

DEPARTMENT OF HUMAN SERVICES
Office of Behavioral Health, Services for People with Disabilities, County Administration, Office of
Self-Sufficiency, Adult Assistance Programs, Office of Early Childhood
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA

Friday, December 21, 2018
9:00 am – 12:00 pm and 1:30 pm – 3:00 pm

9:00-9:10 INTRODUCTIONS AND OPENING COMMENTS

- Presenter: Tony Gherardini, Deputy Executive Director, Department of Human Services

9:10-11:15 OFFICE OF BEHAVIORAL HEALTH

Main Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- Robert Werthwein, Director, Office of Behavioral Health

Supporting Presenters:

- Sarah DeVore, Director, Division of Budget and Policy
- Michael Tessean, Deputy Director, Office of Behavioral Health
- Jill Marshall, CEO, Colorado Mental Health Institute-Pueblo

Topics:

- Court Orders Concerning Competency: Page 1, Questions 1-11 in the packet, Slides 13-16
- Behavioral Health Crisis Response System: Page 20, Questions 12-14 in the packet, Slides 23-29
- Workforce Shortage and Administrative Burden: Page 25, Questions 15 in the packet, Slides 22

11:15- 11:30 BREAK

11:30-12:00 SERVICES FOR PEOPLE WITH DISABILITIES

Main Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- Mark Wester, Director Office of Community Access and Independence

Supporting Presenters:

- Sarah DeVore, Director, Division of Budget and Policy
- Eric Johnson, Deputy Director Office of Community Access and Independence
- Georgia Edson, Division Director Regional Center Operations

Topics:

- Regional Centers for People with Disabilities: Page 27, Questions 16-17 in the packet, Slides 33-35
- R2 Compensation for Direct Care Employees (Veterans Community Living Centers): Page 30, Questions 18-20 in the packet, Slides 36-38
- Rural Interpretation Services Program: Page 33, Questions 21-24 in the packet, Slides 39

12:00-1:30 BREAK

1:30-2:00 OFFICE OF EARLY CHILDHOOD

Main Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- MaryAnne Snyder, Director, Office of Early Childhood

Supporting Presenters:

- Sarah DeVore, Director, Division of Budget and Policy

Topics:

- Early Intervention evaluations: Page 39, Question 25 in the packet, Slides 47-49

2:00-3:00 OFFICE OF ECONOMIC SECURITY

Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- Ki'i Powell, Director, Office of Economic Security

Supporting Presenters:

- Katie Griego, Director, Division of Employment and Benefits
- Sarah DeVore, Director, Division of Budget and Policy

Topics:

- County Tax Base Relief: Page 42, Questions 29 in the packet,
- TANF Pilot Projects: Page 43, Questions 30-33 in the packet, Slides 67-71
- R5 Improving Nutrition in Rural and Underserved Communities: Page 45, Questions 34-35 in the packet, Slides 56-57
- R9 Colorado Works Basic Cash Assistance COLA: Page 46, Questions 36-37 in the packet, Slide 73
- R13 Trails Operations and Maintenance: Page 49, Questions 38 in the packet,
- Low Income Energy Assistance: Page 49, Questions 39-40 in the packet, Slides 58-59

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COURT ORDERS CONCERNING COMPETENCY

Efforts to Date

1. **What is the total amount of funding appropriated to the Department to date to address competency-related court orders and to comply with the settlement agreement that was initially signed in 2012?**

The Department has been appropriated \$31,818,034 since FY 2013-14 in order to address competency-related court orders and to comply with the settlement agreement. See Table 1.

Under Colorado law, CDHS is the entity responsible for evaluating criminal defendants regarding competency to proceed to trial. In the event a defendant is found incompetent by the court, CDHS is also the entity responsible for providing restoration to competency treatment to defendants. A criminal case may not move forward until CDHS has restored a previously incompetent defendant to competency.

Since FY 1999-2000, Colorado has seen a 592% increase in demand for competency evaluations and a 1,250% increase in demand for restoration services. In 2011, Disability Law Colorado (DLC) sued CDHS in federal court (CLA v. Bicha); alleging that the length of time defendants were waiting to receive competency evaluations and restoration services violated their constitutional rights under the 14th Amendment. Many states have experienced similar litigation. The parties entered into a settlement agreement in 2012, which they renegotiated in 2016. Under the settlement agreement, the Department must offer admission to detainees whom the court has ordered to receive inpatient evaluations or restoration within 28 days of when the defendant is ready for admission and complete jail based competency evaluations within 30 days. Legislative changes such as HB 16-1410 and SB 17-012 and emergency supplemental funding, including the funding of an expansion of RISE (Colorado's jail-based restoration program), have enabled CDHS to comply with settlement timeframes for jail-based competency evaluations since January 1, 2017. The Department is compliant with two of the three requirements. The Department has not been compliant with admitting inpatient restorations within 28 days. Despite numerous emergency supplemental funding requests, including the expansion of RISE implementation of a statewide outpatient restoration program, CDHS has been unable to meet the settlement agreement timelines since mid-2017 due to a spike in the demand for inpatient competency evaluations and restoration services, which has not relented.

Table 1. Funding Requests Appropriated to CDHS to Address Competency-Related Court Orders to Comply with the settlement agreement				
Fiscal Year	Request Titles	Amount Funded	# Beds Added	# Court Referrals
FY 2012-13		\$0	0	1,558
FY 2013-14	R-3A (Jail Based Restoration)	\$2,455,769	22	1,855
FY 2014-15	S-19 Sanity Evaluation Cost (special case)	\$499,079	0	2,255
FY 2015-16	ES-01 Court Ordered Evaluation Caseload and Jail-based Space	\$2,727,097	30	2,542
FY 2016-17	R-03 Court Ordered Evaluation and Jail-based Bed Space (ongoing funding for ES-01)	\$4,117,235	0	3,174
FY 2017-18	ES-01 Jail-based Bed Space	\$2,406,026	28	3,649
	JBC Staff Initiated: Outpatient Competency Restoration	\$461,702	0	
	S-01b Court Ordered Reports FTE Caseload	\$380,959	0	
	S-01c Purchased Bed Capacity	\$275,596	10	
	CC-02 Institute Hawkins Building L2 Unit	\$5,420,468	24	
FY 2018-19	R-05a Jail-based Bed Space	\$7,398,658	34	Projected 4,510
	R-05c Court Ordered Reports FTE Caseload	\$1,085,726	0	
	R-05d Purchased Bed Capacity	\$3,412,101	0	
	R-05e Outpatient Competency Restoration	\$1,177,618	0	
TOTAL		\$31,818,034	148	21,039*

*Includes projected FY 2018-19 court orders

2. Discuss the Department's efforts to date to work cooperatively with local behavioral healthcare providers and stakeholders within the criminal justice system to implement community-based competency restoration education services that are integrated with locally available behavioral health services. Specifically, describe the Department's progress to date implementing each of the following requirements of SB 17-012:

SB 17-012 was signed into legislation on May 18, 2017 and funding was available for outpatient restoration services starting FY 2017-18. The judicial system makes the final determination for location of restoration services. As per statute, decisions from the court are based on judges' discretion, which may not consider the clinical needs of the individual. The court ordered 240 referrals for outpatient restoration since November 2017, with 131 individuals currently receiving services. Outpatient restoration services allow individuals to seek restoration services while connecting to mental health treatment within their communities while resolving pending criminal charges.

The following is a timeline of the Department's efforts related to SB 17-012:

- On November 29, 2017, the Department released a request for proposals (RFP) seeking one vendor to secure statewide services for outpatient restoration services.
- In December 2017, in an effort to begin services quickly, on a limited scope, the Department contracted with one provider to provide community-based restoration services prior to awarding the Request for Proposal (RFP).
- On January 5, 2018, the RFP closed.
- In January and February 2018, the selection committee scored and sent clarifying questions out to the applicants. The selection committee determined that none of the applicants meet the requirements needed to award the contract for outpatient restoration services statewide. In February one additional restoration provider was trained.
- In March 2018, the selection committee notified the Department that there were no applicants able to provide restoration services statewide and that the RFP was an unsuccessful procurement. Five contracts were signed with interim restoration providers in March and restoration services were available in the Denver Metro area and El Paso County.
- In March and April 2018, the Department restructured its approach to procure services by changing the selection process from an RFP seeking a single vendor, to a (RFA) and contract with multiple service providers directly.
- In June 2018, a request for applications RFA was published soliciting providers statewide. Meetings began with Colorado Behavioral Healthcare Council (CBHC) to reach out to all of Colorado's community mental health centers (CMHCs) regarding contracting opportunities for outpatient restoration services.
- In July 2018, the Department worked with stakeholders to host informational webinars in order to provide information on the opportunity to provide restoration services and solicit interest from mental health centers.
- In August 2018, the Department worked with Alliance Colorado to solicit interest from 56 providers who serve individuals with intellectual and developmental disabilities. These efforts resulted in one contract in Grand Junction with STRiVE.
- In September 2018, at the request of stakeholders, the Department modified the RFA.

- In October 2018, the Department relaunched a revised RFA. In addition, the Department eliminated the need for CMHCs to have to apply and instead could utilize an already existing contract and rates for each CMHC.
- In November 2018, the Department sent contract agreements to all CMHCs.
- On November 2, 2018, the RFA closed for non-CMHCs and a total of 21 private providers submitted applications.
- In November and December 2018, agreements were signed for services from seven CMHC's and all 21 private providers.
- The Department has outreached the remaining CMHCs and is in various stages of negotiation to secure agreements.
- The Department continues to train new providers in order for them to provide restoration services, 36 providers to date. All providers will be trained and operational by the end of February 2019.

As of December 12, 2018, community-based competency restoration educators are in place and providing services in the following counties: Arapahoe, Boulder, Clear Creek, Denver, Douglas, El Paso, Gilpin, Grand, Jefferson, Larimer, Mesa, Summit, and Weld.

The Department has secured signed agreements and anticipates community-based services to begin by the end of January with providers in the following counties: Adams, Alamosa, Archuleta, Cheyenne, Conejos, Costilla, Delores, Elbert, Fremont, Huerfano, Kit Carson, Las Animas, La Plata, Lincoln, Logan, Mineral, Montezuma, Morgan, Phillips, Pueblo, Rio Grande, Saguache, San Juan, Sedgwick, Washington, and Yuma.

The Department anticipates the remaining CMHCs, which serve the remaining counties, to enter into agreements by January, 2019 with training and services beginning in February, 2019.

A. Develop standardized juvenile and adult curricula for the educational component of competency restoration services by December 1, 2017;

The Department conducted a comprehensive review of juvenile curricula utilized nationwide. In November 2017, the Department developed a juvenile curricula based on the foundation of the State of Utah's copyrighted juvenile curriculum. Editing and subject matter expert reviews were completed in May 2018 and disseminated immediately.

In October 2017, the Department reviewed the adult curricula throughout the nation. The Department determined the Florida CompKit, which was already in use in the program, should continue to as Colorado's standard. Although, CompKit remains the national standard for adult competency restoration, the Department updated curriculum to better align it with the needs for Colorado.

B. oversee providers of the education component of competency restoration services;

The Department trains all contracted providers to the standardized restoration curriculum for adults and juveniles. Contracted restoration providers commit to participating in quarterly continuing education meetings. For ongoing quality assurance, the Department has auditing procedures that require restoration providers to submit reports each month.

C. develop models for providing competency restoration services that integrate the education component with other case management and treatment, ensuring ongoing treatment, avoiding duplication, achieving efficiencies, and preserving the integrity of the competency evaluation process;

In January 2018, the Department developed a model that focuses on competency education, referring and connecting patients for proper medication; treatment planning that addresses specific barriers to competency, and consistently evaluating readiness for a competency evaluation. In addition to all of these components, the providers are responsible for case management services that focus on patient engagement in treatment and addresses any barriers for success in the community.

Since January 2018, the Department facilitated 7 trainings to 44 providers on the model developed by the Department for outpatient restoration.

To preserve the integrity of the competency evaluation process, all competency evaluators operate independently of all competency restoration services.

D. engage with key stakeholders to develop best practices in the delivery of competency restoration services; and

The Department has engaged with both internal and external stakeholders in order to establish best practices in competency restoration treatment. By November 2017, the Department completed a literature review, reached out to restoration providers both within Colorado and nationwide, including Wisconsin, Virginia, Texas, Michigan and Utah, in order to identify a curriculum for juveniles and adults and best practices for competency restoration treatment. The Department has provided information and solicited feedback from stakeholders regarding the implementation of statewide outpatient restoration services.

Stakeholder engagement includes:

- A joint meeting between the plaintiffs (DLC), the Department, mental health center representatives, State Public Defender's Office, District Attorney (DA) representation, advocates and other stakeholders to brainstorm on potential solutions for competency restoration needs. This ultimately resulted in the creation of SB 18-252.
- Consulted with the State Court Administrator's Office on interagency efforts, such as:
 - Aligning processes to ensure the process of outpatient restoration is timely and efficient statewide
 - Establishing protocols for the Bridges Program (court based liaisons)
- Attended the Chief Justices meeting
- Presented to judicial districts, including:
 - Denver District and Juvenile Courts
 - Boulder County Community Justice Services
 - Jefferson County Juvenile Courts
 - Denver Pre-Trial Services
 - 19th Judicial District

- Presented at the Judicial Conference and Colorado District Attorney’s Council (CDAC) Conference
- Collaborated with Community Behavioral Health Council (CBHC) and mental health centers statewide to provide information and solicit feedback on contracting for community-based services.
- On December 20, 2018, the Department will begin attending meetings in judicial districts, as invited, in order to provide information and respond to questions, concerns and feedback.

E. Make recommendations for legislation.

In the 2018 legislative session, the Department contributed to the crafting of SB 18-252. The Department strongly supported 2018 Senate bills 249 through 252. SB 18-252 failed to pass due to a filibuster.

The Department is not bringing any legislative proposals on this issue at this time. If the legislature chooses, the following are some policy considerations that would allow for the expansion of community-based competency services and potentially reduce the demand for inpatient psychiatric beds for the purpose of competency restoration:

- Dismissal of charges or bonding out for low-level non-violent charges
- Limit inpatient restoration orders only to those that meet inpatient criteria pursuant to C.R.S. 27-65-105
- Require no-cost bonds for defendants who could benefit from community-based competency services
- Promote courts ordering outpatient competency
- Pursue jail-based restoration while the defendant is awaiting community or inpatient bed placement
- Begin restoration services immediately upon a finding of incompetency
- Establish a uniform maximum length of time for restoration efforts
- Tighten up court deadlines to speed up defendants waiting for services and those waiting to be discharged

3. Provide an update concerning the most recent expansion of the jail-based program for individuals requiring competency evaluations or restoration services (the Restoring Individuals Safely and Effectively (RISE) Program).

A. When will the 114-bed capacity that was funded for FY 2018-19 be fully operational?

B. Where will the 114 beds be located?

Currently, the jail-based restoration and evaluation program has a census of 96 beds, housed at the Arapahoe County Detention Facility. In September 2017 funding was approved for 28 beds at the jail-based restoration and evaluation program. Funding was approved for an additional 34 additional beds effective July 1, 2018. Table 2 shows when those beds were added.

Table 2. Number of RISE Beds in Colorado		
DATE ONLINE	NUMBER OF BEDS	LOCATION
November 2013	22	Arapahoe County Jail
February 2016	16	Arapahoe County Jail
August 2016	14	Arapahoe County Jail
October 2017	4	Arapahoe County Jail
May 2018	8	Arapahoe County Jail
September 2018	16	Arapahoe County Jail
October 2018	16	Arapahoe County Jail
Pending	18	TBD

On April 5, 2018 the Request for Proposals (RFP) for the 18-bed jail-based restoration program was published, was amended on May 1, 2018, and closed on May 21, 2018. On August 6, 2018, the Request for Proposals for the 18-bed unit was awarded to the WellPath (formerly known as Correct Care, formerly known as GeoCare). While the Department assists in locating a jail to work with, it is the awarding vendor who actually contracts with the jail. At that time, WellPath approached the Arapahoe County Sheriff’s Office after their award and was informed the jail is unable to provide additional space for the 18-bed expansion.

The following is an update of the Department and WellPath’s ongoing efforts to identify a jail for the 18-bed space.

- In May 2018, WellPath explored the possibility with Adams County and they expressed little interest.
- In May 2018, WellPath explored the possibility with Jefferson County. The Sheriff reported that they cannot participate due to capacity issues.
- In September 2018, the Department attended the Colorado Jail Association Meeting in Broomfield and toured a vacant unit at the jail.
- In October 2018, WellPath submitted a proposal to Douglas County for providing medical services, including the jail-based restoration program in the proposal. WellPath did not win the bid for contracted medical services in Douglas County. Both the vendor and the Department have followed up with Douglas County to discuss contracting for a jail-based program.
- In October 2018, WellPath met with Denver County and they expressed they would only be willing to explore this opportunity if the program only served Denver inmates.
- In October 2018, WellPath met with Park County. However, there were concerns regarding the location being too far from the metro area and that the jail could not open a RISE unit in a timely fashion.

- In November 2018, WellPath spoke with Weld County officials who expressed interest but lacks capacity for 18 additional beds.
- In November 2018, WellPath spoke with Mark Waller, El Paso County Commissioner, who was supportive of the project and would assist with scheduling a meeting with Sheriff Elder.
- In November 2018, WellPath met with Adams County Sheriff-Elect Rick Reigenborn, who expressed concerned with current vacancies and could not commit to the program at this time.
- In November 2018, WellPath met with Weld County Sheriff Reams who expressed interest; however, he currently lacks capacity for the program. He does have a jail expansion project but it will not meet the required timelines.
- In November 2018, WellPath spoke with Mesa County Captain Art Smith who shared that they lack the capacity.
- In December 2018, the Department and WellPath met with Boulder County jail, which expressed interest, but could not onboard the beds until 2020.
- In December 2018, the Department and WellPath met with Broomfield and toured the vacant unit. Broomfield indicated a timeline for implementation in 2020 due to requests and approvals needed from the city and county. Additionally, they anticipate they will need to occupy the unit by 2022.
- In December 2018, WellPath attended the new Sheriffs' orientation meeting to explore opportunities with the 27 new Sheriffs taking office.
- In December 2018, WellPath met with Arapahoe County Sheriff-Elect Brown and discussed the possibility of expanding in the Arapahoe County Jail. Sheriff-Elect Brown reported that he is supportive of the program and he will meet with Chief Line in late December 2018 to explore possible expansion.
- In December 2018, WellPath spoke with Jefferson County and they reported that they are still struggling with capacity issues.
- WellPath has a meeting scheduled with Boulder County on December 19, 2018 to explore expansion and timelines.

4. The Department requested funding in January 2018 to expand inpatient psychiatric bed capacity by 10 beds by contracting with one or more hospitals. The General Assembly provided the requested funding for FY 2017-18 and FY 2018-19. What is the status of this initiative?

The Department closed a Request for Proposals (RFP) on April 18, 2018 for the contracting of 10 psychiatric hospital beds outside the Department's existing facilities. The inpatient hospital beds are to be utilized for individuals currently in jail and court-ordered for restoration services. The RFP received no bids. The Department then reached out to independent private hospitals to gauge interest for contracts.

In June and July of 2018, the Department contacted UCHHealth, Denver Health, SCL Health Denver Springs, Memorial Hospital, and Centura hospital networks regarding interest in contracting inpatient beds. The results of those contacts are as follows:

- Denver Health expressed interest in partnering with the Department for 3 contracted beds for January 2019 with the opportunity for additional beds 6 months following execution of the contract.
 - A draft proposal for statement of work was received from Denver Health for review on October 26, 2018. The proposal indicates a cost per day of \$908; however the Department was funded for a daily rate of \$876.68 per day.
 - A finalized contract for review was sent on December 6, 2018.
- SCL Health Denver Springs indicated they were unable to proceed currently, as all beds were in use and they could not presently accommodate a forensic population. They did indicate interest in the future if they build a new hospital.
- Memorial Hospital indicated they are at full capacity and unable to contract beds at this time.
- Centura did not express an interest in the proposal.

In November 2018, Peak View Behavioral Health reached out to the Department and expressed an interest in contracting for up to 5 beds. The Department is currently reviewing the cost proposal sent by Peak View Behavioral Health on November 30, 2018. The proposal indicates a cost per day of \$1,800; however the Department was funded for a daily rate of \$876.68 per day.

In December 2018, the Department contacted the community mental health center Mind Springs regarding interest in contracting hospital beds for their hospital (Well Springs) that opened new beds as of December 11, 2018. The Department is awaiting a response from Mind Springs. The estimated daily rate for the hospital is \$1,021.

In June and July 2018, the Department spoke with two hospital vendors (Centura and SCL) that provide services on the Western slope, but neither were interested in the proposal at the time.

5. What actions is the Department taking to help local communities effectively implement and integrate the programs and services that have been funded to date and that are described in the first two issue briefs in the JBC staff budget briefing?

It should be noted that many of these bills improve access to mental health services and may potentially reduce the number of individuals with mental illness entering the criminal justice system. However, none of the bills relieve the Department from its current legal obligations to admit individuals who are court ordered for restoration services at a state facility.

- **SB 17-012 Outpatient Restoration Program (Reference Question 2)**
- **SB 18-251 Court Liaison Program**

This program is not managed within CDHS, but within the State Court Administrator's Office. The Department provides consultation to the Administrator's Office on the

clinical process related to competency evaluations and restorations. Specifically, the Department coordinates with court liaisons on the availability of outpatient restoration within each judicial district and assists in the coordination of information between the restoration treatment services providers/case managers and the courts.

- **SB 18-249 Diversion Grant Program**

This program is not managed within CDHS, but within the State Court Administrator's Office. The bill creates up to four pilot programs in judicial districts that divert individuals with low-level criminal behavior and a mental health condition to community resources and treatment rather than continued criminal justice involvement.

- **SB 16-202 Substance use funds**

The Managed Services Organizations (MSO) directly manage \$12M in funds provided by SB 16-202 "to cover expenditures for substance use disorder services that are not otherwise covered by public or private insurance." These funds are locally managed and are subcontracted from the MSOs to local community partners. The FY 2017-18 MSO report did not list the specific community partners, but it does include the types of services funded, including;

- \$1.05M for 15 beds for intensive residential services in NE Colorado
- \$786K for intensive and residential services in Denver Metro
- \$560K for residential opioid treatment services in SLV and Southern Colorado
- \$452K for an opioid treatment clinic in Lamar, CO
- \$433K for intensive outpatient treatment in Wheat Ridge, CO
- \$376K for medication-assisted treatment for opioid addiction in Larimer County
- \$348K for jail-based opioid treatment in Denver County
- \$318K for treatment, recovery and care management in Fremont, Chaffee, Custer counties
- \$240K for screening and referrals for at-risk youth
- \$115K for school-based prevention programming in NE Colorado
- \$170K for peer run recovery housing supports
- \$195K for specialized residential services for pregnant women in NE Colorado
- \$143K for family-based treatment and prevention in Denver
- \$126K for case managers in Denver Drug Courts
- \$162K for transitional housing for pregnant and parenting women in El Paso

The full report can be found at: <https://www.colorado.gov/pacific/cdhs/publications-reports>

- **Mental Health Services for Juvenile and Adult Offenders**

The goal of the Offender Behavioral Health Services line item is to address Colorado's continued growth in the demand for community-based mental health services for individuals with mental illness involved in local and State criminal justice systems. This program is managed by the local community mental health center and includes:

- "in-reach" coordination prior to release;

- expanding partnerships with local problem-solving courts;
- coordination with law enforcement and co-responder models;
- and partnerships with youth-serving agencies, including juvenile assessment centers, detention facilities, problem-solving courts, municipal courts, schools and probation.

