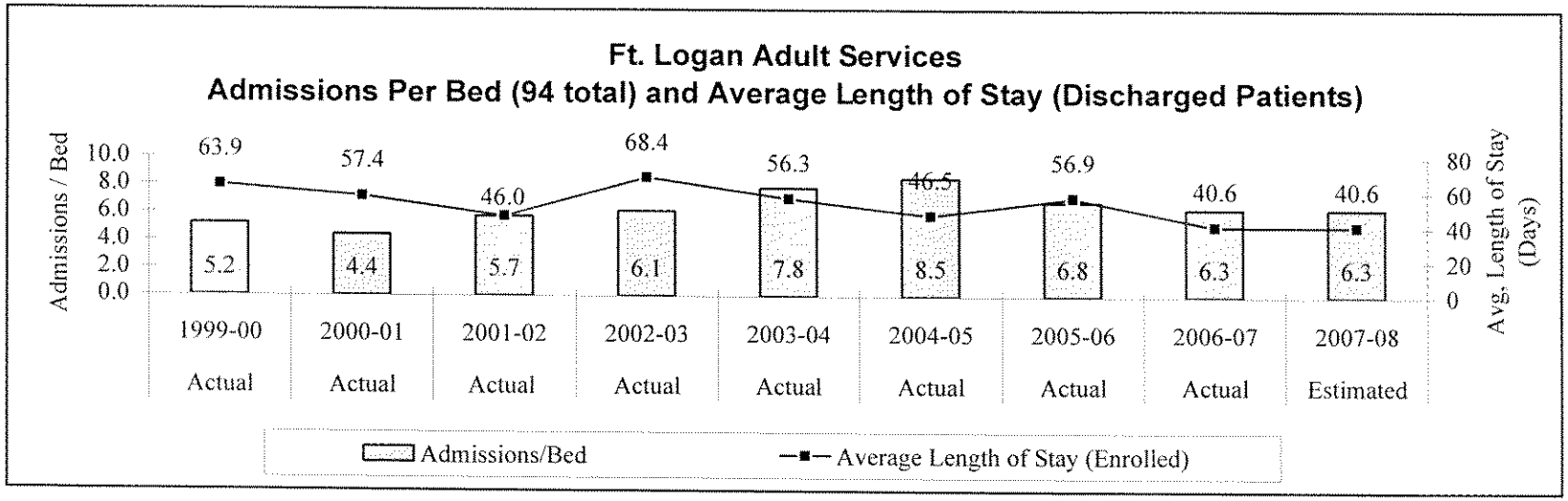
The behavioral health organizations (BHOs) and community mental health centers (CMHCs) are increasingly demanding that inpatient services be intensive and brief. They prefer to admit patients multiple times for very short stays, rather than for single episodes that last for weeks or months.

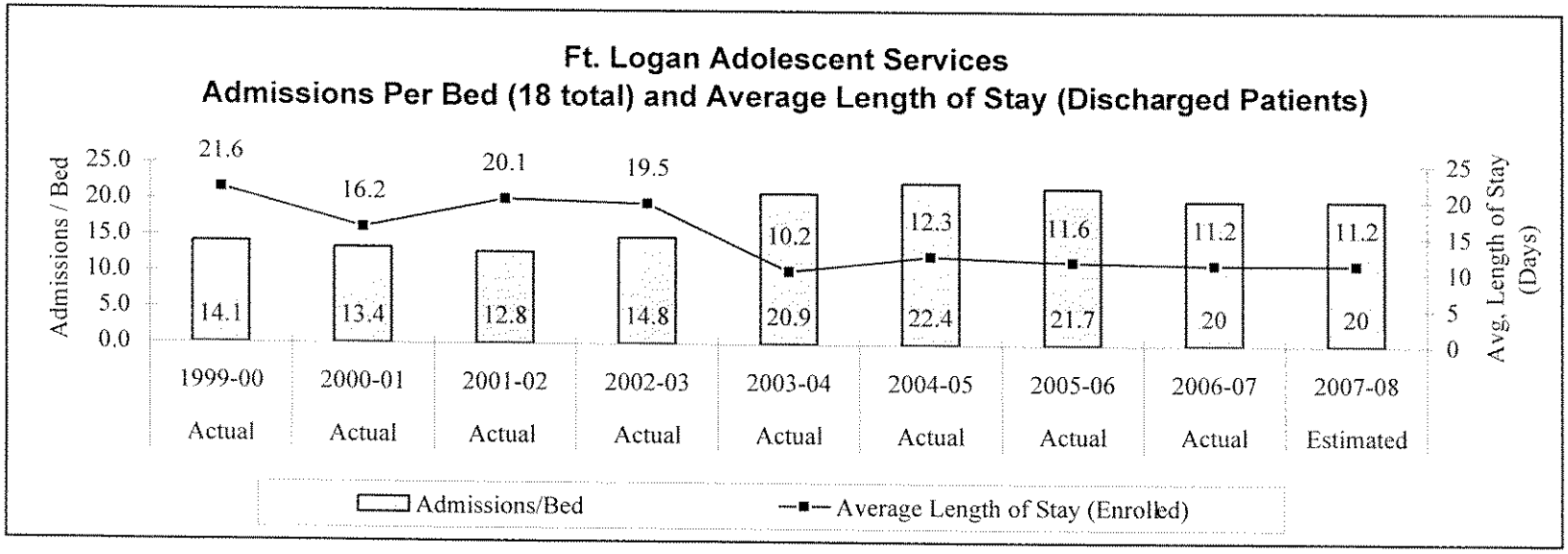
The 45-day Medicaid inpatient psychiatric benefit limit (implemented in FY 2003-04) has also put pressure on the Institute to reduce the length of stay for patients under age 21 and age 65 and over.

