

Final
STAFF SUMMARY OF MEETING

COMMITTEE ON TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE
CRIMINAL JUSTICE SYSTEM

Date: 07/20/2016

ATTENDANCE

Time: **08:52 AM to 12:44 PM**

Humphrey E

Lee X

Place: HCR 0112

Newell X

Woods E

This Meeting was called to order by
Representative Singer

Martinez Humenik *

Singer X

This Report was prepared by
Amanda King

X = Present, E = Excused, A = Absent, * = Present after roll call

Bills Addressed:	Action Taken:
General Overview of Advisory Task Force Activities	Witness Testimony and/or Committee Discussion Only
Discussion of Collaborative Management Program	Witness Testimony and/or Committee Discussion Only
Discussion of Advisory Task Force Staffing Needs	Witness Testimony and/or Committee Discussion Only
Competency Restoration Subcommittee Update	Witness Testimony and/or Committee Discussion Only
Data and Information Sharing Subcommittee Update	Witness Testimony and/or Committee Discussion Only
Housing Subcommittee Update	Witness Testimony and/or Committee Discussion Only
Future Committee Meeting Dates and Letter Discussion	Witness Testimony and/or Committee Discussion Only

08:52 AM -- General Overview of Advisory Task Force Recent Activities and Accomplishments

(Note: Due to technical difficulties about the first 15 minutes of the meeting did not record.)

Representative Singer called the meeting to order. A copy of the meeting agenda and the membership list for the Task Force Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice System (MICJS) (Attachment A and Attachment B) were distributed to the committee. Susan Walton, Advisory Task Force Chair, and Camille Harding, Advisory Task Force Co-Chair, introduced themselves to the committee. Ms. Walton discussed the importance of the task force meetings. She highlighted the activities of the task force subcommittees on housing, data and information sharing, and competency restoration and stated that the subcommittees would be providing full reports later in the meeting.

09:05 AM

Ms. Walton and Ms. Harding responded to questions about the research that the subcommittees are conducting. Senator Martinez Humenik encouraged the task force to review what other states are doing related to various issues. There was discussion about the legislative process. Senator Newell referenced two Legislative Council Staff memos, one concerning housing legislation and one concerning the definition for serious mental illness and screening tools (Attachment C and Attachment D). Representative Singer mentioned the lack of staffing for the task force.

09:14 AM

Ms. Walton discussed the Medication Consistency Workgroup of Behavioral Health Transformation Council that some MICJS Task Force members also serve on. She discussed the work of the Medication Consistency Workgroup concerning the development of a medication formulary and purchasing options for various facilities. Senator Martinez Humenik and Ms. Walton dialogued about the issues related to medication for inmates. Ms. Harding responded to questions about the interagency involvement in the Medication Consistency Workgroup.

09:21 AM

The committee and Ms. Walton discussed the level of involvement of the various task force members. Ms. Walton discussed the lack of participation by the task force representatives from the Department of Labor and Employment and the Division of Housing in the Department of Local Affairs. Senator Newell suggested having letters sent to Department of Labor and Employment and the Division of Housing to encourage their participation on the task force. Ms. Walton discussed the pending appointments of a Judicial Branch representative and Bill Martinez from the Colorado Mental Health Institute at Pueblo. Committee discussion about task force member involvement and task force staffing ensued. The committee directed Legislative Council Staff to draft letters to Department of Labor and Employment and the Division of Housing in the Department of Local Affairs concerning the involvement of the departments' representatives in the task force's activities.

09:30 AM -- Discussion of Collaborative Management Program

Representative Singer referenced Senate Bill 16-039, concerning including a mental health professional in the memorandum of understanding relating to a local-level collaborative management process for children and families. Representative Lee discussed Park County submitting its Collaborative Management Program application after the deadline and the potential loss in funding for Park County.

09:34 AM

Ms. Walton discussed the Park County's recent submission of a memorandum of understanding (MOU) for the Collaborative Management Program and the fact that the MOU was submitted nine hours late because one necessary signatory was unavailable to sign the document. She said that due to the late submission Park County could be denied funding in the amount of \$80,000 to \$100,000 for the year. Ms. Walton discussed the benefits of the collaborative management teams and the impacts of being denied the funding. She referenced the State Board of Human Services rule concerning the Collaborative Management Program and 2014 State Audit that addressed the Collaborative Management Program.

09:40 AM

Dr. Robert Werthwein, Department of Human Services, discussed the 2014 audit that raised the issue of MOUs being authorized after the deadline. The audit can be accessed at: <http://bit.ly/1AHReKZ>. Mr. Werthwein dialogued with the committee about the State Board of Human Services rule concerning the Collaborative Management Program MOU application process. Mr. Werthwein responded to questions from the committee about the audit and need for specified deadlines for the MOU applications. Committee discussion about the department's process for reviewing rules, the audit, and the MOU process continued. Ms. Walton made further comments about MOU situation that arose in Park County. Committee members commented on the Collaborative Management Program and related MOUs, including the need for an appeals process in the relevant rules. Representative Lee asked for the Department of Human Services to provide an update to the committee about whether there is a mechanism that would allow for the acceptance of Park County's application.

10:04 AM -- Staffing of Advisory Task Force Staffing Needs

Ms. Walton discussed the recent challenges of finding staffing for the advisory task force. She discussed the need for a staff person to prepare minutes, assist with various communications, conduct research, orient new task force members, and prepare legislative updates. Committee discussion ensued about the need for staffing for the task force and the associated funding. Ms. Harding discussed the potential Department of Health Care Policy and Financing staff involvement with the task force. Representative Singer discussed sending a letter to the Joint Budget Committee and the Governor regarding funding for staffing for the task force, to which the committee members agreed.

10:18 AM -- Competency Restoration Subcommittee Update

Sheri Danz, Advisory Task Force Member, and Tariq Sheikh, Advisory Task Force Member, provided an update on the recent activities of the advisory task force's competency restoration subcommittee. Mr. Sheikh stated that subcommittee is almost ready to present recommendations to the task force and oversight committee on the issue of competency restoration. He discussed meeting with Dr. Patrick Fox, Department of Human Services, concerning competency restoration. He discussed the current competency restoration process and referenced the educational materials that are used to restore juveniles to competency. Mr. Sheikh discussed the need for an individualized approach that includes a treatment team and separate restoration provider to restore individuals to competency.

10:23 AM

Ms. Danz stated that there is no designated provider for restoration services for juveniles in Colorado. She stated the need to outline the guiding principles for restoration services. Ms. Danz and Mr. Sheikh discussed including adults in any potential legislation to offset costs and reduce the backlog for in-patient services. Ms. Danz discussed establishing the most integrated and least restrictive treatment setting, which was a phrase used by Dr. Fox during the subcommittee's discussions with him. Ms. Danz discussed the development of the guiding principles that will be reviewed at the July 21 subcommittee and task force meetings. Senator Newell referenced the Legislative Council memorandums that had been distributed earlier in the meeting. The committee dialogued with Ms. Danz and Mr. Sheikh about competency restoration for juveniles. Ms. Danz discussed the need for uniform standards for competency restoration, while still allowing flexibility for individual and community needs. Discussion ensued about the need for restoration services for juveniles and potential legislation to address competency restoration. In response to members' comments, Mr. Sheikh discussed elements of the juvenile justice systems, including the juvenile sex offender registry. Senator Martinez Humenik referenced the Second Chance Coalition in Minnesota.

10:50 AM

Mr. Sheikh and Ms. Danz responded to comments from the committee about competency restoration and how juveniles access treatment services. Mr. Sheikh discussed efforts by district attorneys to help juveniles who are involved in the juvenile justice system. Ms. Danz referenced prior legislation concerning a juvenile-specific definition for competency. Mr. Sheikh referenced the judicial discretion in determining a management plan for a juvenile. Senator Newell suggested that the competency restoration subcommittee develop recommendation for the committee to inform a potential letter to the Chief Justice concerning judicial trainings on management plans. Mr. Sheikh and Ms. Danz responded to comments about the juvenile sex offender registry. Senator Newell requested a presentation on the juvenile sex offender registry at the next committee meeting. Amanda King, Legislative Council Staff, clarified who had been sent the Legislative Council Staff memorandum referenced earlier in the meeting.

11:16 AM -- Data and Info Sharing Subcommittee Update

Peggy Heil, Advisory Task Force Member, presented to the committee regarding the recent activities of the Data and Information Sharing Subcommittee of the task force. She provided an information packet to the committee (Attachment E). Ms. Heil stated that the subcommittee was formed in response to a request by the Colorado Commission on Criminal and Juvenile Justice for the advisory task force to study the issue of why so many individuals with serious mental illness end up in jails and to recommend possible solutions to address the issue. She stated that there is not good data to evaluate the scope of the problem. Ms. Heil discussed the current lack of sharing of treatment information between facilities and systems and the identified need for a system to allow this type of information sharing between the public mental health systems and the criminal justice systems.

Ms. Heil stated that Colorado was one of seven states that was awarded a Bureau of Justice Assistance Second Chance Act Statewide Recidivism Reduction Strategic Planning Program Grant. The mission of the grant is to reduce criminal justice involvement and recidivism of individuals with serious mental illness by implementing a statewide, electronic, criminal justice health information exchange. She reviewed the information in the information packet, including the grant summary, the entities who have been involved in the grant, the jail survey results, and the identified gaps in information sharing. Ms. Heil discussed the definitions of serious mental illness and recidivism that will be used in relation to the grant activities. She stated that there would be a need to develop a consent process for the electronic information exchange. Ms. Heil discussed developing agency agreements to share behavioral health data and engaging attorneys regarding planning recommendations, consent forms, and procedures.

11:27 AM

Ms. Heil stated that the implementation grant application had not been released yet. She said that the implementation grant process would be more competitive than the planning grant process. Ms. Heil said that the subcommittee is exploring other funding options for the electronic information exchange and is coordinating with the Behavioral Health Transformation Council's Medication Consistency Workgroup. She referenced the work of the Medication Consistency Workgroup and stated that Dr. Patrick Fox, Department of Human Services, was actively involved in developing the medication formulary proposed by the workgroup. She discussed the preferred formulary for psychotropic medications and the policy brief on statewide pharmaceutical purchasing in the information packet.

11:31 AM

In response to a question, Ms. Heil said she would provide a list of members for the Medication Consistency Workgroup and discussed the entities who were involved in the workgroup. Committee discussion with Ms. Heil occurred about possible legislation related to the work of the Medication Consistency Workgroup, potential purchasing options for medications for inmates, and how inmates access health care and medications while in jail. In her responses, Ms. Heil referenced possible partnerships with federally qualified health clinics and the utilization of emergency rooms by inmates. Ms. Heil discussed how inmates access necessary medications and other treatments upon their release and the possible utilization of telemedicine options. Committee discussion about the information packet materials ensued.

11:52 AM -- Housing Subcommittee Update

Jennifer Longtin, Housing Subcommittee Co-Chair, provided an update on the Housing Subcommittee of the advisory task force. She provided a handout to the committee (Attachment F). She discussed the research that two interns are conducting on behalf of the Housing Subcommittee. The research includes reviewing legislation and zoning regulation and conducting a multi-state survey to describe model supportive housing and treatment programs. Ms. Longtin discussed existing housing voucher programs and the desire to expand the existing programs to provide housing and companion services for those exiting the criminal justice system.

11:59 AM

Matt Domboski, Housing Subcommittee intern, discussed the research about housing programs in other states he is compiling. He stated he also plans to meet with city officials to learn more about the Denver Social Impact Bond Program.

12:01 PM

Kelsey Holder, Housing Subcommittee intern, discussed the zoning issues that often arise when trying to establish housing for certain populations. She referenced an existing apartment complex that is zoned as a congregate home in Aurora that may be a possible model. She discussed Fort Lyon Supportive Residential Community Program.

12:04 PM

In response to a question, Mr. Domboski discussed a potential model program in New York and the state funding for that program. Ms. Longtin discussed the restrictions associated with federal funds for housing. Committee discussion ensued about social impact bond programs for housing, further researching previous legislation in Colorado related to housing for those exiting the criminal justice system, and possibly engaging the National Conference of State Legislatures to assist with the research the Housing Subcommittee is conducting. In response, Ms. Holder stated she has been in conversations with Urban Peak regarding housing issues.

12:16 PM

Ms. Longtin stated that the Housing Subcommittee is developing a white paper to address the issues regarding housing that may require legislation. Ms. Longtin discussed the focus of the Housing Subcommittee on expanding the housing voucher program. Committee discussion with Ms. Longtin ensued about possibly repurposing state buildings in the future to provide housing for persons exiting the criminal justice system. Committee discussion occurred about presentations at the next committee meeting on repurposing vacant buildings. Senator Newell discussed the housing vouchers for the Chafee Foster Care Independence Program.

12:28 PM -- Discussion of Future Committee Meeting Dates and Letters from the Committee

Ms. Harding discussed the *Navigating the Mental Health & Substance Abuse Disorder System* document and the *Quality Health Improvement Project - Improving Access to Key Services for At-risk Children and Families* that were distributed to the committee (Attachment G and Attachment H).

Ms. King referenced a Legislative Council Staff memorandum that outlines the interim committee bill deadlines (Attachment I). The committee discussed potential future meeting dates, but it was determined that the meeting date would be selected via e-mail.

The committee discussed which entity should be sent a letter about potential staffing for the task force. Ms. King discussed fiscal note information for previous legislation that provided funding for staff support to the task force. The committee requested that the following letters be drafted:

- a letter to the Department of Labor and Employment about representative participation on the advisory task force;
- a letter to the Division of Housing in the Department of Local Affairs about representative participation on the advisory task force;
- a letter to the Joint Budget Committee, the Governor's Office, and legislative leadership concerning staffing for the advisory task force;
- a letter to the State Board of Human Services concerning the Collaborative Management Program and allowing for an appeals process when funding is denied due to an application deadline being missed due to extenuating circumstances; and
- a letter to the Chief Justice regarding including trainings on management plans at judicial trainings.

12:44 PM

The committee adjourned.

AGENDA

**Legislative Oversight Committee Concerning the
Treatment of Persons With Mental Illness in the
Criminal and Juvenile Justice Systems**

Wednesday, July 20, 2016

8:30 a.m.

House Committee Room 0112

- 8:30 a.m. Call to Order**
- *Representative Singer, Legislative Oversight Committee Chair*
- 8:35 a.m. General Overview of Advisory Task Force Recent Activities and Accomplishments**
- *Susie Walton, Advisory Task Force Chair*
- 9 a.m. Discussion of Task Force Relations with Oversight Committee and Staffing of Task Force**
- *Susie Walton, Advisory Task Force Chair*
- 9:30 a.m. Status Update on Competency Restoration Subcommittee Activities**
- *Sheri Danz, Advisory Task Force Member*
 - *Tariq Sheikh, Advisory Task Force Member*
- 10 a.m. Status Update on Data and Information Sharing Subcommittee Activities**
- *Peggy Heil, Advisory Task Force Member*
- 10:30 a.m. Status Update on Housing Subcommittee Activities**
- *Kathy McGuire, Advisory Task Force Member*
- 11 a.m. Discussion of Future 2016 Legislative Oversight Committee Meeting Dates**
- *Amanda King, Legislative Council Staff*
- 11:15 a.m. Public Comment**
- 11:30 a.m. Adjourn**

MICJS Advisory Task Force Members

State or Private Agency	Representative(s) and Affiliation(s)	
Department of Public Safety (1)	Peggy Heil	Division of Criminal Justice
Department of Corrections (2)	Kerry Pruett	Mental Health Programs Administrator
	Susan White	Division of Parole
Local Law Enforcement (2) - one of whom will be in active service and one of whom shall have experience dealing with juveniles in the juvenile justice system	Commander Thomas DeLuca	El Paso County Sheriff's Office (active service representative)
	Chris Johnson	County Sheriffs of Colorado (representative with experience dealing with juveniles in the juvenile justice system)
Department of Human Services (5)	Jagruti Shah	Office of Behavioral Health
	Ashley Tunstall	Division of Youth Corrections
	Melinda Cox	Division of Child Welfare
	vacant	Colorado Mental Health Institute at Pueblo
	Moe Keller	Mental Health Planning and Advisory Council
County Department of Social Services (1)	Susan Walton, chair	Park County Department of Human Services
Department of Education (1)	Michael Ramirez	Teaching and Learning Unit
State Attorney General's Office (1)	Cynthia Kowert	Assistant Deputy Attorney General
District Attorneys (1)	Tariq Sheikh	17th Judicial District - District Attorney's Office
Criminal Defense Bar (2)	Karen Knickerbocker	Office of the Colorado State Public Defender
	Gina Shimeall	Criminal Defense Bar
Practicing Mental Health Professionals (2)	Fernando Martinez	San Luis Valley Mental Health Center
	Lisa Thompson	Colorado Coalition for the Homeless
Community Mental Health Centers in Colorado (1)	Harriet Hall	Jefferson Center for Mental Health
Person with Knowledge of Public Benefits and Public Housing in Colorado (1)	Pat Coyle	Colorado Department of Local Affairs, Division of Housing
Colorado Department of Health Care Policy & Financing (1)	Camille Harding, co-chair	Clinical Services Office
Practicing Forensic Professional (1)	Richard Martinez, M.D.	Colorado Office of Behavioral Health/JCDSOM
Members of the Public (3)	Bethe Feltman	Member with a mental illness who has been involved in the Colorado criminal justice system
	Deirdre Parker	Parent of a child who has a mental illness and who has been involved in the Colorado criminal justice system
	Jack Zelkin	Member with an adult family member who has a mental illness and who has been involved in the Colorado criminal justice system
Office of the Child's Representative (1)	Sheri Danz	Deputy Director
Office of the Alternate Defense Counsel (1)	Kathy McGuire	Private attorney
Colorado Department of Labor and Employment (1)	Patrick Teegarden	Director of Policy and Legislation
Judicial Branch (4)	vacant	
	Judge K.J. Moore	1st Judicial District
	Susan Colling	Juvenile Programs Coordinator, Probation Services
	Tobin Wright	Chief Probation Officer in the 16th Judicial District

Updated: March 22, 2016



**Colorado
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MEMORANDUM

May 27, 2016

TO: Senator Linda Newell

FROM: Anne Wallace, Research Analyst, 303-866-4364

SUBJECT: Prior and Current Legislation on Housing for Persons Leaving the Criminal and Juvenile Systems

Summary

This memorandum responds to your request for information on legislation that has been introduced or enacted regarding housing for persons leaving the criminal or juvenile justice system. In the past ten years, four bills have dealt directly with the issue. They are described in Table 1.

