

Agenda

Department of Human Services- Mental Health and Alcohol and Drug Abuse Division Department of Health Care Policy and Financing (Mental Health Only) Budget Hearing

December 12, 2007
1:30 – 5:00 pm

1:30 – 1:40

Introductions and General Overview

The Colorado Department of Human Services, Office of Behavioral Health and Housing, includes: Behavioral Health Services (Division of Mental Health and Alcohol and Drug Abuse Division); two Mental Health Institutes at Fort Logan and Pueblo; and the Supportive Housing and Homeless Programs. This Office oversees the full continuum of services provided by the public behavioral health system to citizens of Colorado who are considered indigent and have no means to pay for care. Services include inpatient psychiatric hospitalization, including the state's only forensics hospital; community-based mental health care; prevention, intervention and treatment for substance use disorders; and housing assistance to individuals with special needs (e.g. developmental disabilities and mental illness).

1:40 – 2:15

Mental Health Institutes

Over time the Department has shifted its policies regarding the Institutes from one of long-term residential treatment to short-term stabilization. While the State has done a good job downsizing its institutions (both regional centers and mental health institutes), it has become increasingly aware of a number of smaller populations with co-occurring disorders that require both intensive short-term, acute specialized treatment, as well as long-term intensive residential services. Examples of these populations include individuals with developmental disabilities (including autism) and severe mental illness; traumatic brain injury and mental illness; or individuals with developmental disabilities who are sexual offenders. Given recent experience with these populations, it has become increasingly clear that the Department is ill equipped to appropriately care for these individuals in either the short- or long-term given the Department's current treatment/care facilities and modalities.

- 1. Regarding, shorter lengths of stay, is it really effective to have people stay in institutions for shorter times, or, would longer lengths of stay be more beneficial?**

Response:

The Department analyzed acute adult civil admissions to the Mental Health Institutes during FY 2006-07 comparing patients admitted once versus more than once during that period of time. The Department found no statistically significant difference in the length of stay for those who were admitted once versus those who were admitted more than one time during that fiscal year. The average admission length of stay for individuals admitted once was 35.4 days (N = 758) and 33.1 days for those admitted more once (N = 306); 71.2 % of all admissions were one-time admissions during FY 2006-07. When surveying the literature relating length of stay to likelihood of readmission, it is apparent that multiple variables impact this relationship including age, age of onset of illness, diagnosis, severity of illness and community circumstances to which an individual is discharged. Typically, controlled studies examining the relationship between admission length of stay and readmission rate tend to show no relationship between these two variables over a specified period of time. However, large epidemiological studies tend to find a correlation between length of stay for a given admission and the likelihood of being readmitted.¹

2. Has the department been able to identify how many people have co-occurring disorders and need long-term hospitalization, such as those with co-occurring developmental disabilities and mental illness? Is Ft. Logan a good solution to this problem?

Response:

No, the Department has not yet identified the number of people in the populations mentioned above requiring long-term hospitalization. The Department would like to study this issue over the next year (by January 1, 2009) to determine the extent and types of both long- and short-term services needed and the fiscal impact of creating such. Ft. Logan could be a good solution to part of the problem. The Department is currently examining whether some of the vacant units on the campus could be converted to provide short-term stabilization services to people with co-occurring developmental disabilities and mental illness, including reviewing the proposal received from the Citizens for Fort Logan. However, at this time, the Department does not see Fort Logan as an appropriate long-term solution for this population. Therefore, the Department is also examining what other capacities need to be developed to meet the long-term placement needs of these populations.

3. Is it better to consolidate patients with co-occurring mental health illnesses and developmental delays in one place? Is the department treating these patients? How?

¹ A study from the Illinois State Hospital system published in the American Journal of Psychiatry in 1993 found that there was a significant relationship, when controlling for age, diagnosis etc., between length of stay and the likelihood of being readmitted. A similar study published in Psychiatric Services in 2004 utilizing a large epidemiologic database including patient data from across the United States, focusing on employer-based private health insurance data, demonstrated similar results.

Response:

Treatment of patients with both mental illness and developmental disabilities is occurring at both Mental Health Institutes. These patients are admitted due to serious behavior problems, usually aggression toward others, and come from various settings, including Regional Centers, group homes, family homes and jails. The type of treatment is driven by the presenting primary disorder (i.e. Axis I), as well as the specific behavioral issues that interfere with the ability to function in the community. Pharmacologic therapy is variable, often including antipsychotic medication targeting psychotic symptoms and mood stabilizers to decrease mood instability and impulsivity that fuel aggression. Treatment plans are individualized. In addition to medication, behavior therapy (based on operant conditioning principles) is almost always part of the treatment plan, used to systematically increase pro-social and adaptive behaviors, and to decrease aggressive behavior directed toward self and others. Acute behavioral emergencies may require emergency medication administration and seclusion and/or restraint to ensure patient and staff safety.

Currently, this treatment is conducted on various units throughout the Institutes, in part driven by referral source (e.g., patients referred from jails are treated in the Institute for Forensic Psychiatry). On 12/7/07 there were three dually diagnosed inpatients at Fort Logan (total census 161). At the Colorado Mental Health Institute at Pueblo (CMHIP), there were 16 such patients (total census 404). The CMHIP is developing a special needs unit in the new High Security Forensic institute to treat dually diagnosed patients on one unit, utilizing specifically trained staff and concentrated programming, headed by a psychiatrist and psychologist with special interest in treating patients with serious mental illness and developmental disabilities.