- **SB 18-250 Jail-based Behavioral Health Services**

The Department is on target to meet the deadlines to the Jail-Based Behavioral Health Services program (JBBS) to expand and include mental health treatment.

- On November 19, 2018, the Department released a Request for Application to Colorado County Sheriff Departments operating rural and frontier county jails to provide mental health services in their jails.
- The applications were due back to the Department by December 17, 2018, with a February 2019 contract execution target date. However, due to a large number of new Sheriffs being elected and taking office in January 2019; the Department has communicated to Sheriffs that it will continue to accept applications until all the funding is allocated.

- **SB 17-207 Strengthening the Crisis System**

As of May 1, 2018, SB 17-207 ended the use of jails for the purpose of holding individuals who are a danger to self or others who have not committed a crime. The funding with this bill supports criminal justice liaisons and expand funding for various crisis enhancements in the four crisis regions, Law Enforcement Assisted Diversion pilots, and the Co-Responder pilots.

- ***Law Enforcement Assisted Diversion (LEAD)***

There are currently four communities implementing the LEAD pilot program. The procurement process entailed:

- Request For Application (RFA) released in October 2017
- Awards were announced in January 2018
- Contracts released to the awardees in February 2018 for approval by local officials
- Contracts were signed in April 2018

Date on which services began:

- Alamosa: May 23, 2018
- Longmont: July 9, 2018
- Pueblo: August 27, 2018
- Denver: Has not been fully implemented yet due to a series of staffing changes and program implementation setbacks within the City and County of Denver. They are set to officially begin by the end of December 2018.

- ***Co-Responder Services***

The Co-Responder Pilot program is in eight communities across Colorado with two additional communities receiving funds via federal mental health block grant.

The procurement process entailed:

- Request For Application (RFA) released in October 2017
- Awards were announced in January 2018
- Contracts released to the awardees in February 2018

Dates on which services began:

- City and County of Broomfield: May 14, 2018
- City and County of Denver: Has not been fully implemented yet due to a series of setbacks and changes within the City and County of Denver. They should be fully operational in December 2018.
- El Paso County Sheriff's Office: July 1, 2018
- Evans Police Department/Greeley: November 2018 (due to hiring and recruitment challenges)
- Grand Junction Police Department: July 1, 2018
- Larimer County Board of County Commissioners: April 4, 2018
- City of Longmont: April 2018
- Pitkin County Public Health: November 2018, (due to delays and challenges with subcontract execution, hiring and recruitment)

- **SB 17-019 Medication Consistency**

The Department is on target to meet all the deadlines identified in SB 17-019. The Medication Consistency program is a collaboration between local jails, behavioral health providers, mental health institutes, and the Department of Corrections (DOC), all essential partners in coordinating the treatment for individuals moving across systems. Since the bill's passage, the Department has:

- Completed the medication formulary in coordination with public and private provider partners;
- Engaged in public comment and promulgated rule, adopted June 1, 2018 which went into effect August 1, 2018;
- Administered a community-based survey with the Colorado Jail Association to help inform the implementation of the legislation and to determine the best ways to support local jurisdictions; and
- Hired 1 FTE to manage the Medication Consistency pilot program. Ongoing efforts will continue as the Department works with the state health information exchanges (HIEs) to enhance interoperability features within the criminal justice system.

CDHS is continuing to implement this new program through the following activities in progress:

- Development of a plan to electronically share relevant health data across various treatment providers in an effort to support clinical interventions for clients moving in and out of various treatment settings- including jails and DOC.
 - CDHS is contracting with the two Health Information Exchanges, Colorado Regional Health Information Organization (CORHIO) and Quality Health Network (QHN), to provide consultation and support to jails and medical staff in jails to access and utilize patient records to provide appropriate care interventions.
 - Working with the Department of Health Care Policy and Finance (HCPF) to submit an application for 90/10 federal capacity funding to enhance pharmaceutical data in the health information exchanges;
 - Creating an inter-agency contract to have pharmacy students support medication reconciliation for clients booked into rural jails; and
 - Completed the draft educational manual for state and local partners.
- **SB 17-021 Housing Assistance To Released Mentally Ill Offenders**
This program is managed by the Department of Local Affairs, Division of Housing.
 - **Residential Services for Individual with Co-occurring Disorders (CIRCLE)**
 - The medically based, high-intensity treatment program is run by Crossroads Turning Points Inc. Crossroads is one of Colorado’s largest evidence-based substance use disorder treatment providers within the Signal Behavioral Health Network.
 - The Circle Program was relocated from CMHIP to the community to remove inpatient hospital status requirements and offer greater community access.
 - The program opened on December 18, 2018.
 - **SB 18-270**
 - The \$3.1 million statewide program transitions “high-risk individuals” from hospitals and withdrawal management facilities to local community behavioral health services.
 - The State Board of Human Services adopted rules that defined eligibility for the program on November 2, 2018.
 - The RFP for the single state contractor to operate the program closed November 29, 2018.
 - The services will begin in January 2019 and include sub-contracts in rural and metro areas for in-person and tele-supported transition services.

R1 Mental Health Institute at Pueblo (CMHIP) Expansion

6. Provide data concerning the number of vacant positions at both mental health institutes. Please include data for fiscal years 15-16, 16-17, and 17-18 so that the Committee can see the

trends that preceded and followed the actions taken by the federal Centers for Medicare and Medicaid Services (CMS) starting in June of 2017 in response to patient safety violations related to insufficient staffing levels at CMHIP.

Vacancy data is tracked as a distinct point in time as opposed to on an aggregate fiscal year. As a result, Table 3 provides vacancy data, by Institute, for November of 2015, 2016, 2017, and 2018 to demonstrate the trends in vacancies experienced by each facility during these years. The table includes vacancies in direct care staff positions. Direct care staff positions include the following job classifications: Client Care Aide, Correctional/Youth/Security Officer, Health Care Services Trainees, Health Care Technician, Mental Health Clinician, and Nurse.

Table 3. Percentage of Direct Care Staff Positions that Are Vacant For CMHIP and CMHIFL				
	November 2015	November 2016	November 2017	November 2018
CMHIP	12%	17%	18%	15%
CMHIFL	10%	12%	10%	10%
Average Across Both Facilities	12%	16%	16%	14%
<i>Source: Department of Human Services analysis of data contained in Colorado Payroll Personnel System.</i>				

In November 2017, CMHIP Registered Nurses received an increase to the mid-point of the salary range. This change has had a clear impact on RN vacancies at CMHIP.

- In October 2017, there were 63 vacant Registered Nurse positions.
- In November 2018, there were 26 vacant Registered Nurse positions.

Pay increases for direct care staff were put in place in July 2018 for all direct care staff. The Department has also made significant efforts to improve staffing at CMHIP by improving scheduling, maximizing staffing, and strengthening leadership development such as:

- Leadership analyzed available resources within the hospital, shift coverage, leave approval process, and utilization of part-time reserve staff. The process included using historical data to identify call-offs, anticipated leave, and distribution of FTE across different units.
- Established consistency for staffing and coverage across the hospital.
- Management training program to provide guidance for all CMHIP supervisors, managers, and leaders designed to ensure that all managers are effective in coaching, mentoring, and leading staff in consistent and equitable ways.
- A psychiatric technician training program starting Winter 2019 will offer promotions with existing staff as well as increase the psychiatric technician workforce.

- CMHIP Voice of the Employee (VOE) committee provides feedback to CMHIP leadership on policies, and other ways to improve communication, patient care, and daily operations.
- On October 1, 2018, the Department implemented new electronic scheduling system for more accessibility by staff of their schedules and vacant shifts, identify gaps (vacancies) in scheduling, increase time to plan to cover staff leave, allow for more flexibility for staff.
- On October 22, 2018, the Department implemented a new pilot schedule for CMHIP using ideas and information collected during formal staff listening sessions. The pilot consists of a phased approach to implementation with continued ongoing conversations with staff to determine what is working well, as well as areas for improvement.

7. Explain how the Department plans to attract and retain employees to fill the 62.6 FTE positions requested through R1 as well as the positions that will be required when the new 24-bed forensic unit that is being constructed at CMHIP becomes operational.

The Department recognizes that hiring 62.6 FTE in Pueblo will be a challenge. While any organization employing this many FTE at a 24/7 facility will have a certain level of vacancies at any given time, CMHIP continues to improve its retention rate. As a result, it is reasonable to assume that CMHIP will be able to fill the required direct care and clinical staff positions for the proposed 42-bed expansion and new 24-bed forensic unit.

The salary adjustments that the General Assembly approved last year made CMHIP more competitive with the private sector market. Prior to the increase, on average, direct care staff salaries at CMHIP were about 22% below the market salary for a similar position. The compensation initiative reduced, but did not eliminate, the difficulties CMHIP was having in hiring and retaining direct care staff. Although this initiative has only been in place since July 2018, preliminary results for staffing at CMHIP are encouraging, indicating improvements in the following areas:

- **Vacancy rates:** The vacancy rate for direct care staff at CMHIP was about 18% in November 2017. In November 2018, just three months after the pay increase, this rate has dropped to about 15%.
- **Hiring:**
 - Between February and June 2018, CMHIP hired an average of 13 new direct care employees per month.
 - Between July and November 2018, CMHIP hired 12 new direct care employees per month.
- **Separations:**
 - Between February and June 2018, CMHIP had 23 direct care separations.
 - Between July and November 2018, CMHIP has 17 direct care separations.

Capital Construction Requests Related to Inpatient Psychiatric Bed Capacity

8. [Background Information: The Department's FY 2019-20 budget requests propose inpatient psychiatric bed capacity expansions for the Mental Health Institute at Pueblo (42 beds), for the Mental Health Institute at Fort Logan (44 beds), and a new Secure Treatment

Facility for Competency Restoration at the site of the existing Ridge View Youth Services Center (210 beds). When combined with the 24-bed expansion for CMHIP that was funded in FY 2017-18, this amounts to a 320-bed (48.0 percent) capacity expansion compared to the 667 beds that are currently funded.]

A. Why is the Department focusing its budget request on expanding inpatient psychiatric bed capacity?

The Department is focusing its budget request on expanding inpatient psychiatric bed capacity as it continues to receive court orders to provide inpatient restoration services which the Department must accommodate under C.R.S. 16-8.5-111(2)(b). Under current law, the Department does not have the discretion to move to outpatient those individuals who have been court ordered to the Department for inpatient services. Within our current statutes, judges have full discretion regarding where patients receive services without Department input or direction on clinical need. Therefore, the Department has to focus its resources on building beds that will directly impact the waitlist and wait times.

While the expansion of the existing outpatient restoration services along with the Department's other community-based efforts may potentially reduce the demand for inpatient restorations, there are no assurances that courts will refer to those programs. Increasing the Department's current bed capacity is the only way to guarantee it can come into compliance with the current settlement agreement in *CLA v. Bicha*. The Department is currently not meeting the terms of the settlement agreement.

B. Why is the Department not requesting additional resources to expand community-based, out-of-custody competency-related services?

The Department has an existing outpatient restoration program that was implemented in December 2017. The need for outpatient restoration in Colorado is still unknown and its utilization is outside of the control of the Department. The Judicial System makes the final determination on the location of an individual's restoration services. As per statute, decisions from the court are based on the judge's discretion, which may not consider the clinical needs of the individual. Given the large dollar amount of the requests currently presented to the Joint Budget Committee (JBC) and Capital Development Committee (CDC), the Department decided to focus its efforts to solutions that are most likely to bring the State into compliance with the terms of the settlement agreement.

9. [Background Information: The Governor's November 1, 2018, capital construction request included \$15,462,659 for a "Secure Treatment Facility for Competency Restoration", however, the actual request that describes the project was not submitted with the other requests.]

A. Why did the Department choose to wait until December 10 and use the supplemental process to request capital construction funding for the first of a three-phase project to convert the Ridge View Youth Services Center to a secure psychiatric treatment facility for adults who require competency restoration services?

There was a placeholder in the Governor's November 1st budget for a secure treatment facility. The Department presented a supplemental for planning and design expenses to the Governor for consideration, which will speed up the process for opening the facility.

Supplemental documents are embargoed until released by the Governor's Office, which occurred on December 10. In addition, a supplemental request allows the Legislature to disperse the funding request over multiple fiscal years, decreasing the annual requested amount for the long term projections.

B. When did the Department begin planning to close down the existing 500-bed staff-secure juvenile facility at Ridge View?

The Department has been considering the potential of repurposing the Ridge View campus for some years but Department leadership has been reluctant to take that step until recent months. However, as the census at Ridge View continued to decline, and the Department's requests in successive budget years for a new hospital were not approved, Department leadership felt it was time to pursue that option. Concurrently, the Department was -- and is -- facing increasing pressure in the federal court action. The strong direction from the court is that the Department must expeditiously get into compliance with the terms of its 2016 settlement agreement.

C. The Department did not mention its plan to close down the juvenile facility at Ridge View during its budget hearing on November 28 concerning the Division of Youth Services. Why not?

The request was a multi-phased proposal to the Governor, with the first phase taking the form of a supplemental that was embargoed until the Governor's December 10th submission of supplemental requests to the General Assembly's Capital Development Committee. Once the Governor's Office of State Planning and Budgeting approved and submitted the request, the Department distributed it to stakeholders, lawmakers and staff.

10. Describe the status of the Department's efforts to conduct a site master plan for each of the mental health institutes and any associated operational program plans. If these plans have been completed, describe how the most recent capital construction requests relate to these plans.

The Department currently has a three-phased, cash-funded, capital request before the Capital Development Committee to fund completion of a Department-wide facility master plan. The request will complete individual Facility Program Plans (FPPs) for all facilities that do not yet have an FPP and compile all plans together into a Department-wide master plan.

With respect to the Mental Health Institutes, the Department was appropriated \$815,000 in FY 2014-15 to complete FPPs for both CMHIP and CMHIFL. These plans were completed in 2017 and submitted to the Office of the State Architect. The FPPs for the mental health institutes provide a plan to help the Department meet a well-documented need for additional mental health inpatient bed capacity. The need for inpatient capacity is documented in:

- The 2015 WICHE study - The Western Interstate Commission for Higher Education (WICHE) completed a study of mental health system capacity that identified a need for 1,125 inpatient mental health treatment beds by 2025, primarily in the Denver-metro area.

- The 2012 settlement agreement (amended in 2016) in which the Department is mandated to ensure that it offers a bed within 28 days to criminal defendants that judges order to the Department to receive in-patient competency evaluations or in-patient competency restoration. Over the past 17 years, the volume of competency evaluations has increased by nearly 500% and the volume of competency restorations has increased by more than 1,200%. This increase in volume has resulted in the Department having to eliminate civil inpatient mental health treatment beds at CMHIP and use the facility nearly exclusively to try to comply with the settlement agreement.

The solution proposed in the CMHIP and CMHIFL FPP suggests building a new mental health institute in the Denver-metro area to address the shortage of mental health inpatient treatment beds and help the Department to comply with the terms of the settlement agreement, the solution proposed would cost nearly \$400 million. The Department submitted a six-phased capital construction request for a new hospital during last year's budget cycle, however, due to the overwhelming cost of the project and a desire to look for less expensive alternatives, the project was not funded. Since that time, the Department has worked to identify solutions that continue to meet the programmatic needs of increasing patient beds (as identified in the FPPs for CMHIP and CMHIFL) while doing so at a lower cost. The solutions identified that are before the Capital Development Committee and Joint Budget Committee will provide the same overall number of new beds needed in the Denver-metro area at about 10% of the cost of the new hospital, and in about one-third of the time. Specifically, the Department is asking for:

- \$17.8 million to renovate two cottages at CMHIFL, creating 44 new beds.
- \$3.7 million in supplemental funding to begin the design phase to renovate the Ridge View campus to a secure mental health treatment facility. This is a three phased project costing a total of \$34.3 million to provide 210 new mental health inpatient beds.

11. How does the Department plan to address the need for inpatient psychiatric beds on the Western Slope?

The 21 counties in the western region, account for 8% of the total statewide 'Incompetent to Proceed' restoration referrals for FY 2017-18. The Department spoke with two hospital vendors that provide inpatient psychiatric services on the Western slope, but neither were interested in contracting with CDHS to provide beds for restoration patients, at this time. Mind Springs has been contacted, as it recently opened a psychiatric hospital. The Department and Mind Springs will explore the option of using beds for a forensic population after Mind Springs is able to analyze admissions data to determine capacity to admit a forensic population.

For crisis stabilization unit (CSU) and acute treatment unit (ATU) beds for the general public, the western slope currently has 11 CSU beds, located at the Transitions program at West Springs Hospital in Grand Junction. Montrose was funded as part of SB 17-207 to open additional CSU beds and it will include a Withdrawal Management facility. They are working to make the facility operational and address licensing requirements to open.

BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

12. The request for proposal (RFP) recently released by the Department seeks to contract with “Administrative Services Organizations” in order to separate administrative functions from the delivery of Crisis System services. The RFP allows for up to 25 percent of the total funding allocated to each region to be used for administration. Why does the Department believe that adding this administrative layer and shifting funding away from direct services and into administration will improve services to clients?

The newly-named Administrative Service Organizations are simply the formal title for the crisis vendors similar to the system today. The new RFP neither creates an additional layer of administrative services nor increases administrative expenses. It does, however, require that administrative costs be reported uniformly and accounted for within an administrative cost line. Currently, such costs are scattered through program expenses, making it more difficult to track them. It also caps those expenses, which are currently averaging 23.3 percent of total costs, at 25 percent. The RFP also more clearly defines the role of these vendors to reduce the conflicts of interest that currently exist, and creates a more sustainable structure to support local alternative service models and expand the provider network to allow people more diverse opportunities for care in more locations. That is intended to address the concerns the Department has heard expressed by local officials and alternate providers who feel they are locked out of the current system.

The Department is not shifting additional dollars away from direct services that already exist today. Instead, the new structure puts a hard cap on overhead expenses and more clearly defines the appropriate expenses and outputs from the administrative organization. In addition, the Department is adding funds from the federal mental health block grant to the crisis system.

Since the inception of the crisis system in 2013, the Department has identified several operational efficiencies and cost saving opportunities that were not requirements in the original RFP and have not been realized. The Department chose to ensure that the administrative functions of the crisis system were clearly outlined in the current 2018 RFP to ensure transparency, accountability and high quality services were delivered.

The crisis system is currently operated by four administrative entities (which have been given the proper name “administrative service organizations” in the new RFP) which are responsible for administering the state program and subcontract with service providers in the community to deliver crisis services.

Each of the four current vendors of the crisis system are administrative entities that are owned and operated by the State’s 17 state’s community mental health centers (CMHCs). The administrative entity (overseen by the CMHCs) subcontracts the work back to the CMHCs as the primary service providers for the crisis system (see Table 4). This model unnecessarily limits the opportunity for other existing community providers from contributing to the safety net services. The current business rules related to the crisis vendors do not protect against conflicts of interest that can be driven by having the service provider administer funding to themselves.

Table 4. Current Crisis Vendor Operations and Ownership				
Crisis Vendor	Colorado Crisis Connections	West Slope Casa	Southern Colorado Crisis	North Range Behavioral Health
CMHC Ownership	<ul style="list-style-type: none"> ● Mental Health Center of Denver ● Mental Health Partners ● Aurora Mental Health ● Jefferson Center for Mental Health ● All Health ● Community Reach Center 	<ul style="list-style-type: none"> ● Mind Springs ● The Center for Mental Health ● Axis Health Systems 	<ul style="list-style-type: none"> ● Aspen Pointe Health Solutions ● Sol Vista ● San Luis Valley Mental Health ● SouthEast Health Group 	<ul style="list-style-type: none"> ● Summit Stone ● North Range Behavioral Health ● Centennial Mental Health

The Department anticipates that the CMHCs will still be an integral part of the services in the community and contract with the ASO to be one of the providers offering crisis services. The new administrative standards create expanded access to services and remove conflict of interests and allow the opportunity for the statewide crisis system to work in conjunction with counties efforts and funds aimed at providing mobile and crisis response services.

What ASOs will do that the current vendor does not:

The ASO model will delineate between the responsibilities of providing clinical care and oversight of an adequate network that includes other state and local investments in behavioral health. Leveraging multiple programs such as LEAD, co-responder programs, child and adolescent in-home respite providers, and a broad network of mobile responders enables programs to target populations that need specialized interventions and expands funding sources for the greatest delivery of services. Some additional examples of the enhanced ASO responsibilities in the RFP include:

- Improved clinical standards that align with best practices and quality oversight of the system
- Telephonic follow up for people at-risk who were screened for suicidality and discharged home
- Stronger coordination with hotline referrals to ensure clients are connected with mobile services
- Improved transparency and standard operational practices
- Develop contracts with payers including commercial plans and Medicaid to leverage OBH health plan coverage for reimbursable services
- Ensure clinical trainings and develop trainings for partners
- Expanding network arrangements with other local providers, such as EDs and first responders-including Co-responder and LEAD programs, EMS and law enforcement

- Improved screening protocols for individuals at risk of suicide with the ability to see evidence of follow-up in the data collection system.
- Clinical Director and/or contracted MD/DO to develop clinical protocols, oversee utilization management, and admission criteria to higher levels of care, conduct clinical supervision of staff, and develop models of integration and telehealth to improve access
- The requested funding for the crisis record will allow for documentation in the field for all mobile responses and allows any provider conducting follow up to leverage Health Information Exchange and view previous health history and risk factors to effectively treat the patient and reduce duplicative services.

13. Describe the improvements the Department is seeking for the Crisis System, and why the recently released RFP is the best strategy for improving services for individuals experiencing a behavioral health crisis.

In preparation for re-procuring the crisis system, the Department established a Crisis Steering Committee (a public multi-stakeholder group including the current vendors), supported by an independent facilitator (SHG Advisors) which identified several issues that need improvement:

- Standard business rules by region are needed
- Improved data and evaluation system and better technology infrastructure
- The Department should amend its regions to reflect those of the RAEs
- Increase services for children and adolescents
- Leverage co-responder programs in the crisis system and improve community-based mobile response
- Utilize peers in the crisis system
- ASO administrative expenses include additional requirements for patient follow-up, and greater opportunity to leverage other investments for a diverse provider network. The ASO will maximize 3rd party and Medicaid funding, therefore their proportion of operating expenses to revenue will only decrease.

In an effort to ensure services meet the needs of clients and communities the Department has taken the steering committee recommendations and integrated the requirements into the FY2019-20 RFP.

Moving from four crisis regions to seven crisis regions to align with RAE regions creates consistency in providers for clients. At least 50 percent of clients using the crisis system are covered by Medicaid.

The RFP also allows for a broader network of providers to ensure mobile responses as a prioritized service in communities. The new standards promote the provision of crisis intervention services in the community rather than emergency departments and CMHCs engages clients where they are and promotes access to treatment services.

The ASO model is a sustainable effort to support local programs and pilots supported and led by the Legislature that can be included in a network of providers responding to behavioral health emergencies. Specifically, expanding the network of mobile providers allows the administrative entities to include various co-responder programs, emergency medical providers and build upon other locally funded response services.