Table 1

Legislation Regarding Housing for Persons Leaving the Criminal Justice System

Bill Title	Disposition	Summary
House Bill 14-1355: Reentry Program for Adult Parolees	Enacted	The bill directs the Department of Corrections (DOC) to develop and implement initiatives to decrease recidivism, enhance public safety, and increase the offender's chances of achieving success upon his or her release. The initiatives must include efforts to assist each offender's transition from a correctional facility into the community. The DOC is required to develop and implement a grant program for community organizations that provide reentry services to offenders.
Senate Bill 09-019: Establishment of a Pilot Program to Fund Grants to Local Governments to Facilitate Changes in Land Development Regulations to Accommodate the Housing Needs of Persons with Mental Illness who are Involved in the Criminal Justice System	Postponed indefinitely	The bill would have established a pilot program to encourage local governments to change their zoning regulations to allow housing facilities for individuals who are mentally ill and who are involved with the criminal justice system.

Open records requirements: Pursuant to Section 24-72-202 (6.5)(b), C.R.S., research memoranda and other final products of Legislative Council Staff are considered public records and subject to public inspection unless: a) the research is related to proposed or pending legislation; and b) the legislator requesting the research specifically asks that the research be permanently considered "work product" and not subject to public inspection. If you would like to designate this memorandum to be permanently considered "work product" not subject to public inspection, or if you think additional research is required and this is not a final product, please contact the Legislative Council Librarian at (303) 866-4011 within seven days of the date of the memorandum.

**Table 1 (Cont.)
Legislation Regarding Housing for Persons Leaving the Criminal Justice System**

Bill Title	Disposition	Summary
House Bill 09-1022: Assistance to Counties to Implement Recidivism Reduction Programs for the Mentally Ill	Enacted	The bill created a Recidivism Reduction Grant Program within the Division of Criminal Justice in the Department of Public Safety. The grant program provided three-year implementation grants for programs to reduce recidivism through mental health courts, transitional housing, reentry services, and community corrections programs. The program was repealed, effective July 1, 2013.
Senate Bill 08-007: Assistance to Inmates Prior to Release from County Jails	Enacted	The bill created the Inmate Assistance Demonstration Grant Program within the Division of Criminal Justice in the Department of Public Safety. The grant program provided funding to counties to develop relationships, partnerships, and pre-release agreements with appropriate agencies and to assist jail inmates prior to release in accessing public benefits. The program was repealed, effective July 1, 2012.

Source: Legislative Council Staff

Other Housing-Related Legislation

Housing legislation has been introduced or passed in recent years that did not specifically address reentry of inmates or juveniles. For example, in the 2016 session, bills to extend the allocation of low-income housing income tax credits (House Bill 16-1465) and to build a veterans community living center on the site of the Fitzsimmons Army Medical Center (House Bill 16-1397) were passed by the General Assembly and are pending action by the Governor. A concurrent resolution to create a real estate transfer tax to fund affordable housing (Senate Concurrent Resolution 16-004) and a bill to create inclusionary zoning programs in unincorporated areas (House Bill 16-1334) were postponed indefinitely by the legislature.



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MEMORANDUM

June 3, 2016

TO: Senator Linda Newell
FROM: Conrad Imel, Research Analyst, 303-866-2756
SUBJECT: Serious Mental Illness Definition and Screening Tools

Summary

This memorandum responds to your request for a survey of the definition of "serious mental illness" used by other states and for examples of screening tools used by correctional institutions to determine whether an inmate has a mental illness. You requested such information in relation to both adult and juvenile offenders. This memorandum provides information on the statewide definitions of serious mental illness concerning corrections, specifically, or public health, generally. The attachments to the memorandum provide sample tools used to screen inmates for mental illness upon intake.

Definitions of Serious Mental Illness

Many states do not have a statewide definition for "serious mental illness," either specific to corrections, or generally relating to public health. Table 1, below, provides the definitions from the 15 states identified by staff that define serious mental illness. The table only includes state laws or administrative rules that define the term directly for correctional purposes, or state laws that define it for public health purposes. Statutory or rule-based definitions related to mental capacity to stand trial, capacity to write a will, or definitions of mental illness in insurance codes are omitted. Administrative rules related to specific health matters, such as public assistance or professional licensing, are also omitted.

Open records requirements: Pursuant to Section 24-72-202 (6.5)(b), C.R.S., research memoranda and other final products of Legislative Council Staff are considered public records and subject to public inspection unless: a) the research is related to proposed or pending legislation; and b) the legislator requesting the research specifically asks that the research be permanently considered "work product" and not subject to public inspection. If you would like to designate this memorandum to be permanently considered "work product" not subject to public inspection, or if you think additional research is required and this is not a final product, please contact the Legislative Council Librarian at (303) 866-4011 within seven days of the date of the memorandum.

**Table 1
Statewide Definitions of Serious Mental Illness**

State	Citation	Location	Definition
Arizona	Ariz. Rev. Stat. § 36-550 (4) [Effective July 1, 2016].	Public Health and Safety, Mental Health Services	<p>"Seriously mentally ill" means persons who, as a result of a mental disorder as defined in Ariz. Rev. Stat. § 36-501, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation.</p> <p>Note: Ariz. Rev. Stat. § 36-501 (24), referenced above, defines "mental disorder" as a substantial disorder of the person's emotional processes, thought, cognition, or memory, distinguished from:</p> <ul style="list-style-type: none"> • conditions that are primarily those of drug abuse, alcoholism or intellectual disability, unless, in addition to one or more of these conditions, the person has a mental disorder; • the declining mental abilities that directly accompany impending death; and • character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.
Idaho	Idaho Admin. Code 16.07.33.011 (10), referenced in Idaho Code § 19-2524.	Department of Mental Welfare, Adult Mental Health Services	<p>"Serious mental illness" means any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) incorporated in Section 004 of these rules:</p> <ul style="list-style-type: none"> • schizophrenia spectrum and other psychotic disorders; • bipolar disorders (mixed, manic and depressive); • major depressive disorders (single episode or recurrent); or • obsessive-compulsive disorders.
Iowa	Iowa Code § 229.1 (20).	Hospitalization of Persons with Mental Illness	<p>"Seriously mentally impaired" or "serious mental impairment" describes the condition of a person with mental illness who, because of that illness, lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment, and meets any of the following criteria:</p> <ul style="list-style-type: none"> • is likely to physically injure the person's self or others if allowed to remain at liberty without treatment; • is likely to inflict serious emotional injury on members of the person's family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment; or • is unable to satisfy the person's needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.

**Table 1 (Cont.)
Statewide Definitions of Serious Mental Illness**

State	Citation	Location	Definition
Louisiana	La. Rev. Stat. Ann. § 37:1103 (14).	Professions and Occupations, Mental Health Counselors	<p>"Serious mental illness" means any of the following diagnoses:</p> <ul style="list-style-type: none"> • schizophrenia or schizoaffective disorder; • bipolar disorder; • panic disorder; • obsessive-compulsive disorder; • major depressive disorder - moderate to severe; • anorexia/bulimia; • intermittent explosive disorder; • autism; • psychosis NOS (not otherwise specified) when diagnosed in a child under seventeen years of age; • Rett's disorder; • Tourette's disorder; or • dementia.
Michigan	Mich. Comp. Laws § 330.1100d (3).	Mental Health Code	<p>"Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:</p> <ul style="list-style-type: none"> • a substance use disorder; • a developmental disorder; or • a "V" code in the Diagnostic and Statistical Manual of Mental Disorders.
New Hampshire	N.H. Rev. Stat. Ann. § 135-C:2 (XV).	New Hampshire Mental Health Services System	<p>"Severely mentally disabled" means having a mental illness which is either so acute or of such duration as to cause a substantial impairment of a person's ability to care for himself or to function normally in society in accordance with rules authorized by N.H. Rev. Stat. Ann. § 135-C:61 (rulemaking authority for the commissioner of the Department of Health and Human Services).</p>
New York	N.Y. Men. Hyg. Law § 1.03 (52).	New York Mental Hygiene Law	<p>"Persons with serious mental illness" means individuals who meet criteria established by the commissioner of mental health, which shall include persons who are in psychiatric crisis, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability. Persons with serious mental illness shall include children and adolescents with serious emotional disturbances.</p>

**Table 1 (Cont.)
Statewide Definitions of Serious Mental Illness**

State	Citation	Location	Definition
New York (cont.)	N.Y. Correc. Law § 137 (6)(e).	New York Correction Law	<p>An inmate has a serious mental illness when he or she has been determined by a mental health clinician to meet at least one of the following criteria:</p> <ul style="list-style-type: none"> • he or she has a current diagnosis of, or is diagnosed at the initial or any subsequent assessment conducted during the inmate's segregated confinement with, one or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and such diagnoses shall be made based upon all relevant clinical factors, including but not limited to symptoms related to such diagnoses: <ul style="list-style-type: none"> ○ schizophrenia (all sub-types), ○ delusional disorder, ○ schizophreniform disorder, ○ schizoaffective disorder, ○ brief psychotic disorder, ○ substance-induced psychotic disorder (excluding intoxication and withdrawal), ○ psychotic disorder not otherwise specified, ○ major depressive disorders, or ○ bipolar disorder I and II; • he or she is actively suicidal or has engaged in a recent, serious suicide attempt; • he or she has been diagnosed with a mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; • he or she has been diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; • he or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; or • he or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health.
North Carolina	N.C. Gen. Stat. § 122C-3 (33a).	Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985	<p>"Severe and persistent mental illness" means a mental disorder suffered by persons 18 years of age or older that leads these persons to exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long term or indefinite duration. This disorder is a severe and persistent mental disability, resulting in a long-term limitation of functional capacities for the primary activities of daily living, such as interpersonal relations, homemaking, self-care, employment, and recreation.</p>

**Table 1 (Cont.)
Statewide Definitions of Serious Mental Illness**

State	Citation	Location	Definition
Oregon	Ore. Admin. Rules 291-048-0210 (14).	Department of Corrections, Mental Health Special Housing	<p>"Serious mental illness" means an inmate that, in the judgment of the department, because of a mental disorder is one or more of the following:</p> <ul style="list-style-type: none"> • dangerous to self or others; • unable to provide for basic personal needs and would likely benefit from receiving additional care for the inmate's health or safety; • chronically mentally ill, as defined in Or. Rev. Stat. § 426.495; or • will continue, to a reasonable medical probability, to physically or mentally deteriorate so to become a chronically mentally ill person described in above unless treated.
Rhode Island	R.I. Gen. Laws § 40-1-5.4-7 (10).	Behavioral Healthcare, Developmental Disabilities and Hospitals	<p>"Serious mental illness" means an illness which is biologically based, severe in degree, and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifetime duration. Serious mental illness includes schizophrenia, bi-polar disorders as well as a spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation, alcohol, or drug abuse or anti-social behavior.</p>
South Dakota	S.D. Codified Laws § 27A-1-1 (24).	Mental Health Professionals	<p>"Severe mental illness" means substantial organic or psychiatric disorder of thought, mood, perception, orientation, or memory which significantly impairs judgment, behavior, or ability to cope with the basic demands of life. Intellectual disability, epilepsy, other developmental disability, alcohol or substance abuse, or brief periods of intoxication, or criminal behavior do not, alone, constitute severe mental illness.</p>
Utah	Utah Code § 62A-15-102 (7).	Substance Abuse and Mental Health Act	<p>"Severe mental disorder" means schizophrenia, major depression, bipolar disorders, delusional disorders, psychotic disorders, and other mental disorders as defined by the division.</p>
Vermont	Vt. Stat. Ann. tit. 28 § 906 (1).	Corrections, Services for Inmates with Serious Functional Impairment	<p>"Serious functional impairment" means:</p> <ul style="list-style-type: none"> • a disorder of thought, mood, perception, orientation, or memory as diagnosed by a qualified mental health professional, which substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life and which substantially impairs the ability to function within the correctional setting; or • a developmental disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting.
	Code Vt. Rules 13-130-024.	Agency of Human Services, Department of Corrections, The Use of Administrative and Disciplinary Segregation for Inmates with Serious Mental Illness	<p>"Serious mental illness" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. This includes, but is not necessarily limited to, diagnoses of schizophrenia, schizoaffective disorder, psychotic conditions not otherwise specified, bipolar disorder, and severe depressive disorders.</p>

**Table 1 (Cont.)
Statewide Definitions of Serious Mental Illness**

State	Citation	Location	Definition
Wisconsin	Wis. Stat. § 51.01 (14t).	Charitable, Curative, Reformatory and Penal Institutions and Agencies, State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act	"Serious and persistent mental illness" means a mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, that may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support, and that may be of lifelong duration. "Serious and persistent mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include degenerative brain disorder or a primary diagnosis of a developmental disability or of alcohol or drug dependence.
	Wis. Admin. Code DOC 303.02 (31).	Department of Corrections, Discipline	"Serious mental illness" means a diagnosed major mental disorder that is usually characterized by psychotic symptoms, significant functional impairments, or both, including schizophrenia, bipolar disorder, or major depressive disorder.

Source: Legislative Council Staff.

Fewer states have definitions of serious mental illness specifically concerning juveniles. Staff was able to identify four states with definitions concerning only juveniles. Those definitions are listed in Table 2.

Table 2
Definitions of Serious Mental Illness Relating to Juveniles

State	Citation	Area	Definition
New York	N.Y. Men. Hyg. Law § 1.03 (53).	New York Mental Hygiene Law	"Children and adolescents with serious emotional disturbances" means individuals under 18 years of age who meet criteria established by the commissioner of mental health, which shall include children and adolescents who are in psychiatric crisis, or children and adolescents who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability.
	14 N.Y. Code, Rules, and Reg. § 501.2 (g).	Department of Mental Hygiene, Office of Mental Health, Mental Health Services - General Provisions	"Serious emotional disturbance" means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas: <ul style="list-style-type: none"> • ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or • family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or • social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or • self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or • ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).
Oregon	Or. Rev. Stat. § 419C.520 (3).	Juvenile Code, Delinquency	"Serious mental condition" means a condition that requires supervision and treatment services for the safety of others and is: <ul style="list-style-type: none"> • a mental illness of major depression; • a mental illness of bipolar disorder; or • a mental illness of psychotic disorder.
Tennessee	Tenn. Code Ann. § 33-1-101 (22).	Mental Health and Substance Abuse and Intellectual and Developmental Disabilities	"Serious emotional disturbance" means a condition in a child who, currently or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet psychiatric diagnostic criteria that results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities and includes any mental disorder, regardless of whether it is of biological etiology.

Table 2 (Cont.)
Definitions of Serious Mental Illness relating to Juveniles

State	Citation	Area	Definition
Texas	37 Texas Admin. Code § 343.100 (59).	Public Safety and Corrections, Texas Juvenile Justice Department, Secure Juvenile Pre-adjudication Detention and Post-adjudication Correctional Facilities, Definitions, Applicability, and General Documentation Requirements	"Serious Mental Illness" means a professional diagnosis of any of the following disorders: psychoses, schizophrenia, bipolar with psychotic features, depression with psychotic features, severe post-traumatic stress disorder, and schizoaffective disorders.

Source: Legislative Council Staff.