4. How much would a study cost to determine the number of people with co-occurring disorders who need treatment? How long would it take to conduct the study?

Response:

The Department is currently conducting a statewide Population In Need (PIN) Study that will estimate the prevalence of adults and children with co-occurring (mental health and substance abuse disorders) in the developmental disabilities system. For between \$50,000-\$100,000, this study could be expanded to include a co-occurring mental health and developmental disabilities estimate that includes prevalence; the amount and type of services utilized. It will take one year to complete this study and develop appropriate service options for this population.

5. What does the department think of using Ft Logan as a triage center?

Response:

The Department supports consideration of placing a triage center on the campus of Fort Logan. In the past, the Colorado Mental Health Institute at Fort Logan was considered to provide space for a psychiatric observation unit or drop off center to accommodate the needs of mentally ill individuals in the Denver Metropolitan area, prior to the current triage center project. As the State psychiatric

hospital located in the Denver Metropolitan area and the primary inpatient psychiatric hospital utilized by many of the metropolitan community mental health centers, the Fort Logan site offers many advantages. Currently, Fort Logan accepts many referrals for inpatient hospitalization after individuals are taken by law enforcement, emergency medical services (EMS) transportation personnel or family members to metropolitan area hospital emergency rooms. These individuals are then further assessed by the community mental health center crisis teams. A triage center located on the Fort Logan campus would provide community emergency psychiatric crisis care and those individuals receiving crisis care would then return to the community for follow-up mental health services, but those individuals needing acute inpatient psychiatric care would be admitted to Fort Logan for further stabilization. Collaborative efforts focused on defining immediate treatment goals to be accomplished through psychiatric inpatient care and the further identification of the individual's mental health needs upon return to the community utilizes the current relationship Fort Logan has with many community mental health centers and improves continuity of care within the mental health system for the State of Colorado.

2:10 – 2:35

Compression Pay

The Mental Health Institutes are the largest state employer of nurses. Although the nursing shortage is a state and nationwide problem, it particularly affects the Institutes because nurses perform the core business functions of the organization as opposed to providing an ancillary role in service delivery. The Department's decision item will improve the Mental Health Institutes' ability to retain qualified nurses and will thus ensure quality of care and patient and staff safety, and will avoid the potential for Medicare and Medicaid revenue losses which could result from not complying with regulatory staffing and treatment standards.

6. How have the retention issues impacted other areas of the Institutes' budget, such as worker's comp claims, patient injuries, etc.?

Response:

Registered nurses (RNs) direct the delivery of day-to-day care on the inpatient units at the Institutes. The daily provision of treatment and the maintenance of a calm and therapeutic milieu begin with the guidance of experienced RNs who are familiar with the patients, their treatment plans, and the unit procedures and routines. The absence of RNs due to the Institutes' inability to offer sufficiently attractive compensation (salary and benefits) necessitates the daily pulling of RNs from one unit to another, as well as the use of RNs and other nursing staff with lesser certification (such as Mental Health Clinicians) from a pool of temporary or contract nursing staff. This lack of continuity in RN staffing disrupts treatment and the work environment. Unit environments with irregular staffing experience decreased program activity (e.g., group therapy, therapeutic recreation, etc.), and patients who are less involved in programming (with presumably greater idle time) are much more likely to aggravate psychotic symptoms and act out aggressively towards peers and

staff. Such aggressive behavior results in assaults on staff and other patients, medical costs for the injuries sustained, increased use of seclusion and restraint, a further decrease in treatment interactions (as staff focus upon safety and security), and ultimately, as further incentive for RNs and other staff to seek employment elsewhere. The Department incurs training costs for every RN that leaves. In the Mental Health Institutes, the vast majority of direct-care staff injuries resulting in lost work time and medical expenses are caused by patient violence.

Below are figures demonstrating the frequency of assaults upon staff and patients, which the Department seeks to mitigate through this request.

	FY 2004-05	FY 2005-06	FY 2006-07
# MHI Pt to Pt Assaults	203	238	271
# MHI Patient Days	192,077	191,756	191,669
# MHI Pt to Pt Assaults / 1000 Pt Days	1.06	1.24	1.41
# MHI Pt to Staff Assaults	275	195	252
# MHI Patient Days	192,077	191,756	191,669
# MHI Pt to Staff Assaults / 1000 Pt Days	1.43	1.02	1.31

Patient assaults upon staff account for the following share of worker compensation claim costs at the Institutes:

FY 2005-06, 51 claims for \$884,650 (or 26% of all claims and 26% of total costs);
 FY 2006-07, 53 claims for \$1,323,214 (or 26% of all claims and 43% of total costs); and
 FY 2007-08 (1st quarter), 20 claims for \$144,128 (or 36% of all claims and 31% of total costs).

These workers compensation costs affect the entire Department because they are the basis for the amount charged to the Executive Director Office budget for worker compensation insurance premiums. The Office of State and Veterans Nursing Homes is currently working to minimize workers' compensation claims and OBHH will adopt their 'lessons learned' to the Institutes as applicable.

7. Other than the factors which are inherent to the Institutes (types of patients, etc.), are there other issues which could be affecting nurse recruitment and retention? Is the Department pursuing any other efforts to improve the recruitment and retention of nurses at the Mental Health Institutes?