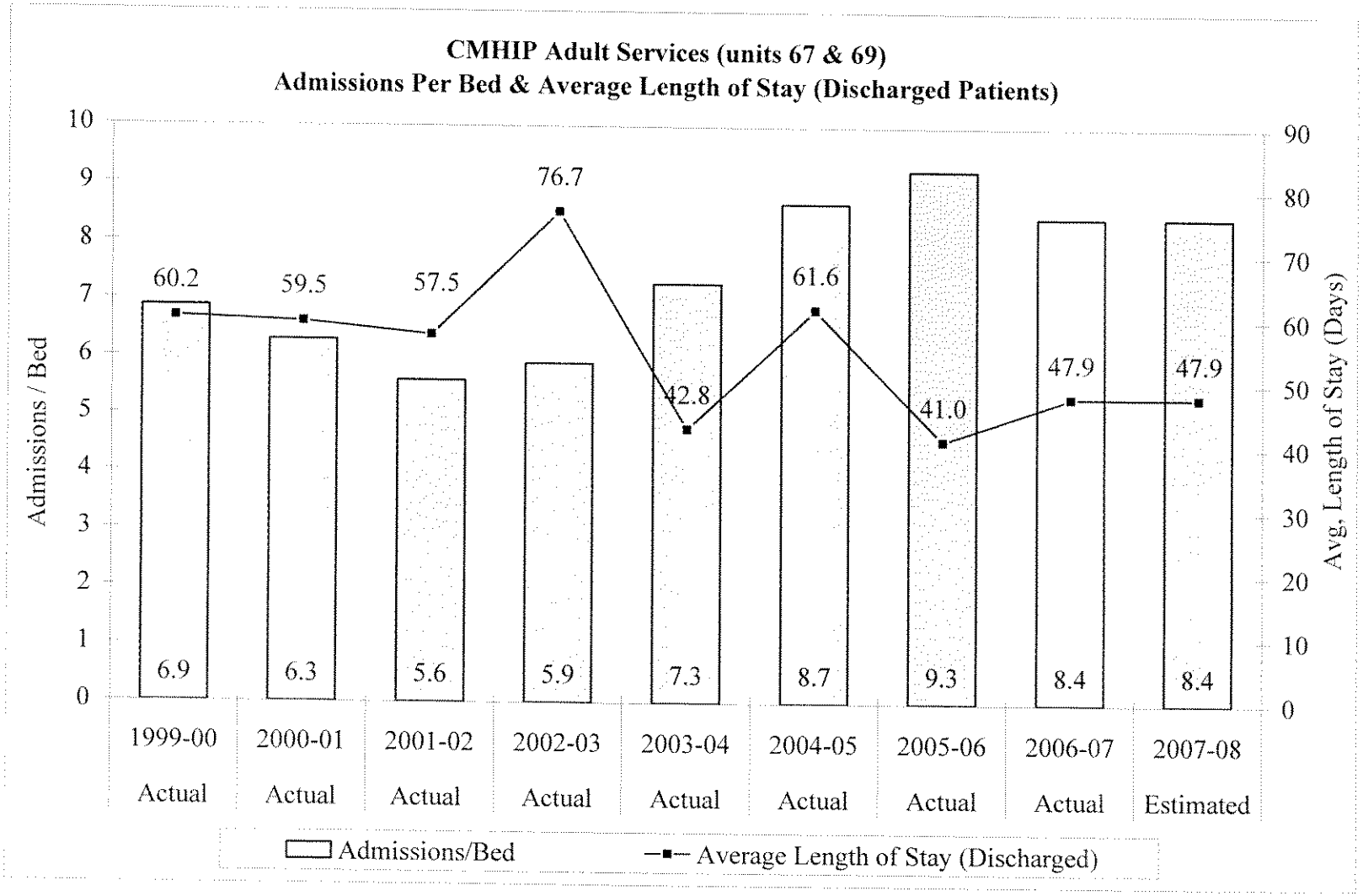
The Institute's ability to respond to the BHOs' and Centers' needs and to the Medicaid benefit limit impacts the amount of Medicaid revenue received and the Institute's ability to continue to operate as the safety net for consumers of all ages with serious mental illnesses and emotional disorders.