Screening Tools

Adult offenders. Correctional facilities use screening tools to test inmates for mental illness. There are generally two evaluations that may occur: a brief initial screening, and, if necessary, a more thorough evaluation. A 2013 study analyzed 24 different screening tools for adults, and found five to be the "most promising" tools for identifying inmates with mental illness: the Brief Jail Mental Health Screen (BJMHS), the Correctional Mental Health Screen for Men (CMHS-M), the Correctional Mental Health Screen for Women (CMHS-W), the England Mental Health Screen, and the Jail Screening Assessment Tool.¹ Staff was able to obtain copies of the CMHS-M and CMHS-W (Attachment A) and the BJMHS (Attachment B). The Colorado Department of Corrections (DOC) evaluates inmates in accordance with Administrative Regulation 700-03, which is appended as Attachment C and includes a copy of a mental health screening form.²

Juvenile offenders. The most common tool identified by staff that is used to evaluate juveniles is the Massachusetts Youth Screening Instrument - version 2 (MAYSI-2), which has been adopted for use in juvenile justice programs in 39 states. The MAYSI-2 is a 52-item self-report tool for youth to screen for mental health, trauma and substance abuse issues, as well as screening for suicidal ideation. The Colorado Division of Youth Corrections (DYC) uses the MAYSI-2 to evaluate youthful offenders sentenced to either detention or commitment within DYC. The MAYSI-2 instrument is copyrighted and unavailable for distribution.

The Global Appraisal of Individual Needs—Short Screener (GAIN-SS) is a behavioral health screening tool designed to identify adolescents in need of more detailed assessment for substance use or mental disorders, though it can also be used to evaluate adults. A copy of the GAIN-SS tool is appended as Attachment D.

¹Martin, Michael S., et. al., "Mental Health Screening Tools in Correctional Institutions: A Systematic Review," *BMC Psychiatry*, 2013, available at: <http://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-275>.

²At facilities that house residential treatment programs specifically designed for the mentally ill, DOC uses assessments such as Inventory of Offender Risk, Needs, and Strengths (IORNIS); the Weschler (IQ test); the Personality Assessment Inventory (PAI); and the Millon Clinical Multiaxial Inventory (MCMI-III) to evaluate mentally ill offenders. Those assessments are copyright protected, so DOC cannot share the contents of the evaluations.

In Colorado, for juvenile offenders sentenced as adults to DOC, the Youthful Offender System intake entails a clinical interview (mental health appraisal), cultural fair (IQ test) and the Minnesota Multiphasic Personality Inventory (MMPI or MMPI for adolescents). These assessments are copyright protected and cannot be distributed.

In response to this request, DYC provided two additional tools that it uses to evaluate the mental health of juvenile offenders. The Staff Impressions Rating Scale-Revised (Attachment E) is a nine-item instrument used by staff to assess a youth's risk of self-harm or harm to others. This tool is used to evaluate offenders sentenced to either detention or commitment in DYC. The Mini Mental Status Exam (MMSE, Attachment F) is a questionnaire used to measure cognitive impairment. The MMSE assesses functioning in registration, attention and calculations, recall, language, ability to follow simple commands, and orientation. This is used to evaluate juveniles committed to DYC.

**MICJS Data and Information Sharing Subcommittee
Legislative Oversight Committee Meeting**

June 23, 2016

Accomplishments:

- Convened several subcommittee meetings (Attachment A)
- Summarized focus group findings (Previously provided)
- Surveyed jails to determine their health, mental health, IT and Pharmacy providers (Attachment B)
- Added 'criminal justice system diversion' to the planning grant mission (See grant briefing sheet)
- Selected the SAMHSA definition of 'Serious Mental Illness'
- Defined recidivism as return to a criminal justice facility for any reason
- Surveyed the criminal justice governance committee representatives to identify information sharing needs, gaps and benefits according to sequential intercepts (Attachment C)
- Surveyed behavioral health providers to determine content priorities for a criminal justice behavioral health provider to community mental health provider information exchange – 100 providers completed the survey.
- Determined that an electronic consent process was the preferred method to obtain and manage consent in the electronic exchange
- Facilitated a team of technology experts who conducted on-site interviews with 45 officials from 16 Colorado agencies in order to prepare technical recommendations for a statewide electronic justice and behavioral health information sharing system (Attachment D)
- Completed the required Bureau of Justice Assistance (BJA) Planning and Implementation Guide

Current activities:

- Developing recommendations for agency agreements to share behavioral health data
- Developing mental health and substance use consents
- Assembling a team of lawyers to review the planning recommendations, consent forms and procedures
- Processing steering committee recommendations on the preliminary site visit feedback to guide the development of a plan for information exchange IT infrastructure.
- Preparing a final report with detailed findings, technical recommendations and a roadmap for building out the information exchange.
- Preparing for the BJA Implementation Solicitation which will be released soon with proposals due within 4 weeks of solicitation release.
- Researching additional funding options
- Coordinating activities with the Behavioral Health Transformation Council Medication Consistency Workgroup (See attached common formulary and policy briefing)

Grant Summary

Grant: Second Chance Act Statewide Adult Recidivism Reduction Strategic Planning Program

Award Period: October 1, 2015 to September 30, 2016

Solicitation Overview: This solicitation provides funding for a 12-month strategic planning process that targets recidivism reduction for a high risk adult population. Upon the completion of the Statewide Recidivism Reduction Strategic Plan, BJA will invite states to submit applications for implementation grants of up to \$1 million with the potential for two subsequent supplemental awards of \$1 million each.

Vision: All justice involved individuals with serious mental illness will be provided improved continuity of care in prescribed psychotropic medications and evidenced-based behavioral health services that incorporate Risk-Need-Responsivity principles, whether under criminal justice supervision or receiving community-based treatment services, to promote positive community adjustment, improved health, reduced recidivism and improved public safety. Closing continuity of care gaps will promote a quick and smooth adjustment whether the person is transitioning into the justice system or is being released back out to the community

Mission: To reduce criminal justice involvement and recidivism of individuals with serious mental illness by implementing a statewide, electronic, criminal justice health information exchange (CJHIE) that will facilitate continuity of mental health services in order to safely stabilize individuals in the community. The CJHIE will enable health care professionals to access and securely share patient health information such as psychotropic medications, screenings, assessments, and treatment history to appropriately address psychiatric and criminogenic needs and risks, whether the individual is entering jail or prison, in a mental health crisis system, or returning to the community from custody. The CJHIE will enable a two-way exchange of health and behavioral health information between the justice and health communities so that individuals with mental illness can be diverted from the criminal justice system when appropriate and those being released from incarceration can reenter the community successfully.

Proposal: This grant will facilitate recidivism reduction of justice involved individuals with behavioral health needs by initiating an interagency planning process to develop a statewide justice to health information exchange infrastructure. Health providers in the community and criminal justice agencies will be able to access prior assessment and treatment data to ensure evidence based treatment and continuity of care as offenders transition to different systems. It is anticipated that this infrastructure will reduce gaps in service, facilitate evidenced-based treatment, and ultimately reduce recidivism of offenders with serious mental illness.

Goal 1: Define the grant high risk target population of offenders with serious mental illness, the majority of which have co-occurring substance use disorders

Goal 2: Identify electronic information exchange needs and opportunities for the statewide grant planning process

Goal 3: Develop a statewide justice to health information exchange system plan to improve triage, assessment, treatment and continuity of care for individuals with mental illness or substance use disorders whether they are in the criminal justice system, newly established mental health crisis system or community reentry.

Agencies that provided letters of support for the planning grant proposal or are currently participating in the planning process: Colorado Behavioral Healthcare Council (CBHC), Colorado Counties, Inc. (CCI), Colorado Criminal Justice Reform Coalition (CCJRC), Colorado Jail Association, Colorado Governor's Office, Colorado Regional Health Information Organization (CORHIO), Colorado Department of Corrections (DOC), Colorado Department of Healthcare Policy and Finance (HCPF), Colorado Department of Human Services (DHS), Colorado Department of Public Safety (DPS), Colorado Judicial Branch, County Sheriffs of Colorado (CSOC), Denver Office of Behavioral Health Strategies, Equitas Foundation, Mental Health Colorado, National Alliance on Mental Illness (NAMI).

Proposal supported by the following Colorado policy planning groups: Commission on Criminal and Juvenile Justice (CCJJ), Task Force Concerning Mental Illness in the Criminal Justice System (MICJS), and the Behavioral Health Transformation Council (BHTC)

Planning Phases

There are five separate functions that will be considered during the planning process. Each of these functions must be designed in compliance with HIPAA, 42 CFR Part 2, and state law and will involve a different level of information access and permissions. These functions include:

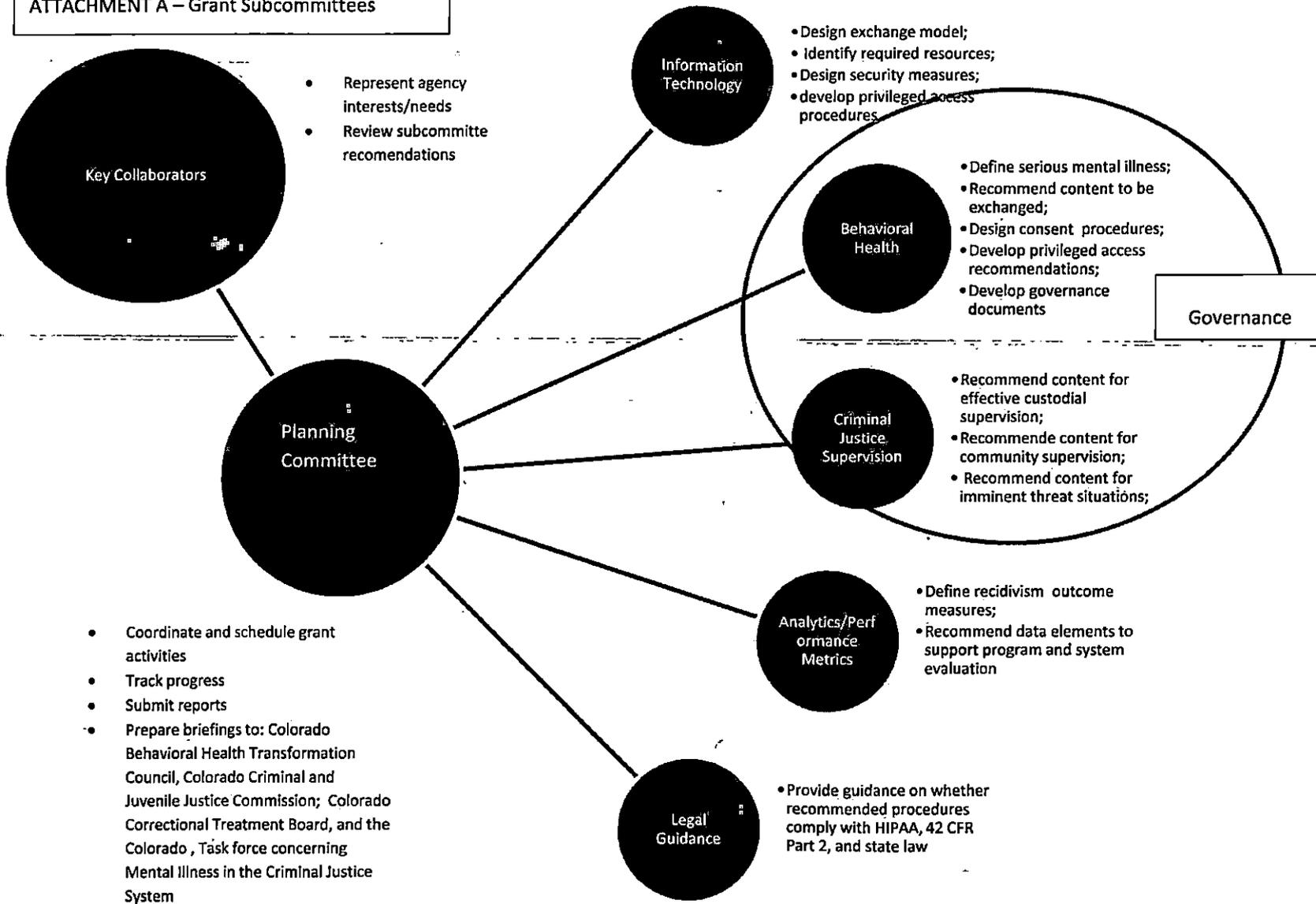
1. Criminal justice health provider and community health provider continuity of care information exchange
2. Information for program evaluation/data collection
3. Information for criminal justice supervision
4. Criminal justice status information for health providers
5. Information for law enforcement response to a crisis situation involving risk of imminent threat to the health or safety of a person or the public

The group will initially focus on the first priority involving criminal justice health provider and community health provider information exchange for treatment continuity of care. The group also needs to define two data elements to successfully complete the BJA planning grant process:

1. Develop a common definition for Serious Mental Illness (SMI) that can be used by all agencies that participate in the statewide information exchange system.
2. Develop a consistent recidivism measure that can be used across agencies to measure recidivism reduction progress.

For additional information please contact Peggy Heil at peggy.heil@state.co.us

ATTACHMENT A – Grant Subcommittees



Colorado Second Chance Act Statewide Recidivism Reduction Planning Program Grant Structure

Committee	Planning Committee	Key Collaborator Steering Committee	Information Technology Subcommittee	Governance Subcommittee		Analytics and Reporting Subcommittee	Legal Guidance
				Behavioral Health Workgroup	Criminal Justice Supervision Workgroup		
Assigned Tasks	1) Guide the planning process to ensure all activities result in achievement of project (grant) goals; 2) Schedule subcommittee meetings; and 3) Present subcommittee recommendations and achievements to Key Collaborator Steering Committee for approval	Review subcommittee recommendations; represent agency feedback and needs; keep agency apprised of grant progress and implementation recommendations; generate agency support for the planned system	Goal 2, 3: Design justice and health information exchange models and identify needed resources to implement the system; develop recommendations to secure health information; develop recommendations regarding privileged access	Goal 1, 2, 3 & Function 1: Develop standard definition for serious mental illness; recommend behavioral health content to be exchanged electronically; develop consent procedures; develop privileged access recommendations; develop governance documents	Goal 2, 3 & Function 3: Recommend content to be exchanged in an imminent threat situations; recommend content to be exchanged for effective custodial supervision or community supervision of individuals with serious mental illness such as housing placement, program recommendations and supervision conditions	Function 4: Develop standard definition for recidivism that can be used across agencies to measure the location and outcomes of the target population; recommend information exchange data elements that will support program and system evaluation	Review consent, privileged access, and governance recommendation for compliance with HIPAA, 42 CFR Part 2; and state law
Colorado Behavioral Healthcare Council		Frank Cornelia, Director of Government & Community Relations		Frank Cornelia, Director of Government & Community Relations			

Colorado Dept. of Corrections		Rena Jordan, Director of Clinical and Correctional Services		Jill Lampela, Chief of Behavioral Health	Frances Falk, Deputy Director of Prison Operations; Morrisa Robertson, Division of Adult Parole		
Colorado Dept. of Healthcare Policy and Financing	Micah Jones, Special Projects Coordinator; Katie Mortenson, Quality and Compliance Specialist	Camille Harding, Quality and Health Improvements Unit Supervisor, Colorado Health Care Policy and Financing	Chris Underwood, Health Information Office Director; Micah Jones, Special Projects Coordinator	Katie Mortenson, Quality and Health Improvements Unit Specialist	Micah Jones, Special Projects Coordinator		
Colorado Dept. of Human Services	Ashley Tunstall, Director of Behavioral Health and Medical Services for Division of Youth Corrections	Patrick Fox, Chief Medical Officer for the Dept. of Human Services and Deputy Director of Clinical Services for the Office of Behavioral Health	Herb Wilson, Business Technology Director	Marc Condojani, Director of Community Treatment and Recovery Programs; Ashley Tunstall, Director of Behavioral Health and Medical Services for Division of Youth Corrections; Kendall Sauer, Evaluation Manager, Office of Behavioral Health; Bennie Lombard, Manager, Offender Substance Use	Jagruti Shah, Manager, Offender Mental Health Programs	Jagruti Shah, Manager of Offender Programs for Office of Behavioral Health; Kendall Sauer, Evaluation Manager, Office of Behavioral Health	

				Disorder Programs; Jagruti Shah, Manager, Offender Mental Health Programs			
Colorado Dept. of Public Safety	Peggy Heil, Behavioral Health Initiatives Manager	Peggy Heil, Behavioral Health Initiatives Manager		Peggy Heil, Behavioral Health Initiatives Manager	Courtney Kramer, Implementation and Fidelity Specialist, Office of Community Corrections	Peg Flick, Senior Analyst; Peggy Heil, Behavioral Health Initiatives Manager	
Colorado Jail Association		Jeff Goetz, President, Colorado Jail Association and Boulder County Jail Commander			Chris Weldon, Delta County Jail; Shawn Laughlin, Broomfield Jail; Michael Toovey, Moffat County Jail; Laurie Stolen, Larimer County Jail; Matthew Elbe, Weld County Jail; Wendy Habert, El Paso County Jail; Chris Rutan, Denver County Jail		
Colorado Judicial Department		Brenidy Rice, Problem Solving Court Coordinator; Eileen Kinney, Senior Manager, Colorado Division of Probation			Kyle Gustafson, Problem Solving Courts;		Kyle Sauer, Senior Assistant Legal Counsel, Office of the State Court Administrator