Response:

The type of patients admitted to the Mental Health Institutes (individuals who typically have failed intensive outpatient interventions or referrals from the criminal justice system) and the stigma and

clinical challenges associated with treating them (as well as working in a State Hospital) directly influence nurse recruitment and retention. The fact that virtually no patient comes to the Institutes on a voluntary basis presents considerable challenges to the therapeutic relationship and influences a given nurse's decision to choose to work in this environment. In addition to these features, a national nursing shortage further impacts the difficulties the Institutes face in recruiting and retaining nurses. Private sector facilities have significant latitude in recruitment packages offered, including schedule options, salary, tuition reimbursement, and continuing education opportunities, which systematically disadvantage the Institutes.

As a result, the Institutes have worked with nurse recruiters to augment Human Resources functions. These individuals have been involved in recruitment efforts outside the Institute such as visiting job fairs and training facilities, marketing Institute career opportunities, and directly interviewing and hiring nursing staff across a range of disciplines. The Mental Health Institutes have also engaged in other efforts to retain and recruit nursing staff such as tuition reimbursement programs (20/20 program), outreach efforts to nursing schools and job fairs, incentive payments to employees who recruit new employees, investigation of career ladder options, employee award and recognition programs, and electronic suggestion boxes. These efforts have resulted in a substantial increase in the rate of registered nurse hires.

Institute administration believes that day- to-day working environment safety directly influences recruitment and retention. Towards this end, the Institutes have launched a comprehensive plan to eliminate vacancies, balance work schedules across nursing disciplines, and thereby improve treatment team fidelity. These efforts will very likely pay direct dividends in terms of increased treatment time for patients, improved therapeutic alliance, and thereby diminished acute behavioral emergencies and the need for seclusion and restraint (the leading cause for staff injuries). To augment these schedule changes across nursing disciplines, increased training on verbal de-escalation techniques, physical management, and therapeutic alliance enhancement (recovery model), as well as other continuing education opportunities for nursing staff, are ongoing. Lastly, it is anticipated that the completion of the state of the art High Security Forensic Institute in Pueblo will allow an appropriate treatment environment that will improve treatment and patient outcomes, but also improve staff safety for registered nurses and other nursing staff in dealing with challenging psychiatric patients.

8. Does the Department believe that if approved, this decision item will sufficiently address the matter, or could this potentially become a recurring issue? Why has the Department targeted Nurse I's and not other nursing classifications or staff at the Institutes?

Response:

The nursing compression pay decision item, if approved, will correct the current imbalance and inequity between the salaries required to hire nurses with the salaries of Institute nurses with several

years of experience. Assuming the demand for qualified nurses continues to exceed the supply, the Institutes will continue to be forced to pay starting salaries towards to top of the nursing salary ranges. If annual salary increases provided to existing Institute (and other State employed) nurses do not allow the State to reach the average salary paid in the overall Colorado labor force, the compression problem will exist. Currently, the FY 2007-08 average salary for a Nurse I equivalent nurse in the private sector is 8.5 percent greater than the average Nurse I salary for a State nurse.

9. Are you aware of whether this issue is affecting other Divisions and if there are any successful models that the Institutes can apply?

Response:

While other divisions and departments across the State employ nurses, the vast majority are employed by the Institutes. The Department is experiencing nurse compression pay issues at other agencies, particularly those on the Western Slope, where the oil and gas drilling boom is drawing from an already limited nursing pool. The Department's compression pay request represents the most typical model to address salary compression issues.

10. What do you believe will be the impact on community mental health centers if COLA is provided at the requested level given the fact that community mental health nursing staff are paid less than their counterparts at the state?

Response:

The community mental health centers (CMHCs) have the latitude to distribute the cost of living increase where it is needed in the organization. If the CMHCs need to fund nurses at higher salaries they can prioritize this funding accordingly, however they must balance this decision against other competing priorities they have across the organization. Although CMHC nurses are paid somewhat less than their counterparts in the Institutes, they also are asked to do substantially different work than is performed by nurses in the MHIs. The patients in the MHIs are, on average, substantially more ill and more aggressive, and require much more intensive intervention (e.g., seclusion and restraint, involuntary medication administration) during their stays in the hospital than patients seen in CMHC settings. When patients become too ill or potentially aggressive, they are no longer deemed appropriate to be treated in an outpatient (i.e. CMHC) setting. Similar to other State departments and divisions, RNs do not perform the core business functions for the CMHCs. As a result, the CMHCs hire far fewer nurses than the Institutes; the CMHCs have on average less than one RN per center, whereas the Institutes have over 230 RNs. The Mental Health Institutes are also subject to a 1.35:1 staff to patient ratio on the forensic unit, and subject to adequate staffing ratios through Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements, which makes nurse retention all the more critical

11. How does this fit in with the overall state salary survey? Why isn't the salary survey enough to compensate nurses? Why do the state's nurses require a higher level of pay than the salary survey can provide?

Response:

The State's salary survey process does not address salary compression issues or ensure that average salaries paid to various State occupational classes equal average salaries paid to the same occupational classes in the overall Colorado labor market. The Department of Personnel and Administration's annual compensation survey and corresponding salary survey recommendations to the General Assembly are designed to adjust the midpoint of State classification ranges to equal the midpoint of the same occupational class salaries in the Colorado labor market. This annual percentage change to maintain comparability in the midpoint is the annual salary survey (now part of achievement pay) adjustment.

Applying the annual salary survey adjustment to each State classified position (including nursing) will not bring the average pay for State positions (and hence the average for each classification) equal to the Colorado labor market average, if the average State salary is below the Colorado labor market average. The table below demonstrates this difference. While the FY 2007-08 salary midpoint for the Nurse I classification is essentially equal (0.7 percent lower) to the Colorado market midpoint, the average Nurse I salary is 8.5 percent lower.