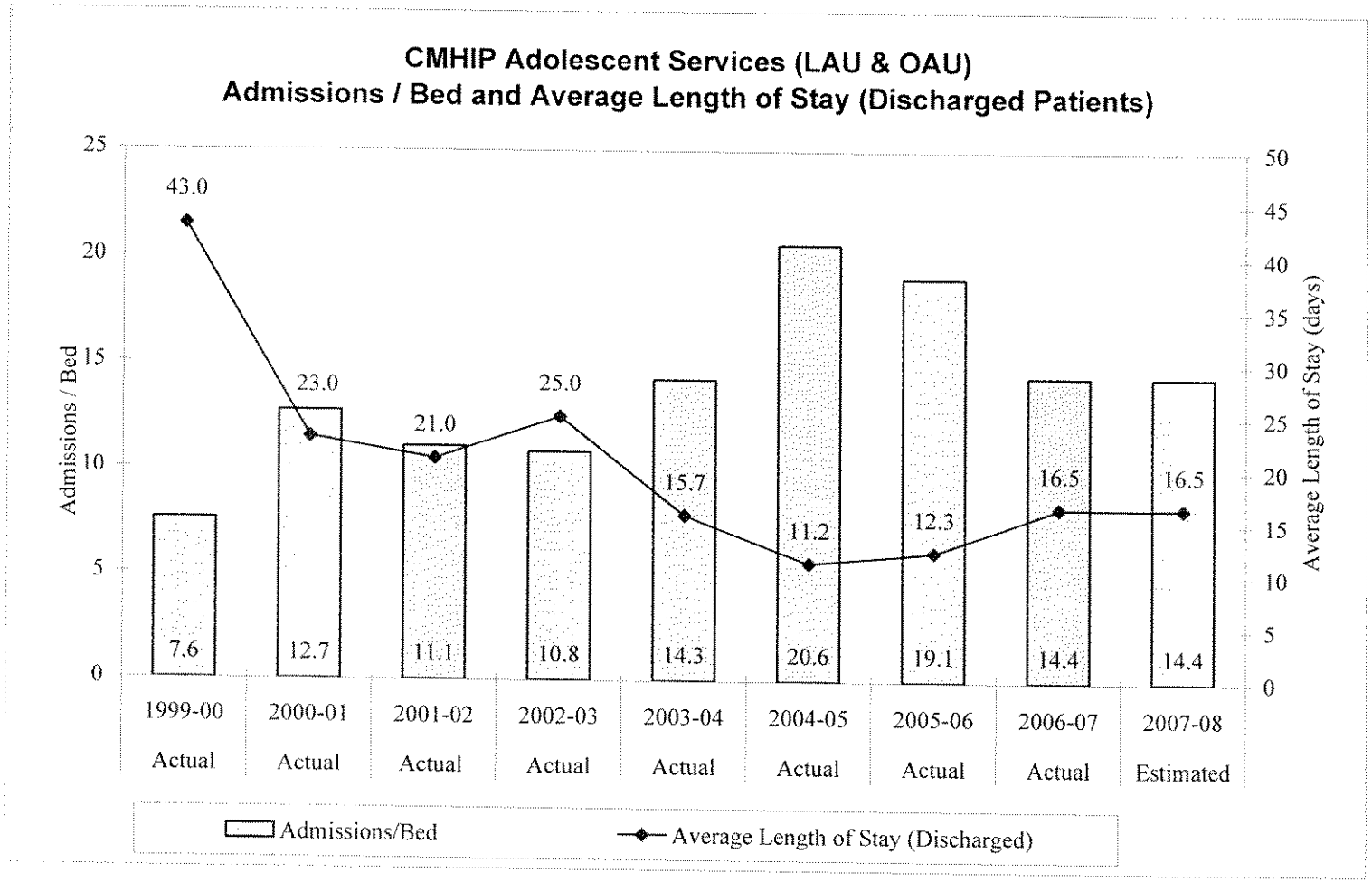
In response to these demands, the Institutes have implemented new therapeutic approaches, improved coordination and collaboration with community providers, and increased discharge planning efforts. These strategies have resulted in a decrease in the average length of stay (LOS) and an increase in the number of admissions to the Institutes during the last two years.

The following four graphs show the number of admissions per bed and the average lengths of stay at the Mental Health Institutes over the last eight years:


Ft. Logan Adult Services
Admissions Per Bed (94 total) and Average Length of Stay (Discharged Patients)
Admissions / Bed
Avg. Length of Stay (Days)
63.9
57.4
46.0
68.4
56.3
46.5
56.9
40.6
40.6
5.2
4.4
5.7
6.1
7.8
8.5
6.8
6.3
6.3
1999-00 Actual
2000-01 Actual
2001-02 Actual
2002-03 Actual
2003-04 Actual
2004-05 Actual
2005-06 Actual
2006-07 Actual
2007-08 Estimated
Admissions/Bed
Average Length of Stay (Enrolled)


Ft. Logan Adolescent Services
Admissions Per Bed (18 total) and Average Length of Stay (Discharged Patients)
Admissions / Bed
Avg. Length of Stay (Days)
21.6
16.2
20.1
19.5
10.2
12.3
11.6
11.2
11.2
14.1
13.4
12.8
14.8
20.9
22.4
21.7
20
20
1999-00 Actual
2000-01 Actual
2001-02 Actual
2002-03 Actual
2003-04 Actual
2004-05 Actual
2005-06 Actual
2006-07 Actual
2007-08 Estimated
Admissions/Bed
Average Length of Stay (Enrolled)


CMHIP Adult Services (units 67 & 69)
Admissions Per Bed & Average Length of Stay (Discharged Patients)
Admissions / Bed
Avg, Length of Stay (Days)
0
1
2
3
4
5
6
7
8
9
10
0
10
20
30
40
50
60
70
80
90
60.2
59.5
57.5
76.7
42.8
61.6
41.0
47.9
47.9
6.9
6.3
5.6
5.9
7.3
8.7
9.3
8.4
8.4
1999-00 Actual
2000-01 Actual
2001-02 Actual
2002-03 Actual
2003-04 Actual
2004-05 Actual
2005-06 Actual
2006-07 Actual
2007-08 Estimated
Admissions/Bed
Average Length of Stay (Discharged)


CMHIP Adolescent Services (LAU & OAU)
Admissions / Bed and Average Length of Stay (Discharged Patients)
Admissions / Bed
Average Length of Stay (days)
25
20
15
10
5
0
50
45
40
35
30
25
20
15
10
5
0
43.0
23.0
21.0
25.0
15.7
11.2
12.3
16.5
16.5
7.6
12.7
11.1
10.8
14.3
20.6
19.1
14.4
14.4
1999-00 Actual
2000-01 Actual
2001-02 Actual
2002-03 Actual
2003-04 Actual
2004-05 Actual
2005-06 Actual
2006-07 Actual
2007-08 Estimated
Admissions/Bed
Average Length of Stay (Discharged)

The move to more admissions with shorter lengths of stay results in increased staff workloads, even in an era when the total number of Institute beds is declining. The admission, stabilization and discharge processes are among the more resource intensive processes performed in the Institute. If 20 patients use a single bed during a year, the staff must perform these intensive processes a total of 20 times each. In the past, only 14 patients may have used the same bed during the year, and the staff performed these intensive processes 14 times each. When this pattern is repeated to varying degrees on other units in the Institute, the increase in workload for the teams on the units is significant.