		Services					
Colorado Regional Health Organization	Toria Thompson, Behavioral Health Information Exchange Coordinator	Toria Thompson, Behavioral Health Information Exchange Coordinator	Toria Thompson, Behavioral Health Information Exchange Coordinator	Toria Thompson, Behavioral Health Information Exchange Coordinator			
Consultants	Bob May, Assistant Director of Program and Technology Services	Bob May, Assistant Director of Program and Technology Services	Bob May, Assistant Director of Program and Technology Services; Ashwini Jarral, Director of Operations; Vijay Nathan - Project Director, CNT Infotech Dwight Hunter - President, Hunter Research, Inc.	Charles Smith, SAMHSA Regional Administrator	Debbie Allen, Adams County Criminal Justice Planner		TBD, Senior Assistant Attorney General, Colorado Attorney General's Office; Kate Tipping, Public Health Advisor SAMHSA
County Government		Regina Huerter, Denver Office of Behavioral Health Strategies		Regina Huerter, Denver Office of Behavioral Health Strategies		Kally Enright Arapahoe Criminal Justice Planner; Alison Birchard Research and Planning Analyst Boulder County; Regi Huerter, Denver Crime Commission	

			Enterprise Applications assigned to Dept. of Public Safety				
Mental Health America of Colorado		Moe Keller, Vice President of Public Policy and Strategic Initiatives		Moe Keller, Vice President of Public Policy and Strategic Initiatives			
National Alliance on Mental Illness Colorado		Vacant - TBD, Executive Director					
Other	Stephanie Kohler, MD, MPH student	Terri Hust, Policy Coordinator, Colorado Criminal Justice Reform Coalition					Mark Ivendick, Disability Law Colorado (Designated Colorado's Protection and Advocacy (P&A) System); TBD Attorney from the Public Defender's Office; TBD Attorney from the Colorado District Attorney's Council

[Redacted Header]						
San Miguel	San Miguel County Jail	970-728-3081	Telluride Medical Center (Contracted services)	Midwestern Mental Health in Coordination with Telluride Medical Center (as needed services other than JBBS grant services)		Sunshine Pharmacy (local pharmacy)
Sedgwick		970-474-3355		Centennial Mental Health?		
Summit		970-453-2232	Local community care clinic, Summit medical center ER	Mind Springs?	County IT	Walgreen, walmart or city market
Teller	Teller County Jail	719-687-7776	Correctional Health Partners	Linda Hewett N.P.	Teller County	Diamond Pharmacy
Washington	Washington County Detention Center	970-345-2244	HCP Systems, LLC	HCP Systems, LLC	Jail Staff	CJ Barnes Pharmacy
Weld	North Jail Complex	970-356-4015	Correct Care Solutions (CCS)	CCS/Jail Staff	Spillman	Diamond Pharmacy
Yuma	Yuma County Jail	970-332-4805	Jail staff	Centennial Mental Health	Office staff	Foltmer Drug

Montrose	Montrose County Sheriff's Office	970-252-4005	Correct Care Solutions (CCS)	Correct Care Solutions (CCS)	Jail Staff	Contracted by Correct Care Solutions
Morgan	Morgan County Detention Center	970-542-3455	Correct Care Solutions	Centennial Mental Health	Morgan County Government	Diamond Pharmacy
Otero		719-384-5941	Valley Wide Health Clinic	Southeast Mental Health	County IT	
		970-325-7272				Safeway, La Junta
Park		719-836-4373				
		970-854-3644				
Pitkin	Pitkin County Jail	970-920-5331	Local nurse	Mind Springs Health/JBBS	County IT/Provelocity	Carl's Pharmacy, Aspen
Prowers		719-336-8054				
Pueblo	Pueblo County Detention Center	719-583-6135	Correctional Health Partners	Correctional Health Partners	Pueblo County Staff	Diamond Pharmacy
Rio Blanco	Rio Blanco County	970-878-9550	Take to local clinic/NA	Mind Springs	Rio Blanco County IT	Meeker Drug
Rio Grande		719-657-4000	Rio Grande Hospital	Rio Grande County Hospital ER	WSB Computers, Alamosa	Rio Grande Pharmacy, Del Norte
Routt		970-879-1090	CHC Corizon Health Care Inc? (Same as Moffat) private correctional health care company provides a nurse practitioner and nurse part time	Mind Springs, Summit County	County IS	
Saguache	Saguache County Jail	719-655-2544				

Jefferson	Jefferson County Sheriff's Office Detention Center	303-271-5444	Correct Care Solutions	Psychiatrist with CCS; Correctional Psychology Associates/Professional Psychology Associates provides additional psychologist and clinician services	Sheriff's Office Staff	Correct Care Solutions (CCS)
Kit Carson	Kit Carson County Jail	719-346-7006	Jail Staff	Centennial Mental Health	County Staff	WB Drug
La Plata		970-247-1161	cicity Seares, MD?	Axis Health Systems	La Plata County IT	Walgreens, Durango
Lake	Lake County Jail	719-486-1249	Rocky Mountain Family Practice	Sol Vista Mental Health	Grace Global	Safeway
Larimer	Larimer County Sheriff's Office Jail	970-498-5213	Correct Care Solutions	Jail staff	Jail Staff	Diamond
Las Animas		719-846-6453				
Lincoln	Lincoln County Jail	719-743-2426	Lincoln Community Hospital	Centennial Mental Health	Jail Staff	Lincoln Community Hospital
Logan		970-522-2578				
Mesa	Mesa County Detention Facility	970-244-3500	Correct Care Solutions	Correct Care Solutions (CCS)	Mesa County IT	Diamond Pharmacy
		719-658-2600				
Moffat		970-824-4498		Mind Springs?		
Montezuma		970-565-8452				

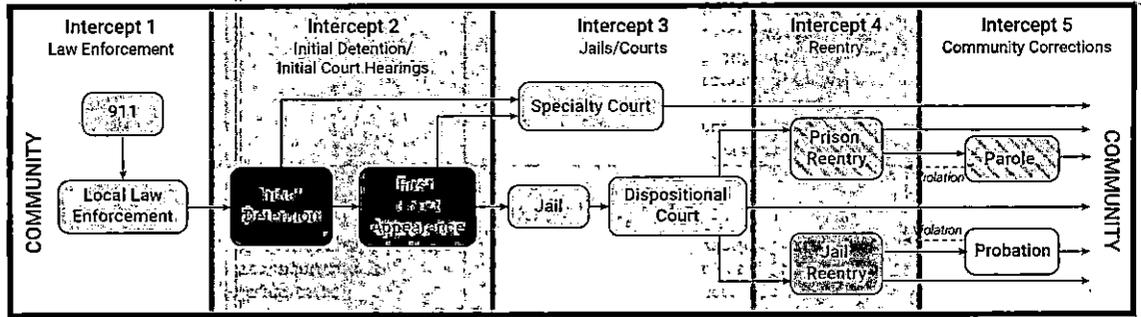
Douglas	Douglas County Jail	303-660-7505	Correctional Care Solutions (CCS)	Correctional Healthcare Solutions and Arapahoe/Douglas Mental Health Network	Jail Staff regarding the jail management system, otherwise technology for medical vendor is maintained by the vendor	Diamond Pharmacy through CCS
Eagle		970-328-8564				
El Paso	El Paso County Criminal Justice Center	719-390-2000	Correct Care Solutions (CCS)	Correct Care Solutions (CCS)	El Paso County Sheriff's Office	Correct Care Solutions (CCS)
Elbert		303-621-2027				
Fremont		719-276-5555				
Garfield	Garfield County Detention Facility	970-945-1377	Correctional Health Partners	Correctional Health Partners	Jail Staff	Correctional Health Partners
Gilpin		303-582-3576				
Grand	Grand County Jail	970-725-3857	Middle Park Medical Center	Mind Springs Mental Health	Grand County Information Systems	City Market Pharmacy
Gunnison	Gunnison County Detention Center	970-641-1108	Gunnison Valley Hospital	The Center for Mental Health	Gunnison County	PDC Pharmacy
		970-944-2291				
Huerfano		719-738-1600				
Jackson		970-723-4242				

		719-767-5633				
Clear Creek	Clear Creek County Jail	303-679-2395	Jail staff and CCS (Correctional Care Services)	Jefferson Mental Health	Allen IT	HIS (Independent Health Services)
Conejos						
Costilla	Costilla County Jail	719-376-2196	San Luis Valley Wide Health Clinic	San Luis Valley Mental Health Center, Alamosa	WSB Computers	Community Health Pharmacy through Valley Wide, Walgreens
Crowley	Crowley County Jail	719-267-5555	Centennial Family Health	Southeast Mental Health	Jay Bond	Ordway Pharmacy
Custer		719-783-2270	Custer County Medical Center	Sol Vista Mental Health	County IT	Fox Drugs, Florence, CO
Delta	Delta County Sheriff's Office - Jail or Detention Facility	970-874-2021	Contact Nurse/Delta County Nurse and Doctor Robert Breathouwer	The Center for Mental Health	Doug Williams County IT	Delta City Market
Denver	Denver County Jail/Van- Cise Simonette Detention	720-913-3600	Denver Health	Denver Health	Jail Staff	Denver Health
		970-677-2257				

ATTACHMENT B - Survey of jail providers

County	Name of Jail	Phone Number-	Name of Health Services Provider	Mental Health Provider	IT Provider	Pharmacy
Adams	Adams County Detention Facility	303-654-1850	Corizon Health Care Inc.	Community Reach Center	Jail Staff	Corizon Health Care Inc.
Alamosa		719-589-6608				
Arapahoe	Arapahoe County Detention Facility	720-874-3500	Jail staff and CCS (Correctional Care Services)	Jail staff	David Bessen	Jail staff
Archuleta	Archuleta County Detentions Facility	970-264-8458	Dr. Jim Pruitt	Axis Mental Health	Archuleta County IT Department	Jackish Drugstore
Baca	Baca County Jail	719-523-6677	Jail staff dispenses any medications that they come into the jail with. Inmates with medical issues are taken to Southeast Colorado Hospital	Southeast Mental Health, La Junta	Lars Grahn	Gale Drug, Springfield, CO
Bent		719-456-0796				
Boulder		303-441-3600		Boulder County Mental Health Partners		
Broomfield	Broomfield Police Detention Center	720-887-2000	Correctional Care Solutions (CCS)	Correctional Care Solutions (CCS)	City and County of Broomfield IT	Diamond Pharmacy
Chaffee	Chaffee County Detention Facility	719-539-7150	Advisory Physician: Dr Rick Ruitter, nurses Cathy Casey & Mary Gage	Adult Mental Health Services Inc.	Staff	HIS Pharmacy

ATTACHMENT C – Information sharing needs, gaps and benefits



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

Colorado Identified Communication Needs between Criminal Justice Agencies and Behavioral Health Care Providers Organized by Intercepts from the above SAMHSA's GAINS Center Model—
Subcommittee Responses

Intercept 1 Law Enforcement (911, Local Law Enforcement)	Intercept 2 Initial detention/court hearings (Initial detention, First Appearance Court)	Intercept 3 Jails/Courts (Jail, Specialty Court, Dispositional Court)	Intercept 4 Reentry	Intercept 5 Community Supervision (Community Corrections, Probation, Parole)
No information on disruptive citizen	Actively Psychotic when booked into jail	Lack of adequate services available	When released, especially if homeless, there is no ability to follow up with a person in need	There is a challenge with client follow though, access to a working phone, and providing accurate contact information (ie. Phone numbers, relative phone numbers, email, etc.)
No resources for adequate referral	No psychiatric provider information available	Not able to begin or secure services while still incarcerated	Need to link various service providers to release information to assist in wrapping services around the person prior to release.	No access to up to date information such as the fact that an individuals was taken off all medications and the reason and date.
Ends up at jail due to lack of alternatives	No treatment history available (who was last to treat, what was the last course of treatment, what exacerbates problems)	No mental health professional on duty at the jail	No point person to hand off care in the community	Providers concentrate on getting an individual stable without understanding the impact of where the individual lives, obtains medications, or receives support to get things done. Need more concern with total continuum of care.
	Community treatment provider does not have a contact at the jail to continue medication or treatment upon arrest	Unless suicidal, the individuals may not be seen by a psychiatrist for weeks before they can get back on any medications.	Not able to get an appointment at the community mental health center upon release.	Officers notified of medication changes in case they make the individual act or speak differently or confusion.
	When the individual is a poor historian and records cannot be accessed from other sources in the community	Need information the date of the last IM shot. Jails may get the order but do not receive information on the last time it was given.	Historical knowledge of personality disorders vs SMI may not transfer with a person so it may take time for an appropriate treatment plan/response to symptoms	Officers to be notified of BIG flags that are noted in treatment, in case there are future problems. E.g., taking a person to urgent care for issues, then finding out the offender is going to medical appointments and the stress from that could be affecting behaviors.
	Different medications available in the community vs. those that are available in the jails. Many medications can be abused and are therefore not offered or limited in their use. In addition, many mental health centers receive samples of some of the newer and more expensive medications which are not typically offered in the jails.	Communication breakdowns between the problem solving court supervision and treatment team during staffings, change in status or needs imposed by the team, probation officer or treatment provider or when the probation officer or treatment provider did not provide timely new information about the SMI participant that would be critical to how the court addressed stability and re-offense risk.	Community treatment providers do not request health information from the jail.	Continuity of care gaps can occur during any transition between agencies/providers (e.g., jail, probation, hospitals)

Intercept 1 Law Enforcement	Intercept 2 Initial detention/court hearings	Intercept 3 Jails/Courts	Intercept 4 Reentry	Intercept 5 Community Supervision
	Lack of an immediate resource for medication verification when someone is arrested. Many arrests are made outside of regular business hours.	Loss of Medicaid means criminal justice entities struggle to provide adequate healthcare (piecemeal funding involving grants or stretching the criminal justice budget. Some smaller jails do not have specific contracts with mental/behavioral health entities for in-house services.	Transferring and filling prescriptions is problematic and delays can result in deterioration of the individual's stability and mental health	Although assessment/diagnostic services seem adequate, treatment services are more limited especially inpatient services
	Inmates do not come into jail with medications and the jail does not know what they are taking.	Unwillingness of many inmates to participate in mental health treatment. Jails must use M1 holds to force or fund treatment. Even then, not all hospitals will see the patient.	Inadequate substance abuse treatment history impairs current determinations of the appropriate treatment level	Delays in placement into existing services
	It may be several days before the jail doctor can see the individual and medications can be ordered under the jail process. Many of the medications that the individual was prescribed in the community are extremely expensive and must be readjusted since the individual loses Medicare or Medicaid coverage. The county must pay for the medication. Each jail allows certain medications due to the issue.		Lack of proper history can result in referrals to programs that are not equipped to handle SMI symptoms (e.g., in community corrections TC or IRT which are not designed to treat SMI needs)	Clients who are opiate-seeking may go to a hospital in the community and be given/prescribed more opiates without having the previous use history
	Few criminal justice entities use a standardized means of detecting inmates with mental and behavioral health issues (most conduct suicide risk assessments). Most rely on patient reports of diagnoses and medications, which may be incomplete, mistaken, and/or willfully incorrect		From a mental health stand point, it can be very difficult to arrange or even plan for multi-agency coordination of care and/ or continuity of care when release dates change and mental health services are unaware. This makes it difficult and almost impossible to coordinate much needed medication management and access to medications.	Clients may not be the best reporters of current/recent medication and could be prescribed medications that interact poorly or re-prescribed medications that have significant side effects
	Jail healthcare staff spend a significant amount of time gathering inconsistent information to verify diagnoses/past treatment/current medications which is costly. Small jails may not have the means to obtain this information.		Upon release many CL have very little basic needs (adequate housing, food, access to necessities). In many cases MH services are very low on the priority list.	
			May be several weeks to get an intake appointment at a community mental health center and several weeks after that to get an appointment with a psychiatrist.	

General issues that cross all intercepts:

- Crises may resolve but no continuity in a treatment plan or follow up to ensure stabilization is maintained by various players in utilized systems.
- Duplication of requirements for different systems, increases costs for the person. Information sharing could reduce redundancy in requirements (i.e. UAs) and costs and increase the person's ability to be successful and compliant.
- If relapse occurs in one system, other systems often are not made aware, lose track of person when moved from one system to another.