FY 07-08	State	Market	Difference
Nurse I Midpoint	\$4,878	\$4,912	0.7 %
Nurse I Average Salary	\$4,689	\$5,088	8.5 %

This difference in average salaries between State nursing positions and the Colorado market is partially due to the years when the State experienced significant budget shortfalls and could not provide salary survey adjustments commensurate with the private sector. The table shows the last five years of recommended salary survey increases and approved salary survey increases for the Health Care Services job classifications.

Salary Survey	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
Market Salary	6.1 %	6.7 %	5.1 %	3.9 %	3.7 %
Approved Funding	6.1 %	0.0 %	2.0 %	3.0 %	3.7 %

*Source: Department of Personnel and Administration, "Colorado State Personnel System Compensation Time Line."

The salary survey process does not ensure average state salaries will equal the average salaries in the labor market. The Institutes are often forced to hire nurses at salaries comparable to those offered by the private sector. The salary of these newly hired nurses are often close to the salaries of Institute nurses with several years of Institute experience, creating a salary compression problem. These salary inequities have been compounded by limited salary survey increases funded over the last several years. Lower average salaries, compression inequities, the risk of injury and the

systemic shortage of nurses in Colorado and across the nation combine to often make the Institutes the nursing employer “of last resort.” As a result, the Institutes constantly struggle to maintain adequate staff-to-patient ratios; provide adequate quality of care; ensure patient safety; retain an experienced and well-trained staff; and meet regulatory standards.

2:35 – 2:45

Community Mental Health Services: Indigent Care

The Department is requesting \$3.0 million to serve an additional 966 indigent citizens with severe mental illness. Untreated mental health disorders result in higher costs for a multitude of other systems, including Child Welfare, hospitals, and the criminal justice system. Based on information derived from the Department of Human Services’ 2002 Population-in-Need Study for the Joint Budget Committee, it is estimated that around 17,000 low-income people with mental illness in Colorado would seek services but do not have access to them. At an annual cost of \$3,063 a person, serving people with mental illness in the community is more cost effective than serving them in the corrections systems where the annual cost of a mental health bed is \$65,841 in Department of Corrections (DOC) and \$52,732 in Division of Youth Corrections (DYC). The DOC has experienced a 583 percent increase in the number of mentally ill offenders over the last 13 years. Currently, about 18 percent of DOC’s total jurisdictional inmate population is classified as mentally ill.

12. Is Colorado just the most "mentally healthy" state? Could this be why the usage rate of mental health services in Colorado is lower than in other states?

Response:

Colorado is not considered the “most ‘mentally healthy’ state” in the Country. Coloradoans, like many other western States citizens, experience higher than average mental health problems. Mental Health America recently published a study (November 2007) comparing states according to rates of depression and suicide. Data was collected from nine (9) national databases: United States Census, National Vital Statistics System, National Survey on Drug Use and Health, Survey of Mental Health Organizations, Behavioral Risk Factor Surveillance System, IMS Health National Prescription Drug Audit, and National Association of State Mental Health Program Directors (NASMHPD-NRI). Colorado was ranked nationally as the 16th highest in rates of depression and the 8th highest in rates of suicide.

Colorado’s community mental health services utilization rate of 13.72 persons per 1,000 persons in the general population, as reported to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2006, represents a substantially lower rate of community mental health services utilization when compared to the national average of 18.58 per 1,000. Based on the Department’s 2008 Population In Need Study, the first phase of which was completed in November 2007, 62 persons out of 1,000, living at or below 300% poverty, have a serious emotional disorder

(SED) or serious mental illness (SMI). These data suggest that there is a large gap between those Coloradoans with a serious emotional disorder or serious mental illness and those who are accessing community mental health services. Several factors may contribute to this incidence: funding, capacity, accessibility, and stigma. Further examination of service utilization and disparities in care will be completed during the second and third phases of the 2008 PIN study.

13. If the Department does receive the funding for indigent care, how will the department target mental health for co-occurring disorders? How is department planning to allocate the additional funding both geographically and by need?

Response:

Until the 2008 Population in Need Study is finalized, the Department would not make changes to its current allocation formula (since it does not have the data), which presently does not target indigent funding for co-occurring disorders. The Department has based its allocations to providers on a historical model that dispersed funds geographically and by need, and adjusted over time in response to state audits, reductions or increases in funding, and developed in collaboration with the provider community. Within an individual provider's contract, the Department allocates funding by first establishing the number of persons (adults with Serious Mental Illness and youth with Serious Emotional Disorders) to be served, using the average cost per person estimate. Then, this number of persons to be served is allocated across age, severity and minority categories by applying prevalence numbers based on those found in the 2008 Population in Need Study. The Department also uses the contracting process develop and support evidenced-based treatment practices.

The first phase of the 2008 Population in Need Study was completed in November 2007. The preliminary analysis of the prevalence estimates for the state indicate that prevalence estimates generally followed population density in the state and the numbers of people with serious disorders are greatest where expected, i.e., along the front range and particularly in the Denver metropolitan area. The overall number of persons who live below the 300% poverty level in Colorado decreased by 8% over the last 5 years, from 2,080,723 persons in 2002 to 1,911,299 persons in 2007, a difference of 169,424 individuals. Fourteen out of the 17 (82%) of the mental health service areas reflect this decrease. Only Adams, Arapahoe/Douglas, and North Range show increases in the number of individuals living below 300% of the federal poverty level.