Table 5. Crisis RFP timelines

	RFP Published (*Anticipated)	RFP Submission Deadline (*Anticipated)	Award Announcements (*Anticipated)	Contracts Executed
Crisis Services	September 4, 2018	November 5, 2018	*End of December, 2018	On or before July 1, 2019
Crisis Hotline	*November 29, 2018	*January 11, 2019	*Early February 2019	On or before July 1, 2019
Crisis Marketing	*Week of January 7, 2019	*Week of February 11, 2019	*Mid-March 2019	On or before July 1, 2019

R11 Behavioral Health Crisis Response System Enhancements (and related IT Capital Request)

14. Describe the operating and capital requests related to the Crisis System.

A. How will the proposed electronic record system improve system services?

There are four Components of the Crisis Response System Enhancements:

1. Crisis Record System

The Crisis Record System is primarily intended for the hotline and mobile crisis providers. The crisis record system combines the mobile system and hotline systems by enabling documentation in one record when calling the hotline or conducting a mobile response in the field. This addresses one concern in the system to ensure coordinated responses between the time a person calls the hotline and when mobile services arrive and serve the client. In the current system, a CDHS audit found that only 50% of clients recommended for a mobile response by the hotline clinicians that assessed risk factors were deployed by the current Crisis Service Organizations. The reasons for not deploying mobile responses were due to staffing, previous knowledge of the client and determining a mobile response was not required, and disagreements about the need for mobile. This system will make the communication between those two vital services virtually seamless and allow the State to ensure requirements for mobile responses are being effectively executed. Allowing hotline staff and mobile providers to view data collected in the system will also ensure coordination post discharge from crisis services. Currently, the resource and referral service is all telephonic and a manual process that requires human interaction via the hotline, text, or chat services. Currently, there is no resolution to identifying the end result for the patient by the hotline beyond the telephonic outreach by hotline staff to the provider or the patient. Documentation in one record that is connected to HIE will allow a comprehensive view regarding the resolution of a crisis

via the Crisis Record and gives the Department greater oversight as for system monitoring, give ASOs better oversight of their sub-contractors, and provides support and approved documentation to address grievances, such as through the Ombuds office

2. *Health Information Exchange (HIE)*

Integrating CDHS crisis data into the Crisis Record System and the two state HIEs will allow CDHS to evaluate the behavioral health system, including continuity of care and successful discharge planning. HIE will allow providers to:

- View critical treatment information such as:
 - previous emergency room visits
 - previous crisis service utilization
 - physical health conditions impacting treatment
 - medication and labs
- Share information across systems when treating the same patient; and
- Support clients with higher needs utilizing multiple systems.

The collection of client-level data will allow CDHS and community-based organizations to address social factors that affect mental health such as (i.e. lack of housing, food insecurity, utility needs, violence, and transportation.) By combining community-level data and patient-level data CDHS is hoping to build better more innovative programs that would address the consumer needs and ensures individuals are coordinated across systems.

3. *Mobile app for clients*

A separate component of this solution includes a website and resource directory that can be downloaded or used on a mobile phone. This would allow an individual to search behavioral health resources around the state. Additionally, a client could interact via text or instant message with hotline staff and increases access for youth by using mobile technology.

4. *Pilot to integrate first responders*

A portion of this request is to pilot utilization of the crisis system with first responders to determine when mobile crisis may be deployed rather than law enforcement when an individual is in a behavioral health emergency. Additionally, leveraging co-responder teams in the crisis system and using the crisis record to document these responses will allow for development of standard practices and determinations regarding use of law enforcement versus behavioral health providers when responding to individuals in an emergency.

B. Will approval of these requests help to address the need for competency services?

These services will not immediately reduce the need for competency services. Individuals receiving competency services are referred by the court, not the community. However, there is the potential that through improved community response and partnership with law enforcement, the number of individuals receiving appropriate crisis intervention and

behavioral health responses in the community may result in fewer individuals being arrested and instead diverted to an appropriate clinical setting.

WORKFORCE SHORTAGE AND ADMINISTRATIVE BURDEN

15. The Department requested funding starting in October 2017 to increase salaries for direct care staff at both mental health institutes. The Department is requesting additional funding to increase salaries for physicians and psychiatrists at both institutes over the next two years (R12 Contract medical staff salary adjustments).

A. What actions is the Department taking to address the behavioral health workforce shortage and the ability of community-based providers to attract and retain behavioral health professionals?

Shortages in the behavioral health workforce is not unique to Colorado, and in fact, is considered a worldwide crisis. In 2014 [News Bulletin](#) the Substance Abuse and Mental Health Services Administration (SAMHSA) declared the behavioral health workforce to be in crisis. In 2015, the American Hospital Association (AHA) released a [report](#) on the condition of the behavioral health system in the United States, concluding that by the year 2030, there will only be one geriatric psychiatrist for every 6,000 older Americans with mental illness and substance abuse issues. AHA also states that the U.S. Bureau of Health Professions estimates that in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312. In summary the population of people with mental illness and substance abuse is growing, while the workforce available to address the need is aging and shrinking. The AHA suggests that to build a more robust workforce will require improvements across four key focus areas.

- **Education and Training:** There is a lack of interest in going into the behavioral health professions, particularly in primary care.
- **Practice Environment:** According to AHA there is a lack of inpatient beds dedicated to mental health treatment in community hospitals, and the trend is that these beds have been decreasing.
- **Financing:** Spending on behavioral health care is disproportionately lower than in other health care sectors (hospital care, physician and clinical services, prescription drugs, and dental services). As a result, salaries for behavioral health professionals are well below those for other health care sectors, rendering the professions less attractive for people determining their future career paths. Additionally, Federal financing for behavioral health is limited and often not cost-beneficial, resulting in a shortage of entities willing to provide behavioral health and substance abuse treatment.
- **Recruitment and Retention:** Low wages and benefits, heavy caseloads, and lack of funding for programs has resulted in high-turnover in the behavioral health and substance abuse workforce.

The Department, as a provider of behavioral health and substance abuse treatment through its two Mental Health Institutes, has had to work to overcome many of these barriers in order to recruit and retain staff to provide services. The direct care staff pay increases were crucial to the Department being able to better position itself as an employer of choice and compete in the

behavioral health employment sector. The Department also undertook several other internal initiatives to improve workplace culture and recruit and retain individuals once hired. A list of these initiatives can be found in [Attachment B](#). As indicated in responses to question numbers (6) and (7) above, the direct care staff pay raises, as well as other internal Department efforts have helped to improve the Department's ability to hire and retain behavioral health and other direct care workers.

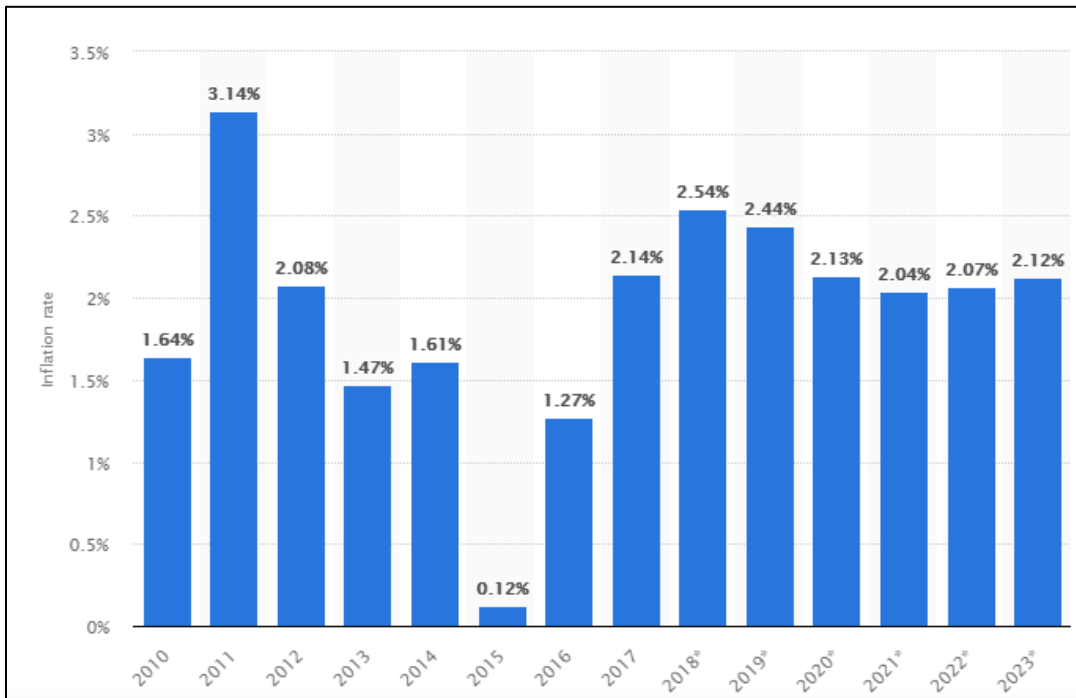
In addition, the Department's Office of Behavioral Health has several efforts focused on behavioral health workforce development, such as:

- The Department partners with the State Innovation Model in the creation and distribution of online training modules at Colorado University. These are modules designed to improve capacity for primary care and integrated care teams to provide behavioral health services.
- The Department's Certified Addiction Counselor (CAC) Clinical Training Program is designed to train addiction counselors. Currently, there is a combined total of 4,100 CACs in Colorado. Since January 2018, there have been 495 new addiction professionals entering the behavioral health workforce.
- The Department funds and supports training for peer navigators and non-clinical professionals across the crisis system, the substance use treatment network, and in the CMHCs. Peers manage the non-clinical elements like outreach and navigation, allowing clinicians to practice at the top of their license.

Is the requested 1.0 percent community provider rate increase for FY 2019-20 likely to be sufficient?

The 1.0 % community provider rate increase for FY 2019-20 is most likely not sufficient. According to *statistica.com*, Chart 1 shows the projected annual inflation rate in the United States from 2010 to 2023. Between 2015 and 2018, the estimated five-year average rate of inflation is 1.5% per year. Local inflation factors and the competitive market for behavioral health workers may impact the realized inflation rate by Colorado providers.

Chart 1: Annual Inflation Rate



11:15-11:30 BREAK

11:30-12:00 SERVICES FOR PEOPLE WITH DISABILITIES

Main Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- Mark Wester, Director Office of Community Access and Independence

Supporting Presenters:

- Sarah DeVore, Director, Division of Budget and Policy
- Eric Johnson, Deputy Director Office of Community Access and Independence
- Georgia Edson, Division Director Regional Center Operations

Topics:

- Regional Centers for People with Disabilities: Page 27, Questions 16-17 in the packet, Slides 33-35
- R2 Compensation for Direct Care Employees (Veterans Community Living Centers): Page 30, Questions 18-20 in the packet, Slides 36-38
- Rural Interpretation Services Program: Page 33, Questions 21-24 in the packet, Slides 39

SERVICES FOR PEOPLE WITH DISABILITIES

REGIONAL CENTERS FOR PEOPLE WITH DISABILITIES

16. Please describe the difference between the acuity level of individuals served in the regional centers and those served in the community. How is the level of need determined and what decisions or conditions drive placements in regional centers?

The regional center system serves people who are in crisis and no longer have a community provider who is willing to serve them. People are admitted to the regional center system when the Community Centered Board has determined that all other community provider options have been exhausted.

The majority of referrals made to the regional center system are considered “emergency admissions,” having met one or more of the following conditions:

- Multiple (one or more) severe behavior incidents in the past six months. A severe incident is defined as injury to self or others that result in actual harm.
- Several, (at least three) consecutive community placement failures. A community placement failure is one in which a provider has given notice of failing to be able to serve the individual within the first 90 days of treatment.
- Several hospital admissions due to behaviors or medication reviews (at least three or more in the last six months prior to referral).
- Requires 2:1 staffing ratio (two staff to one person) during waking hours, as documented by the individual's care plan.
- Worked with the Community Support Team (CST) to try to stabilize the person for at least 60 days with no improvement or increase in stabilization.

Any person, regardless of treatment model, being admitted to a regional center must have an imposition of legal disability (ILD). This is granted by a district court based on legal disability as defined in Section 27-10.5-110, C.R.S. This is reviewed by the court every six months to ensure that persons needing regional center system level of care are being kept in the least restrictive environment possible.

Historically, the regional center system served a larger proportion of the intellectual and developmental disability population in Colorado. As the number of private providers in the community grew, the number of people admitted into and served by the regional center system declined. The people served in the regional center system who were admitted prior to 2013 are considered ‘long term’ residents. Upon their admission there was no expectation of transitioning back to a community placement. Many people in the long-term category have resided at the regional center for the majority of their lives, consider the regional centers their home and are not interested in community options at this time. Usually people supported in this category have severe, complex medical problems and are at high risk for deteriorating into life-threatening acute situations, requiring extensive nursing and physician availability. This type of person does not represent a typical referral today, as private providers can often meet their needs.

In response to the changing needs of the intellectual developmental disability (IDD) service system in Colorado, in 2013 the regional center system began focusing on treatment and stabilization. Current referrals are for people in acute crisis and/or at risk of entering the criminal justice system and cannot be served by a private provider in the community. People referred exhibit severe and complex behaviors, such as extreme self-injurious or aggressive

behaviors. People in this category are likely to have a co-occurring mental illness, require an intensive level of supervision (i.e., a 1:1 or 1:2 two staff to one person), engage in property destruction, pose a flight risk, and/or engage in socially unacceptable behavior. Referrals for admission often have an extensive history of unsuccessful placements with private providers. People admitted after 2013 do so with the goal of meeting transition criteria, and returning to their community of choice.

Level of need determination and conditions driving placement:

When a person is referred for admission, there are three primary factors that determine where the person will be admitted:

- The person's geographic location
- The level of care required for the person
- The availability of an appropriate bed at a regional center location

There are times when one regional center location is at capacity, and another regional center location is considered. When considering one location over another, the licensure type is considered. The ICF/IID (Intermediate Care Facilities - Individuals with Intellectual Disabilities) level of care is able to offer most services and supports from regional center professional staff that have the expertise to meet the complex needs of the person. This includes, but is not limited to: psychiatric services, behavior treatment, day services, medical services, occupational therapy, physical therapy, and speech therapy. These services are part of the wrap around services afforded to every person in ICF/IID care. A person can need the same services in Home and Community Based Services - Developmental Disability (HCBS-DD) waiver services, but the services are often provided by Medicaid State plan providers in the community, often the same Medicaid State plan providers utilized by other HCBS-DD provider agencies. Once a person has been referred to the regional center system, they have typically exhausted available providers of the HCBS-DD waiver. This can make finding services more difficult and many services may not occur as quickly as they would in the ICF/IID program. The Wheat Ridge Regional Center provides only ICF/IID care. Grand Junction Regional Center offers ICF/IID and HCBS-DD waiver level of care. Pueblo Regional Center provides only HCBS-DD waiver level of care.

17. Please provide an update on the Grand Junction Regional Center relocation, including the timeline for completion.

Senate Bill 16-178 requires the Colorado Department of Human Services (CDHS) to vacate the campus by July 1, 2018 or as soon as all current persons residing on the campus are transitioned to settings that support their well-being and respect their individual choices. During the 2018 session, the General Assembly appropriated \$3,511,411 to build two new homes and renovate two existing homes to accommodate 24 people in the Grand Junction Regional Center (GJRC) ICF/IID program.

In June 2018, the GJRC campus garage, laundry, and warehouse closed. In July 2018, the administrative, day program, and facilities staff moved off of the campus. Currently there are 19

individuals living on the GJRC campus. They will remain on the campus until the new and renovated homes are ready for occupancy.

GJRC staff is working with the Colorado Department of Public Health and Environment to relicense two existing HCBS-DD homes to ICF/IID. The homes that will be relicensed have been chosen. The people in those homes have chosen other GJRC HCBS-DD licensed homes and are in the process of moving. Once the homes are vacated, the renovations necessary for code compliance will occur and the relicensing process can begin. The process takes approximately six months and is projected to be completed in the summer of 2019. At that time 12 people will move from the campus to the relicensed homes.

The Department is completing the Facilities Program Plan for the new homes in December 2018, which will allow the project to move into the design phase. Approval for the designs of the renovated homes is expected to be completed by April 2019. Once the design is approved and the site(s) are found, the new homes will be built allowing the last of the residents in services to move off campus.

The General Assembly directed the Department explore a “public-private partnership” for the use of the 29 Road group home. At this time, no private agency has come forward requesting the use of the 29 Road group home. The Department will post a formal Request for Information (RFI) in early 2019 to formally solicit interest from the private provider community. If the RFI does not yield interest, the Department may request the Legislature to reconsider and authorize the sale of the property.

R2 COMPENSATION FOR DIRECT CARE EMPLOYEES (VETERANS COMMUNITY LIVING CENTERS)

18. Please provide an update on the Pueblo Regional Center Corrective Action Plan, including the status of the moratorium on placements in the regional center.

The moratorium was officially lifted at Pueblo Regional Center (PRC) August 15, 2018. Lifting the moratorium recognizes the significant improvements PRC has been making—with the support of CDHS’ state agency partners and members of the General Assembly—to provide better services and a safer environment for all persons receiving services at PRC. Those improvements included pay increases for many staff working directly with persons served, improved scheduling and the implementation of new processes to help PRC understand trends and improve performance.

- In FY 2018-19 the staff turnover rate was reduced to 2.4%.
- PRC has greatly reduced the number of required unplanned back to back shifts. In FY 2018-19 only 1.51% of total shifts were unplanned double shifts.
- The direct care vacancy rate is 11.75%. PRC has intentionally held positions vacant as the census declined due to the moratorium. With the ability to take new admissions, it is expected that there will be a planned hiring process and the vacancy rate will decrease as appropriate.

- PRC has implemented a significant culture change when responding to incidents. Specifically, PRC management, including house managers, meets each weekday to review incident reports. This provides significant on-the-job training and support. This process demonstrates a report, review and respond approach to incident management. Staff experience the importance of reporting incidents and the direct result of better supports for residents through trending and tracking incidents.
- House managers have been hired for each home, where they maintain an office and provide on-site, face to face re-training, coaching and support for staff.

As of December 1, 2018, PRC has admitted two new people, bringing the census to 45.

19. How do staffing levels for the direct care providers affect occupancy rates at the Veterans Community Living Centers?

The VCLCs schedule direct care staff (i.e., RNs, LPNs, and CNAs) based on a patient hours per day model (PPD), which provides a set amount of direct care staff hours based on the facility's census and resident acuity levels. For example, if a VCLC has a census of 100 and staffs at a 3.0 PPD, then it will schedule 300 hours (100 x 3.0) of direct care staff each day. Because the PPD rate used by each facility is based on the acuity of its residents, the PPD rates will rise or fall as the medical needs of the VCLCs' residents change.

PPD staffing levels can limit occupancy rates at the VCLCs if the facilities do not have enough staff to meet their PPD level for a given census. Using the previous example, the VCLC would not be able to increase its census from 100 to 110 and maintain a 3.0 PPD level unless it was able to hire additional direct care staff to work the additional 30 hours (10 x 3.0) per day required to meet the 3.0 PPD. Since the beginning of Fiscal Year 2017-18, two VCLCs have limited their admissions at various times because they did not have enough staff to maintain their set PPD levels.

20. Please provide an update on the vacancy and turnover rates for direct care staff at the mental health institutes and regional centers since the implementation of salary increases over the past three years.

Table 6 shows a comparison of vacancy and turnover rates for direct care staff at the Regional Center and the Mental Health Institutes since the implementation of salary increases over the past three years. As the table shows, the salary increases have improved the Department's ability to fill vacancies and improve retention.

Table 6. Comparison of Vacancy and Turnover Rates for Direct Care Staff at the Regional Centers and the Mental Health Institutes

Facility	9/12/16 Vacancy Rate	6/26/17 Vacancy Rate	6/18/18 Vacancy Rate	Cumulative Turnover Rate FY 2016-17	Cumulative Turnover Rate FY 2017-18
Grand Junction	16%	3%	4%	15%	11%
Pueblo	29%	10%	11% ¹	32%	18%
Wheat Ridge	15%	7%	8%	31%	22%
CMHIP ²	Not Comparable	19%	15%	21%	21%

¹Pueblo Regional Center was under an admission moratorium until August 2018. As a result, its staff vacancy rate increased due to holding vacant positions open so that they could be filled once the moratorium ended to care for the additional residents. Staffing levels at Pueblo Regional Center, as of June 2018, would reflect an effective vacancy rate of near zero because filled positions are sufficient to provide care for the current resident census.

²CMHIP includes comparison of vacancy and turnover for Nurse I, II, and III only. This is because pay increases for these classes were completed in November 2017. Pay increases for other direct care job classifications at CMHIP and CMHIFL were not effective until July 1, 2018, which is too recent to demonstrate significant change.

In the past ten years, how many federal findings have indicated that staffing issues, including vacancy rates and staff turnover, have put the health and safety of residents of state operated facilities at risk? Please provide a description of each finding, including: the facility, whether or not the Department increased staff salaries in response to the finding, and the cost of the salary increases. In addition, please discuss subsequent instances in which the Department has requested funding or requested and received funding to increase salaries for employees in other programs in order to ensure salary equity with the same job class and/or to address compression pay issues.

Since 2008, three of the Department's Veterans Community Living Centers have received findings related to staffing on surveys conducted either by the federal Veterans Administration or the Colorado Department of Public Health and Environment (CDPHE), as discussed below:

- Fitzsimons – CDPHE survey in 2015 had findings for insufficient staffing and grievances about staffing.
- Florence – VA survey in 2008 had a finding for lack of nurse supervision.
- Homelake – CDPHE survey in 2016 had a finding for insufficient staffing.

The Department did not increase staff salaries as a result of any of these findings. However, the Department did create and fund three new Nurse III positions to respond to the Florence finding. The Department requested funding to increase salaries at the Mental Health Institutes, the VCLCs, and the Division of Youth Services during the 2018 session, and the General Assembly approved this funding request for the Mental Health Institutes. The Department has re-submitted the request for the VCLCs and the Division of Youth Services for the 2019 session.

RURAL INTERPRETATION SERVICES PROGRAM

21. PLEASE PROVIDE A DESCRIPTION OF TYPES OF COMMUNICATION SERVICES (OTHER THAN ASL/ENGLISH INTERPRETING SERVICES) THAT MAY BE USED TO MEET THE NEEDS OF INDIVIDUALS WHO ARE DEAF, HARD OF HEARING, OR DEAFBLIND, INCLUDING BUT NOT LIMITED TO VIDEO REMOTE INTERPRETING (VRI), AND COMMUNICATION ACCESS REALTIME TRANSLATION (CART).

ADA Title II entities (state and local governments) must give primary consideration to the communication preferences of individuals who are deaf, hard of hearing or deafblind when meeting their needs. The following is an all-inclusive list of ADA compliant auxiliary services and aids:

(1) Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

(2) Qualified readers; taped texts; audio recordings; brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

(3) Acquisition or modification of equipment or devices; and

(4) Other similar services and actions.

Acquisition or modification of equipment or devices can mean the addition of current technological innovations in microelectronics and computerized control systems (e.g., voice recognition systems, automatic dialing telephones, etc.).

Similar devices and actions could include retrieving items from shelves, assistances in reaching a marginally accessible seat, pushing a barrier aside in order to provide an accessible route, etc.

22. PLEASE PROVIDE COST ESTIMATES FOR EXPANDING THE RISP PILOT TO INCLUDE CART AND/OR VRI SERVICES IN RURAL COLORADO.

The demand for CART and VRI is unknown at this time because the RISP Pilot has been focused on ASL/English interpreting services, but there are several factors which could limit their use. For example, it is unclear how familiar rural communities are with CART, as the Commission has found that the town hall/informational meetings are often people's first experience with CART services. Also, there are concerns about whether remote CART and VRI would work well in rural areas due to internet/broadband issues. Finally, consumers must have a laptop, tablet or other device with which to stream remote CART and VRI, and it is unclear how those devices would be provided.

As a result of the factors mentioned above, the demand for CART services is likely to be a fraction of the demand for sign language interpreting services. As a result, the Commission’s preliminary estimate is that it will provide 208 hours of CART services per year, or four hours per week, based on our comparative analysis of ASL/English interpreting and CART services provided in the past three years. Thus, the cost will be \$18,720 annually (4 hours per week x 52 weeks x the Commission’s \$90 per hour fee).

The Commission pays about four dollars per minute for VRI services. Assuming eight VRI events per month at thirty minutes each, the Commission estimates the VRI cost would be \$11,520 annually (8 VRI events per month x 12 months x 30 minutes x \$4 per hour).