In addition, the Institutes are receiving patients with higher acuities needing this short-term stabilization, which further increases the staff workload. Patients are only at the Institute when they are very ill, and very ill patients need more intensive services than patients who are stabilized and further along the road to recovery.

Competency Restorations at Pueblo

The adult civil units at the Colorado Mental Health Institute at Pueblo have not yet experienced the rapid turnaround cycle to the degree seen at CMHIFL, in part because some community providers have asked that not all patients be treated with this type of protocol. However, shorter lengths of stay for CMHIP adult civil patients are expected to increase in future years. However, the adult civil units at CMHIP have been impacted by CMHIP needing to use beds on these units to provide court-ordered inpatient competency evaluations and restorations due to the significant increase in demand for these services. Under normal circumstances competency evaluation and restoration patients would be treated on the forensics units.

CMHIP has experienced a dramatic increase in adult competency evaluation referrals for county jail inmates. In FY 2001-02, the hospital conducted 433 evaluations, in FY 2005-06, the institute conducted 815 evaluations; this represents an 88% increase. The CMHIP is expected to see a steady increase in demand for competency evaluations and competency restoration treatment in coming years, as indicated by trends during the first half of the decade. Historically, 20 percent of these evaluations result in competency restorations. Currently, 30 to 40 percent of those individuals being evaluated are subsequently being admitted to CMHIP for restoration services.

CMHIP Exams (sanity, competency, mental condition, etc.) and Incompetent to Proceed (ITP) (i.e. competency restorations) Referrals per Fiscal Year

FY	Exams				ITPs				% Increase from FY0001	
	In Pt.	Out Pt.	Total	% Increase	In Pt.	Out Pt.	Total	% Increase	Exams	ITPs
2000-01	234	181	415		86	0	86			
2001-02	168	262	430	3.6%	96	0	96	11.6%	3.6%	11.6%
2002-03	81	333	414	-3.7%	107	0	107	11.5%	-0.2%	24.4%
2003-04	90	415	505	22.0%	111	0	111	3.7%	21.7%	29.1%
2004-05	102	441	543	7.5%	136	0	136	22.5%	30.8%	58.1%
2005-06	191	629	820	51.0%	164	5	169	24.3%	97.6%	96.5%
2006-07	224	615	839	2.3%	228	17	245	45.0%	102.2%	184.9%

The number of referred inpatient exams and ITPs includes those awaiting admission.

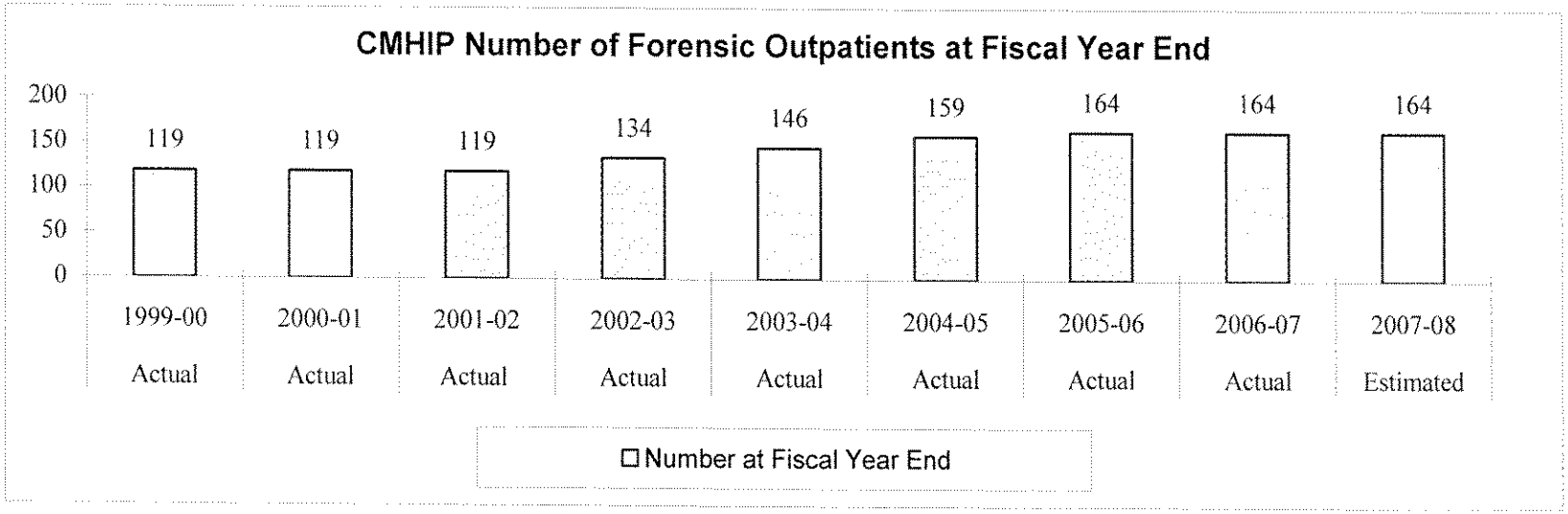
In addition to the increase in competency orders, the department's federal court settlement agreement in Neiberger v. Schoenmakers required the CMHIP IFP to comply with a number of requirements, including a 1.35-to-1 staff-to-patient ratio and a census limit on some units.