2:45 – 3:10

Update on the High Security Forensics Institute in Pueblo

14. Please provide some additional information about the uses of the new forensics facility in Pueblo. What will a facility of that size be used for, in addition to the 200 beds?

Response:

The Institute for Forensic Psychiatry operated by the Colorado Mental Health Institute at Pueblo is the State's only forensic hospital and serves as the primary treatment facility for adults with coexisting severe mental illness and criminal involvement. The entire bed capacity for the Institute for Forensic Psychiatry, once the new 200-bed High Security Forensics Institute (HSFI) is complete, will be 324 beds, or an additional 32 beds. In December 2006, the Department was funded for 20 of the additional 32 beds through an emergency supplemental to help avert a lawsuit associated with the demand for competency evaluations and restorations. The Department's current decision item requests operating funding and FTE for the remaining 12 beds and the treatment mall in the new facility.

The new 200-bed, High Security Forensic Institute combines the state's current maximum and medium security forensic programs into a single facility. In addition to traditional medium and maximum-security units, the HSFI will include:

- 24 beds dedicated to male DOC mentally ill inmates;
- 24 beds for inpatient competency evaluations and restorations;
- 8 beds for female mentally ill inmates from the DOC;
- 16 beds for high risk/violent individuals with co occurring mental illness and developmental disabilities;
- 16 beds for physically debilitated forensic patients (such as those that do not need medical hospitalization, but do require portable oxygen, walkers, specialized nursing care, and other resources not appropriate on, or safe for, regular forensic psychiatric units); and
- a courtroom to expedite medication and other necessary hearings.

The number of patients admitted and served in the high security units is managed due to requirements from the Neiberger lawsuit to prevent over crowding and to achieve the required staff to patient ratios. The new facility will have a centralized treatment area or 'treatment mall', which is expected to greatly improve the therapeutic programming for medium- and maximum-security patients. Therefore, the HSFI must have sufficient staff to not merely provide custodial care, but to administer prompt, active and effective treatment. This treatment emphasizes education, rehabilitation and risk reduction. In the treatment mall, patients will learn key tools to manage their illness, understand and adhere to medication regimes, identify signs and symptoms of relapse, as well as acquire the skills to manage social and environmental pressures. This clinical therapeutic

programming will be based on the best practices, utilizing interventions that are empirically supported by research.

15. What has the CMHI-Pueblo done about patients just walking away? Is this still a problem?

Response:

The Colorado Mental Health Institute at Pueblo (CMHIP) is the State's only facility for the treatment of forensic psychiatric patients. Although it is, by definition, a detention center, it is first a hospital. CMHIP's administration and staff continually balance the treatment needs of patients with community safety, with a goal of eventual community reintegration of individuals placed there by the courts. Community reintegration cannot occur without progressive access to the community, thus patient escapes are an ever-present possibility, one that staff are well aware of and rigorously guard against. CMHIP strives for a zero escape rate, however, this can never be a reality given the hospital's mission. To put this issue in some perspective, 2007 data from the Western State Psychiatric Hospital Association indicate that the average escape rate for participating hospitals (rate per 1000 patient days) was 0.2, the rate for CMHIP was 0.13. There is currently only one patient on escape status since 2000 from CMHIP. The number of patient escapes from CMHIP for the last five fiscal years are as follows:

FY 2003-04: 12

FY 2004-05: 9

FY 2005-06: 6

FY 2006-07: 9

16. Once the new Forensics Institute is built, what happens to the 20-bed facility? Can it be used for anything else, less intensive?

Response:

When the High Security Forensic Institute at CMHIP is completed, it will provide the Institute for Forensic Psychiatry with a net increase in medium/maximum-security beds compared to the current configuration; the number of intermediate and minimum-security beds will remain unchanged. The 20 bed medium security unit (HS12) that was reopened via an emergency supplemental provided to CMHIP in early 2007, along with the remainder of medium security, as well as all of maximum-security, will be closed to patient care activities; these buildings may be used for staff offices or storage space. This is due to the fact that this clinical space is physically old and deteriorated, as well as sub-optimally configured, rendering it dangerous to patients and staff. Larger spaces, such as dining room facilities, may be used for occupational therapy activities with patients. The Department is currently examining the optimal use for these buildings, including usage by other areas of the department or other state departments.

3:10 – 3:15

General Questions

17. The Governor’s budget has funding in the Recidivism Package for community-based mental health and substance abuse services. Will the RFP developed by the Department of Corrections and the Department of Public Safety to contract for the community-based services include participation from the Department of Human Services, Division of Mental Health and ADAD, to ensure the current infrastructure of community mental health centers and substance abuse treatment providers are involved in providing these services? What efforts are underway to ensure continuity of care and prevent further fragmentation of the mental health and substance abuse systems?

Response:

In order to address this question, the Department contacted the Department of Corrections and the Department of Public Safety (DPS). The three departments, DOC, DPS and DHS, are committed to working in partnership and enhancing the behavioral health (mental health and substance abuse) services available to offenders who are being diverted from or transitioning out of prison.

The Governor’s FY 2008-09 Crime Prevention and Recidivism Reduction Package (a.k.a., the Recidivism Package) provides \$1,800,000 General Fund for the DOC for transitional services to 200 parolees who have severe substance abuse problems and other co-occurring disorders. According to the DOC approximately 32 percent of parolees have a drug offense as their most serious offense and this percentage is increasing annually. The Governor’s proposal provides roughly \$9,000 General Fund for transitional services per person for 200 parolees for a year-long program which could include a variety of services such as substance abuse treatment, housing, vocational, and mental health.