Information sharing capabilities that could improve stabilization and successful management of justice involved individuals with significant behavioral health treatment needs:

- Action plans that any 1st responder would benefit from knowing about this person when they encounter them
- The ability to maintain individuals on Medicare and Medicaid while they are in custody
- Information sharing that could reduce the amount of time between arrest and entry into a problem-solving court
- Explore the possibility of a wraparound approach between court staff, attorneys, jail staff, and MH providers
- Database that can be shared between correctional facilities, hospitals and community agencies. (this is frequently discussed and highly unlikely due to HIPPA)
- A central information point will help smaller jails get information to start services faster. Information needs to be easy in/easy out as most jails do not have special staff to handle it. More help can be found and accessed if jail were able to get mental health information the same way they can access warrants and criminal history.
- A universally accepted release of information form
- Electronic access to ROI and other information to expedite sharing of information
- Any information sharing capability that improved the timeliness and accuracy of information received and shared between treatment providers, probation officers and Problem Solving team members
- Current treatment plans, treatment providers, meds, etc.
- Have community mental health center liaisons that come in to the jail before an offender is released to begin intake, etc.
- Ability to schedule an appointment in the community when a criminal justice facility knows that someone is getting out and an emergency process if someone is getting out unexpectedly
- Ensuring that medication, services and housing are set up prior to transition to a new agency or community
- Accessible process to sign individuals up for Medicaid/payer source
- Resources for bridge medications between the time the individual is released and obtains a permanent mental health provider
- Have "correctional" teams at community mental health centers that have knowledge of and attend to both criminogenic as well as behavioral health needs
- Shared knowledge of what programs/diversion/treatment courts/probation conditions/pretrial conditions/court orders the person is under
- Point of contact when compliance/stability becomes faulty
- Clear point people at each of the facilities to streamline communication
- Treatment agencies could log check-in/out times for monitoring
- CJ agencies can send updates/alerts to treatment agencies/hospitals (e.g. benzo abusing, psychotic symptoms, recent relapse, etc.)
- Treatment agencies may send prescription to community corrections facilities so it isn't lost with the client
- CJ agencies can alert provider that the client stopped taking medications and/or wishes to stop (treatment provider may be able to send a yes/no based on possible effects of stopping abruptly, etc.)
- The Office of Behavioral Health Jail Based Behavioral Health Services (JBBS) program helps bridge the gaps between services.

Perceived benefits of an information sharing system:

- Criminal justice system believes it will reduce difficulty in gathering information and costs to society of untreated individuals reoffending as a result of their mental illness or substance abuse issues
- Behavioral health providers see it as an opportunity to create more continuity of care and reduce recidivism

Concerns about information sharing (Response to the idea of information sharing system is mainly positive but there are a few concerns):

- Cost of mental/behavioral health information exchange itself
- Cost of delivering appropriate treatment once inmates' diagnoses and medications are identified
- Concerns about secondary disclosure of health information

ATTACHMENT D – Site visit summary

Bureau of Justice Assistance Statewide Recidivism Reduction Planning Grant
Consultant Team Technology Assessment Site Visit
June 6 – 9, 2016

Consultants

- Robert May – Assistant Director, IIS Institute (Justice & health information exchange expertise)
- Vijay Nathan - Project Director, CNT Infotech (Health information exchange expertise)
- Dwight Hunter - President, Hunter Research, Inc. (Criminal justice information exchange expertise)

Site Visit Summary

The objectives of the site visit were to: develop an inventory of current technology being utilized by relevant agencies and service providers; understand the current state of behavioral health information sharing currently in practice; assess technology and operational capacities, capabilities and limitations related to the collection and transmission of behavioral health data; and identify the data elements to be shared, what systems currently collect and hold that information, and what legal and policy issues may be involved in sharing them.

The consultant team interviewed 45 representatives from 16 agencies ranging from:

- Several major state agencies
- Small and large jail
- Small and large community mental health center
- Behavioral Health organization
- Governor's Office of Information Technology
- Colorado Integrated Criminal Justice Information System (CICJIS)
- Colorado health information exchange organizations

Next Steps

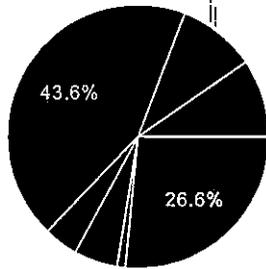
- The team is continuing to gather information and interview people from several additional agencies remotely
- The team developed preliminary feedback on establishing a real-time statewide electronic justice and behavioral health information exchange with a plan for implementation. The ideas were discussed at a grant steering committee meeting on July 14th.
- The team will produce a final report with more complete detail on the site visit, technical recommendations and a roadmap for building out the exchange.

96 responses

Publish analytics

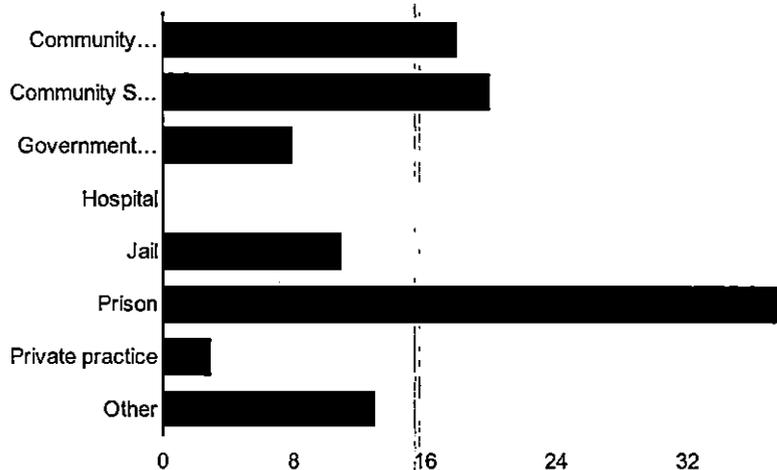
Summary

What is your professional background



Medical Profession (non-behavioral health)	0	0%
Mental Health Therapist (Professional Counselor, Clinical Social Worker, Marriage and Family Therapist)	25	26.6%
Peer Specialist	1	1.1%
Psychiatrist	5	5.3%
Psychologist	4	4.3%
Substance Abuse Counselor	41	43.6%
Other (Administration, etc.)	9	9.6%
Other	9	9.6%

What is your primary work setting? (Check all that apply)



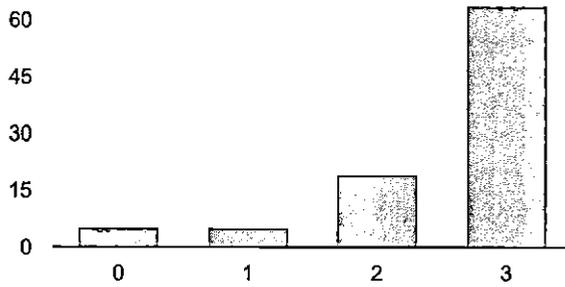
Community Mental Health Agency (delivering primarily mental health services)	18	19.4%
Community Substance Abuse Treatment Agency (delivering primarily substance abuse services)	20	21.5%

Government Agency (OBH, HCPF, DHHS, etc.)	8	8.6%
Hospital	0	0%
Jail	11	11.8%
Prison	38	40.9%
Private practice	3	3.2%
Other	13	14%

Content Rating

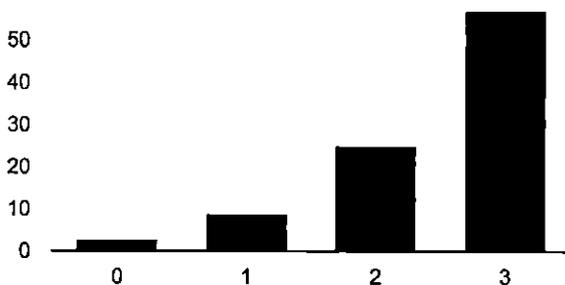
Informed Consent/Release with listed permissions and expiration date

Checkbox that the requesting professional has a signed release on file and therefore their request is valid



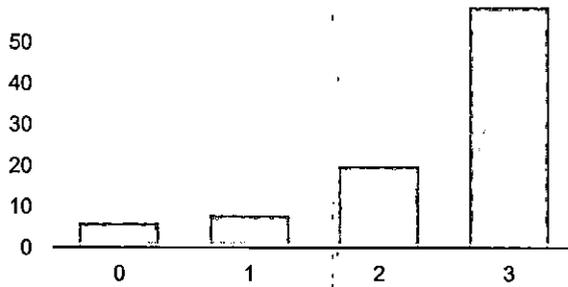
No need: 0	5	5.4%
1	5	5.4%
2	19	20.4%
High need: 3	64	68.8%

Scanned PDF image of the signed consent listing the specific agencies and content that can be shared



No need: 0	3	3.2%
1	9	9.6%
2	25	26.6%
High Need: 3	57	60.6%

Ability to check a centralized system (manually or automated) for patient consents and then share data accordingly.



No need: 0	6	6.5%
1	8	8.6%
2	20	21.5%
High need: 3	59	63.4%

Please type any additional comments on informed consent in the space below

Every place has their own form and want things on their own request sheet. It would be easier if it was more uniformed.

I would prefer a central database with scanned consents. This way we can verify it is valid as can anyone else, without having to keep track of separate consents.

The client permission or ability to opt out to have their consents posted to a centralized system.

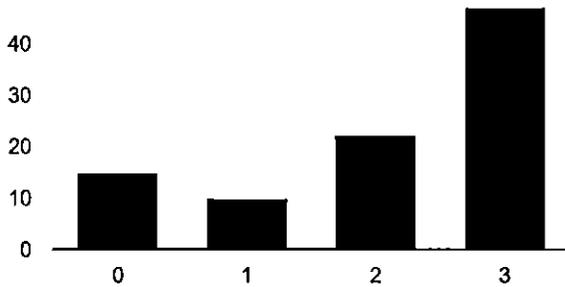
N/A

RESADA is in the beginning phase of reconstruction with a new director. We do not currently have electronic records.

multi-agency consent or Releases of Information would be greatly helpful and reduce the amount of intake paperwork.

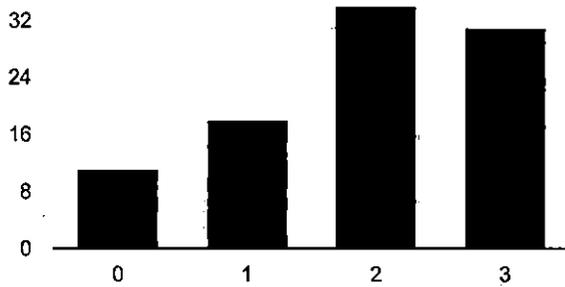
The next three questions refer to information on the client's benefits status

Medicaid status



No need: 0	15	16%
1	10	10.6%
2	22	23.4%
High need: 3	47	50%

Disability benefit status



No need: 0	11	11.7%
1	18	19.1%
2	34	36.2%
High need: 3	31	33%

Please add any additional comments on disability benefits status in the space below

In Colorado we are dealing with situations where the client is put on Medicaid when they leave prison and then lose the benefit when they come to Community Corrections. They they can not get the medications they have been given or other medical needs.

Hopefully in the future RSC's may have the option to bill Medicaid, though this is not the case currently I believe it is going in that direction. To be able to find members who are currently under Medicaid would be helpful.

I work for DOC, and I don't necessarily need the benefit status for my work, but I think this may be useful for other providers. At the very least, I like to know if a patient will have insurance as this may help guide prescription choices if they are soon to release and may not be able to afford certain medications.

Medicaid does not cover court ordered/related assessments so typically it does not matter if client has medicaid for assessments.

If there is a pending application or appeal in process.

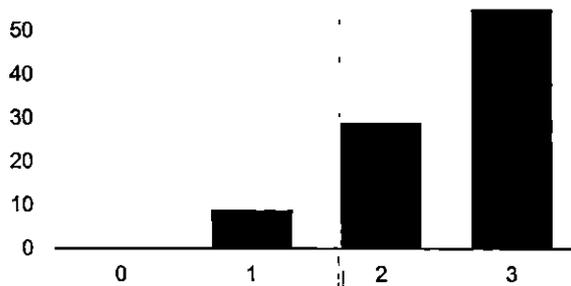
unknown

Also information on if client has applied for Medicaid and if they have any other insurance coverage our program is grant funded and not covered by insurance.

RESADA is not currently able to use Medicaid

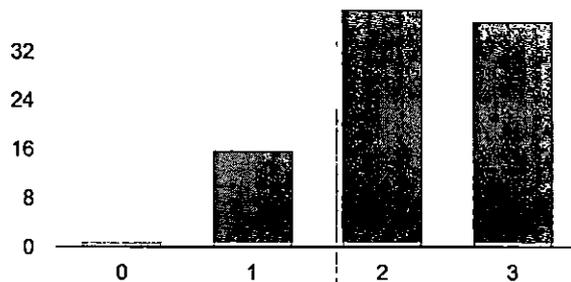
The next five questions refer to Standardized Assessments

Name of the assessment, date completed, person completing the assessment and assessed level of need



No need: 0	0	0%
1	9	9.7%
2	29	31.2%
High need: 3	55	59.1%

Domain (subcategory) assessment scores

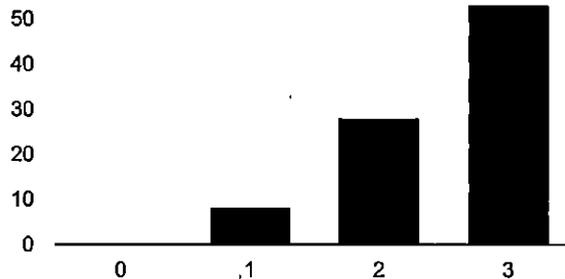


No need: 0	1	1.1%
1	16	17.2%

2 39 41.9%

High need: 3 37 39.8%

Name of assessment updates, date completed, person completing the assessment and assessed level of need



No need: 0 0 0%

1 8 9%

2 28 31.5%

High need: 3 53 59.6%

Please list all standardized assessments that your agency conducts to determine behavioral health treatment needs, recidivism risk level or criminogenic needs.

LSI, Soar-r, DUSR, Mini Mental Health examination, URICA, SARA Oregon Assessment, ASUS-R, CCJMHS-ASSI-R

Very little in terms of BH tx needs recidivism risk and ciminogenic needs. WE do have a intake from but is mostly informs us to drug use, income status, drugs used, length of sobriety and avenues through which they found Recovery.

None currently

LSI - ASUS - SSI - ASUDS

PhQ9, PTSD Checklist, Cage AID, AUDIT

LSI-R, WRNA, SSI-R, Ohio TBI Screen

Static 99r, SOTIPS, Abel

This is done by other mental health professionals in DOC, so I'm not sure which specific assessments are completed.

Not sure besides clinical psychiatric evaluations

Depending on the referral question, we will use the MMPI-2, LSI-RNR, WAIS/WASI, and various instruments for competency evaluations, animal abuse evaluations, etc.

SOA-R, ASI, DURS

LSI, TxRW, ASUS, SSI, SOA-RS, ASI

SOA-R

SSI-R, CCJMHS-A, PCL-C, HELPS, SBIRT, Mental Status, GAD-7, PHQ-9, CPSS Trauma Screen,

Substance Use Assessment, ASAM, SOCRATES, CAGE, starting new fiscal year - LSI

ASI, ASAM, CCAR, PHQ9, GAD 7

LSIR

SSI, LSI, ASUS, SOARS, TxRW, Psycho Social, CCJMHS-A, Life Events, HELPS, PTSD, and IEC

PCL-C, HELPS, PHQ depression, infectious disease medical and behavioral, Adult Assessment / Adult Substance Use Disorder Assessment, Interstate Compact

ASI, A-SUS-R, Beck Depression Inventory, TBI Screen, Civilian Trauma Screen, Mood

Questionnaire, WRNA-Women's risk and needs assessment, LSI, Proxy, Burns Anxiety Inventory

SASSI, ASI, ASAM

As needed, ASAM, ASI, PCL-5, Mental Status Exam, Depression screening - Beck, interview, other assessment instruments when indicated, such as, the PHQ 9, TSI

SOA-R, ASI, SASSI, SOCRATES/URICA, MCMI- III

LSI, SSI-R, SOA-R, ASUS-R, BPRS.

ASI, mental status exam, ASAM triage, Infectious disease screening, ICD substance use disorder checklist

SOA-R, LSI

SOA-R and LSI

LSI - ASUS

LSI; ASUS-R

SOA-R results are posted on the CDOC data base.

LSI

SOAR

Simple Screening Instrument-Revised, Level of Supervision Inventory-Revised, Standardized Offender Assessment-Revised

Simple Screening Index, Level of Supervisory Inventory- Adult Substance use Survey, Treatment Recommendation Worksheet

ASUS-R, Tx-RW, LSI,

LSI, ASUS, BIOPSYCHOSOCIAL

MMPI, MILLON

AUDIT, DAST, PHQ 4-9, PCL Short, ASI, ASAM, mini Mental Satus exam

LSI, SOA-R; ASUS, TxRW

LSI;ASUS;TxRW;SSI

HELPS, PCL-C, PHQ9, GAD7

Adult Integrated Assessment

LSI/StandardOffenderAssessment/AdultSubstanceUseSurvey/

TreatmentRecommendationWorksheet (TxRW)/Treatment Qualifier/Discharge Recommendation

ASI, SASSI, Beck Depression, Trauma Symptom Inventory

LSI, TxRW, ASUS R, SSI-R, CCJMHS-A

Cross-cutting measures 1 and any follow up tools if scores indicate high need, LSI, Extended Assessment

AUDIT, DAST-10, PCL-C, PHQ-9, SF12, ASAM criteria

Please add any additional comments regarding standardized assessments in the space below

Inter-rater reliability will be an issue here and the psychometric properties of all assessments should be evaluated before too much stock is placed in them. Assessments may also vary by diagnosis and this variability may make having a single assessment an impossible task. Is there a specific question that you are trying to answer with these data? It would be important to know what question we are trying to answer with information on the date and assessment score in order to more fully assess the utility of this information.

provide a brief description of assessments.