These factors have resulted in a competency evaluation and restoration waiting list that had run as high as 83 in December 2006, with individuals often waiting in excess of one month and many much longer. The table above documents a steady increase in evaluation and restoration services demand during the first half of the decade. The waiting list was at first reduced, in part, as a result of serving restoration patients with less violent offenses to the adult civil units, which now averages a daily census of 15 competency restorations. The steady increase in referrals had exceeded CMHIP's ability to admit all patients in a timely fashion, generating the long waiting list and precipitating a District Court contempt citation and the associated Zuniga Settlement Agreement. In December 2006, the Department received supplemental funding from the General Assembly to open a 20-bed unit to drastically reduce the waiting list. As a result the waiting has been reduced to levels acceptable to the courts and the Department is in compliance with the Zuniga Settlement Agreement.

Increased Transitioning for Pueblo Institute for Forensic Psychiatry Patients to the Community

The Colorado Mental Health Institute at Pueblo has been working to safely transition forensic patients into community settings. These efforts were started by the Neiberger lawsuit settlement agreement that was completed 12/31/06. Under the Settlement Agreement, the CDHS agreed to increase staffing ratios, increase therapeutic programming, modify physical facilities, prioritize construction of a new facility, and develop a community placement program. The Institute was in full compliance with these settlement-related mandates and will continue the treatment processes initiated there from.

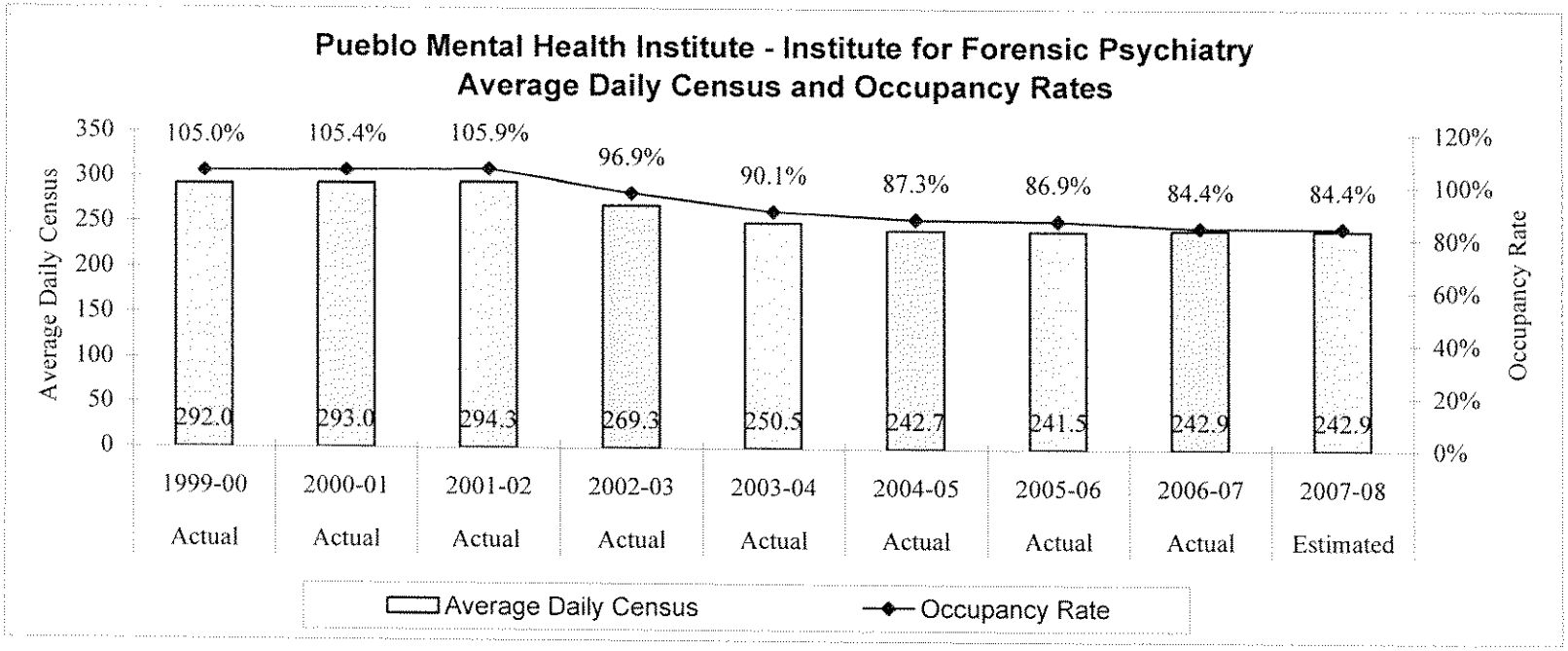
The Neiberger settlement agreement resulted in significant patient treatment of persons determined by the courts to be Not Guilty by Reason of Insanity (NGRI) and ultimately many of these patients have been successfully released into the community. This process was facilitated by the enhanced inpatient treatment efforts and resources, as well as enhanced out-patient treatment and follow-up resources. The Forensic Community Based Services (FCBS) program was the tangible result of these efforts. As is demonstrated in the graph below, the clinical and resource enhancements have resulted in increased numbers of community-dwelling forensic patients followed by FCBS over the last several years. The following chart shows the number of forensic NGRI and ITP not treated as outpatient clients over the last eight years:



The High Intensity Forensic Community Placement Program (HIFCPP) is a program designed to facilitate community reintegration for severely affected patients adjudicated NGRI; it is part of FCBS. The relatively small caseloads, coupled with frequent patient-staff interaction and structure allowed this group of patients to be safely returned to the community, and in the vast majority of cases, to stay there. The following table shows the number of patients receiving support to reside in the community through the High Intensity Forensic Community Placement Program that was implemented in FY 2003-04:

	FY 2002-03 Actual	FY 2003-04 Actual	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Estimated
Number of patients receiving support to reside in the community through the High Intensity Forensic Community Placement Program (HIFCPP)	N/A	30	30	30	30	30

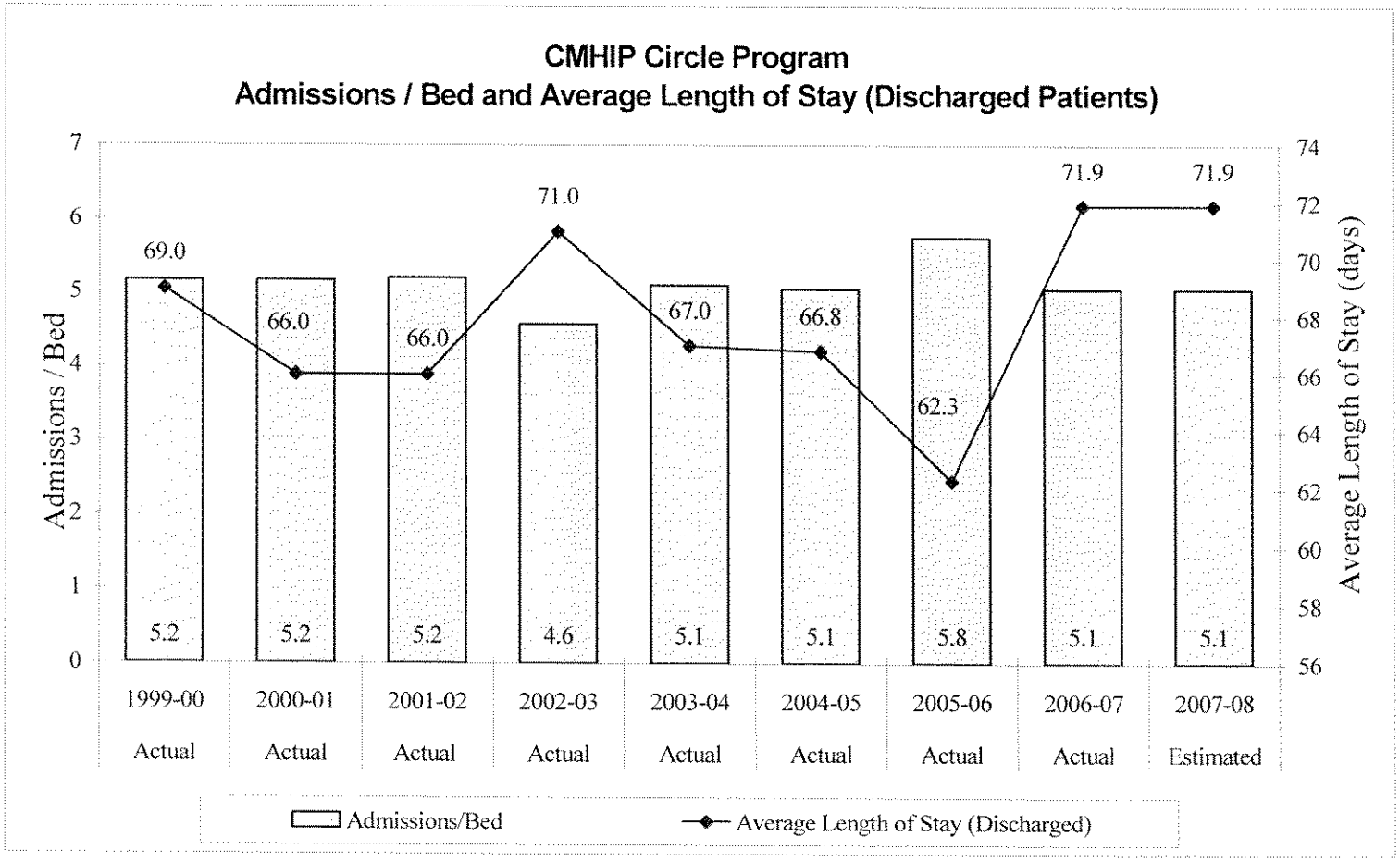
The following chart shows the average census and occupancy percentage of forensics inpatients over the last eight years:



Note: Capacity of the Institute for Forensic Psychiatry increased to 298 beds in January of 2007 as a result of the supplemental appropriation provided in FY 2006-07 for an additional 20 beds to address the competency evaluation and restoration waiting list.