The Governor is interested in having community-based programs compete for funding on a performance basis in order to ensure the most efficient use of taxpayer dollars. Based on the experience of Boulder’s successful PACE model, having local communities interest and support to help fund services was deemed critical to program success. The Governor’s proposal makes dollars available for communities to bid through a Request-for-Proposal (RFP) process. This is a different funding structure than has been traditionally utilized. The Division of Youth Corrections is also integrally involved in the Governor’s recidivism efforts.

The RFP will be jointly reviewed with DHS and approved by the DOC and the DPS. The funds will be authorized through the DOC, which is the lead agency for this initiative, consistent with its performance measures to lower recidivism rates in Colorado. Local community mental health centers and substance abuse providers may bid on the RFP in as much as they can provide the breadth of services that the RFP requires.

The Department has other initiatives underway to ensure continuity of care and to enhance mental health and substance abuse system integration. The Department has been directly involved with House Joint Resolution 1050, the Behavioral Health Task Force, which is critically examining Colorado's Behavioral Health Care system including funding streams, fragmentation of service delivery, and organizational structures of other states involved in behavioral health transformation. This Task Force will be submitting recommendations to the legislature at the end of January 2008. Likewise, the Department has been working closely with the Governor's Cabinet regarding behavioral health care system integration and inter-departmental collaboration to enhance service delivery to our citizens.

The Alcohol and Drug Abuse Division, the Division of Mental Health and the Division of Youth Corrections continue to work very closely and maintain strong working relationships with community providers, service organizations, family members, and consumers to enhance continuity of care and system integration.

3:15 – 3:30

Alcohol and Drug Abuse Division

18. There are effective medications for the treatment of alcoholism and drug addiction. To what extent do your publicly funded substance abuse treatment providers currently use medications in treatment? What is the estimated need for substance abuse treatment medications for the medically indigent and what are the resources ADAD would require to meet that need?

Response:

ADAD does not have a systemic way to collect statewide data regarding medications used by the publicly funded substance abuse treatment providers. Anecdotally, the two major medications used are Antabuse and Methadone. Antabuse is an inexpensive medication used by alcohol-dependent clients in concert with counseling. Clients pay the full cost of Antabuse in the course of their treatment. Another medication demonstrated in clinical trials to be highly effective in assisting clients with alcohol dependence to achieve and maintain sobriety is Naltrexone, which is available in daily oral and once monthly injectable forms (Vivitrol). The oral version of Naltrexone averages \$1,000 per course of treatment (six months), or \$4,000 every 6-months for the injectable version.

Methadone is an effective medication for the treatment of opiate addiction. There are 11 licensed opioid replacement treatment sites in Colorado that dispense methadone to 1,953 clients. ADAD funds partially cover the costs of methadone. Suboxone is a highly effective medication for the treatment of opiate addiction and is used by some Colorado opioid replacement treatment providers, but on a very limited basis because of the lack of public funding. Suboxone and the associated physician and nursing time costs average \$5,500 per client per year. For every 100 clients who needed Suboxone, \$550,000 would be needed by ADAD to provide such medication. Signal Behavioral Health Network, ADAD's largest Managed Service Organization, has been working with Alkermes (the pharmaceutical company for Vivitrol). Signal is close to securing free Vivitrol for 120 clients to conduct a quality improvement study with three treatment providers in their network. This limited supply of Vivitrol could readily be expanded and if 200 ADAD funded clients were to receive Vivitrol, it would cost an estimated \$800,000.

There is a significant need for substance abuse medications for the medically indigent that can be used to help with different aspects of the treatment process such as suppressing withdrawal symptoms during detoxification, re-establishing normal brain function, preventing relapse and diminishing cravings throughout the treatment process. Currently, there are medications for opioid (heroin, morphine) and tobacco (nicotine) addiction, and other effective medications are

being developed for treating stimulant (cocaine, methamphetamine) and cannabis (marijuana) addiction.

ADAD's reimbursement rates to providers are inadequate to provide necessary medications. Seventy-six percent (76%) of clients, who receive substance abuse treatment from ADAD publicly funded providers, are uninsured and unlikely to be able to afford such medications. Additionally, the majority of providers do not have physicians or other licensed prescribers onsite and would rely on coordination with other health care professionals for access to medications and related care.

19. A recent national survey states that 334,000 Coloradoans need treatment for alcoholism and 119,000 need treatment for illicit drug use but do not receive it. What would it require to narrow the gap to increase the number of Coloradoans who receive treatment? Does ADAD have a long-term strategic plan to address this gap in access to services? If so, please provide the Committee with a copy and if not, what is the timeline for developing such a plan?

Response:

The most recent National Survey of Drug Use and Health (figures above) validates a high need for substance abuse treatment in Colorado. The prevalence estimates from Colorado's 2008 Population In Need (PIN) Study found that 4.4% of adults living below 300% of poverty (58,565 individuals) have substance use disorders. This prevalence figure does not include an estimate of persons currently receiving services and therefore the current estimate of the treatment gap (unmet need) is not yet known. The 2008 PIN Study will be finalized in January 2009. Phases two and three of the 2008 PIN Study will utilize the best data available to determine the population who currently receives services and the treatment gap or unmet need.