In addition, individuals would need a laptop, tablet or other device to take advantage of CART and VRI services. If the RISP program were to provide such devices, that would be another added cost, as would be the process of figuring out how to make such devices accessible across the State.

23. GIVEN THAT THE DEPARTMENT AND COMMISSION WOULD LIKE MODIFICATIONS TO THE USES OF THE \$700,000 CASH FUNDS SPENDING AUTHORITY APPROVED BY THE GENERAL ASSEMBLY, PLEASE PROVIDE AN UPDATED FY 2018-19 AND FY 2019-20 BUDGET DETAILING HOW THE FUNDS WOULD BE USED, INCLUDING A COST BREAKDOWN FOR EACH ACTIVITY.

Table 7 shows the updated FY 2018-19 and FY 2019-20 budgets for the \$700,000 RISP pilot funding approved by the General Assembly.

Table 7. Proposed RISP Pilot Budgets for FY 2018-19 and FY 2019-20		
Description	FY 2018-19	FY 2019-20
Staffing (\$440,000 original allocation)		
ASL/English interpreters/staff	230,000 for 4.0 FTE	285,000 for 5.0 FTE
Free-lance interpreters	209,730	45,254
Sub Total	\$439,730	\$330,254
Training (\$200,000 original allocation)		
RISP scholarships	26,400	56,100
Certification readiness training	127,870	259,646
Interpreter test scholarships	20,000	0
RISP mentees	16,000	48,000
SHARP fellowship	10,000	0
Sub Total	\$200,270	\$363,746
Outreach (\$60,000 original allocation)		
Contractor	54,000	0
Travel costs for the CCDHHDB staff	6,000	6,000
Community Engagement Specialist	0	0 (subsumed under 5.0 FTE above)
Sub Total	\$60,000	\$6,000
TOTAL	\$700,000	\$700,000

Staffing Budget

The original directive attached to the \$700,000 was to hire 8.0 FTE of ASL/English interpreters to be placed in Early Childhood Councils (ECC) in rural areas across the State. Based on census data and the number of requests for its interpreter services, the Commission concluded that it could support hiring one RID-certified interpreter in FY 2018-19 to be based in Grand Junction. This person could cover interpreting services requests for the Western Slope and also would be responsible for managing and filling RISP interpreting service requests. This person may also be able to assist the RISP pilot with providing 24/7 access to interpreting services. The Commission also concluded that it could hire an additional staff interpreter for Alamosa and Pueblo counties in FY 2019-20.

In addition to hiring the staff interpreters, the Commission recommends investing in developing an infrastructure that would support increasing the number of qualified ASL/English interpreters in rural areas. Specifically, the Commission recommends hiring 2.0 FTE of mentors in FY 2018-19 who would recruit and work with individuals seeking to become certified interpreters. The mentors would be based out of the Commission's Denver office but would travel frequently throughout the State. One mentor would be an experienced, highly regarded certified ASL/English interpreter with training in mentoring. The other mentor would be an expert in deaf culture and ASL and would provide culture and language training. Ideally, this person would also be a Certified Deaf Interpreter (CDI) and would provide mentoring for individuals interested in becoming CDI.

Finally, the Commission would like to hire a community engagement specialist in FY 2018-19 because the program requires consistent technological support to maintain the website and interpreting services requests. This specialist would also create community-friendly videos and video-logs and publicize the program.

To summarize, the Commission would like to hire the following 4.0 FTE during FY 2018-19 for the RISP pilot:

- Sign language interpreter/scheduler based in Grand Junction (1.0 FTE/Technical IV)
- Interpreter/mentor (1.0 FTE/Trainer IV)
- Deaf culture/ASL mentor (1.0 FTE/Trainer IV)
- Community engagement specialist (1.0 FTE/Technical IV)

Then, the Commission would like to hire an additional 1.0 FTE sign language interpreter for Alamosa and Pueblo Counties in FY 2019-2020.

In addition to the 4.0 FTE discussed above, the Commission will continue to rely on independent contractors for sign language interpreting services in rural areas. The Commission estimates that the independent contractor expense will be \$209,730 in FY 2018-19 and \$45,254 in FY 2019-20.

Training Budget

The Commission determined that training should be priority for the RISP pilot in order to increase the number of qualified ASL/English interpreters in rural areas. The Commission will provide training by (1) partnering with the University of Northern Colorado's (UNC) American

Sign Language Interpreting Studies (ASLIS) program, (2) offering scholarships for taking the required tests for professional certification, (3) offering paid mentoring experience, and (4) supporting a State Human Services Applied Research Practicum (SHARP) Fellow’s training in doing research on the needs of rural individuals who are deaf, hard of hearing, and deafblind.

First, CCDHHDB staff is working closely with ASLIS staff on developing a two-pronged approach to offer initial and advanced interpreter training to those who are committed to working in rural areas of the State:

- Prong 1: RISP Scholarships will be offered to current junior and senior students in the ASLIS program who wish to pursue community sign language interpreting. Graduates of this program will be eligible for Registry of Interpreters for the Deaf (RID) certification, because they will hold an undergraduate degree.
- Prong 2: UNC will coordinate and run a RISP Certification Readiness Training Program (formerly known as the “I-GO” training series). This program will assist current uncertified practitioners by providing a series of online courses.

The Department and UNC are working to finalize an inter-agency agreement with respect to the aforementioned programs. Table 8 below summarizes projected expenses.

Table 8. Projected Expenses for UNC/ASLIS Partnership				
	RISP Scholarships		Certification Readiness Training	
FY	Recipients	Total cost	Targets	Estimated cost
2018-19	2 juniors	\$26,400 (including 10% indirect costs)	January-June 2019: curriculum development and one 4-5 day intensive training at Greeley for 1 lead facilitator and 10 facilitators	\$127,870 (including indirect costs)
2019-20	2 seniors and 2 juniors, with a \$1,500 internship stipend for seniors	\$56,100 (including 10% indirect costs)	One year online participant training with a 4-5 day intensive to be held offsite at a rural location for up to 20 participants (free of charge, although this may be modified)	\$259,646 (including indirect costs)
Total		\$82,500		\$387,517

Second, the RISP Pilot will set aside \$20,000 to assist practitioners with paying for RID interpreter certification tests, which cost \$425 to \$510 per test for non-members. At an average cost of \$500 per test, this budget would provide support for approximately 40 tests (each person must take two tests, so this would support 20 individuals).

Third, the RISP Pilot plans to offer paid mentoring support for practitioners who are not yet certified and for newly certified interpreters. The cost for each RISP mentee is projected to be \$40/hour for ten hours per week for 20 weeks for each mentee for a total of \$8,000 per mentee for FY 2018-19 and \$40/hour for 12 hours per week for 20 weeks for each mentee for a total of \$9,600 per mentee for FY 2019-20. The RISP pilot will be able to recruit mentees once staffing

is in place. The goal is to begin working with two mentees in FY 2018-19, at a cost of approximately \$16,000. The goal would be to recruit five mentees for FY 2019-20, resulting in \$48,000 in mentee costs.

Fourth, the Department has selected a graduate student to be a FY 2018-19 State Human Services Applied Research Practicum (SHARP) Fellow. This person is receiving training and support to conduct a research project collecting and analyzing data related to the need for ASL/English interpreting services in rural Colorado. The SHARP Fellow stipend is \$10,000.

Outreach Budget

The Commission entered into a contract with an outreach specialist/consultant, who is a doctoral student with knowledge and expertise in the deaf, hard of hearing, and deafblind communities. The contractor has developed educational and outreach materials for RISP, organized RISP town hall meetings, and publicized the availability of the RISP pilot. The Commission will not use the contractor in FY 2019-20 as this position's scope of work will be taken over by the Commission's community engagement specialist to be hired in FY 2018-19. The Commission will also allocate \$6,000 for the staff's outreach expenses during FY 2019-20.

24. HOW DOES THE DEPARTMENT AND COMMISSION PARTNER WITH OTHER STATE DEPARTMENTS OR LOCAL AGENCIES TO RAISE PUBLIC AND EMPLOYER AWARENESS CONCERNING THE NEEDS OF INDIVIDUALS WHO ARE DEAF, HARD OF HEARING, OR DEAFBLIND; AND THE LEGAL RESPONSIBILITIES PROVIDER AGENCIES, LAW ENFORCEMENT, COURTS, SCHOOLS, ETC. HAVE IN ENSURING THE AVAILABILITY OF EFFECTIVE COMMUNICATION METHODS FOR INDIVIDUALS WITH HEARING IMPAIRMENTS?

The Commission collaborates with State Departments and local agencies that have expertise in providing services to our common stakeholder populations. The collaboration includes the Commission's facilitation and sponsorship of the Advocacy Coalition for Equality (ACE). Quarterly ACE summits increase knowledge of each other's resources through cross-trainings. The collaboration also builds greater capacity for system navigation among providers specializing in services for individuals who are deaf, hard of hearing, and deafblind. ACE members are also involved in workgroups that focus on system navigation, information sharing and equal access in the justice system for individuals who are deaf, hard of hearing or deafblind.

The agencies listed below are members of ACE. The consultations and trainings that occur through ACE promote awareness of best practices for more culturally affirmative programs, services and events through the provision of ADA compliant auxiliary services and aids.

1. Atlantis Community, Inc.
2. Center for Disabilities - Pueblo
3. The Compassionate Side, LLC
4. Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind
5. Colorado Daylight Partnership
6. Colorado Division of Vocational Rehabilitation
7. Colorado Families for Hands & Voices

8. Colorado School for the Deaf and the Blind
9. Deaf Overcoming Violence through Empowerment
10. Goodwill Industries of Denver
11. Helen Keller National Regional Center
12. The Independence Center – Colorado Springs
13. Mental Health Center of Denver
14. Northwest Colorado Center for Independence
15. Rocky Mountain Deaf School
16. Rocky Mountain Employment Services, LLC

In addition to ACE participation and as discussed before, the Commission entered into a contract with an outreach specialist/consultant to develop educational and outreach materials for the RISP pilot, organize and facilitate several RISP town hall meetings, and publicize the existence of the RISP pilot. This contractor is also working on improving the RISP website experience for users (www.colorisp.com).

The RISP Pilot held town hall meetings in multiple counties between September and December 2018:

- September 13: Pueblo (Deaf Gathering)
- September 15: Grand Junction (Deaf Access Workshop for deaf, hard of hearing, and deafblind individuals)
- October 25: Durango (two meetings: general community and deaf/hard of hearing/deafblind)
- October 26: Alamosa (two meetings: general community and deaf/hard of hearing/deafblind)
- October 29: Grand Junction (general community meeting with many deaf, hard of hearing, and deafblind attendees)
- December 8: Pueblo (Deaf Gathering)
- December 11: La Junta (two meetings: general community and deaf/hard of hearing/deafblind)
- December 12: Pueblo (general community meeting)
- December 13: Fort Morgan (two meetings: general community and deaf/hard of hearing/deafblind)

The general community stakeholders at the town hall meetings include individuals from the business, educational, financial, governmental, legal, and medical fields.

The Department supported the town hall effort by conducting a media blitz, which led to news stories in each of the targeted areas. The town hall meetings and publicity resulted in a surge of emails and phone calls to the Commission from people expressing interest in the RISP pilot, particularly those who are interested in sign language interpreter training.

Meetings are also planned for the spring in Garfield, Routt and Summit counties.

Finally, the Commission has engaged several state agencies in a pilot program in which Commission staff schedule auxiliary services for the agencies, in the same way that the Commission does this scheduling for the State's judicial system. The agencies that have agreed to participate include the Division of Vocational Rehabilitation at the Department of Labor and Employment, the Department of Public Health and Environment, and the Division of Parks and Wildlife at the Department of Natural Resources. The Division of Motor Vehicles at the Department of Revenue, the Department of Public Safety, the Department of Education, and the Department of Regulatory Agencies are currently on the waiting list for this pilot program. The Commission has raised awareness of accessibility issues affecting individuals who are deaf, blind, or deafblind with all of the agencies in this pilot or on the waiting list for the pilot.

24. How do the current statutory certification requirements impact accessibility of American Sign Language/English interpreters in rural areas?

Currently, statute [Section 6-1-707(1)(e), C.R.S.] requires individuals to hold a certification from the Registry of Interpreters for the Deaf (RID) before they can represent themselves as being an American Sign Language (ASL)/English interpreter in Colorado. The Commission has concluded that only recognizing RID-certified interpreters is restrictive and prohibitive and has created new hurdles for interpreters entering the workforce throughout Colorado, including rural areas. As a result, the Commission would support considering other types of certifications (e.g., state-level certifications from Texas and Utah) that could be used to prove that an individual is qualified to be an ASL/English interpreter in Colorado. The Commission's understanding is that interested stakeholders are working to introduce legislation during the 2019 session to expand the types of ASL/English interpreter certifications that would be valid in Colorado.

12:00-1:30 BREAK

1:30-2:00 OFFICE OF EARLY CHILDHOOD

Main Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- MaryAnne Snyder, Director, Office of Early Childhood

Supporting Presenters:

- Sarah DeVore, Director, Division of Budget and Policy

Topics:

- Early Intervention evaluations: Page 39, Question 25 in the packet, Slides 47-49

25. Please provide the Committee with an update on the progress being made with the Colorado Department of Education (CDE) in developing Child Find recommendations due June 2019.

The Department has been meeting regularly with CDE since August 2018 to carry out all provisions of HB 18-1333, which requires the Departments to develop joint recommendations for the administration of Early Intervention (EI) evaluations by June 30, 2019. As required by the legislation, CDHS and CDE submitted an interagency agreement (IA) to guide the two agencies' work on October 1, 2018.

Since the completion of the IA, the Departments have begun the next phase of collaboration in which data and information is gathered pertaining to how EI evaluations are currently being conducted across the State. Aspects of EI evaluations that will be studied include establishing clear lines of responsibility and accountability, evaluation tools and timeline requirements, how funding should be allocated, and practices that are minimally disruptive to families. This study period will last until spring 2019. The two Departments have contracted with an independent entity, Marzano Research, to assist with the study.

At present, CDHS and CDE are in the process of convening a stakeholder work group so that the Departments' partners can share their perspective from the field. Marzano's work will also include a variety of stakeholder input opportunities, including surveys, interviews, and other methods, to gain real-time feedback on the existing practices for the administration of EI evaluations.

In the spring, CDHS and CDE will begin to synthesize all of the information gathered during the study period in order to develop recommendations. The Departments are on track to submit their recommendations by the required date.

26. How would the Child Care Tax Credit impact DHS programs, if it passes?

The two child care tax credits proposed in the Governor's FY 2019-20 budget are likely to impact the larger early childhood system, but have minimal direct impact on CDHS programs.

The first expands the existing credit provided to families based on their child care expenses. This credit will help offset the cost of child care for more families (increased income eligibility cap) and at higher levels (increased match percentage). However, only unreimbursed costs qualify so this credit will not substantially impact families utilizing child care subsidies such as the Colorado Child Care Assistance Program (CCCAP). As such, while this credit will benefit some of our clients (particularly those with higher incomes), it is intended to be a broad support for working families across Colorado and will not have material impact on our programs which continue to target low-income families.

The second credit included in the Governor's budget targets child care providers whose care includes infants (children under 12 months) in an effort to stem the loss of licensed care for this age group. This subsidy will encourage more licensed providers to provide care for this age group, more unlicensed providers already providing this care to become licensed, and more licensed providers already providing this care to continue to do so. It further incentivizes providers to offer high-quality care for infants. To the extent this credit is successful in increasing the supply of licensed infant care, there will be more licensed facilities to monitor, which will come with a corresponding workload. A substantial increase in supply may also drive

market prices down, which would reduce the price inflation related costs of CCCAP. However, these impacts are likely to be relatively minor within the larger scope of CDHS programs. In addition, this second credit for providers also includes a financial incentive to encourage providers to move up the quality rating system, Colorado Shines, which is already in place across the state. This additional incentive to increase quality would assist DHS in efforts to encourage high-quality childcare by all of the state's licensed providers.

27. Did the Colorado Child Care Assistance “Cliff Effect” Pilot Program expire in FY 2017-18?

HB 18-1335 eliminated the Colorado Child Care Assistance Cliff Effect Pilot Program by repealing 26-2-808, C.R.S. (2018), and therefore FY 2017-18 was the last year in which the program was funded. Funds were not appropriated to this program in FY 2018-19 and FY 2019-20.

28. Did the Micro Grants to Increase Access to Child Care expire in FY 2016-17?

The General Assembly approved a FY 2017-18 supplemental budget request to use the federal funds originally appropriated for the Micro Grants to support work on the Child Care Automated Tracking System (CHATS). The General Assembly approved a FY 2018-19 budget amendment to permanently end the program.

2:00-3:00 OFFICE OF ECONOMIC SECURITY

Presenters:

- Tony Gherardini, Deputy Executive Director, Department of Human Services
- Ki'i Powell, Director, Office of Economic Security

Supporting Presenters:

- Katie Griego, Director, Division of Employment and Benefits
- Sarah DeVore, Director, Division of Budget and Policy

Topics:

- County Tax Base Relief: Page 42, Questions 29 in the packet
- TANF Pilot Projects: Page 43, Questions 30-33 in the packet, Slides 67-71
- R5 Improving Nutrition in Rural and Underserved Communities: Page 45, Questions 34-35 in the packet, Slides 56-57
- R9 Colorado Works Basic Cash Assistance COLA: Page 46, Questions 36-37 in the packet, Slide 73
- R13 Trails Operations and Maintenance: Page 49, Questions 38 in the packet
- Low Income Energy Assistance: Page 49, Questions 39-40 in the packet, Slides 58-59

COUNTY ADMINISTRATION

COUNTY TAX BASE RELIEF

29. Please provide a listing of the counties that receive CTBR and the dollar amounts received in the most recent year. Can you briefly describe the Tiers (I, II and III) as they relate to CTBR?

Table 9 lists the counties receiving County Tax Base Relief (CTBR) and the total funds earned in FY 2017-18.

Table 9: County Tax Base Relief (FY 2017-18)	
County	Total CTBR Earned
Adams	\$ 158,784
Alamosa	\$ 390,649
Bent	\$ 2,619
Conejos	\$ 74,317
Costilla	\$ 13,923
Crowley	\$ 54,268
Delta	\$ 79,530
El Paso	\$ 657,126
Fremont	\$ 220,587
Huerfano	\$ 44,574
Kiowa	\$ 3,562
Logan	\$ 37,110
Mesa	\$ 181,584
Montrose	\$ 6,253
Otero	\$ 303,751
Prowers	\$ 115,981
Pueblo	\$ 1,457,840
Rio Grande	\$ 47,696
Saguache	\$ 29,601
TOTAL:	\$3,879,756

Source: FY 2017-18 close out workbook: FY18 County Tax Base Relief to Counties.xlsx; distributions post in CFMS

CTBR is computed by a formula [per 26-1-126, C.R.S. (2018)] using the county share of expenditures and the assessed value of property in the county. The computation is executed in three steps (i.e. Tier I, II and III).

- Tier I = (county expenditures - tax levy of 3.0 mills) x 75%
- Tier II is computed in two different ways, based on receipt of Tier I:
 - Counties that receive Tier I = (tax levy of 3.0 mills – tax levy of 2.5 mills) x 50%

- Counties that did not receive Tier I = (county expenditures – tax levy of 2.5 mills) x 50%
- Tier III is also computed in two different ways, based on receipt of Tier II:
 - Counties that receive Tier II = (tax levy of 2.5 mills - tax levy of 2.0 mills) x 25%
 - Counties that did not receive Tier II = (county expenditures – tax levy of 2.0 mills) x 25%

When the appropriated funding is exhausted at any step in the allocation process, the allocation process does not proceed any further.

OFFICE OF SELF SUFFICIENCY

TANF PILOT PROJECTS - R4 REDUCING CHILD NEGLECT VIA EMPLOYMENT AND R6 CHILD SUPPORT EMPLOYMENT

30. What is the status of the Employment Opportunities with Wages pilot program (SB 17-292)?

In October 2018, the Department provided a six month progress report on SB 17-292 [Employment Opportunities with Wages Program, known as Colorado Works Subsidized Training and Employment Program (CW STEP)] implementation to the General Assembly. That report detailed the following:

- 1,071 individuals have been referred to the CW STEP program
- 608 participants were enrolled in the program
- Among the 608 participants, 185 have been placed in subsidized employment
- 91 participants have exited the program. Among participants exiting the program, 74.8% successfully exited to unsubsidized employment.
- 98% of participants that successfully left the program were earning wages at Colorado's minimum wage or higher. 34% of participants exited to a wage higher than \$15/hour.

31. What are the Department's views on the legislation needs/requirements for the requested pilots R4 and R6?

The General Assembly can authorize the creation of these programs by appropriating funds. Legislation is not required to implement either R4 or R6.

TANF funds may be used to provide services that meet the minimum federal eligibility requirements (i.e. income less than \$75,000, child in the home, and lawfully present) and one of the four purposes of TANF (1: Provide assistance to needy families so that children can be cared for in their own homes; 2: Reduce the dependency of needy parents by promoting job preparation, work and marriage; 3: Prevent and reduce the incidence of out-of-wedlock pregnancies; 4: Encourage the formation and maintenance of two-parent families.). Services provided with TANF funds may include work, education, and training activities, work supports to help participants obtain, maintain, or retain a job, provide financial education, provide other short-term benefits to address barriers to employment (e.g. rent, transportation assistance,

utilities), and help develop relationship skills and parenting skills. Both R4 and R6 meet these criteria.

32. How is the evidence-based process working for the Department and what does the Department expect to get from that process?

The Department recently received a copy of the JBC's Internal Evidence-based Policy guidance. The Department is encouraged by the thoughtful attention to evaluation and use of evidence in the consideration of programs and services for Coloradans as the Department's practice follows similar guidance.

When considering and developing programs, the Department's practice includes a review of the existing research literature to understand the context, as well as options for addressing the identified need, defining desired outcomes, and determining how best to measure those outcomes. Through its review, the Department examines how other states/organizations have addressed the issue or problem. For instance, the Department explores:

- has another state or a county successfully used a strategy that could be replicated in Colorado to generate similar results?
- are there standard measures that can be used to evaluate the effectiveness of a proposed strategy?
- if so, how rigorous is existing evidence, as outlined in the JBC's Evidence-Based Policy?

If research yields few results, yet there is the opportunity to pioneer a project, the Department builds a theory of change, identifies the expected outcomes and the mechanisms/actions that are expected to produce those outcomes, and formulates an evaluation plan to follow.

Throughout this process, program staff ensure that the evaluation measures are relevant to the Department's C-Stat measures and goals. Through C-Stat, the Department has demonstrated its commitment to evidence-based strategies and emphasis on making data-driven decisions.

To that end, R-4 and R-6 were created using the outlined strategies as explained above. For instance, the design and evaluation practices for the Colorado Careers Act (HB 13-1004) that established ReHire Colorado were based on these same principles. As the program was being developed, Department staff researched program designs across the country and met with national experts (e.g. National Transitional Jobs Network) to inform program design. Once the program was operational, the Department collaborated with a team of economists from the University of Colorado at Boulder to design and implement an evaluation. Ultimately, the Department chose a randomized control trial (RCT), the pinnacle of the evidence continuum. As such, ReHire Colorado has been administered as a RCT for more than three years. Department leadership regularly reviews the results. Furthermore, this evaluation has helped Colorado to contribute to the national body of research on supported work programs. Results of the ReHire evaluation are presented at national meetings annually.

The expertise the Department has gained through administering and evaluating ReHire Colorado has informed recent proposals for work programs, such as the design of the Subsidized

Employment and Training Program (CW STEP) created by SB 17-292. By prioritizing evidence-based programming and rigorous evaluation, the Department expects to develop and improve programs that increase employment and employability for Coloradans. Finally, both proposals include a robust evaluation to ensure the Department can discern the effectiveness of the program post implementation.