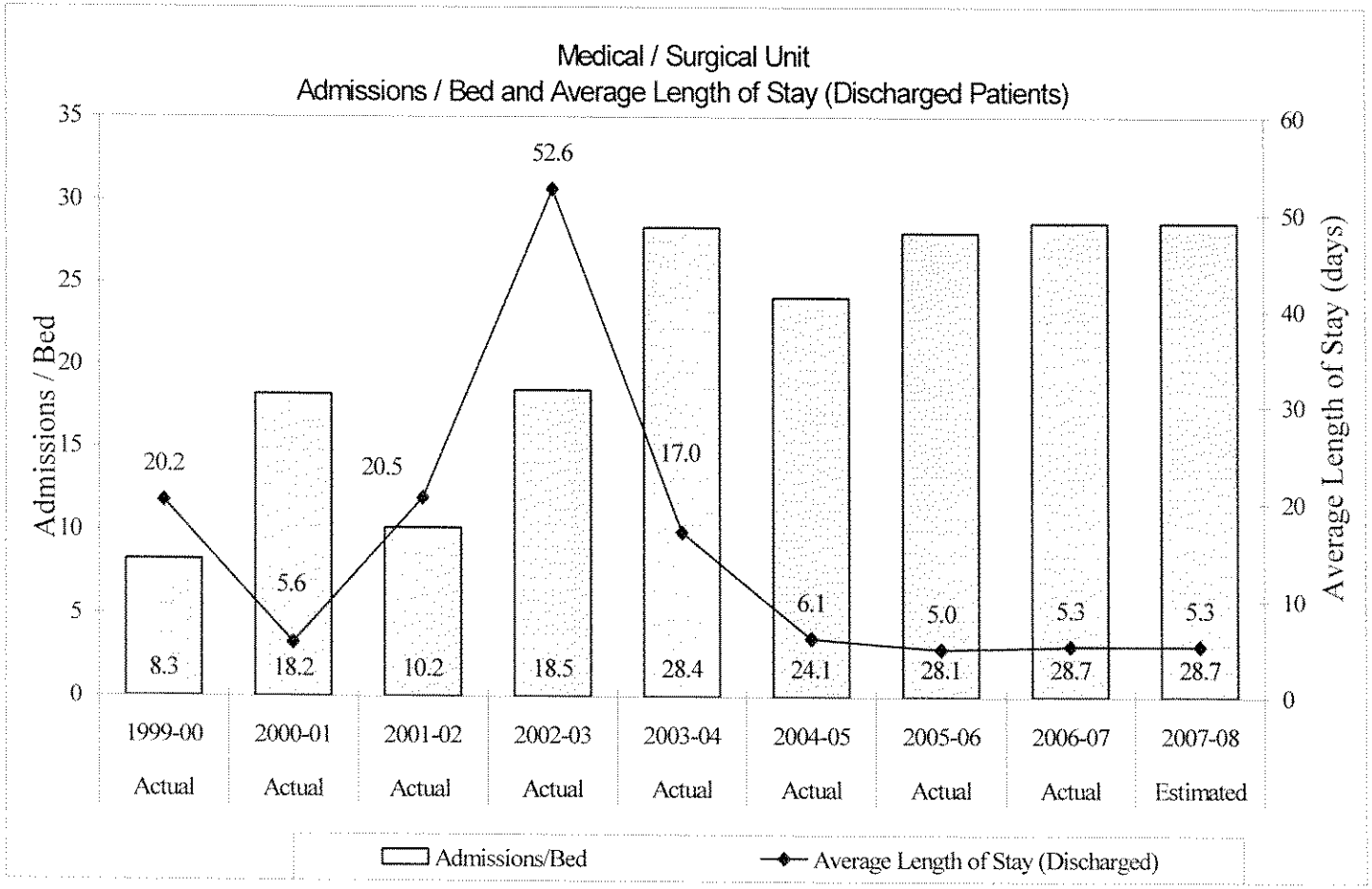
CIRCLE Program

The Circle Program is one unit in the civil division at CMHIP. It provides state of the art residential dual diagnosis treatment for severely affected individuals. Dual diagnosis in the Circle program refers to patients suffering from severe psychiatric illness (e.g. schizophrenia, manic depressive illness) and co-morbid substance use disorders. This unit routinely is full and has a significant waiting list. The graph below displays occupancy trends over recent years.



General Hospital a.k.a. Medical-Surgical Services Unit

The Medical-Surgical Unit (MSS) at the Colorado Mental Health Institute at Pueblo serves patients from the Institutes, Department of Corrections inmates, as well as jail inmates from counties throughout Colorado. This general medical surgical unit provides non-emergent medical care (such as treatment for diabetes, pneumonia, etc.) and surgical services including endoscopy, general abdominal surgery and orthopedic procedures (e.g. knee and hip replacements).



The unit is staffed by institute nursing staff and UCHSC faculty contract physicians. The inpatient occupancy has varied dramatically over time and this relates directly to changes in contract arrangements between non-CMHIP entities and the hospital to provide medical surgical services to various populations. One of the key attributes of this unit, in addition to high quality care, is the secure nature of the unit. This feature obviates the need for the Department of Corrections and county jails to allocate staff to oversee patients treated on the unit, as often occurs in community hospitals. The graph below displays MSS occupancy trends over recent years.

New High Security Forensics Institute (Opening June 2009)

In January 2007, CDHS and CMHIP began construction of the High Security Forensic Institute in Pueblo. This building, which will be completed by late spring 2009, is designed to replace Medium and Maximum Security forensic units in the Institute for Forensic Psychiatry (IFP) at CMHIP. The process of building the structure is associated with a parallel process; re-examination of all clinical programming and staffing needs for medium and maximum security in an expanded facility. As a result, current CMHIP management and line staff are performing additional duties on committees tasked with reassessing every aspect of patient care and security involved on medium and maximum security in IFP. This work requires augmented staff efforts in addition to day-to-day activities. Due to the high security nature of the new hospital, several service areas are required to be duplicated to maintain this high security perimeter. These include on-sight provision of physical therapy, occupational therapy, and general medical care, in addition to psychiatric assessment, treatment, and rehabilitative services. This increase in service provision is required due to the high security nature of the hospital and the desire to minimize/eliminate potential security breaches that can complicate the management of the challenging patient population housed in this building.