ADAD does not have a long-term strategic plan that specifically addresses narrowing the treatment gap. ADAD and the Division of Mental Health are working towards an integrated strategic plan for Behavioral Health Services that will be completed by September 2008. The Behavioral Health Service strategic plan will be informed by the final 2008 Population in Need Study, recommendations of the HJR07-1050 Behavioral Health Task Force (due at the end of January 2008), the Governor's policy decisions regarding behavioral health services, and stakeholder input.

Acknowledging the significant need for additional funding to narrow the treatment gap, ADAD has pursued federal grants to supplement the resources currently available to pay for substance abuse prevention, intervention, and treatment services. ADAD was successful in obtaining three significant system change grants that should have a positive impact on reducing the future and the current treatment gap. Those grants include: 1) a five-year Strategic Prevention Framework-State Incentive Grant (total funds \$11.75 million) to prevent and to reduce substance abuse-

related problems in Colorado communities; 2) a five-year Screening, Brief Intervention and Referral to Treatment (SBIRT) Grant (total funds \$14 million) to provide universal screening for substance abuse in select primary healthcare settings; and 3) a three-year Access to Recovery Grant (total funds \$13.9 million) to provide treatment and recovery support services through a client voucher system that provides choice of providers and services to adolescents and young adults, including those abusing or addicted to methamphetamine.

20. About 50% of clients who are in substance abuse treatment also are affected by a mental health disorder. What is being done to provide treatment for both disorders concurrently? Do substance abuse providers get funds to treat clients with co-occurring disorders? What is your estimate of the resources that would be needed in order to improve the treatment of clients with co-occurring disorders in the MSO system?

Response:

Based on ADAD's FY 2005-06 data, 39% (approximately 8,577 clients) of the 21,814 clients discharged from treatment have co-occurring disorders. Thirteen of the 40 funded substance abuse treatment providers also deliver limited mental health services.

ADAD works with the provider community to encourage integrated treatment and utilization of the evidence-based practices effective with this population. Additionally, ADAD provides technical assistance and training to providers regarding the new substance abuse Medicaid benefit and how it can be braided with other funding streams to provide concurrent treatment.

In general, integrated treatment for both disorders is not widely available. With a few exceptions, substance abuse providers do not receive funding specifically for treatment of the co-occurring population. ADAD funds may be used to treat co-occurring disorders, but most reimbursement rates are inadequate to provide needed psychiatric services and necessary medications in addition to substance abuse treatment. Because funding is also lacking for non-Medicaid mental health indigent care, substance abuse providers are not able to coordinate care with mental health centers even when providers are willing to deliver integrated services.

The 2008 Population in Need Study, when finalized in January 2009, will provide an estimate of the number of persons with co-occurring disorders (SMI/SED and substance use disorders) living at or below 300% of poverty who are in need of treatment. The Department would be better able to estimate the resources needed to improve the treatment of clients with co-occurring disorders once the treatment gap (unmet need) is determined.

21. What services are currently offered to women to decrease incarceration and recidivism rates? How does the Administration's recidivism prevention package seek to address this issue?

Response:

Incarceration rates for women increased between 1995 and 2005 by 197.3% in Colorado compared to the United States' rate of 57.0%². Research now indicates that many female offenders have physical, emotional and social needs that are different from men and thus may require different services. Treatment programs that provide aftercare, and recognize and address issues unique to females can help to decrease incarceration and to reduce recidivism rates.

Women respond to services that emphasize repairing their abusive relationships with men and teaching them how to build positive ones, showing them how to deal with family relationships and child care responsibilities, and helping them sort out their histories of sexual and/or physical abuse and other personal issues, including substance abuse and mental-health problems such as posttraumatic stress disorder (PTSD) and depression.

For FY 2007-08, the Governor's Recidivism Package provided funding for Arapahoe House's New Directions Program to treat an additional 30 women with co-occurring disorders and their children. The women receive a variety of services aimed at decreasing recidivism including substance abuse and mental health treatment, vocational and life skills, and services to increase parenting and familial relationships. These services are provided across a number of female populations including women involved with the child welfare and Temporary Assistance to Needy Families programs, who are also involved in the criminal justice system. Additional capacity to serve women in Short-Term Intensive Residential Remediation Treatment (STIRRT) was also developed in Mesa County (5 residential beds followed by intensive outpatient and traditional outpatient services), and in Pueblo at Crossroads Turning Points (10 residential beds followed by intensive outpatient and traditional outpatient). All programs offer gender-specific treatment for women.

Of the 44 women admitted in 2007 to the Circle Program at the Mental Health Institute in Pueblo, 32 were admitted as a condition of probation or as a court-ordered placement. The Circle Program offers integrated co-occurring treatment to women and has been successful in decreasing incarceration and recidivism rates.

Additionally, the Governor's FY 2008-09 Crime Prevention and Recidivism Reduction package included \$777,920 for 160 additional outpatient therapeutic community (OTC) slots, some of which will be located at the Haven in Denver. The Haven is a substance abuse treatment and life skills program for women offenders transitioning out of the criminal justice system. The Haven provides intensive residential treatment for 89 women and up to 36 infants. Between FY 1999-

² Harrison, P.M. & Beck, A. (Nov., 2006). U.S. Department of Justice, Office of Justice, Office of Justice Programs: Prisoners in 2005, Table 6.

00 and FY 2003-04, the Haven had a recidivism rate of approximately 5.0 percent over 12 months, which is the lowest in Colorado.