33. Will the Joint Budget Committee be provided with data based on the new evidence-based policy?

Yes, the Department will provide program outcome and implementation data to the General Assembly. The Department will provide relevant data that the JBC and/or other Committees want to see, per the evidence-based policy or other requirements. Both employment proposals include a robust evaluation to ensure the Department can discern the effectiveness of the program post-implementation (i.e., in 2022 for R-4 and in 2023 for R-6).

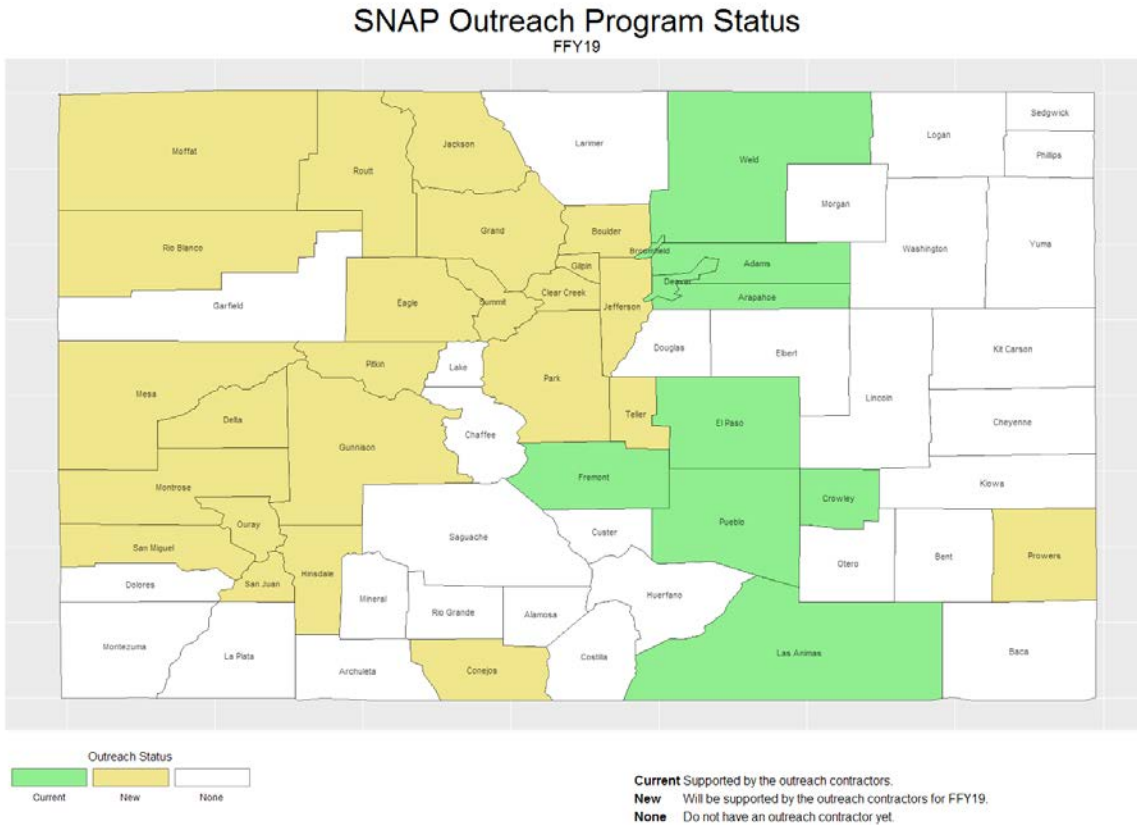
R5 IMPROVING NUTRITION IN RURAL AND UNDERSERVED COMMUNITIES

34. Which rural communities will be targeted, or served, by the R5 request to increase SNAP enrollment?

Currently, the Department has contracted with four non-profit agencies to conduct outreach activities to increase Supplemental Nutrition Assistance Program (SNAP) enrollment in Colorado. Through these contracts, agencies have committed to providing statewide telephone application assistance and some in-person application assistance.

Beginning in October 2018, the Department's outreach contractors began expanding in-person application assistance into rural communities per the Department's focus on rural outreach. However, even with the wider focus on rural outreach, significant areas of Colorado will be underserved (i.e., 30 counties). Therefore, the Department's budget request is important to expand outreach into additional underserved or rural counties in Colorado where in-person assistance does not currently exist (see Figure 1).

Figure 1: SNAP Outreach



35. Will these SNAP outreach efforts address “food deserts”?

While the primary focus of SNAP outreach efforts is to connect Coloradans who are eligible but not enrolled in SNAP with benefits to support their families, increased SNAP enrollment is correlated with increased economic activity in communities. According to the Food Assistance National Input-Output Multiplier (FANIOM) model, created by the U.S. Department of Agriculture’s (USDA) Economic Research Service, every \$5 in new SNAP benefits generates \$9 in total community spending. Moreover, every dollar of SNAP benefits generates an additional \$0.17 to \$0.47 of new spending on food. SNAP recipients spend more dollars on food at local retailers than eligible non-participants. Therefore, increased SNAP enrollment can incentivize grocers and other retailers to commit to serving economically challenged communities where food deserts are most prevalent.

R9 COLORADO WORKS BASIC CASH ASSISTANCE COLA

36. Please provide the Committee with information regarding the State’s TANF reserve level and caseload increase experienced during the last economic downturn, the Great Recession.

Counties are appropriated \$128 million TANF dollars annually. In FY 2007-08, counties spent \$38 million of the \$128 million for basic cash assistance (30% of the county allocation; see

Table 10). In 2008, SB 08-177 required a 30% increase to the basic cash assistance grant from \$421 to \$462 for a monthly grant for a family of three. Expenditures on basic cash assistance across all three years of the Great Recession (December 2007 - June 2009, officially) represented in the table did not exceed the \$128 million yearly allocation and did not impact county or State reserves.

Table 10: BCA as a Percentage of TANF Allocation				
Year	Basic Cash Assistance Expenditures (BCA)	Total Allocation	Percentage of Total Allocation	Notes
FY 2007-08	38,095,541	128,490,913	30%	
FY 2008-09	51,737,883	128,490,913	40%	SB 08-177 required the Basic Cash Assistance increase be raised by 30%.
FY 2009-10	71,079,747	128,713,135	55%	The full impact of SB 08-177 was realized

Table 11 displays the Colorado Works caseload, county TANF Reserves, and State Long Term Reserve (LTR) balances during the Great Recession. The caseload figures represent the average monthly caseload in each fiscal year. Colorado reports the combined total of county and State Reserves as one figure to the federal government because the federal government does not differentiate between county and State reserves.

Table 11: TANF Caseload and Reserve				
Year	Colorado Works Caseload	County TANF Reserves	State Long Term Reserve (LTR)	Notes
FY 2007-08	9,631	\$99,205,507	\$91,095,665	
FY 2008-09	10,470	\$92,240,242	\$83,809,916	In FY 08-09, Year 1 of SB 08-177 dictated that no county have more than 70% of their allocation amount in reserves.
FY 2009-10	13,730	\$55,618,851	\$41,483,178	In FY 09-10, Year 2 of SB 08-177 dictated that no county have more than 55% of their allocation amount in reserves. The legislature simultaneously approved funding out of the State LTR for Child Welfare (\$12.5 M), Statewide Strategic Use Fund (\$10 M) and emergency funding for employment, homelessness, and other benefits or services (\$18 M).

Additionally, during the total span of the Great Recession, Colorado received additional federal funds totaling \$65,139,862 to operate the Colorado Works (TANF) program (as presented in Table 12).

Table 12: TANF funding received during Great Recession			
Federal Funds	FY 2008-09	FY 2009-10	FY 2010-11
Supplemental Funds	\$13,569,691	\$13,569,691	N/A
American Recovery and Reinvestment Act (ARRA) Funds	N/A	\$23,887,234	\$14,113,246
Totals:	\$13,569,691	\$37,456,925	\$14,113,246

37. Does a TANF minimum reserve level of \$33.9 million provide a sufficient programmatic safeguard in the event of an economic downturn?

Yes, a minimum State Long Term Works Reserve (LTR) level of \$33.9 million provides a sufficient safeguard in the event of an economic downturn. The recommended reserve amount is enough to fund approximately one quarter of program expenditures. The LTR does not include the funds available in the county TANF Reserves (currently another \$55 million) that counties may access in case they overspend their annual allocation.

In the event of a significant economic downturn, counties could access their own reserves as well as the State reserves. Currently, more than \$140 million is available in total TANF reserves (State LTR plus County TANF Reserves) to support needy Coloradans. Furthermore, the federal government would likely make additional funds available to states in the event of another significant downturn (similar to the additional federal funds presented in Table 11).

R13 TRAILS OPERATIONS AND MAINTENANCE

38. What portion of the TRAILS program is supported with TANF reserve funds?

TANF appropriations are made from the TANF Block Grant. In FY 2017-18, the federal Administration for Children and Families (ACF) approved the new Trails Modernization system to receive 50% federal reimbursement on eligible operational and maintenance expenses. All operational and maintenance costs are allocated under the federally approved cost allocation plan. As such, the current funding mix is:

- 45% General Fund (\$1,103,814);
- 35% Title IV-E Funds (\$858,522);
- 13% TANF Funds (\$318,880); and
- 7% Title XX Funds (\$171,704).

LOW INCOME ENERGY ASSISTANCE PROGRAM (LEAP)

39. Why did LEAP caseload and expenditures spike in FY 2017-18? Is it due to increasing energy costs?

Table 13: LEAP Caseload		
Year	Caseload	Expenditures
FY 2011-12	100,975	\$31,956,683
FY 2012-13	96,009	\$28,613,522
FY 2013-14	90,004	\$39,284,036
FY 2014-15	81,446	\$47,151,330
FY 2015-16	79,027	\$30,530,109
FY 2016-17	75,875	\$35,517,598
FY 2017-18	70,246	\$41,019,107

The LEAP caseload did not increase from FY 2016-17 to FY 2017-18. It decreased from 75,875 in FY 2016-17 to 70,246 in FY 2017-18. The Department had inadvertently provided incorrect LEAP caseload data for FY 2017-18 in response to the JBC’s annual request for caseload and expenditure data. This error was discovered in response to this question. The Department had unintentionally provided the number of LEAP applications received versus the total number of unduplicated households served.

The declining caseload is at least partially due to the warmer winters Colorado has experienced during the past few years. The Department is actively working to counteract the reduction in LEAP applications through several strategies. These activities include working closely with counties to develop individualized outreach plans, completing a project to allow Coloradans to apply for benefits online through the Colorado PEAK website, and investing in media outreach.

The LEAP expenditures increased in FY 2017-18 due to increased federal funding that allowed the programs to distribute a higher benefit level to recipients.

40. Does the LEAP program work with, or coordinate, with State energy conservation efforts?

Yes, the LEAP program collaborates with statewide energy efforts. Three Colorado agencies collaborate in the administration of energy programs: the Department’s Low-income Energy Assistance Program (LEAP), Colorado Energy Office (CEO), and Energy Outreach Colorado (EOC). Each agency provides energy-related services targeted for different purposes and populations. Despite distinct funding sources and purposes, these agencies coordinate closely to improve outcomes for their income-qualified clients.

A notable difference among the three agencies administering energy assistance is their core purposes.

- The Department's LEAP program focuses on heating bill payment assistance and self-sufficiency among a vulnerable population (42 U.S.C. § 8621-8630);
- The Colorado Energy Office focuses on efficient use of fuel (42 U.S.C. 6861 et seq.; 42 U.S.C. 7101 et seq.); and
- Energy Outreach Colorado is a non-profit agency, with a variety of heating-related services, including education and advocacy, as a core focus (40 C.R.S. § 8.5-103.5).

The LEAP, administered by the Department, provides support to income-qualified households to pay heating costs through a primarily federally funded program. LEAP applications are accepted from November through April. Energy Outreach Colorado provides a variety of energy-related services to its clients, including bill payment assistance in opposite months to the Department's LEAP season, using an array of State and private funds. The Colorado Energy Office (CEO) targets energy efficiency investments (i.e. "Weatherization"), via federal and State funds, into housing structures where the impact can reduce the need for ongoing LEAP assistance.

In FY 2017-18 CEO served 685 LEAP households through its weatherization program. The average annual customer energy savings after receiving weatherization services is \$330 per year (up from \$200 per year in 2014). The LEAP benefit amount is based on actual home heating costs for households. Therefore, weatherization efforts that reduce home heating costs result in a lower dependency on LEAP.



COLORADO
Department of Human Services



FY 2019-20

Joint Budget Committee Hearing

**Department of Human Services:
Services for People with Disabilities, Office of
Behavioral Health, County Administration, Self
Sufficiency, Adult Assistance Programs, and
Early Childhood
December 21, 2018**

Mission, Vision, and Values

Mission

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

Vision

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

Values

The Colorado Department of Human Services will:

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



At the Colorado Department of Human Services, We Are People Who Help People:

- Thrive in the community of their choice
- Achieve economic security through meaningful work
- Prepare for educational success throughout their lives

CDHS at a Glance

CDHS Owned & Active

- 343 buildings that are owned and operated on 20 campuses across the State of Colorado, including:
 - 50 vacant buildings
 - 30 tenant/contract operated buildings
 - 291 CDHS occupied/operated
- Examples of the various uses of buildings include:
 - 2 Mental Health Hospitals
 - 3 Regional Centers, including 40 Group Homes
 - 12 Youth Service Centers
 - 5 Veterans Community Living Centers (4 state-operated)
- Office of State Architect identifies current replacement value of nearly \$774 million
- Average Facility Condition Index score for CDHS buildings is 68.6% compared to statewide target of 85%

CDHS Leased

- 11 Properties, including:
 - 1 Disability Determination Services Office
 - 1 Child Welfare Training Office
 - 1 CDHS Headquarters (1575 Sherman St.)
 - 1 LEAP/Refugee Services Office
 - 5 Administrative NYC Offices
 - 1 Office of Economic Security Training
 - 1 Developmental Disabilities Council



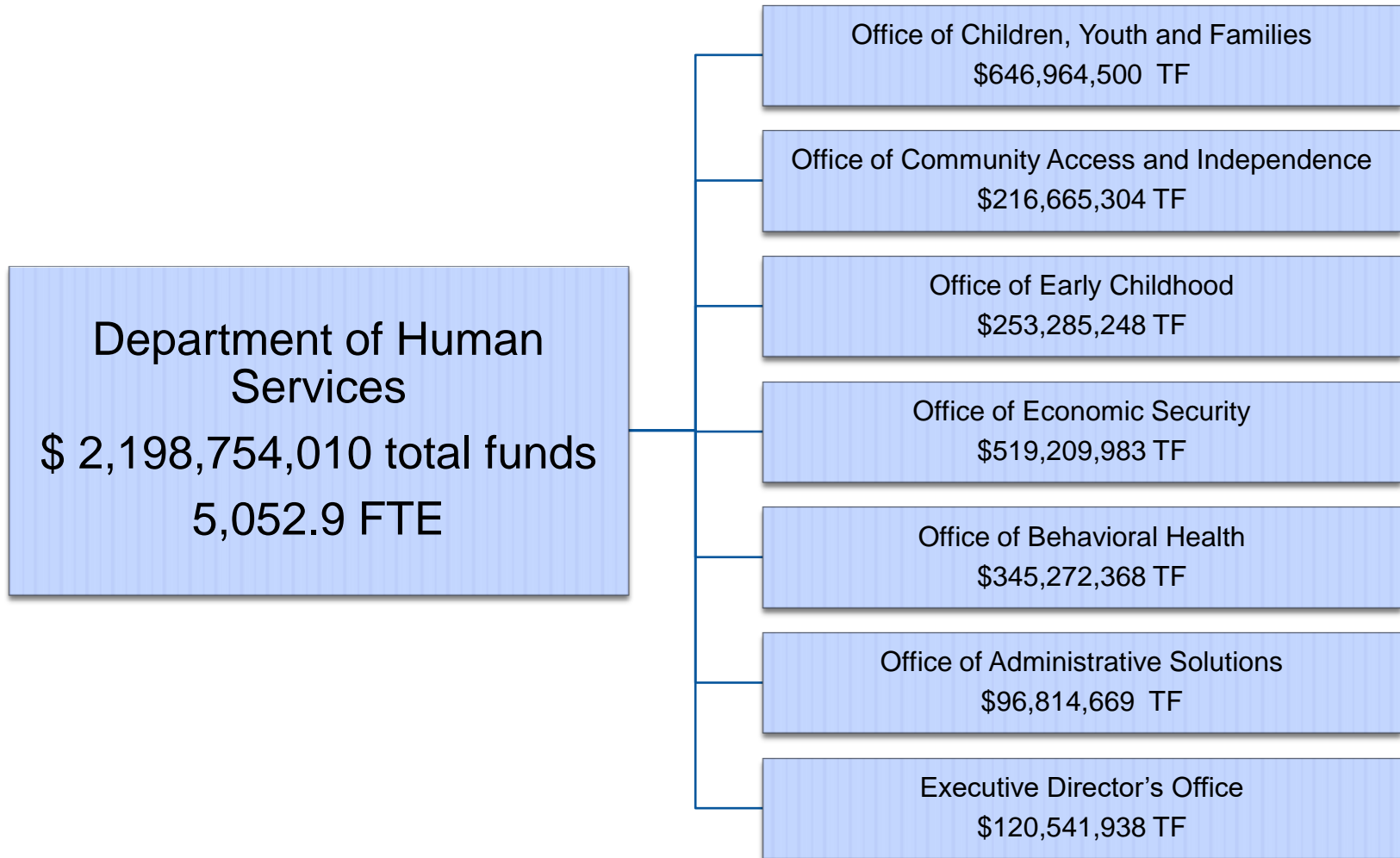
CDHS at a Glance

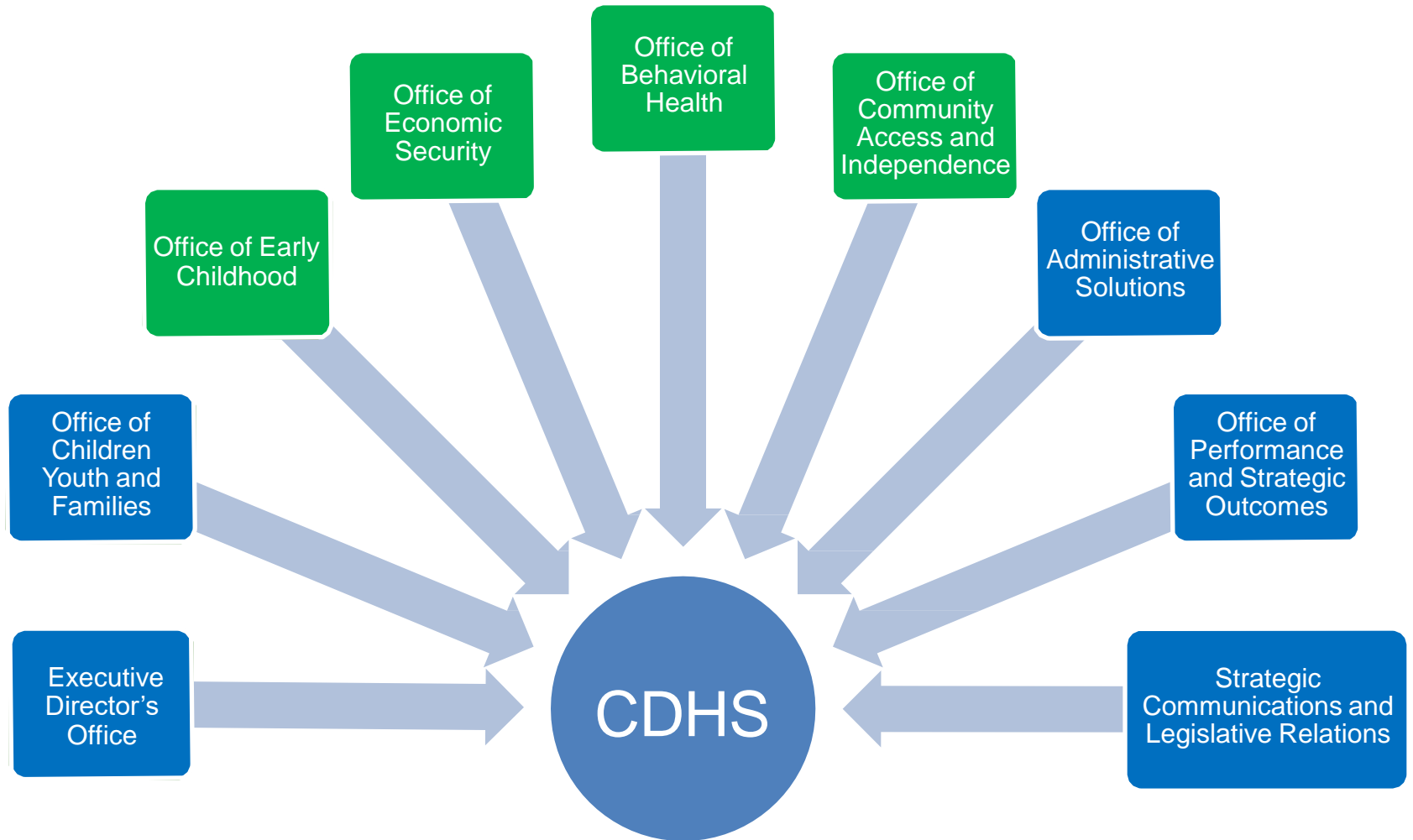
Community Programs

- ✓ County Programs
- ✓ Community Behavioral Health Providers
- ✓ Refugee Services
- ✓ Domestic Violence Program
- ✓ Early Childhood Councils
- ✓ Area Agencies on Aging
- ✓ Tony Grampas Youth Services
- ✓ Ombudsman Programs
- ✓ 66 Boards and Commissions



FY 2018-19 Department Appropriation





Colorado Department of Human Services FY 2019-20 Budget Requests

Office of Community Access and Independence

- Adult Protective Services Support
- DRCO Depreciation Fund Capital Improvements Continuation Project
- Fitzsimons Dayroom, Courtyard, Laundry Room Updates
- Homelake VCLC Rotunda/Workshop Renovations

Office of Behavioral Health

- Mental Health Institute Pueblo Bed Expansion
- Contracted Physician Salary Adjustment
- CMHIFL F2 & F3 Cottage Renovation
- Secure Treatment Facility for Mental Health Restorations
- Colorado Crisis System Enhancements (Operating)
- Colorado Crisis System Enhancements (IT Capital)
- CMHIFL Campus Utility Infrastructure Upgrade
- CMHIP Campus Utility Infrastructure Upgrade
- Community Provider Rate Increase
- Food Service Inflation