TRxW, ASUS-R

N/A

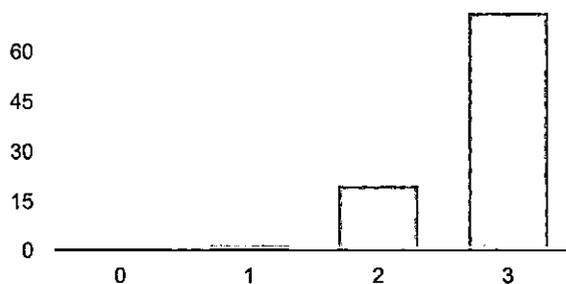
Community Mental Health and Criminal Justice Agencies should have similar assessments to "speak the same language," without compromising treatment culture

I think they are important but at times it takes away from the importance of a quality clinical interview and people reading the assessments focus on the tools and minimize the clinical interpretation

At this time we complete an ASI for assessment for the clients current needs for treatment.

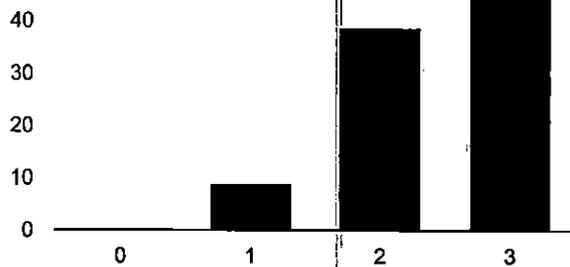
The next four questions refer to the client's diagnoses

Current diagnoses with date of diagnosis



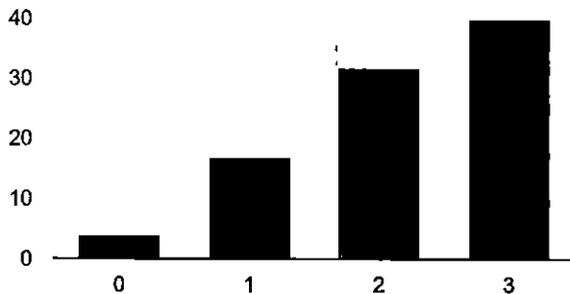
No need: 0	0	0%
1	2	2.1%
2	20	21.3%
High need: 3	72	76.6%

Past diagnoses with date of diagnosis



No need: 0	0	0%
1	9	9.6%
2	39	41.5%
High need: 3	46	48.9%

Name of the professional making the diagnosis



0	4	4.3%
1	17	18.3%
2	32	34.4%
3	40	43%

Please add any additional comments about diagnosis in the space below

It is also helpful with understanding why the diagnosis was determined. It would be helpful to understand the medications that have been tried in the past and why.

Having knowledge of past mental health diagnosis's would help tremendously with members who we are trying to reach but may not know the best way how.

What will be done with the information on the person making the diagnosis? Is this information going to be used and is there any potential for there to be consequences to the clinician for their diagnoses? Is there a reason to collect this information and is there a question to be answered with these data?

I think this is one of the most important things that could be shared - this way those with severe mental illness can be ID quickly when the leave corrections for the community, and vice versa. Furthermore, it would allow us to share diagnosis changes as often in DOC diagnoses are revised when patients are observed for longer periods while in a structured environment and not using.

Including information on treatment response and compliance.

need medications and past medications history

N/A

If they need Mental health services they will be allowed to attend mental health classes.

Diagnostic justification would be helpful, and any significant history of issues

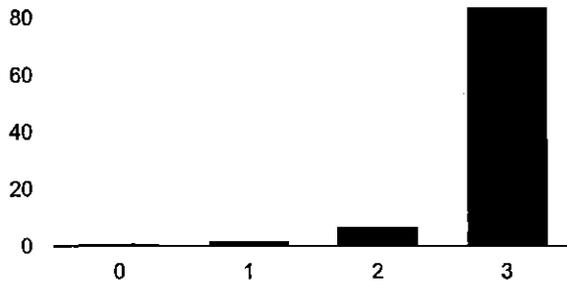
There needs to be opportunity for individuals working under supervision to list the clinician and their supervisor in this process

Diagnosis is for insurance billing and says little about the client's delimmia/issues.

We are not able to diagnosis anything except substance use disorders

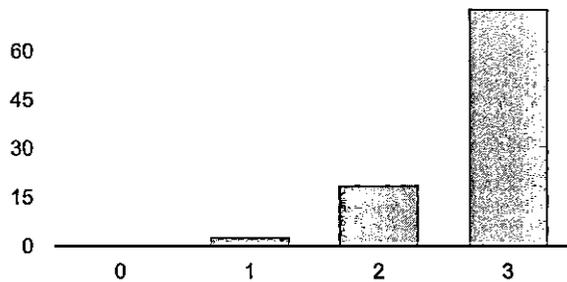
The next three questions refer to the client's suicide risk

Current suicidal ideation



No need: 0	1	1.1%
1	2	2.1%
2	7	7.4%
High need: 3	84	89.4%

Past suicide attempts with date and method



No need: 0	0	0%
1	3	3.2%
2	19	20%
High need: 3	73	76.8%

Please add any additional comments on suicide risk in the space below

A lot of times we have just a few vague statements and we rely on the client's information which is skewed in a lot of different ways for the client's benefits.

It would be interesting to know if there were past suicide attempts, but I wonder whether clients who present with suicidal ideation will be able to provide information on the dates of prior attempts. This level of specificity makes this question harder to ask and answer.

Sometimes it is not possible to obtain past date & method, but recency of past suicide attempts is useful, and also whether treatment/hospitalization was needed following the attempt.

Type of attempts and severity - medical care required or psychiatric hospitalization. Was substance abuse involved.

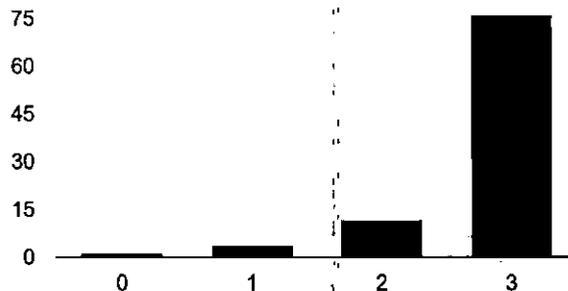
Good to know if attempt involved the use of substances as the plan or if client was under the influence at the time.

If risk is recent the how it was attempted.

follow up identifying self harming bx's, and any hospitalizations from S/I,.

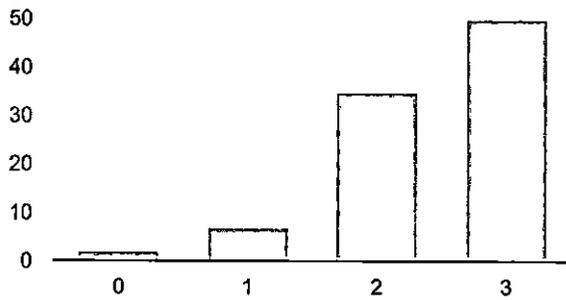
The next ten questions refer to the client's psychiatric treatment history

Current psychotropic medication prescriptions

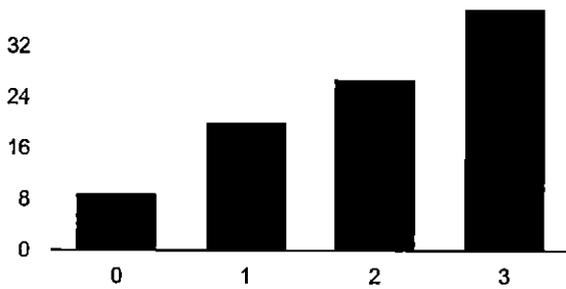


No need: 0	1	1.1%
1	4	4.3%
2	12	12.9%
High need: 3	76	81.7%

Past psychotropic medication prescriptions and the reason for discontinuation

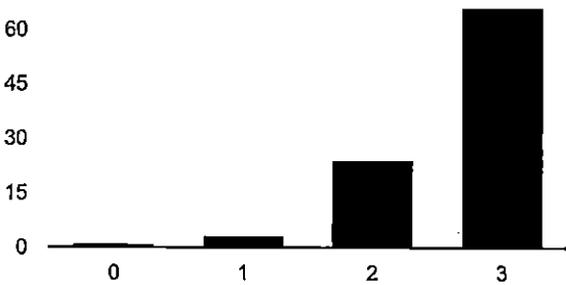


Non-formulary justifications and permissions



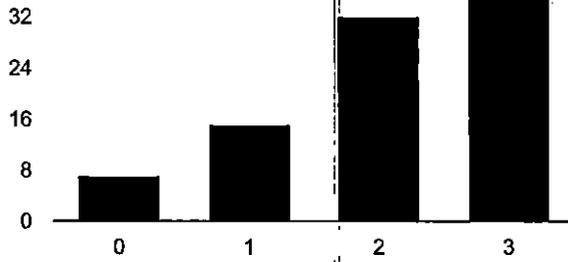
No need: 0	9	9.6%
1	20	21.3%
2	27	28.7%
High need: 3	38	40.4%

Medication compliance, nonadherence, and abuse



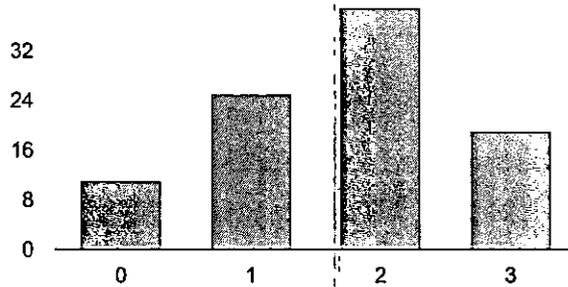
No need: 0	1	1.1%
1	3	3.2%
2	24	25.5%
High need: 3	66	70.2%

Most recent lab results



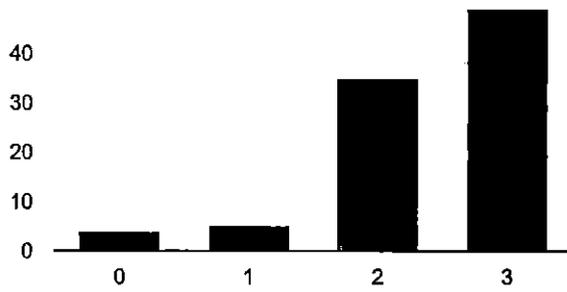
No need: 0	7	7.6%
1	15	16.3%
2	32	34.8%
High need: 3	38	41.3%

Prior lab results

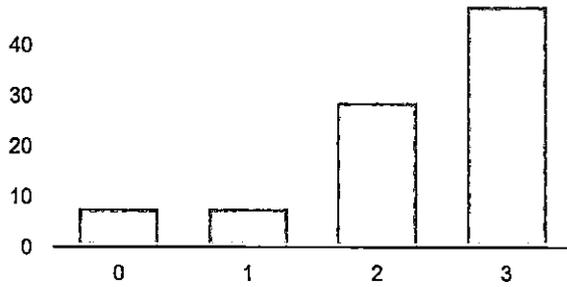


No need: 0	11	11.7%
1	25	26.6%
2	39	41.5%
High need: 3	19	20.2%

Psychiatric discharge summary

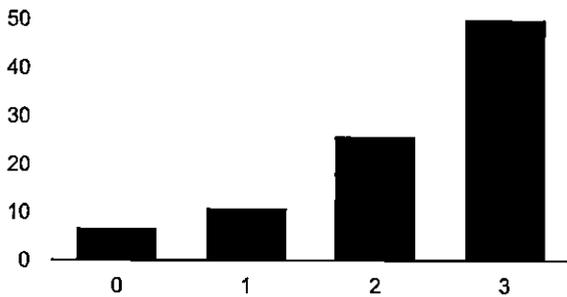


Involuntary medication rulings



No need: 0	8	8.6%
1	8	8.6%
2	29	31.2%
High need: 3	48	51.6%

Emergency medications administered



No need: 0	7	7.4%
1	11	11.7%
2	26	27.7%
High need: 3	50	53.2%

Please add any additional comments on psychiatric treatment information in the space

below

It also helps if the client is transferred with enough medications that we can get an appointment set up.

Again, are there specific questions to be answered with these data? Where will the information come from? There's a lot of information here that could be easily misused.

Ability to share this information between the community and correctional providers would be extremely useful to provide continuity of care. Often times, we must repeat lab work just done because we don't have access to prior results, patients come in unable to describe their medication history or why they are on their current medications, patients seek abusable medications, etc. We have had several occasions in DOC when patients abused their medications in DOC, they were stopped, the patient restarted the med while in the community, and then came back to DOC and had to switch medications again, so ability to communicate potential medication abuse would be helpful for everyone.

Whatever information regarding current and past medication use is beneficial, even if not all of the above is possible.

Our clients require medical and MH clearance, prior to enrollment. This information is maintained by our Medical and MH staff.

Short or long term certifications under C.R.S. 27-65

...

Allergies and adverse reactions

Strong Discharge Summary; helps with continuity of care

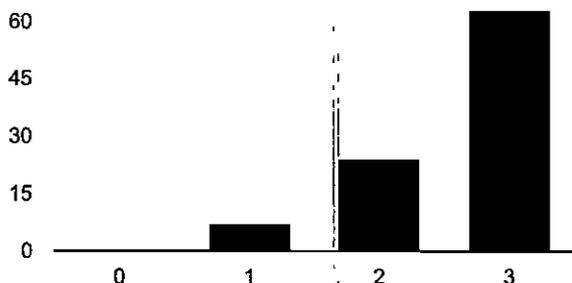
Coordination of care between medical and behavioral health is imperative but traditionally for me (17+ years) more often than not docs dismiss the opinions of the behavioral health issue/needs and work independently with minimal reciprocal communication

Past meds on a list means little without also knowing if the person took them, if they worked, why were they discontinued, etc.

We do not currently have certified mental health staff.

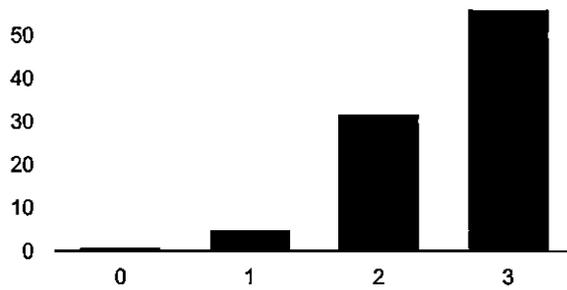
The next five questions refer to treatment program participation

Type of program



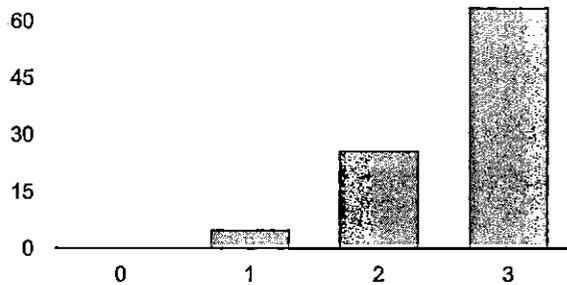
No need:	0	0	0%
	1	7	7.4%
	2	24	25.5%
High need:	3	63	67%

Frequency and duration of participation



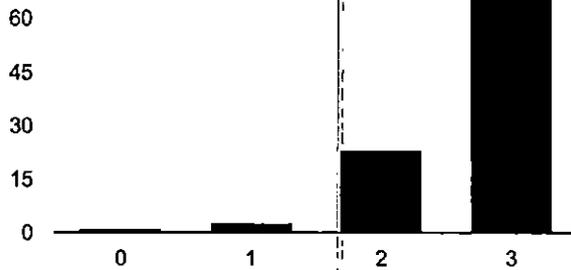
No need:	0	1	1.1%
	1	5	5.3%
	2	32	34%
High need:	3	56	59.6%

Participation status (active, terminated unsuccessfully, completed)



No need:	0	0	0%
	1	5	5.3%
	2	26	27.4%
High need:	3	64	67.4%

Discharge summary upon program termination



1	3	3.2%
2	23	24.2%

High need: 3 68 71.6%

Please add any comments regarding treatment participation information in the space below

disposition , follow-up plans on discharge summary

court ordered treatment, i.e. mental health court

Therapeutic Community

...

The discharge Summary fro previous treatment episodes is extremely important to the continuity of care

It would be beneficial to have more detailed information on their participation and any problems areas they had in prior programs. treatment. Better documentation on these areas.

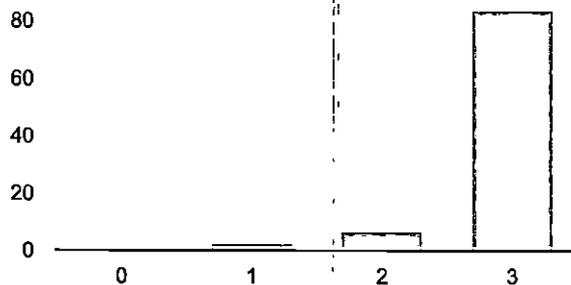
Information on any

Treatment often has a lot to do with the acumen of the provider so discharge summaries have to be weighed that way. Substance abuse Counselors should be an additional speciality beyond graduate level training.