Staff at CMHIP are confronted daily with challenging patients including individuals suffering from development disabilities and serious psychiatric illness. Often times, these individuals become involved in the criminal justice system and are placed at CMHIP, not only as civil patients, but also as competency evaluation and competency restoration cases. Despite the expertise of hospital staff, at this time dually diagnosed DD/MI patients are managed on various units throughout the hospital without appropriate programming or the use of experts in dealing with persons with developmental disabilities across a range of services. CMHIP is currently studying the possibility of creating a DD/MI specialty unit to deal with these significantly impaired individuals to provide them with state of the art services geared toward rehabilitation and restoration and ultimately transitioning to the community and the least restrictive treatment environment. It is anticipated that should the institute initiate this effort, additional staff will be required to provide essential programming to this challenging patient population. This includes relatively high nursing staff levels, as well as the addition of clinicians who are specialists in dealing with developmentally disabled individuals.

As part of Zuniga settlement agreement associated with the contempt citation brought against CMHIP and CDHS administration, several efforts were undertaken by CMHIP IFP to deal with the associated waiting list. These efforts included development of a tracking system and personnel to manage it, opening a medium security competency restoration unit (20-beds funded by a FY 2006-07 supplemental), as well as the development of the Short-Term Assessment and Treatment (STAT) program. The STAT program is a stand-alone admission unit on Maximum Security in IFP. It was developed with a goal of rapid assessment, aggressive treatment intervention and return of evaluated and stabilized patients (such as competency evaluations) to jail settings so that patients can move through the legal system efficiently. Since opening in February 2007, this program has achieved its goal of keeping average length of stay for patients admitted to the unit to 14 days or less. It has also contributed greatly to efficient utilization of inpatient resources regarding competency evaluation cases. Patients are clinically assessed, psychologists evaluate legally related competency issues, reports are efficiently generated and forwarded to the courts, and patients are returned to the jail from which they were referred. This enhanced efficiency, which has greatly influenced management of the waiting list, has come with an increase need for staffing across all disciplines due to the aggressive evaluation and treatment aspects of this unit.

Supportive Housing and Homeless Programs

Within available resources, Supportive Housing and Homeless Programs (SHHP) will serve over 3,500 low-income families and individuals with disabilities and other special needs in FY 2007-08. This number is up 52% since 1997. HUD policy changes and lack of new appropriations has leveled the number of families SHHP can serve, while the need for subsidized housing continue to increase.

Supportive Housing and Homeless Programs (SHHP) maintains a closed wait list for the subsidized housing that it provides primarily to persons with disabilities and the homeless. The wait list is only opened for new applications when the current number of persons on the waiting list falls below the number of persons who can be served in a two-year period; until that time the waiting list is closed and clients cannot add their name to the waiting list. There are currently 391 family and individual households remaining on the wait list, after accepting over 1,400 new applications on one day in November 2005. The wait list will be again be opened for one day in November 2007.

SHHP receives no state funds, further limiting SHHP's ability to provide rental assistance to persons with disabilities and persons who are homeless. Additionally, without state funding, opportunities to leverage federal funding with state match dollars are lost.

Historically, SHHP's staff salaries and benefits have been funded from Section 8 administrative funds. Prior to January 2004, homeless and resource development activities were supplemented using Section 8 administrative funds. After January 2004, Congress re-categorized the use of Section 8 administrative dollars, resulting in denial of funding for homelessness initiatives. SHHP is currently using Section 8 reserves that accumulated prior to the regulation change to fund salaries of staff working on homeless initiatives, but these reserve funds will be depleted in approximately two years.

Traumatic Brain Injury Program

The Traumatic Brain Injury (TBI) Program, defined by statute in 2002 and overseen by the Traumatic Brain Injury Trust Fund Board, began services in 2004 and continues to expand. The TBI Program does not provide direct services but contracts with Denver Options, Inc. to provide services to children and adults with traumatic brain injuries using 65% of the annual TBI budget. During FY 2006-07, a total of 115 children and 343 adults received services through the Traumatic Brain Injury Program, an increase of 53% and 90%, respectively, from FY 2006. Challenged by a growing waitlist for services, currently at 250, the Trust Fund Board made a difficult decision to limit services to one year in a recipient's lifetime, effective March 1, 2007.

As directed by state statute, the TBI Trust Fund also has grant processes for both research and education, receiving 30% and 5% of the annual budget. The research program anticipates increased applications in FY 2007-08 due to a revised application process and outreach to Colorado's medical and research communities. The Education Program has been successful in making geographically-diverse grant awards to 14-15 awardees in the last few years, and plans to increase its outreach to audiences beyond school districts, where the bulk of funding has been awarded.

Additional new workloads for the TBI Program stem from the award of a federal TBI grant ($118,600/year for 3 years) beginning April 1, 2007. The grant will fund an updated statewide TBI needs and resources assessment and related action plan, and new TBI support systems for Colorado's Latino population, the veteran population in the Fort Carson area, and for rural areas generally. It will also fund increased networking with mental health systems and regionalization of existing local TBI support networks. The additional $400,000 of Trust Fund revenues, appropriated to the TBI Program for FY 2007-08, will increase funds available to the services, research and education programs.

One challenge for the TBI Program is inadequate staffing levels. The Joint Budget Committee approved a 0.5 of a requested 1.0 FTE that is needed to address the increased work load associated with more grants and contracts to administer, new targeted populations to

reach, new policies/procedures to develop, and with related operational decisions and contractor oversight. Another challenge is a Long Bill footnote that caps TBI administration costs at 7.5%. This restriction hampers the program's ability to carry out Board-requested directions, such as program evaluations, strategies to increase revenues, and the building of collaborative partnerships. Statutes authorizing the TBI program require that 65% of the revenue received be spent on services, 30% be spent on research grants and 5% be spent on education. With these requirements, TBI is not only a service program, but it has significant administrative needs if it is to operate the research and education grant components effectively.