Colorado Department of Human Services FY 2019-20 Budget Requests

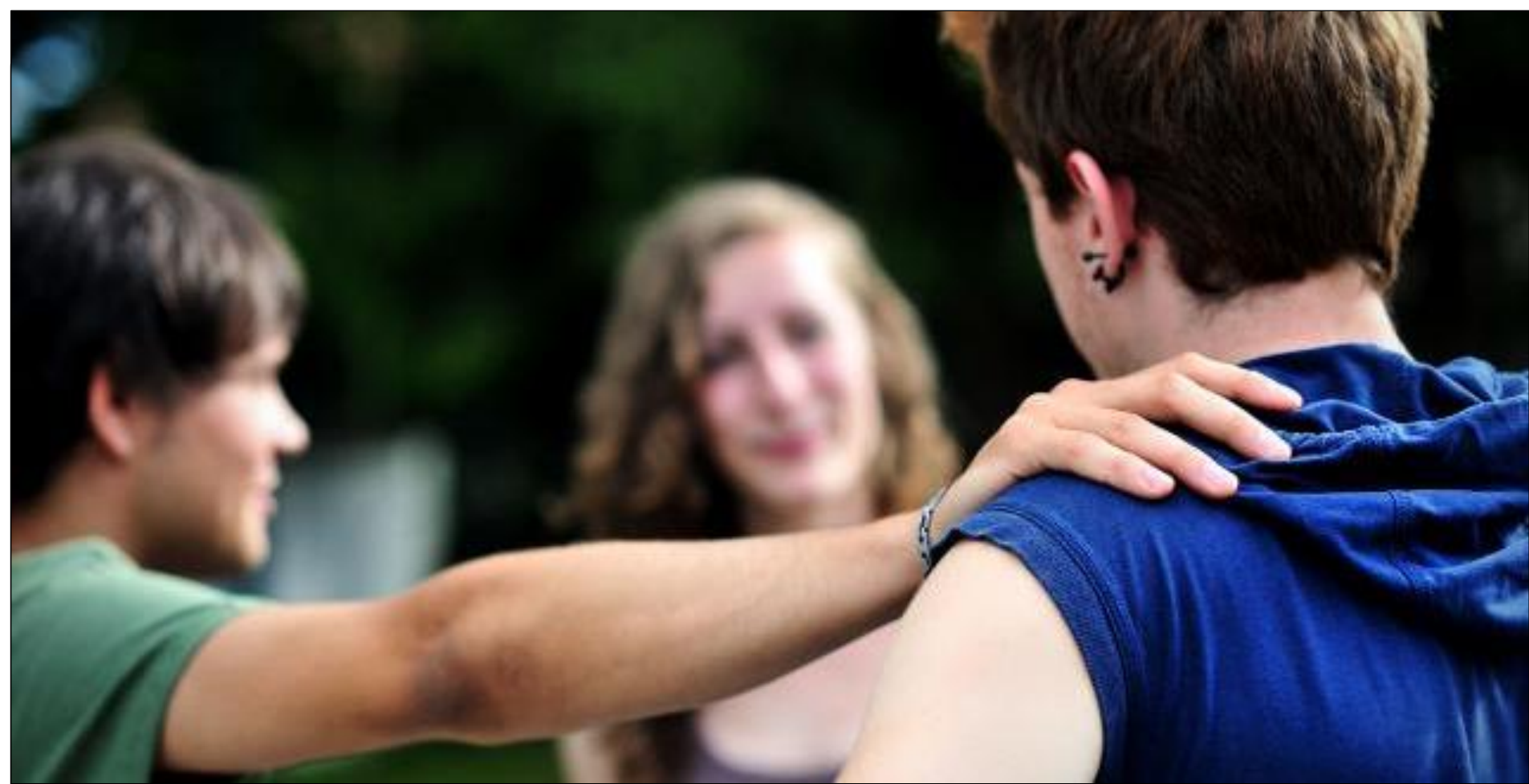
Office of Early Childhood

- None

Office of Economic Security

- Reducing Child Neglect via Employment
- Child Support Employment
- Improving Nutrition in Rural and Underserved Communities
- Old Age Pension Program Cost of Living Adjustment
- SNAP Quality Assurance Line Item
- Colorado Works Basic Cash Assistance Cost of Living Adjustment
- Covering Child Support Unfunded Disbursements





Office of Behavioral Health



COLORADO
Department of Human Services

Office of Behavioral Health

FY 2019-20 Decision Items

- ***Operating Requests***

- Mental Health Institute Pueblo Bed Expansion, \$5,141,144
- Colorado Crisis System Enhancements, \$985,092
- Contracted Physician Salary Adjustment, \$1,127,667
- Community Provider Rate Increase, \$9,253,301
- Food Service Inflation, \$150,910

- ***Capital Requests***

- CMHIFL F2&F3 Cottage Renovation, \$17,835,851
- Secure Treatment Facility for Mental Health Restoration, \$3,731,725
- CMHIP - Campus Utility Infrastructure Upgrade, \$9,155,876
- CMHIFL - Campus Utility Infrastructure Upgrade, \$10,493,712

- ***Capital IT Requests***

- Colorado Crisis System Enhancements, \$1,514,500



Office of Behavioral Health

Division of Mental Health Institutes

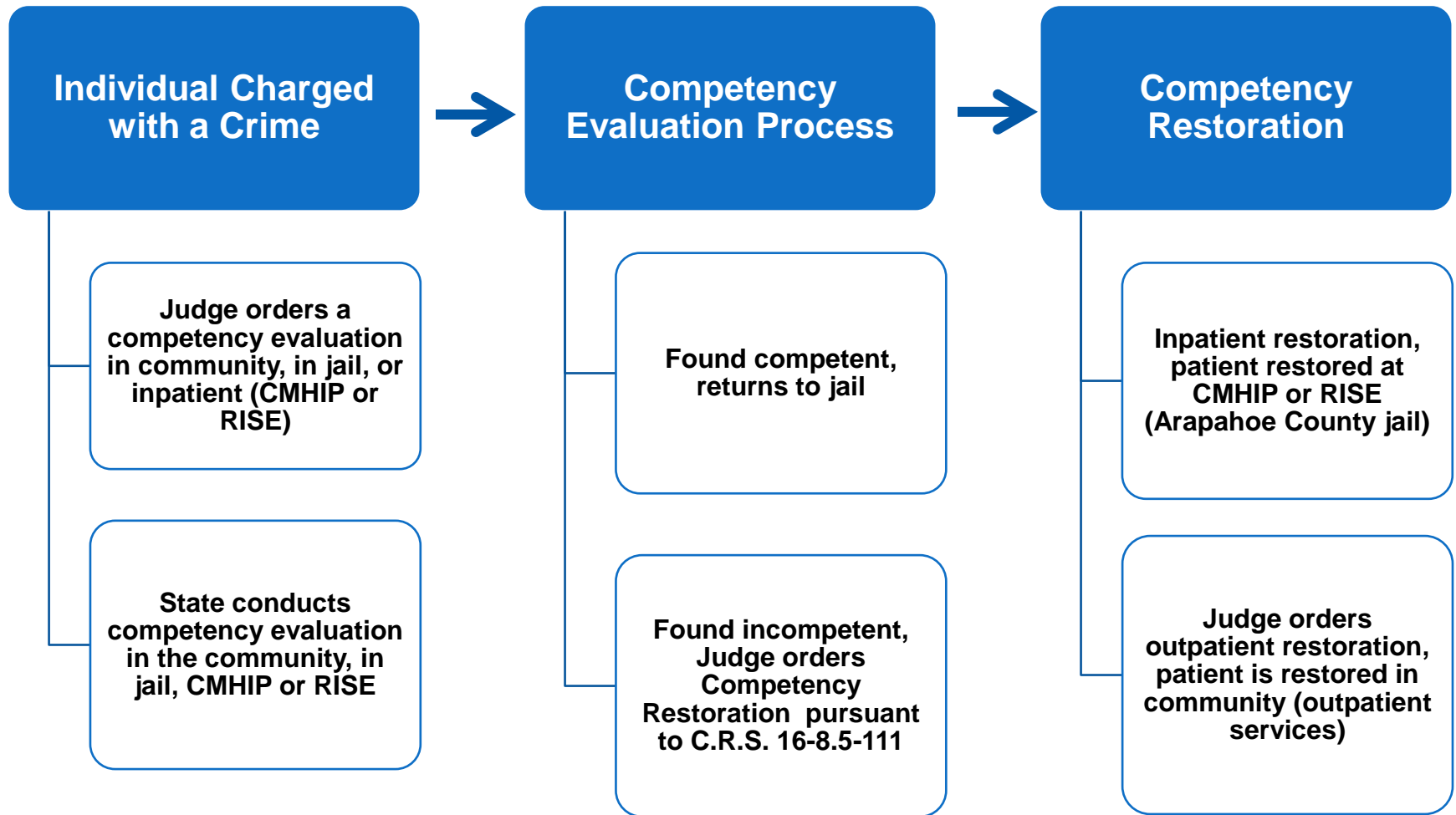
- **Fort Logan (94 beds)**
 - Adult civil patients per CRS 27-65
- **Pueblo (449 beds)**
 - Adult civil patients per CRS 27-65
 - Adolescent civil and forensic
 - Geriatric
 - Forensic ordered by criminal court
- **RISE Program (96 beds)**
 - Forensic ordered by criminal court
 - Arapahoe County Jail

Division of Community Behavioral Health

- Funds mental health and substance use prevention, treatment and recovery for indigent persons
- Administers and regulates community-based behavioral health services
 - substance use prevention and treatment
 - mental health services
 - jail based mental health services
 - opioid treatment services
- Funds and administers the Colorado Crisis Services



Competency Services



Settlement Agreement Update

- Disability Law Colorado sued CDHS in 2011 over pre-trial defendants waiting in jail for CDHS to offer competency services
- The parties entered into a settlement agreement in 2012. The settlement agreement prescribes time frames for these services.
 - jail-based competency evaluations - compliant
 - inpatient competency evaluations - compliant
 - competency restoration services - not compliant
- Due to the overwhelming demand and lack of bed space, CDHS has not been able to comply with the inpatient restoration time frames since June 2017
- CDHS is currently in federal court litigating the issue with the plaintiff, a compliance plan was submitted to court on December 17, 2018

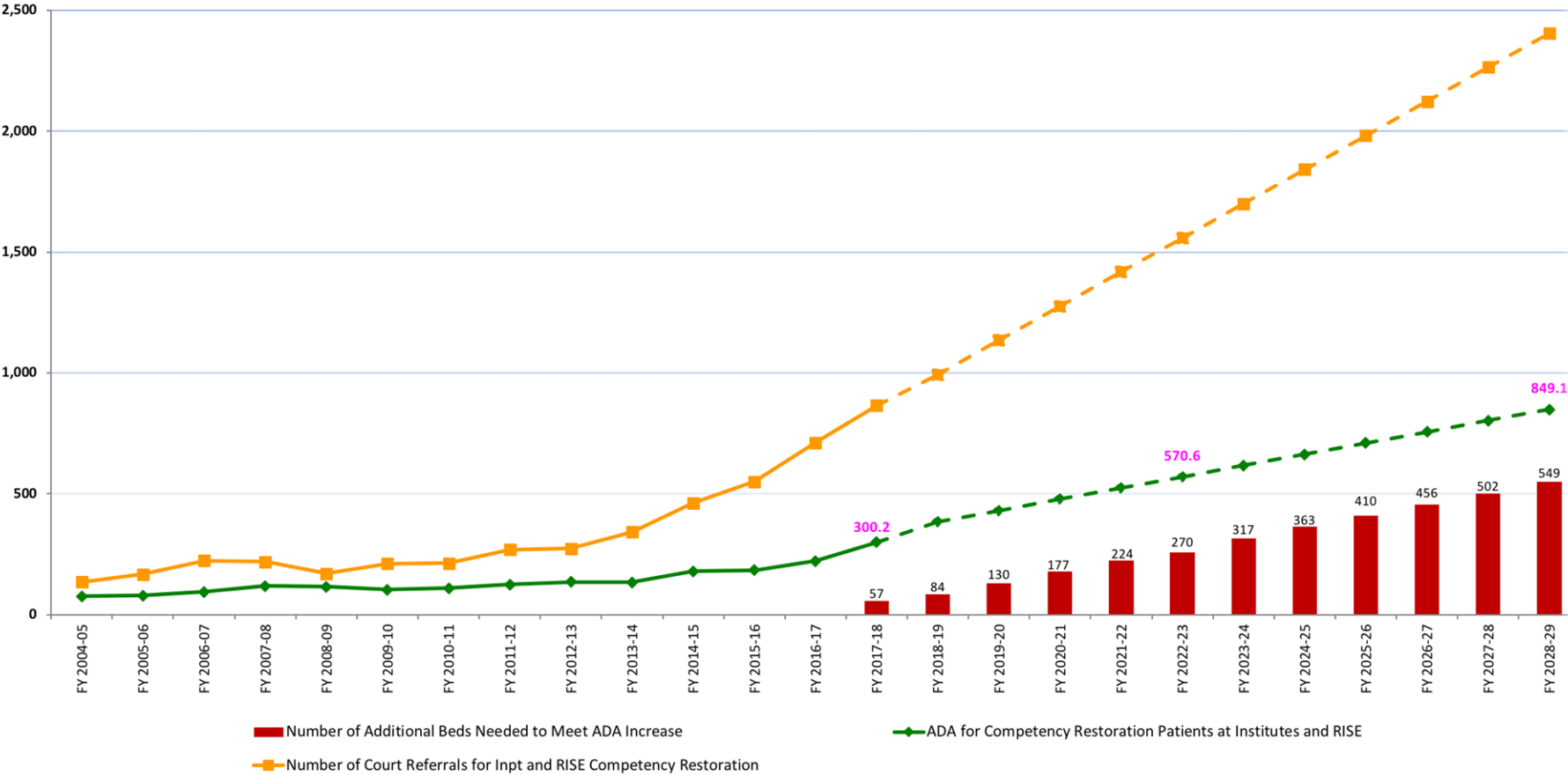


COLORADO

Department of Human Services Office of Behavioral Health

Competency Restorations

Competency Restoration: Average Daily Attendance (ADA) at the Institutes and RISE; Number of Court Referrals for Inpatient Restoration; and Projected Requirement for Increased Beds



Appropriations for Competency Services

Fiscal Year	Request	Amount Funded	# Beds Added	# Court Referrals
2012-13		\$0	0	1,558
2013-14	R-3A (Jail Based Restoration)	\$2,455,769	22	1,855
2014-15	S-19 Sanity Evaluation Cost (special case)	\$499,079	0	2,255
2015-16	ES-01 Court Ordered Evaluation Caseload and Jail-based Space	\$2,727,097	30	2,542
2016-17	R-03 Court Ordered Evaluation and Jail-based Bed Space (ongoing funding for ES-01)	\$4,117,235	0	3,174
2017-18	ES-01 Jail-based Bed Space	\$2,406,026	28	3,649
	JBC Staff Initiated: Outpatient Competency Restoration	\$461,702	0	
	S-01b Court Ordered Reports FTE Caseload	\$380,959	0	
	S-01c Purchased Bed Capacity	\$275,596	10	
	CC-02 Institute Hawkins Building L2 Unit	\$5,420,468	24	
2018-19	R-05a Jail-based Bed Space	\$7,398,658	34	Projected 4,510
	R-05c Court Ordered Reports FTE Caseload	\$1,085,726	0	
	R-05d Purchased Bed Capacity	\$3,412,101	0	
	R-05e Outpatient Competency Restoration	\$1,177,618	0	



Efforts to Date to Increase Bed Capacity

Location	Date Available	Beds Available
CMHIP Admissions & Restorations	Current	168
RISE	Current	96
Contract with Private Hospital	January 2019	3
Contract with Private Hospital	April 2019	3
New RISE Program	May 2019	18
CRU – clinical structure*	December 2019	42
New L2 Unit CMHIP	August 2020	24
CMHIFL F2 & F3*	December 2021	44
Secure Mental Health Treatment Facility at Ridge View Campus*	March 2022	210

*FY 2019-20 budget request



COLORADO

Department of Human Services Office of Behavioral Health

Senate Bill 17-012

Outpatient Restoration Services

Number of People Served - As of December 2018:

- 240 court orders for outpatient restoration
- 131 individuals currently receiving services
- State is exceeding projects; 459 court ordered outpatient restoration referrals

Number of Providers – As of December 2018:

- 21 private providers
- 7 signed contracts with CMHCs
- 7 CMHCs in contract discussions



2018 Legislative Session Policy Efforts

- Dismiss non-violent low level charges
- Inpatient restoration only for those who meet inpatient clinical need
- Require PR bonds for defendants for community based competency
- Pursue jail-based restoration
- Begin restoration services immediately upon a finding of incompetency
- Establish a uniform maximum length of restoration efforts
- Tighten up court deadlines



Immediate Plans to Come Into Compliance

- Compliance plan was submitted to demonstrate the Department's long-term and short-term compliance with the settlement agreement
- By May 2019, have everyone waiting over 28 days for inpatient restoration services admitted to the hospital or RISE
 - As of December 14, 2018 - 69 people
- Short-term plan includes:
 - Freezing adult civil admissions at Ft. Logan
 - Freezing adolescent civil admission at Pueblo
 - Double occupancy for 6 rooms at Pueblo



Long-Term Compliance Plan

FY 2019-20 Budget Requests

- CMHIFL F2&F3 Cottage Renovation, \$17,835,851
- Secure Treatment Facility for Mental Health Restoration at Ridge View, \$34,393,122 (in three phases)
- Funded 24 bed unit at CMHIP
- CRU – Clinical Structure (Operating)



Staffing at the Mental Health Institutes

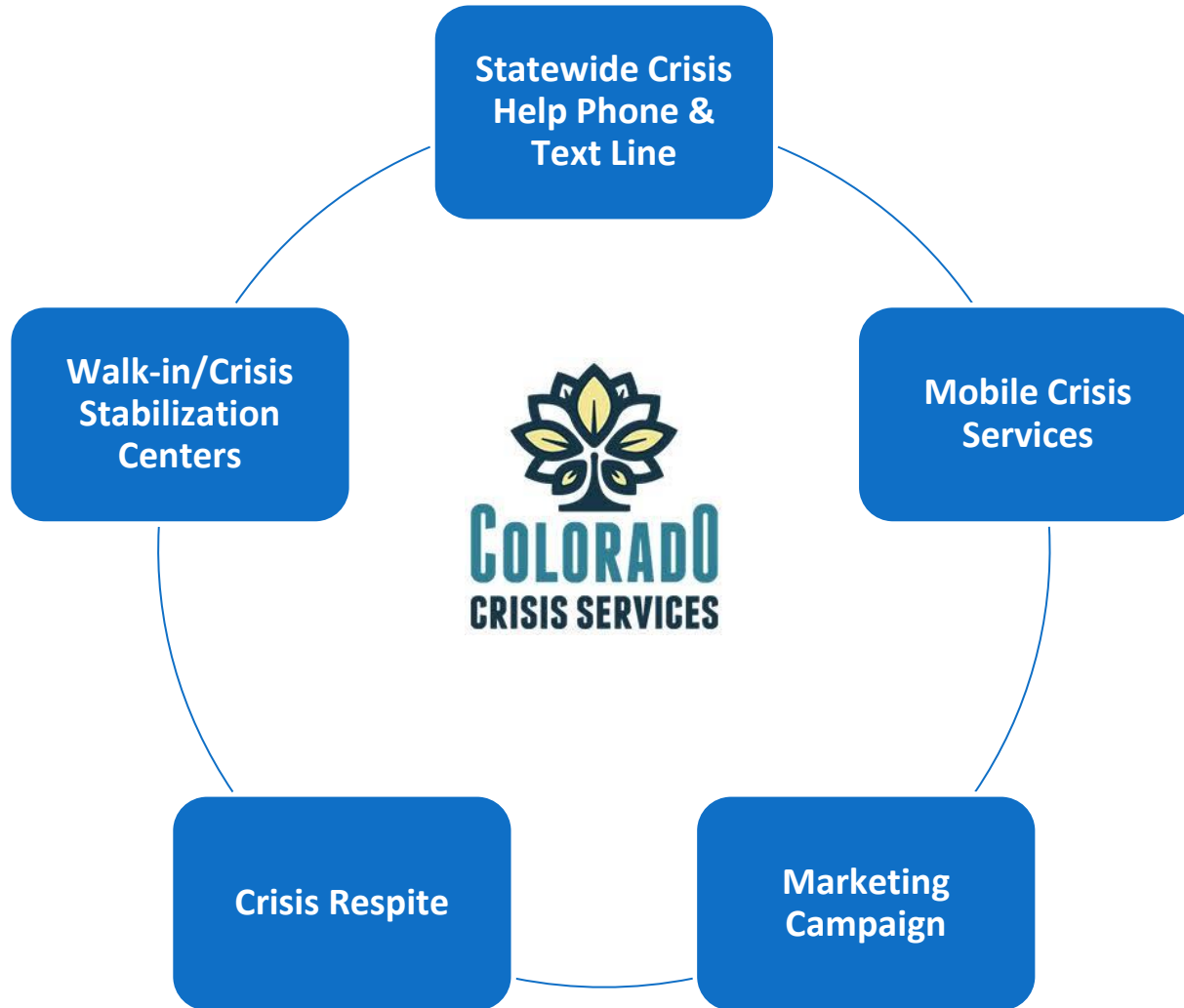
Percentage of Direct Care Staff Positions that are Vacant at Pueblo and Fort Logan

	November 2015	November 2016	November 2017	November 2018
Pueblo	12%	17%	18%	15%
Fort Logan	10%	12%	10%	10%

Source: Department of Human Services analysis of data contained in Colorado Payroll Personnel System.