Feedback regarding strengths identified in Tx, and responses to Tx modalities

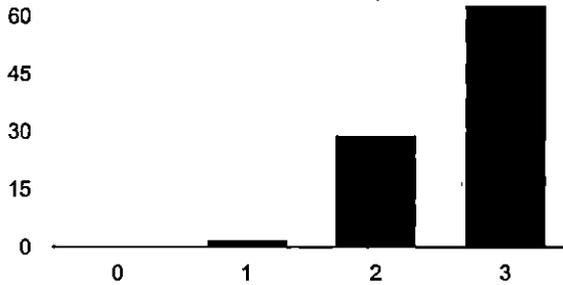
The next three questions relate to the client's substance use

Current substances used



No need: 0	0	0%
1	3	3.2%
2	7	7.4%
High need: 3	84	89.4%

Past substances used



No need: 0	0	0%
1	2	2.1%
2	29	30.9%
High need: 3	63	67%

Please add any comments regarding substance use information in the space below

Are these the only questions around SUD? Do we want/need to know how long they used? How much? How frequently? Whether this use caused involvement in the legal system?

UA testing results

legal implications, court ordered treatment, condition of probation, i.e. DUI

Amount and frequency of use. Any disruptions due to use. Use of a substance for the purpose of gaining an opposing effect from another substance.

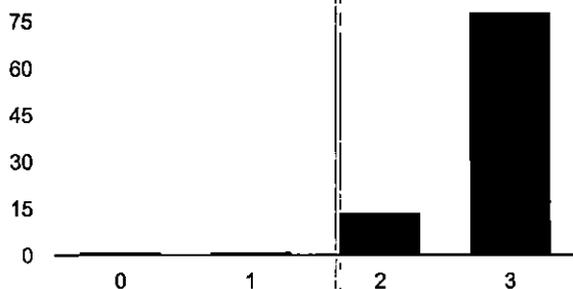
Therapeutic Community

unknown

Follow up area identifying motivation/purpose for change

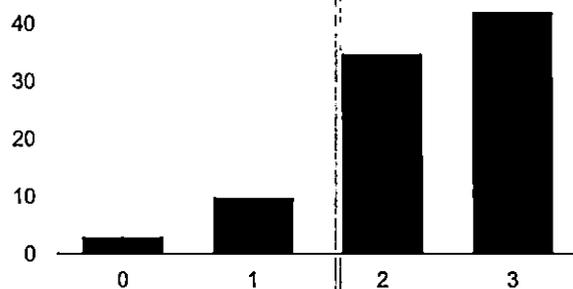
The next five questions refer to additional information that may be useful to providers

Duty to Warn situations



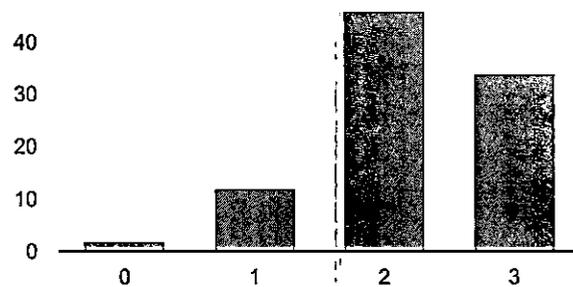
1 1 1.1%
 2 14 14.9%
 High need: 3 78 83%

Intended release address (when returning to the community)



No need: 0 3 3.2%
 1 10 10.6%
 2 35 37.2%
 High need: 3 42 44.7%

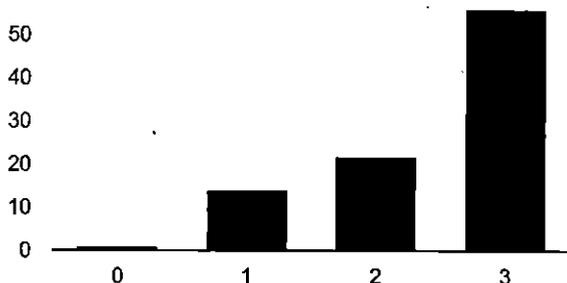
Dates of prior incarcerations



No need: 0 2 2.1%
 1 12 12.8%

2 46 48.9%
 High need: 3 34 36.2%

Emergency contact/support system contact



No need: 0 1 1.1%
 1 14 15.1%
 2 22 23.7%
 High need: 3 56 60.2%

Other content - please provide a list of additional information that might improve continuity of care for people with behavioral health treatment needs

Need shared information on criminogenic needs, share treatment and supervision planning, regular communication and team meetings, role clarification, and good collaboration.

past community treatment providers or resources that could be useful in the area the client would be residing.

Therapeutic Community

unknown

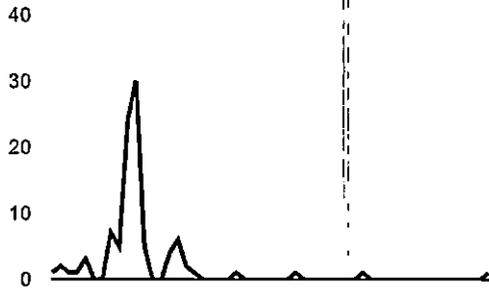
The support system contact would be beneficial for their recovery plans and relapse prevention plans.

psychosocial rehabilitation aftercare plan in place for transitioning clients

I own a small co-occurring agency and the inadequate reimbursement rates from Medicaid as well as how SUD Medicaid clients have to relapse to get more treatment units is absurd. The low reimbursement means there can be very little slack time to play phone tag with other professionals due to the organizational need to maximize billable hours. We get \$7 for a SUD case management contact. We get \$11 for the same thing with a MH client. Why the discrimination? Why spend precious time chasing \$7 when another billable hour maximizes value? The reinforcers otherwise known as reimbursement are also absurd. Then there's the stick of audits and then paying back to Medicaid because somethings are not to the standards that they refuse to give us at the beginning. Get the MBAs out of healthcare.

We are not a criminal justice treatment provided.

Number of daily responses



updated 8/24/15 after input

Preferred Formulary Psychotropic Medications: 2015

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Anticholinergics and Antihistamines			
Benztropine tablets	Cogentin	\$	MH
Benztropine injection	Cogentin	\$\$	P
Diphenhydramine capsules	Benadryl	\$	MH
Diphenhydramine injection	Benadryl	\$	MH
Hydroxyzine tablets	Atarax	\$	P
Trihexyphenidyl 2, 5 mg tablets NTH	Artane	\$	
Fexofenadine	Allegra		
Desloratadine	Clarinex		
Loratadine	Claritin		
Levocetirizine	Xyzal		
Cetirizine	Zyrtec		
Antidepressants (SSRI)			
Citalopram tablets	Celexa	\$	MH
Escitalopram tablets	Lexapro	\$	P
Fluoxetine capsules	Prozac	\$	MH
Fluvoxamine	LUVOX		P
Sertraline tablets	Zoloft	\$	MH
Paroxetine	Paxil	\$	MH
Antidepressants (SNRI)			
Venlafaxine XR capsules	Effexor XR	\$	MH
Venlafaxine tablets	Effexor	\$	P
Duloxetine capsules	Cymbalta	\$\$	MH
Antidepressants (TCA) Tricyclic			

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Amitriptyline tablets	Elavil	\$	MH
Desipramine tablets	Norpramin	\$	P / C
Doxepin capsules	Sinequan	\$	MH
Imipramine tablets	Tofranil	\$	P / C
Nortriptyline capsules	Pamelor	\$	P / C
Antidepressants (Miscellaneous)			
Bupropion tablets	Wellbutrin	\$	P
Bupropion tablets	Wellbutrin XL	\$	P
Bupropion SR	Wellbutrin		P
Bupropion XL	Wellbutrin		MH
Mirtazapine tablets	Remeron	\$	MH
Trazodone tablets	Desyrel	\$	MH
Benzodiazepines (New start vs continue)			
Clonazepam tablets	Klonopin	\$	MH
Lorazepam injection	Ativan	\$	MH
First Generation Antipsychotics			
Chlorpromazine tablets	Thorazine	\$\$	P
Chlorpromazine injection	Thorazine	\$\$	MH
Fluphenazine tablets	Prolixin	\$	P
Fluphenazine Depot injection	Prolixin	\$\$	P
Haloperidol tablets	Haldol	\$	MH
Haloperidol Decanoate injection	Haldol	\$\$	MH
Haloperidol Lactate injection	Haldol	\$\$	MH
Loxapine capsules	Loxitane	\$	P
Perphenazine tablets	Trilafon	\$	P
Thioridazine 25 mg tablets	Mellaril	\$	
Thiothixene capsules	Navane	\$	P
Trifluoperazine tablets	Stelazine	\$	P

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Second Generation Antipsychotics - Atypical (oral)			
Clozapine tablets	Clozaril	\$	MH
Risperidone tablets	Risperdal	\$	MH
Risperdone M tab tablets	Risperdal M	\$	MH
Risperidone microspheres Depot Inj	Consta	\$\$\$\$	P
Ziprasidone capsules	Geodon	\$	MH
Ziprasidone injection	Geodon	\$	P
Olanzapine tablets	Zyprexa	\$	MH
Olanzapine ODT tablets	Zyprexa Zydis	\$	MH
Olanzapine SDV injection	Zyprexa	\$\$	P
Quetapine tablets	Seroquel	\$	MH
Aripiprazole tablets	Abilify	\$\$	P
Paliperidone tablets	Invega	\$\$	P
Iloperidone tablets	Fanapt	\$\$	P
Lurasidone tablets	Latuda	\$\$	P
Asenapine maleate tablets	Saphris	\$\$	P
Paliperidone palmitate injection	Invega Sustena	\$\$\$\$\$	P
Mood Stabilizers/Anticonvulsants			
Carbamazepine chew,tablets	Tegretol	\$	MH
Divalproex tablets	Depakote	\$	MH
Divalproex ER	Depakote	\$\$	MH
Gabapentin capsules	Neurontin	\$	MH
Lamotrigine tablets	Lamictal	\$	MH
Lithium Carbonate capsules /tablets	Eskalith/Lithobid	\$	MH
Oxcarbazepine tablets	Trileptal	\$	P
Topiramate tablets	Topamax	\$	P

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Antianxiety			
Buspirone tablet	Buspar	\$	P
Prazosin	Minipress		P
ADHD medications - Stimulants			
Atomoxetine	Strattera	\$\$	P
Methylphenidate (Ritalin)	Concerta		P
Mixed Amphetamine Salts	Adderall		P
Guanfacine generic- short acting	generic	\$	P
Clonidine generic- short acting	generic	\$	MH
Medications for Addiction Treatment			
Acamprosate (3 x day)			P
Buprenorphine (licensed)	Suboxone		P
Naltrexone ER injection	Vivাত্রol	\$\$	MH
Naltrexone Oral	ReVia		P
Methadone (licensed)	Dolophine		P
Naloxone			MH
MH = Must Have; P = Preferred; C = Have at least one available in the category			
\$ 0.01-1.00 per dose			
\$\$ 1.00-50.00 per dose			
\$\$\$ 50.00-100.00 per dose			
\$\$\$\$ 100.00-500.00 per dose			
\$\$\$\$\$ over 500.00 per dose			

Policy Brief

Statewide Pharmaceutical Purchasing – Bulk Purchasing

Background:

The Behavioral Health Transformation Council - Medication Consistency Workgroup has identified mental health medications that are considered for a basic formulary that can ensure continuity across criminal justice system and behavioral health systems for individuals who are served in both systems. Once an individual is returned to a community from the criminal justice system they often are not connected to the stabilizing medications due to different formularies used between systems. The workgroup has identified a consistent formulary that could be use across all public systems to ensure continuity.

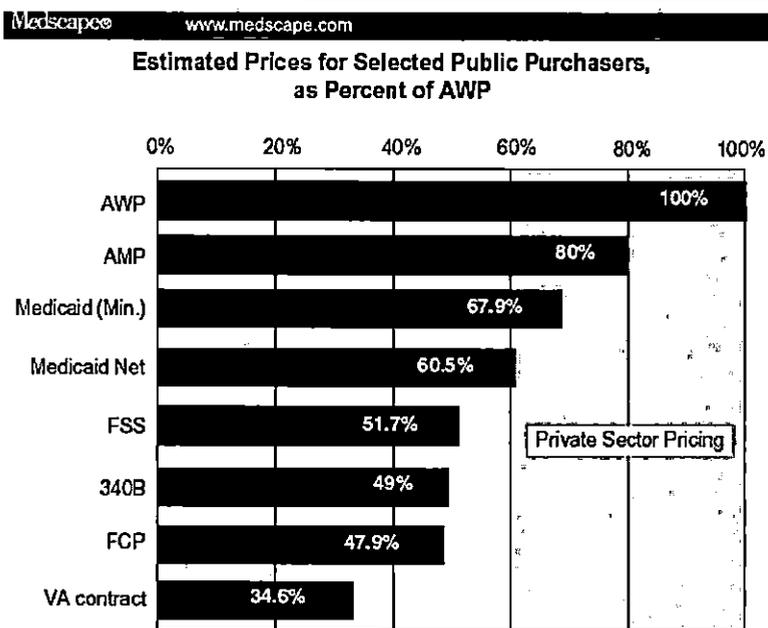


The next step is to identify ways that the formulary can be purchased by multiple public systems that would buy pharmaceuticals in bulk, or other purchasing mechanisms that can be used to reduce the cost on systems and ensure continuity.

Background on pharmaceutical pricing to identify possible solutions for purchasing

There are five federal discount programs to be aware of.

- Medicaid Rebate Program.** Federal Medicaid law requires drug manufacturers to pay state Medicaid agencies a quarterly rebate on brand name drugs equal to 15.1% off of Average manufacture Price (AMP) or the manufacturer's best price, whichever is lower, plus an additional rebate if the price of the drug has risen faster than the rate of inflation. Medicaid net price is approximately 40% below Average Wholesale Price (AWP).
- 340B Program.** Many federally funded clinics, health departments and hospitals are eligible for below-market discounts under section 340B of the Public Health Services Act. 340B providers usually pay less than the Medicaid net price because they are able to negotiate sub-ceiling prices. They also save by not paying the drug mark-ups and dispensing fees to retail pharmacies. Average 340B prices are about half of AWP.
- Federal Supply Schedule.** The FSS is a schedule of contracts and prices for frequently used supplies and services available for purchasing by federal agencies and other entities such as the U.S. territories and tribal governments. FSS prices are on average slightly above 340B prices.
- Federal Ceiling Price.** The Department of Veterans Affairs, Department of Defense, Public Health Service, and Coast Guard ("Big 4") often get pricing below FSS on brand name drugs because these drugs are set at a statutory price called the federal ceiling price (FCP). FCP is set at 24% below the non-federal AMP, often referred to as a non-FAMP. FCP prices are on average slightly below 340B prices.
- VA Contracts.** The VA has been especially successful in negotiating prices below the FCP through the use of a national formulary. VA contract prices can be as low as 65% below AWP.



Stephen Schondelmeyer, PRIME Institute, University of Minnesota (2001).

Source: Am J Health-Syst Pharm © 2003 American Society of Health-System Pharmacists

An understanding of federal drug discounting laws and their impact on the U.S. pharmaceutical market may help states to obtain federal-like discounts for their own drug assistance programs, if properly designed.

Recommendation



The Behavioral Health Transformation Council - Medication Consistency Workgroup is recommending policy options to reduce the cost of pharmaceutical purchasing to achieve medication consistency for community public programs.

Statewide bulk purchasing for all public programs – Use the existing connection to the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) pharmaceutical group buying cooperative Statewide. State Hospitals, Department of Corrections, many counties and local governments currently participate in the MMCAP pharmaceutical buying cooperative. The pharmaceutical group buying cooperative should be encouraged for purchasing pharmaceuticals statewide by all eligible public programs. All counties and local community mental health centers are able to participate and join the State in the pharmaceutical group buying cooperative as authorized in 24-110 (201) and (207.5) as local public procurement units, and may purchase these pharmaceuticals in bulk through the Minnesota pharmaceutical group buying cooperative.

Contact: Regina Huerter | Executive Director | Division of Behavioral Health Strategies | City and County of Denver | 720.913.6606 Phone | regina.huerter@denvergov.org

Pros: This would allow the state and local public entities to use their power of purchasing in much larger quantities than the usual, for a unit price that is lower than the usual. This provides a tremendous amount of savings than if purchasing alone. Through this bulk purchasing it would allow for the pharmaceuticals on the standard formulary to be purchased consistently statewide and ensure consistency in access to medications for patients.

Cons: Local entities may choose not to use other buying options for purchasing of pharmaceuticals.

Authorized Statewide Suppliers and Contracts

Cardinal Health 110, Inc. is the contracted pharmacy wholesaler for State of Colorado facilities, who purchase pharmaceuticals and supplies, as members of the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) pharmaceutical group buying cooperative.

Member facilities have individual ordering authority, personalized account management, and customization of delivery options. MMCAP contracted pharmaceuticals are clearly identified and managed through the Cardinal web-based ordering system, so each member can be confident that pharmaceuticals are being purchased in accordance with contracts.

Diamond Drugs, Inc. is a correctional pharmaceutical service provider option that can be used by facilities that do not operate an internal pharmacy. Diamond Pharmacy services can be contracted through MMCAP by Colorado customers, so pharmaceutical discounts can still be passed down to correctional facilities that don't operate an internal pharmacy. MMCAP-eligible members, who currently use Diamond services, can easily transition their existing account to reflect MMCAP member status, without disruption to existing pharmacy services.