Health Care Policy and Financing

3:30 – 3:45

HCPF Briefing – Mental Health Questions

1. **The current contracts with the Behavior Health Organizations (BHOs) will expire at the end of FY 2008-09. In the re-bid of the BHO contracts, does the Department anticipate adding anti-psychotic prescription drugs as a required service for the new contracts? What would be the advantageous of doing so? What would be the disadvantageous? If moved into the capitation program, how would the Department ensure the savings from the drug rebate program are not loss?**
(See HCPF Hearing Response)
2. **Please comment on staff's recommendation to either: (1) move the actual expenditure authority for anti-psychotic prescription drugs from the Medical Services Premiums line item to the Mental Health Division; or (2) eliminate the "informational-only" appropriation for anti-psychotic drugs in the MH Division with the requirement that the Department continue to report on these expenditures. Which would the Department prefer and why?**
(See HCPF Hearing Response)
3. **Because early caseload reports do not indicate the decline in caseload that the Department's request indicates, does the Department anticipate that both the FY 2007-08 and FY 2008-09 estimates will be revised upward in February 2008? If not, why not?**
(See HCPF Hearing Response)
4. **What is the implementation status of S.B. 07-002? Will the Department be able to track this caseload separately from the rest of the foster children caseload? Does the Department have any expenditure data for this population yet? Does the Department believe that the capitation rate for foster children under 18 should be the same rate applied to young adults over 18? Will the service needs and delivery be the same for this population?**
(See HCPF Hearing Response)
5. **Does the Department believe forecast accuracy for the MH capitation program would improve if caseload was forecasted for each BHO multiplied by the contract rate in place for that BHO for the current FY and estimated contract rate for the next budget year?**

(See HCPF Hearing Response)

- 6. What error rate does the Department believe is an appropriate performance measure when forecasting the original Mental Health Capitation program?**

(See HCPF Hearing Response)

- 7. Does the Department have any concerns about the level of service the BHOs are providing to Medicaid clients under the current capitation rates? Does the Department have any concerns on whether falling caseloads have put any BHO's at risk of financial loss during FY 2007-08 or FY 2008-09?**

(See HCPF Hearing Response)

3:45 – 4:10

Medicaid Mental Health Capitation

8. **How might changes to the mental health capitation program affect the state's network of mental health services for the indigent? How will such questions be addressed as the RFP for the re-bid of the capitation program is developed?**
(See HCPF Hearing Response)
9. **To what extent do the \$16.0 million in non-Medicaid costs reported in child welfare services reflect costs that could or should have been covered by the Medicaid capitation program? Can the Department of Human Services determine this?**

DHS Response:

The bulk of services listed in the briefing document are provided to families and children who are not eligible for Medicaid either due to income or due to not meeting the medical necessity criteria defined in the capitation contract. A small amount of the mental health services are provided to parents who have exhausted their allowable number of session under the capitated Medicaid benefit.

10. **Are the Departments of Human Services and Health Care Policy and Financing considering changes to the delineation of Medicaid costs and responsibilities between BHOs and the counties for children receiving foster care services? Should more costs be carved out of the capitation program and moved under county control? Should some costs currently under county control be moved into the mental health capitation program? How do the departments propose to ensure that children in foster care receive appropriate mental health services? How might this be reflected in the re-bid of the Medicaid mental health capitation program?**

DHS Response:

- DHS is not aware of any changes being contemplated to the delineation of Medicaid costs and responsibilities between BHOs and counties other than as discussed related to the TRCCF and PRTF programming.
- DHS believes that this concept should be analyzed and discussed by both DHS and HCPF before a determination is made. Mental Health Capitation has provided many benefits that are critical for the state including cost containment and accountability that children and families served meet a strict set of criteria. Conversely, Capitation has not offered the flexibility in the types of services available to clients as originally put forward. It is important to assure that the service delivery system adequately addresses the diversity of children's mental health treatment needs to promote safety, permanency and well-being. Medicaid eligible parents sometimes need more therapy sessions in order to address the mental health

issues that interfere with their ability to care for their children then are allowable under Capitation. This is an example of how the cost containment strategy can interfere with providing for the needs of the child and family. If the child is in out of home placement, the issues that need to be addressed to allow the child to safely reunify with the family may not be addressed within the benefits package currently authorized through Capitation.

In discussing the possibilities that exist, it is important to develop a plan that will address CMS requirements for accountability as well as the service array needed by mentally ill Medicaid eligible Child Welfare clients. If the county departments were provided control of Medicaid funding for mental health services, it would be important to assure that an appropriate level of checks and balances are in place.

- The Department does not support moving funds expended in the Core Services Program to the mental health capitation program since many of the clients served do not meet Medicaid income requirements or may not meet the medical necessity requirements.
- The Department would like to partner with HCPF to determine the viability of moving mental health services for children and families served by the Child Welfare System outside of capitation.
- Child Welfare will defer to HCPF regarding how the aforementioned issues can be reflected in the re-bid of capitation services.

11. Do you expect to include counties and child welfare providers in meetings on how the Medicaid capitation program may be modified when the program is re-bid?

DHS Response:

Child Welfare recommends that a specific session be held to provide the counties and providers an opportunity to comment.

12. Is CMS looking at this issue?

(See HCPF Hearing Response)

13. Have you considered any changes to the Medicaid mental health capitation program that might help ensure that individuals with developmental disabilities receive appropriate services? Do you expect to include developmental disability providers/community centered boards in meetings on how the Medicaid capitation program may be modified when the program is re-bid?

(See HCPF Hearing Response)

4:10 – 5:00
Follow-Up