Colorado Crisis Services



Colorado Crisis Services Funding Structure

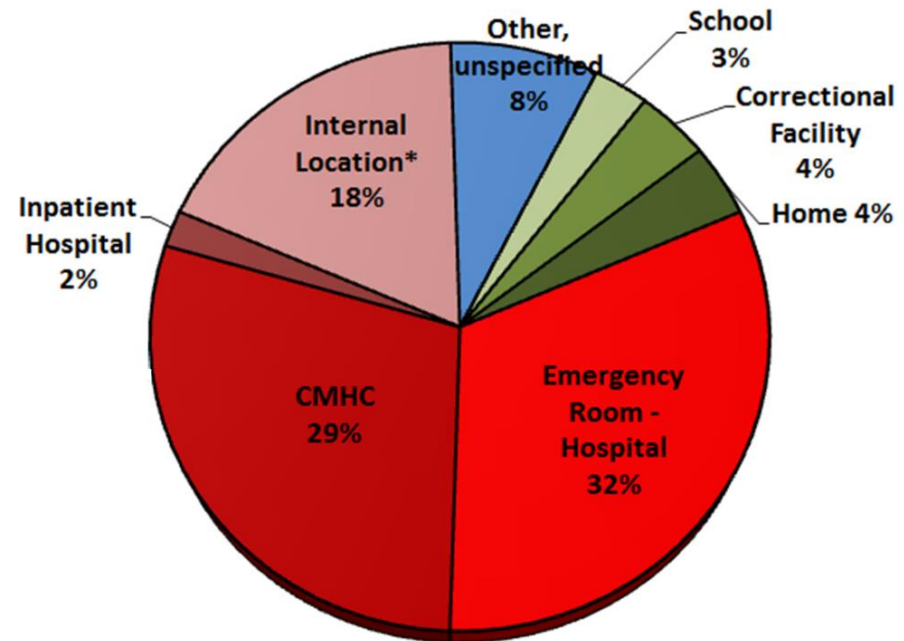
- Under the new funding allocation:
 - From 4 to 7 regions to align with RAE regions
 - Same total amount of funds more evenly distributed across the state
- Funds were distributed based on three drivers:
 - 45% for overall population,
 - 45% for 300% of poverty level, and
 - 10% for population of rural/frontier counties only.
- Administrative costs will be:
 - Reported uniformly and accounted for
 - Adds a 25% cap, which currently averages 23.3%
- New dollars added from federal funds



Colorado Crisis Services ASO Model

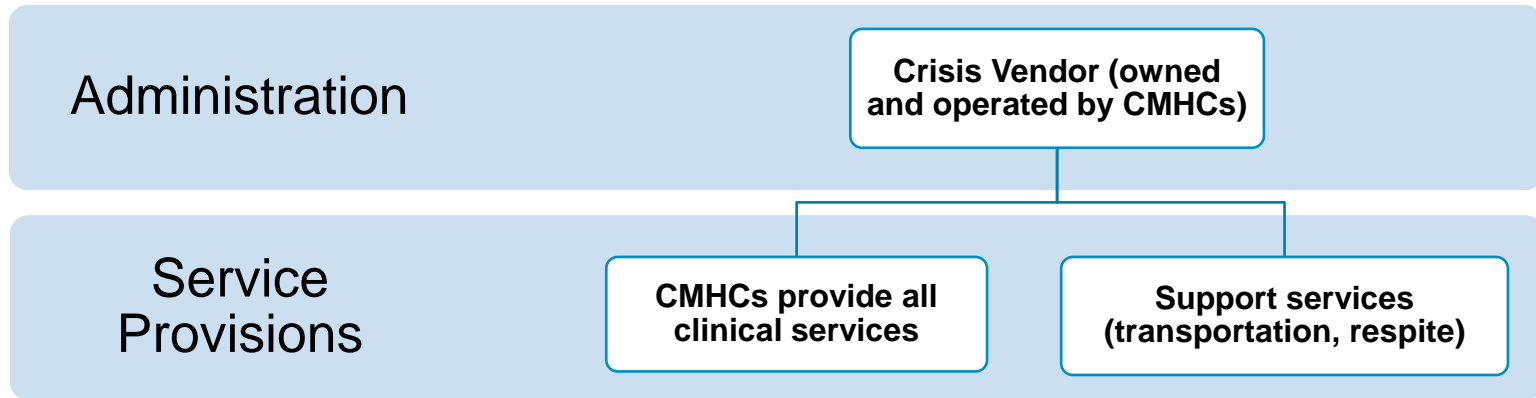
- Concerns with current system:
 - Duplication of efforts between local and Medicaid funded programs with crisis services
 - Lack of response from mobile teams
 - Mobile teams mostly responding to ERs and CMHC locations instead of in the community

Mobile Dispatch by Location
FY 2016-17

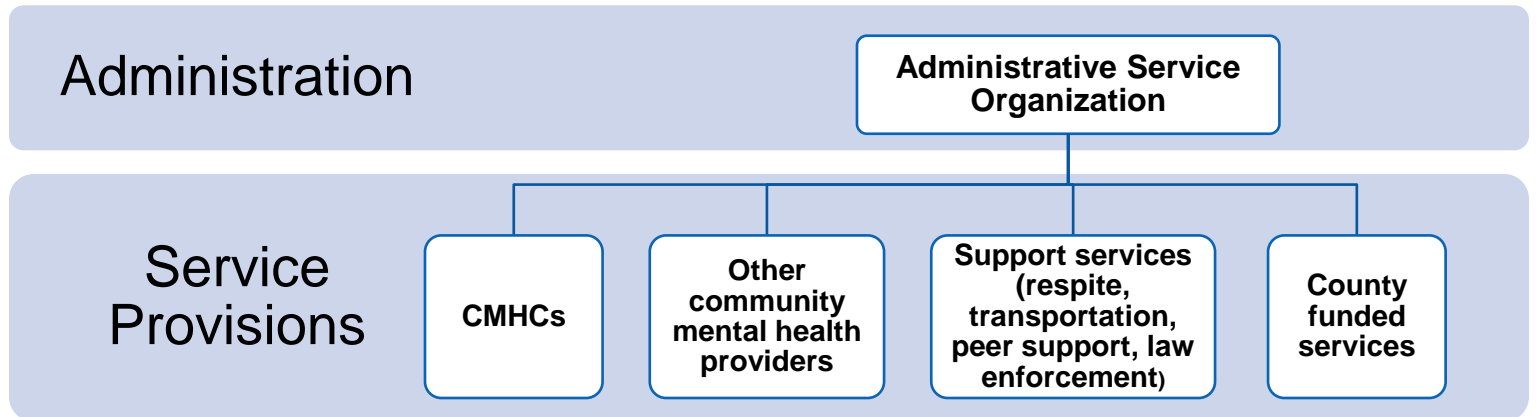


Colorado Crisis Administration & Services Structure

Current



Future



Benefits of the ASO Model

- Diversifying provider network and adding access points
 - Co-responders
 - LEAD programs
 - Emergency medical services
 - County-funded programs
- Standardized patient follow-up
- Separate fiscal interest from clinical decisions
- Ensure hotline referrals are connected with mobile services
- Improved transparency and provider standard operational practices
- Maximize funds across payment sources, i.e., OBH, Medicaid and commercial insurance



Colorado Crisis System Enhancements

GF \$2,499,592

What is the problem?

Patient safety and care is currently compromised by:

- Fragmented record systems that prevent easy and timely care coordination
- Clinical decisions occurring across multiple providers and systems that are not interconnected or visible in real time
- Inconsistent data collection preventing robust program oversight and evaluation
- A lack of timely or immediate access to health records for use by emergency responders and crisis responders to use in making clinical decisions and coordinating appropriate interventions



Colorado Crisis System Enhancements

GF \$2,499,592

What is the solution?

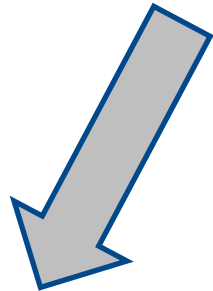
Establishing a single electronic behavioral health record tool for the Colorado Crisis System will:

- Creates one single health record
 - Eliminates duplication
 - A single location for hotline and mobile to document client care
- Health information exchange
 - Allows providers to view real-time client health history
 - Pertinent health information follows the client
- Mobile app for clients
- Pilot to integrate first responders

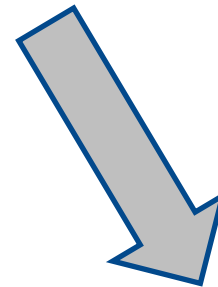


Colorado Crisis System Enhancements

Colorado Crisis System
Enhancements
\$2,499,592 (GF)



\$1,514,500 GF
Capital



\$985,092 GF
Operating





Office of Community Access and Independence



COLORADO
Department of Human Services

Office of Community Access & Independence FY 2019-20 Decision Items

- ***Operating Requests***

- Adult Protective Services Support, \$0

- ***Capital Requests***

- DRCO Depreciation Fund, \$757,405
- Homelake VCLC Rotunda/Workshop Renovations, \$197,573
- Fitzsimons Dayroom/Courtyard/Laundry Room Upgrades, \$199,635



Regional Centers



Grand Junction

HCBS Beds: 80
HCBS Census: 57
HCBS Group Homes: 20
(1 offline home)
HCBS Group Homes After
Relicense: 8 (1 offline home)
ICF Beds: 46
ICF Census: 19
ICF Campus: 4 Dorms
ICF Homes After Relicense: 4
Homes
Services: Residential and Day
Habilitation



Pueblo

HCBS Beds: 88
HCBS Census - HCBS: 45
HCBS Group Homes: 11
(3 offline homes)

Services: Residential and Day
Habilitation



Wheat Ridge

ICF Beds: 142
ICF Census: 126
ICF Group Homes: 19
(0 offline homes)

Services: Residential and Day
Habilitation



Composition of the Regional Centers

- Regional Centers serves three populations (247 residents)
 - Long Term Habilitation (154 residents)
 - Admissions prior to 2013
 - Guardian Engagement
 - Short Term Treatment (68 residents)
 - Admissions from 2013 – present
 - Clients experiencing crisis
 - Intensive Treatment (25 residents)
 - Specialized need
 - Problematic sexual behaviors



Regional Center Updates

Grand Junction Regional Center SB16-178

- Administrative, day program, and facilities staff moved off of the campus in July 2018
- The remaining 19 residents will move into RC homes in the GJ community by summer 2020

Pueblo Regional Center / CMS Update

- The moratorium on admissions at PRC was lifted in August 2018

VCLC Compensation Request

- Request to increase compensation of VCLC direct care staff to the midpoint of the range over two fiscal years:
 - FY 2019-20 \$4.7 million total funds
 - Increases existing and new direct care staff compensation by 11% on average
 - FY 2020-21 (annualized) \$6.2 million total funds
 - Increases direct care compensation to market rate (mid point of the Department of Personnel and Administration salary range by classification)



VCLC Vacancy and Turnover

The VCLCs have experienced challenges in filling vacant positions and have experienced high turnover, as demonstrated in the chart below.

VCLC Direct Care Vacancy and Turnover Rates				
VCLC	FY 2016-17 Turnover Rate	FY 2017-18 Turnover Rate	August 2017 Vacancy Rate	August 2018 Vacancy Rate
Fitzsimons	18%	21%	9%	22%
Florence	35%	16%	17%	11%
Homelake	22%	27%	13%	21%
Rifle	28%	31%	17%	30%

Source: Department analysis of data from CPPS.



What We Have Done Administratively to Hire & Retain Qualified Staff

Implemented continuous open competitive recruitment and hiring for direct care positions

Increased recruitment efforts through multiple venues

Organized hiring events in which applicants can obtain an offer letter the same day that they apply

Utilized referral, signing and retention bonuses

Balanced work schedules to ensure consistent coverage throughout the week

Provided more flexible work schedules for individuals who do not want to work full-time

Engaged staff through open forums where staff can raise any issues of concern

Developing CNA training programs at each of the VCLCs

Developed goal to increase percentage of staffing coverage with regular work hours to reduce need for overtime or extended shifts



Rural Interpreting Services Program (RISP)

The JBC created a two-year pilot at \$700,000 to develop interpreting services for rural areas.

What we've done

- Held 9 town halls
- Needs analysis

What we propose to do

- Hire 2 interpreters to serve the Western Slope/Pueblo
- Hire 2 mentors to develop private practitioners
- Provide grants and training to encourage interpreter certification
- Perform more in-depth needs analysis





Office of Early Childhood



COLORADO
Department of Human Services

Office of Early Childhood

Provide collaborative leadership to align resources for children, families and early childhood professionals to best prepare our youngest Coloradans for future success.

Priorities:

1. School Readiness
2. Safe, Stable and Nurturing Environments
3. Resilience in Early Childhood



Office of Early Childhood

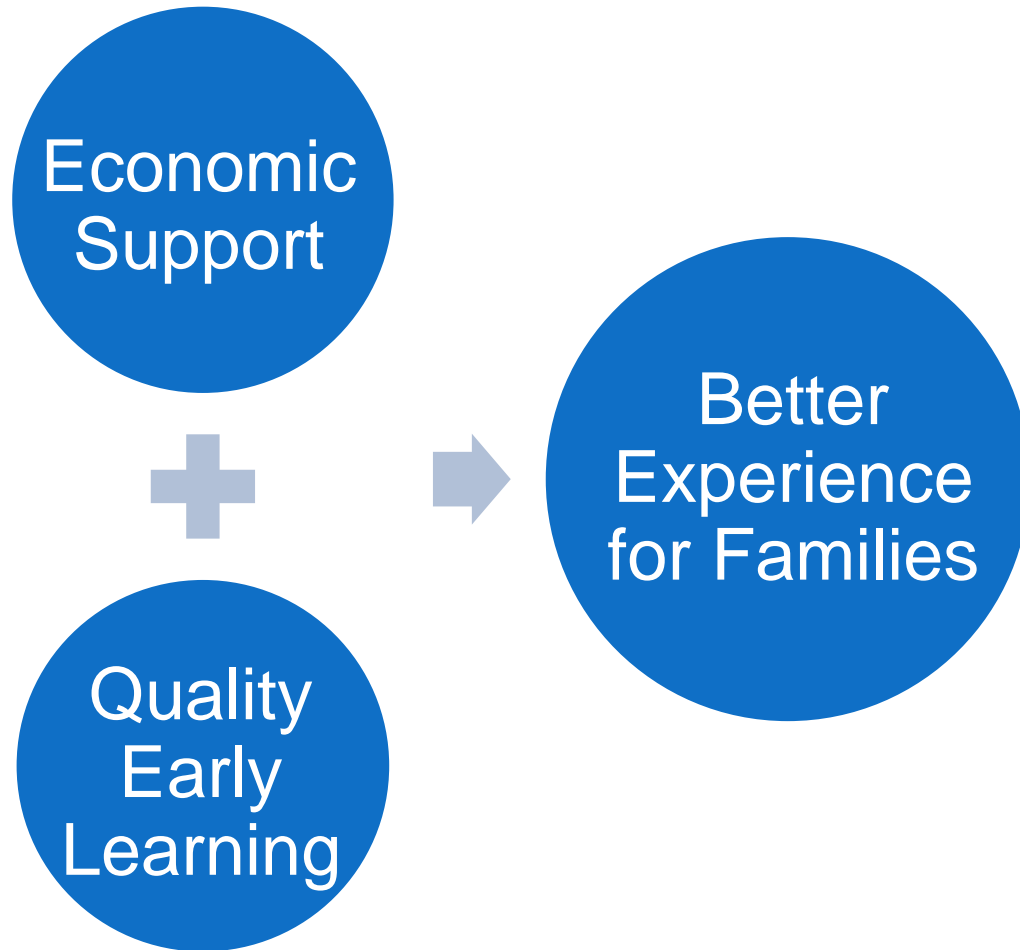
Division of Early Care & Learning	Division of Community & Family Support	Administration
<ul style="list-style-type: none">• Child Care Licensing & Administration• Colorado Child Care Assistance Program• Child Care Quality Initiatives	<ul style="list-style-type: none">• Early Childhood Mental Health• Early Intervention• Child Maltreatment Prevention• Home Visiting• Head Start State Collaboration Director	<ul style="list-style-type: none">• Strategic Operations• Finance



Colorado Child Care Assistance Program (CCCAP)

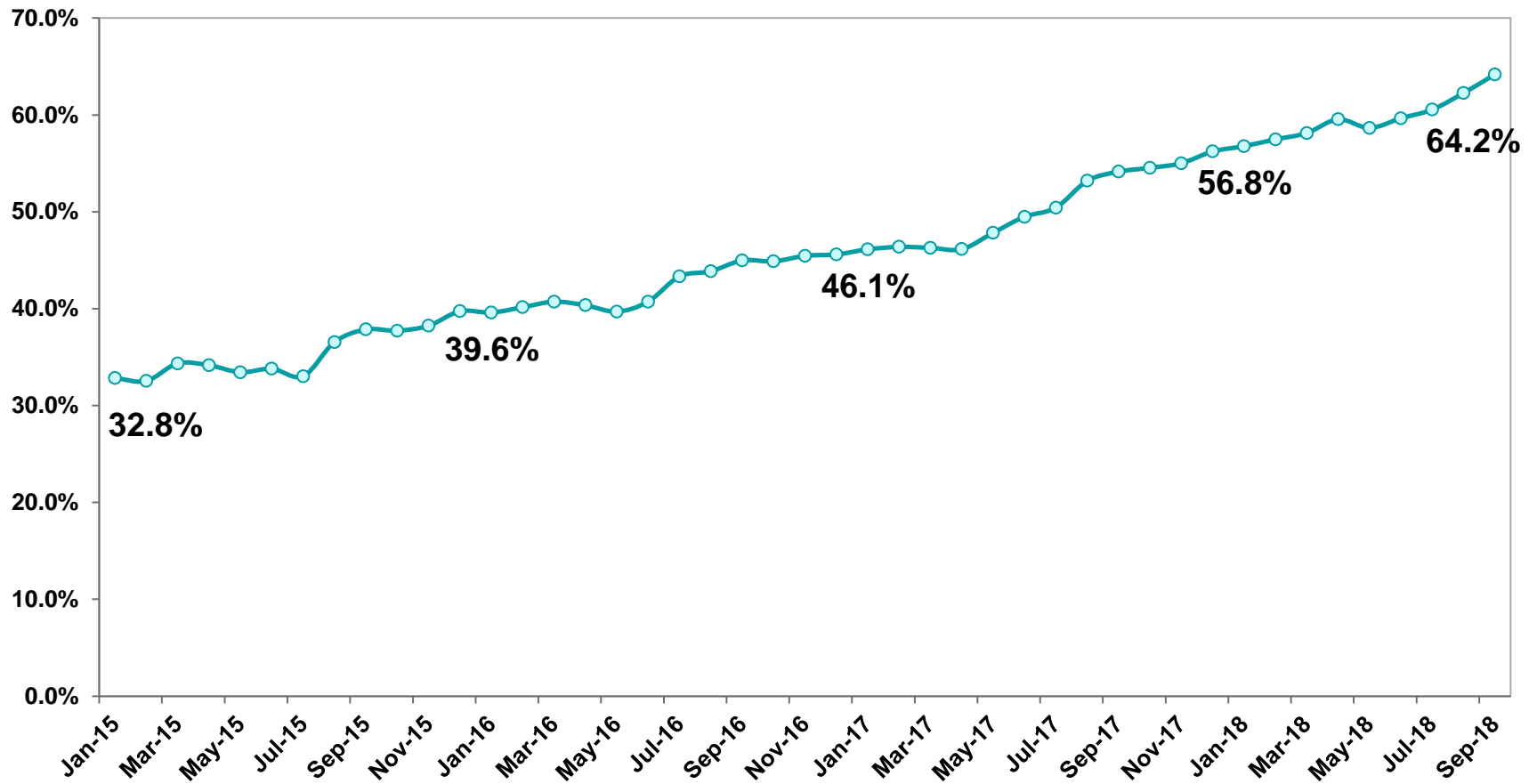
- CCCAP provides child care assistance to **low-income parents/caregivers** who are working, searching for employment or are in training, and those enrolled in the Colorado Works Program who need **child care services to support their efforts toward economic self-sufficiency.**
- CCCAP served **28,662 children** in FY 2017-18, which is less than 10% of fiscally eligible children.

CCCAP: A Two-Generation Approach



High-Quality Care in CCCAP

Percent of Children in CCCAP U5 Served in High Quality Setting



Child Care and Development Fund (CCDF)

In April 2018, Colorado received an increase of approximately \$27 million in its CCDF Discretionary award.

The Department is awaiting notice of the final amount for the current federal fiscal year's award.

Early Intervention (EI)

- EI provides supports and services to families with children birth to age three who have developmental delays
- In FY 2017-18, EI served an average of 8,542 children with developmental delays and disabilities every month

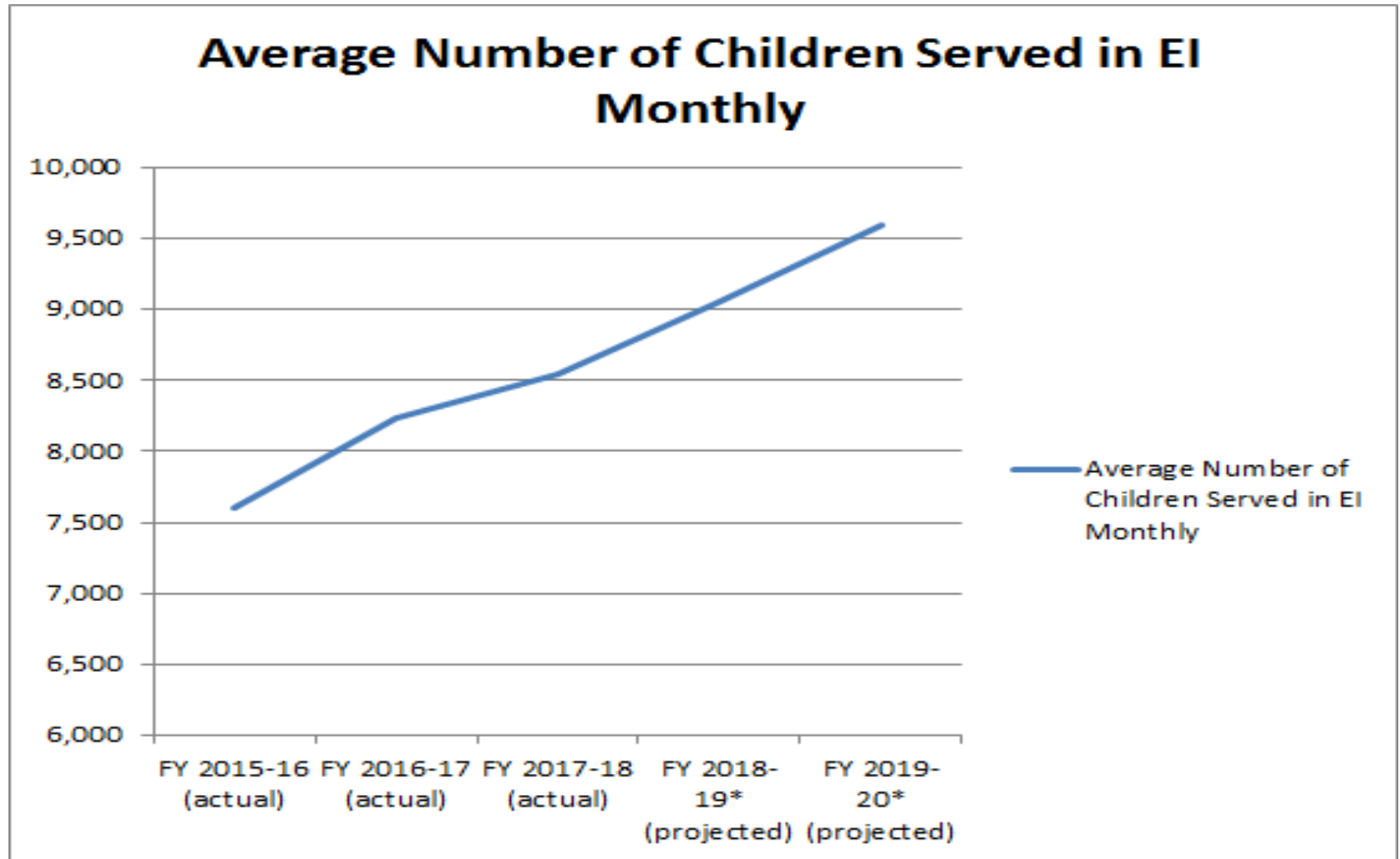


Early Intervention Colorado
for Infants, Toddlers & Families



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Early Intervention Caseload Growth



Source: Early Intervention database



EI Contracts and Funding Methodology Changes

- Changed all CCB contracts from an allocation methodology to cost reimbursement
- Created a shared pool of funds for costs related to independent contractors, which tend to fluctuate

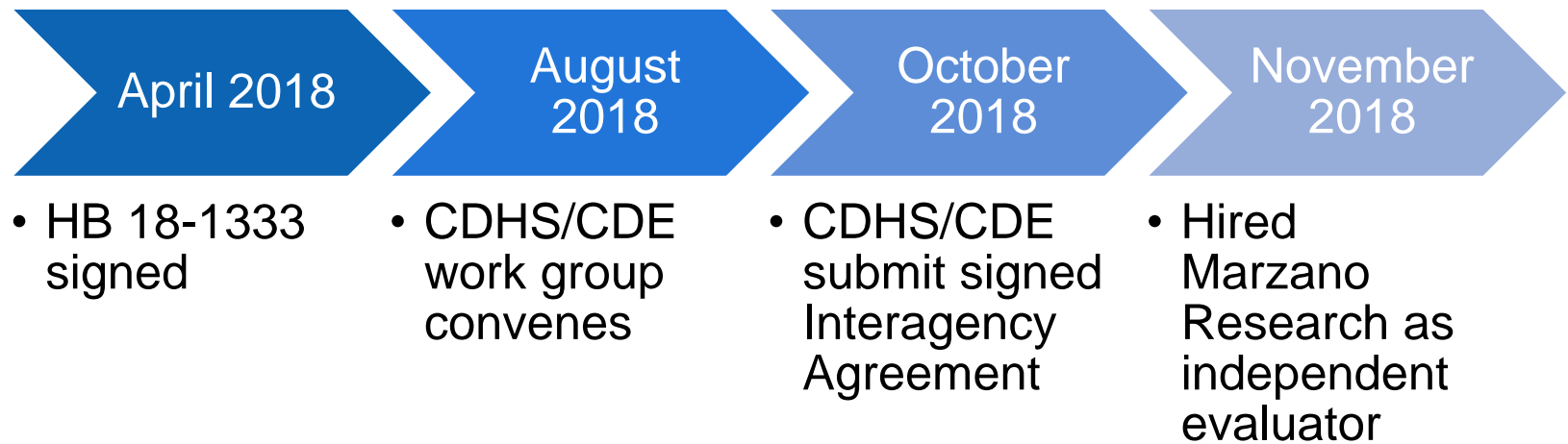
These changes:

- Created greater transparency and predictability
- Resulted in more timely reimbursement
- Are more responsive to fluctuating needs and costs

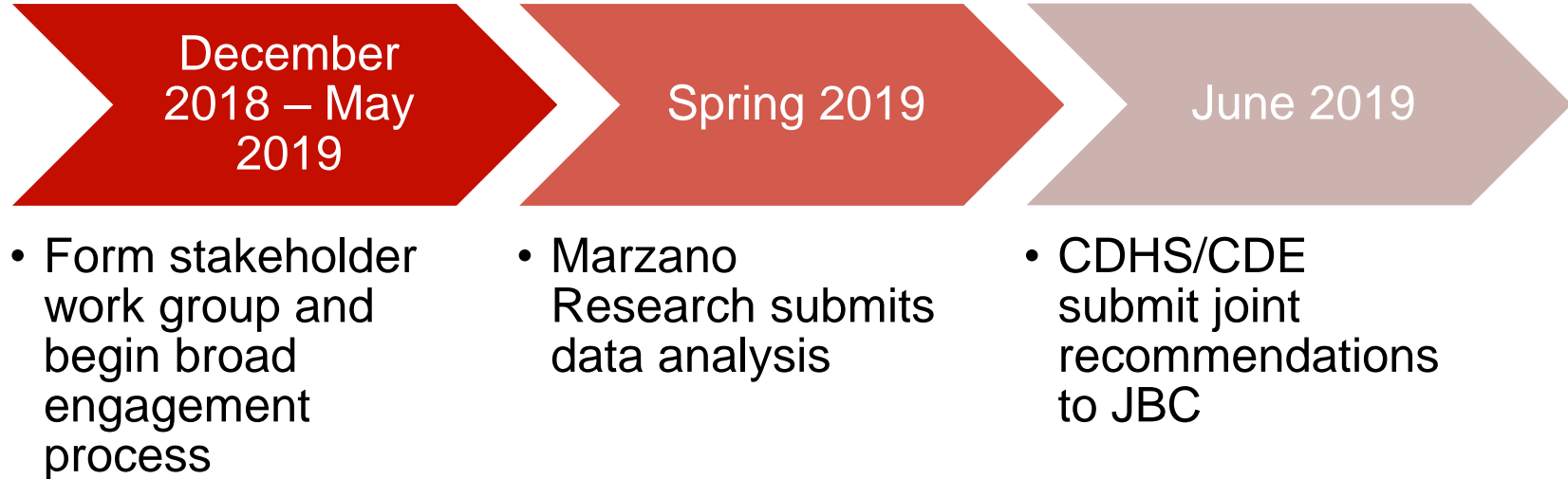


HB 18-1333 Timeline: Completed Work

Requires CDHS and CDE to enter into an interagency agreement to study the administration of EI evaluations.



HB 18-1333 Timeline: Work in Progress





Office of Economic Security



COLORADO
Department of Human Services

Office of Economic Security

Division of Food and Energy Assistance

- Supplemental Nutrition Assistance Program (food assistance)
- Food Distribution and Nutritional Services
- LEAP (Low-Income Energy Assistance Program)

Division of Child Support Services

- Enforces and modifies child support orders
- Collects and distributes child support funding
- Helps locate parents and establish paternity

Division of Employment and Benefits

- TANF (Temporary Assistance for Needy Families)
- AFP (Adult Financial Programs)
- Employment First (SNAP Employment and Training) Program
- ReHire Colorado
 - CW STEP
- CRSP (Colorado Refugee Services Program)



Office of Economic Security

FY 2019-20 Decision Items

- Improving Nutrition in Rural and Underserved Communities: \$1 million and 0.0 FTE
- Reducing Child Neglect via Employment: \$1.7 million and 2.0 FTE
- Child Support Employment: \$966,977 and 1.0 FTE
- Colorado Works Basic Cash Assistance COLA: \$1.2 million
- Old Age Pension COLA: \$3.2 million
- Covering Child Support Unfunded Disbursements: \$150,896 and 0.0 FTE
- SNAP Quality Assurance Technical Adjustment





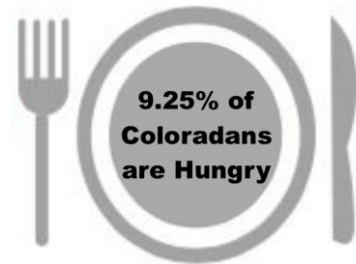
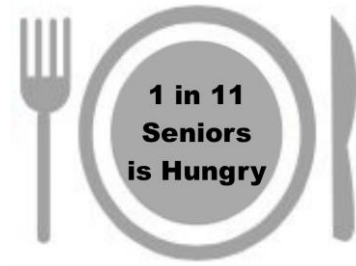
COLORADO
Department of Human Services



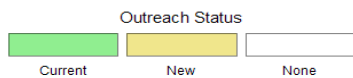
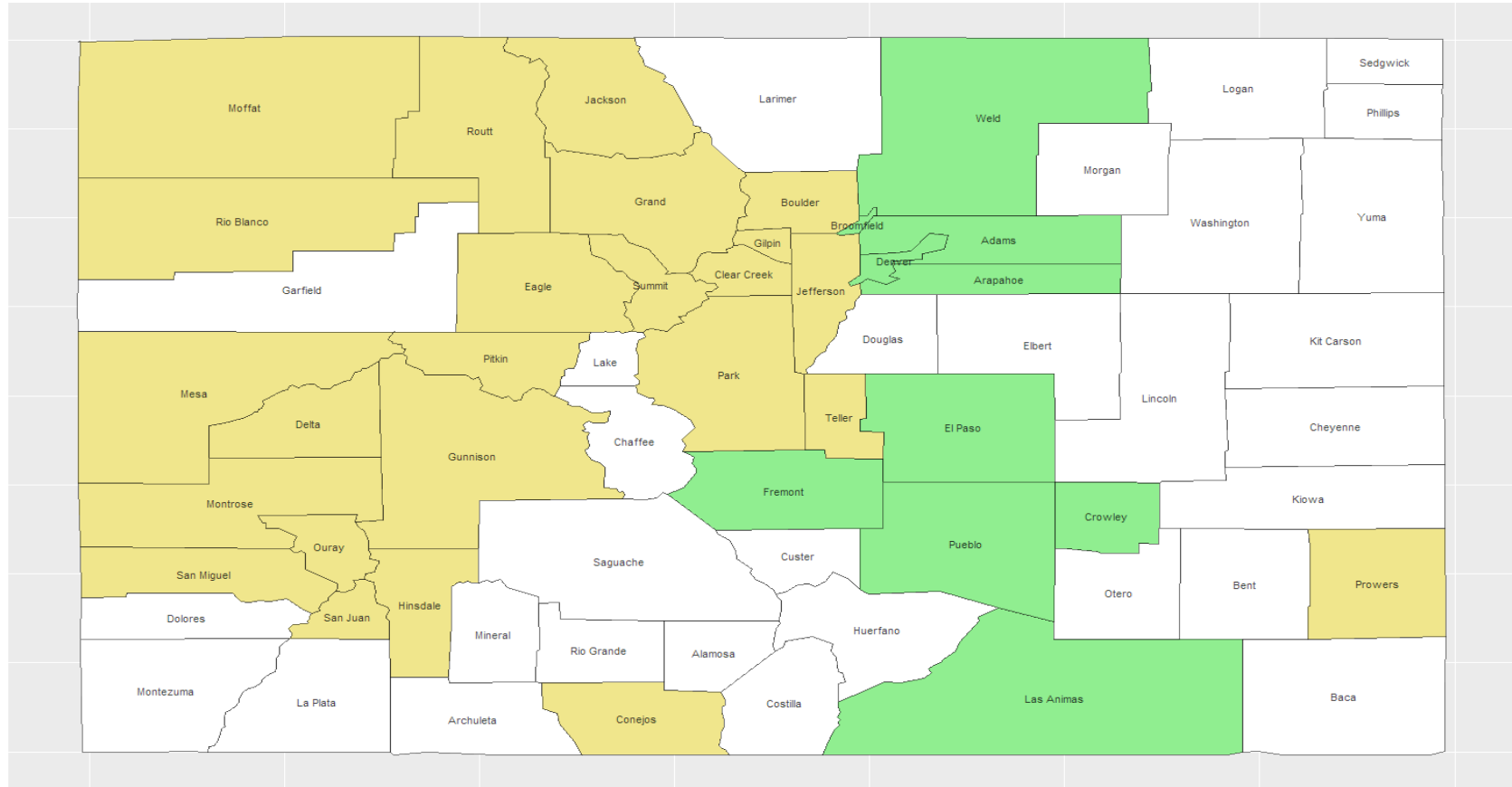
Office of Economic Security

Supplemental Nutrition Assistance Program (SNAP)

Food Insecurity



R-5 Improving Nutrition in Rural and Underserved Communities



Current Supported by the outreach contractors.
New Will be supported by the outreach contractors for FFY19.
None Do not have an outreach contractor yet.





COLORADO
Department of Human Services



Office of Economic Security

Low-Income Energy Assistance Program (LEAP)

Low-Income Energy Assistance in Colorado

	Colorado Department of Human Services (CDHS)	Colorado Energy Office (CEO)	Energy Outreach Colorado (EOC)
Funding Source	<ul style="list-style-type: none"> U.S. Dept. of Health & Human Services 	<ul style="list-style-type: none"> U.S. Dept. of Energy LEAP (Weatherization) 	<ul style="list-style-type: none"> Utility companies, per statute LEAP Independent fundraising
Services	<ul style="list-style-type: none"> Heating assistance for low-income families (LEAP) 	<ul style="list-style-type: none"> Efficient consumption of energy resources, including weatherization (residential & commercial) 	<ul style="list-style-type: none"> Crisis Intervention Program (CIP) Assistance to vulnerable households who are not LEAP-eligible Other energy services





COLORADO
Department of Human Services



Office of Economic Security

Temporary Assistance for Needy Families (TANF)

Colorado Families in Poverty



44,120

individuals on the Colorado Works caseload.

28.8%

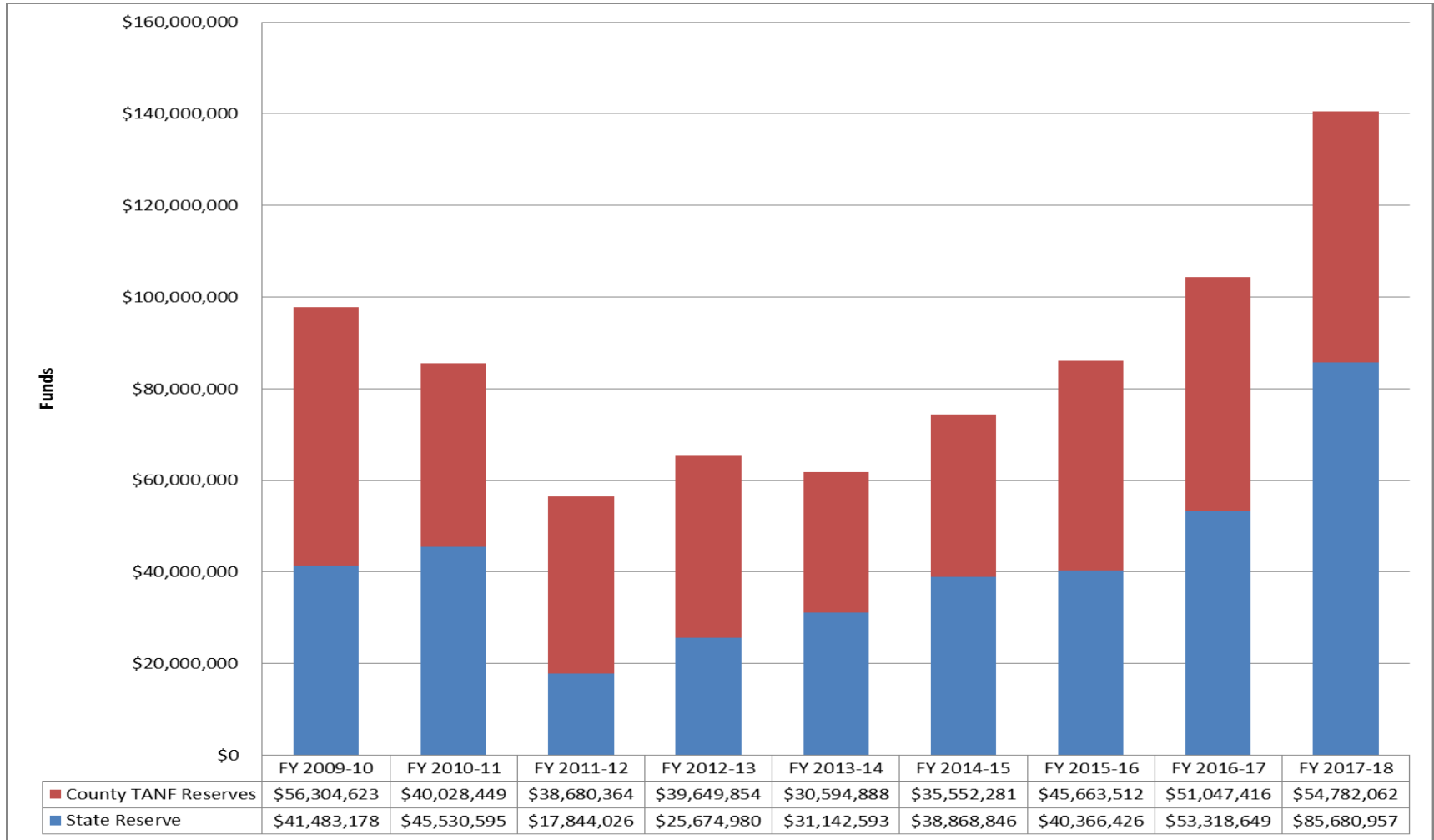
of those individuals are children under the age of six.

70.9%

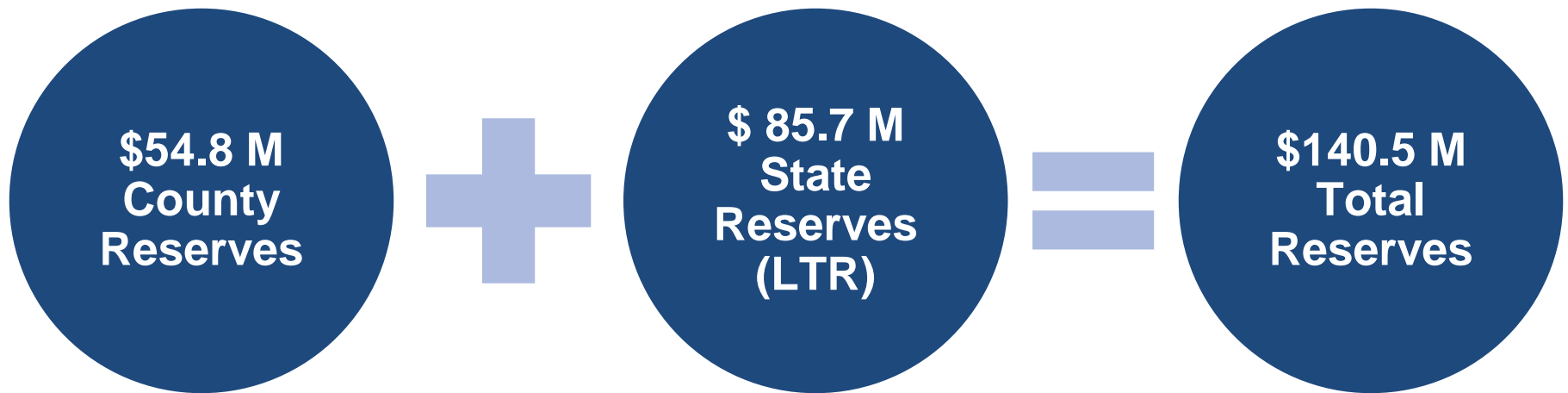
of the Colorado Works caseload is under the age of 18.



State and County TANF Reserves



Temporary Assistance for Needy Families (TANF) Reserves



*FY 2017-18, ending balance

Unmet Needs for TANF

Inadequate Employment Supports/Capabilities

- Only 42% of TANF participants exit to employment
- Of those individuals, 23% of participants who left for employment report not working two months later

Inadequate Financial Assistance

- Until 2018, the monthly basic cash assistance grant had not been adjusted in ten years
- Current level of cash assistance is inadequate to meet basic family needs



Colorado Employment Programs that Work

ReHire Colorado:

- Aims to serve low-income: veterans, workers over 50, and non-custodial parents (NCPs) owing child support
- ReHire provides jobseekers work supports and training through transitional job opportunities

1,350

ReHire participants were placed into subsidized employment

76%

of those individuals transitioned to unsubsidized employment

\$12.00

Median dollar per hour wage at exit from ReHire



Colorado Employment Programs that Work

Subsidized Training & Employment & Program (CW STEP)

- Helps Colorado Works recipients attain a living wage through work-based learning opportunities
- Services include: Internships, transitional jobs, on-the-job training, and apprenticeships

185

STEP participants were placed into subsidized employment

75%

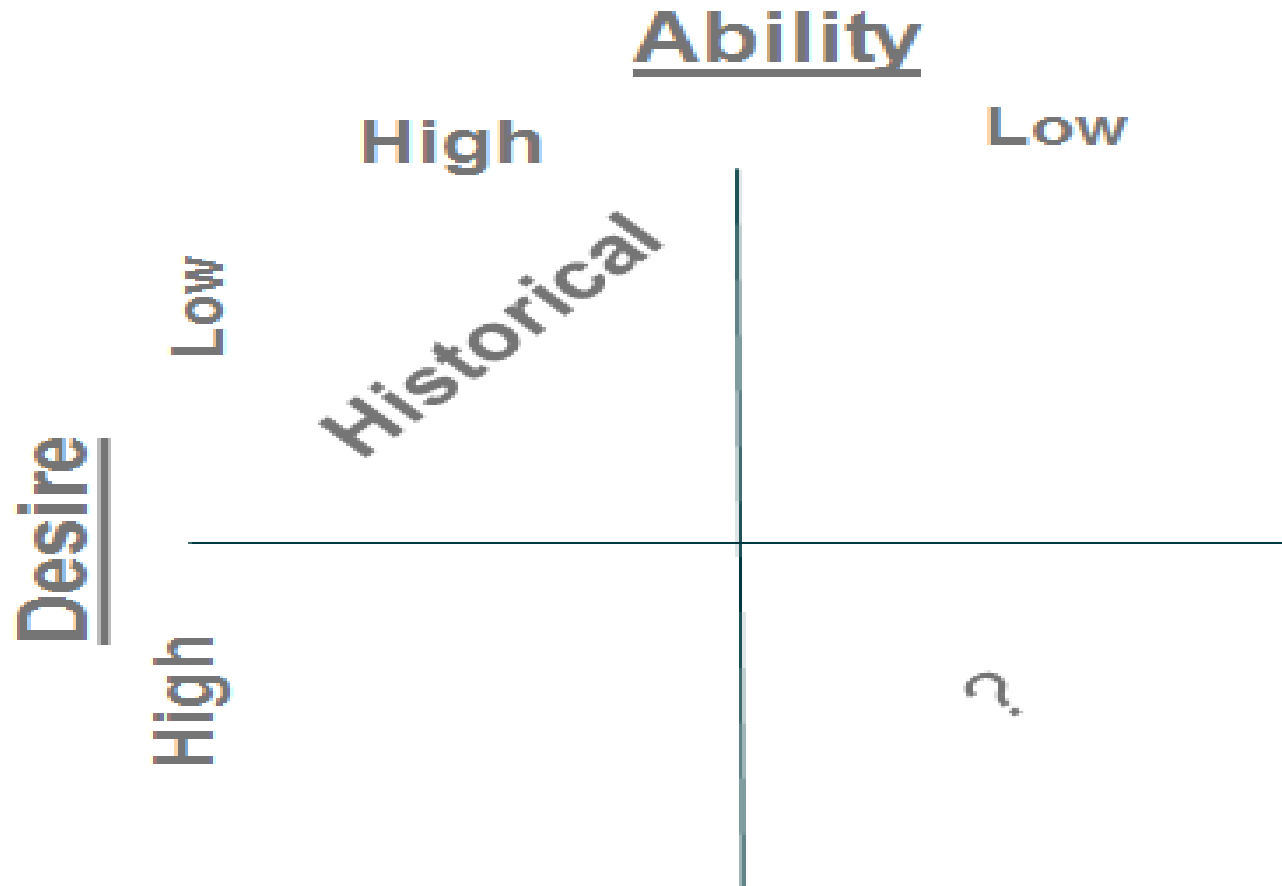
of those individuals transitioned to unsubsidized employment

\$13.42

Median dollar per hour wage at exit from STEP



R-06 Child Support Employment



R-6 Child Support Employment

Supportive Services

Transportation Assistance
Rental Assistance
Driver's License Reinstatement Fees
Work/Interview Clothing
Car Repairs
Work Tools



Classes

Parenting
Relationship Education
Financial Planning
Legal Clinic
Substance Abuse Medication
Motherhood
Fatherhood

Employment Services

Resume Writing
GED Classes
Interview Prep
On-the-Job Training
Job Search Assistance
Soft-Skills Training



R-6 Child Support Employment

Program costs:

- Average cost of \$300 per participant
- 5,200 participants served annually

Expected Benefits:

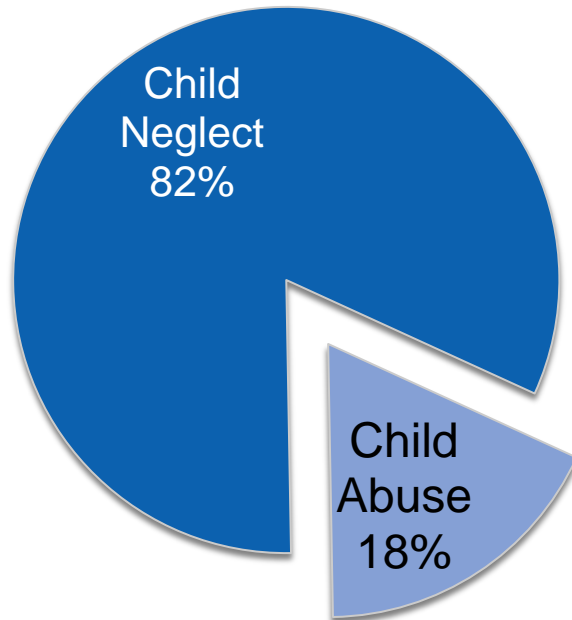
- Average wage of more than \$14/participant
- \$15 M in child support payments, annually



R-4 Reducing Child Neglect Via Employment

13,400 open child welfare cases involve families living below the poverty line

Child Welfare cases



Source: Child Maltreatment, Administration for Children and Families, 2016



R-4 Reducing Child Neglect via Employment

Child Welfare Services	R-4 Services	
	Work-Based Learning	Employment Support Services
Child Protection	Subsidized Employment	Transportation Assistance/Car Repairs
Permanency & Treatment Planning	Transitional Jobs	Work/Interview Clothing
Out-of-Home Placement, including foster care	On-the-Job training	Resume Writing, Interview Prep, and Soft Skills Training
Adoption and subsidized adoption	Apprenticeships and Internships	Job Search Assistance



R-9 Basic Cash Assistance COLA

Qualify:
Earn less
than
\$6,100/year

Receive:
\$508/month

**Cost of
living has
increased:**
BCA↓14.9%

Establish annual COLA of 1.5% to BCA:

- State reserve funds are above \$33.9M
- enacted by the State Board of Human Services



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