Contact: Christine Weber | Purchasing Agent | State Purchasing & Contracts Office | Department of Personnel & Administration | 303-866-6146 Phone | christine.weber@state.co.us

Recommendation

Pilot Integrated care in community Jails with 340B Option – Create a pilot to Enhance and find all opportunities to create and use partnerships with Federally Qualified Health Clinics and Community Mental Health Centers to provide integrated health and behavioral health care in the local community jail. If the Federally Qualified Health Clinic provides care as a part of their scope of services they can provide medications to patients through the federal 340B program. Full integrated care can be achieved if both the physical care and behavioral health care services are provided by Federally Qualified Health Clinics and Community Mental Health Centers. Only the Federally Qualified Health Clinics is eligible to purchase through the 340B program, which can also include all mental health medications.

Contact: Regina Huerter | Executive Director | Division of Behavioral Health Strategies | City and County of Denver | 720.913.6606 Phone | regina.huerter@denvergov.org

Pros: Achieve continuity of care through integrated care and pharmaceutical purchasing for public programs to achieve greater discounts than the bulk purchasing. Once a patient leaves the jail they will have both a health and a mental health care home once returned to the community ensuring continuity of service and medication consistency. Savings through 340B on average is 65% lower than bulk purchasing through private sector pricing.

Cons: Provider systems would have to contract and adapt health and behavioral health service programs in the community jail and could be complicated for local programs to implement.

Considerations combined with bulk and 340b purchasing - Drug Utilization Review – A provider education program for prescribers who are outliers of normal prescribing patterns that result in more costly pharmaceutical utilization and jeopardize patient safety. This is a non-punitive corrective education that improves patient safety and controls pharmaceutical cost.

MICJS Housing Subcommittee Update
Legislative Oversight Committee Meeting
June 23, 2016

Problem: There is a shortage supportive housing for individuals with mental illness who are involved in the criminal justice system. Many of these individuals reenter the community homeless making behavioral health and supportive services difficult to arrange during a critical point of community adjustment contributing to destabilization and higher recidivism rates.

Subcommittee Goal: To research and recommend options to increase supportive housing options for justice involved individuals with mental illness. The subcommittee will develop a white paper with the benefits of supportive housing and alternatives for funding and establishing programs across all areas of the state.

Current Activities:

Two University of Denver Law School Interns will support the subcommittee by gathering the following information:

- Empirical data on housing needs related to justice involved individuals with mental illness including:
- Building an exhaustive list of previous bills and legislation dealing with zoning issues, housing vouchers, insurance incentives, housing investment trust funds, and grant programs to reduce recidivism
- Conducting a Multi-State Survey to describe model supportive housing and treatment programs for justice involved individuals with mental illness which are cost effective.
- Researching available federal grants such as the USDA which has many grant programs for rural areas.
- Researching other means for establishing supportive housing such as redirecting existing funding or repurposing existing facilities to provide supportive housing.

The subcommittee members will:

- Map current supportive housing options and gaps, with the support of the two interns, to identify the most critical needs.
- Produce a white paper on options to address the problem with potential areas for future legislation

Navigating the Mental health & Substance Use Disorder System



*A Resource Guide for Families with
Colorado Medicaid Insurance*



COLORADO
Department of Health Care
Policy & Financing





If your child is a danger to herself or himself, or to other people please go to the nearest hospital, urgent care or emergency room.

Turn to **CRISIS SITUATIONS** (p xxx) for more resources.

Defining Mental Health and Substance Abuse Disorders

It is important for parents to monitor their child's mental health just as its important to monitor their physical health. Many of us find it difficult to understand what mental health actually is and how to identify its signs and symptoms. Below are definitions that will help you understand what mental health as well as determine if your child might have mental health concern:

MENTAL HEALTH is a sign of a child's overall emotional well-being. Mental health can be difficult to understand, because it can be related to medical, social, or behavioral issues that a child may have. In general, mental health refers to a child's ability to:

- Adapt well to his or her environment in ways that are healthy; and
- Cope well with day-to-day stresses, problems, and challenges. When children are not comfortable with how they are feeling, do not have good coping skills, and cannot get along with others, it is possible that they could have a mental health issue.

A MENTAL HEALTH ISSUE impacts a child's emotional wellbeing. An issue could develop from dealing with a bully at school or the loss of a loved one. It could be a short-term problem or long-term mental illness.

MENTAL ILLNESSES are medical conditions that can disrupt a child's mood, thinking, feelings, and ability to interact with and relate to others in his or her life. These disruptions can be emotional changes, behavioral changes, or both. For the majority of children, a change in mood, feelings, and behavior is a natural part of child development. However, when these changes begin to impact a child's ability to function on a daily basis, a mental illness may be the cause of these changes. If this is the case, the child may need mental healthcare.

SUBSTANCE USE DISORDERS occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

PRESCRIPTION DRUG ABUSE is when someone takes a medication that was prescribed for someone else or takes their own prescriptions in a way not intended by a doctor or for a different reason such as to get high. When prescription drugs are abused, they can be addictive and put the person at risk for other harmful health effects, such as overdose.

2 Your Families Mental Health

As a parent, you have frequent contact with your child and are able to notice changes in your child's behavior or emotions. If there are any signs and symptoms of mental health issues it is important to identify them as soon as possible and seek care for your child.

Learning, playing, exploring, and creating relationships are just some of the experiences that your child will gain throughout their childhood. These experiences shape your child's behavior and are heavily dependent on where they live, who they learn from and many other factors. For example, a child living in colder weather will have a better idea on how to dress in such places compared to a child who lives in a climate with warm weather all year around. The environments we live in determine our behaviors such as how we think, what our beliefs are, how we deal with conflict, and how we solve problems. Our child's behaviors constantly change and as parents it is important that we monitor them to make sure that there are no developing behavioral problems.

Adverse events in your child's life may have an impact on their mental health. A loss of a friend or bullying at school can cause your child to develop symptoms that can lead to mental health concerns. A child with mental health issues may not always be easy to identify.

If your child is displaying abnormal behavior, it has to be determined if it is just a phase that the child is going through or constantly persisting. If the behavior is indeed problematic and persistent then your child may indicate a significant mental health concern.

Children with behavioral problems can have difficulties with regulating their emotions and social interactions with others. They are also at a greater risk of developmental delays, which can put a child at a disadvantage to reaching its fullest potential. Therefore, it is important to identify mental health concerns early so children can receive the proper care that they need.

Early identification of your child's behavioral problems can help them get on the right track for a healthy and productive life. Many of the behavioral health problems can be addressed through safe and effective treatments that will support your child each step of the way. Below you will find a table of symptoms and diagnosis that your child may have. If any of the symptoms look familiar please contact your child's primary care provider or go to page xx to learn how to get the needed services for your child.

Symptoms & Possible Diagnosis

Symptoms	Possible Diagnosis
Developmental delays, inattentiveness, or overactivity	<ul style="list-style-type: none"> ● Medical condition or learning disorder ● Developmental disorder ● Attention Deficit Hyperactivity Disorder (ADHD) ● Anxiety or mood disorder
Extreme anxiety or fear	<ul style="list-style-type: none"> ● Medical condition ● Anxiety disorder
Extreme sadness and despair	<ul style="list-style-type: none"> ● Depression ● Bipolar disorder
Problems with food or fear of being overweight	<ul style="list-style-type: none"> ● Eating disorder
Problems after a traumatic event	<ul style="list-style-type: none"> ● Short term reaction to trauma ● Post-Traumatic Stress Disorder (PTSD)
Extreme anger or defiance	<ul style="list-style-type: none"> ● Developmental problems or family tension ● Oppositional defiant disorder
Unsafe use of drugs, prescription drugs or alcohol	<ul style="list-style-type: none"> ● Drug or addiction problem ● Depression or traumatization

TIP

If you notice changes in your child's behavior that concerns you, make sure to write down and keep track how often, when, and where these abnormal behaviors happen. Providing detailed descriptions of your child's behavior will help the pediatrician identify any problems as well as make the necessary referrals to specialists that can find the right treatment for your child.

Mental Illness in Families

Mental health and substance abuse disorders may happen to anyone in the family. Parents, grandparents, aunts and other family members may develop these problems that can impact the health of the whole family. Children who have parents that are mentally ill and/or abusing substances, are at an increased of developing these problems as well.

Environments that are also inconsistent, unpredictable and unsafe for children can cause mental health and substance abuse disorders. Therefore, it is important that parents who have a mental health and/or substance abuse disorder seek treatment to improve their health as well as protect their child from developing any of these problems.

Some protective factors that can decrease the risk to children include:

- Knowledge that their parent(s) is ill and that they are not to blame
- Help and support from family members
- A stable home environment
- Psychotherapy for the child and the parent(s)
- A sense of being loved by the ill parent
- A naturally stable personality in the child
- Positive self esteem
- Inner strength and good coping skills in the child
- A strong relationship with a healthy adult
- Friendships, positive peer relationships
- Interest in and success at school
- Healthy interests outside the home for the child
- Help from outside the family to improve the family environment

If you are a parent who has a mental health and/or substance abuse disorder, please seek treatment as soon as possible and take your child in for a psychiatric evaluation to check their health status. The sooner your family is seen by health professionals the better your family's health and well-being will be.

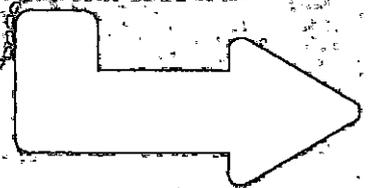
If you need assistance in navigating the mental health and substance abuse disorder system, please follow the steps in this guide to get the needed services for you and your family.

3 Getting Health Insurance

Where should I go to get my child evaluated for a mental health concern? Which doctors will see my child? Who can help connect me to the right services for my child? How can I get my child on Medicaid? What treatments will Medicaid cover for my child?

These are just some of the questions that families are asking when they have a child who might have mental health concerns. The right answers may not always be easy to find as our current health care system can be complex and confusing. In addition, trying to navigate the health care system can be different for each person depending on the type of problems they are having, their age, or even in the region of Colorado that they are living in. To reduce the burden that families are having with accessing and navigating mental health services, we have created this guide that will provide the necessary answers on how to get the right treatment at the right time for your child.

**Signing up for Medicaid
and getting a doctor
for your child**



Getting on Medicaid or Child Health Plan Plus (CHP+)

Before you or your child can be seen by a doctor they will have to be insured. Depending on your family's income you and your child may be eligible for Medicaid which is a public health insurance for low-income Coloradans. To see if you qualify for Medicaid please reference the chart below.

Medicaid Eligibility Monthly Maximum Income Guidelines Effective April 1, 2015¹

Family Size	Parents & Caretaker Relatives 68% Poverty Level ²	Adults (Ages 19-65) 133% Poverty Level	Children (Ages 0-18) 142% Poverty Level
1	\$667	\$1,305	\$1,393
2	\$903	\$1,766	\$1,886
3	\$1,139	\$2,227	\$2,378
4	\$1,375	\$2,688	\$2,870
5	\$1,610	\$3,149	\$3,362
6	\$1,846	\$3,610	\$3,855
7	\$2,082	\$4,071	\$4,347
8	\$2,318	\$4,532	\$4,839
9	\$2,553	\$4,994	\$5,331
10	\$2,789	\$5,455	\$5,824

¹ Co-payments may apply; no co-pays for American Indians, Alaska Natives or pregnant women and her household

² To align with federal policy, effective April 1, 2015, the Parents & Caretaker Relative maximum FPL has been changed from 107% to 68% FPL. For more information go to Colorado.gov/HCPF.



If your income is too high and you are a pregnant women or have a child 18 and under then you may qualify for Child Health Plans Plus (CHP+)

Child Health Plan Plus (CHP+) is public low-cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Medicaid, but not enough to pay for private health insurance.



You may also qualify for Colorado Medicaid or CHP+ if you fall under one of the following categories and meet the income guidelines:

- Children ages 0-18 with household income under 260% Federal Poverty Level (FPL)
- Pregnant women, over the age of 19, whose household income is under 260% FPL
- Parents and Caretaker Relatives (you must have a dependent child) whose household income does not exceed 133% FPL
- Adults without dependent children whose household income does not exceed 133% FPL

Resources

Apply for MEDICAID, make changes to your account, and check the status of an application on the PEAK website.



To get in-person help please visit your county of residence's Department of Human Services or a local application assistance site.

They can help you with:

- Applying for Medicaid benefits
- Questions about your benefits and co-payments
- Questions or issues with bills you may be receiving

Local Department of Human Services- <https://sites.google.com/a/state.co.us/humanservices/home/services-by-county>

Local Application Assistance Site- <http://www.colorado.gov/apps/maps/hcpf.map>

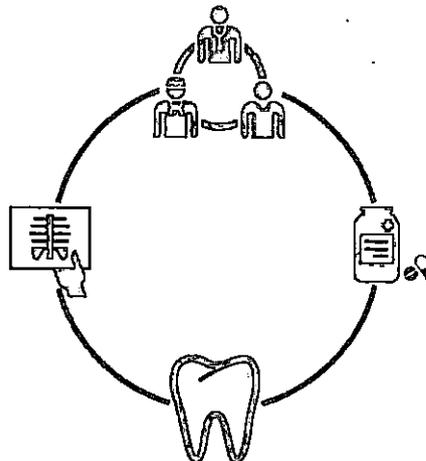
Covered Services for Medicaid and CHP+ Beneficiaries

Medicaid

- Behavioral health
- Dental services
- Emergency care
- Family planning services
- Hospitalization
- Laboratory services
- Maternity care
- Newborn care
- Outpatient care
- Prescription drugs
- Preventive and wellness services
- Primary care
- Rehabilitative services

CHP+

- Primary Care
- Emergency Care and Urgent Care
- Hospital Services
- Dental Care (for children only)
- Prescriptions
- Immunizations
- Maternity Care (prenatal, delivery and postpartum care)
- Mental/Behavioral Health Care



Resources

For more information about specific benefits talk to:

- Your doctor
- Check out Medicaid's Benefit Coverage Standards: <https://www.colorado.gov/pacific/hcpf/benefits-collaborative-approved-benefits-standards>
- Get in touch with the Medicaid Customer Contact Center: Toll Free: 1-800-221-3943 | State Relay: 711 | Fax: 303-866-4411
Customer Contact Center Office Hours: Monday - Friday 7:30 a.m. - 5:15 p.m.
The Contact Center is closed for staff meetings on Fridays from 10 - 11 a.m. and for state holidays.



Member Frequently Asked Questions: To save you time, we've answered many of the most common questions about Medicaid, Child Health Plan Plus, and other topics below. If you still can't find the answer you need get in touch with us using our toll free number listed above.

4 First Steps to Seeking Care

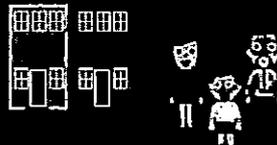
Once you, your child or family have been enrolled into Medicaid, they will be able to use the health care system and get the necessary services that they need. Knowing how to navigate this system can be complex and challenging. Luckily, there are a number of resources that Medicaid provides that can help you access the health care system.

Healthy Communities

Healthy Communities is a program that helps families sign up for Medicaid/CHP+. They can help you with the application process, provide education on available benefits and services, and connect you to other community resources. They are the starting point for getting health care. Below are other services that they can give you:

- Help with Medicaid/CHP+ re-enrollment
- Inform you on preventative health care services
- Help you find a medical home
- Help you find community resources

Healthy Communities are located in your community

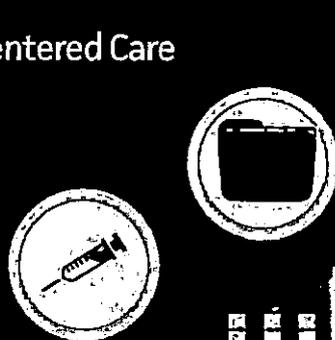


START

Patient-Centered Medical Home

The medical home where you, your child, or family will receive health care

Patient-centered Care



Comprehensive Care



Hospital

Primary Care



Community Mental Health Center



The role of a Community Mental health Center

- Provide mental health care and substance use services
- Crisis services 24/7
- Case Management
- Intensive Out-Patient Services
- Psychiatric Assessment
- Medication Management
- And much more

The role of Primary Care

- Preventative care
- Screenings and health risk assessments
- Health promotion/education
- Evaluation of medical problems and referrals
- Diagnosis and treatment of acute chronic illnesses

Coordinated Care

Regional Care Collaborative Organizations (RCCOs)

Coordination

Behavioral Health Organizations (BHOs)

A RCCO is responsible for coordinating your physical health. Below are other tasks that a RCCO can help you with:

- Help you find specialists.
- Connect you to community and services in your area.
- Make sure that everyone who is involved in your care is talking to each other and working as a team.
- Helps you get a primary doctor.
- Follows up on your referrals.
- Helps you obtain behavioral health services.

A BHO is responsible for coordinating your mental health. Below are other tasks that a BHO can help you with:

- Help you find mental health professionals
- Help you file a grievance or an appeal
- Follows up on your referrals.
- Makes sure that your physical and mental health providers are working together so that you have the most effective treatment

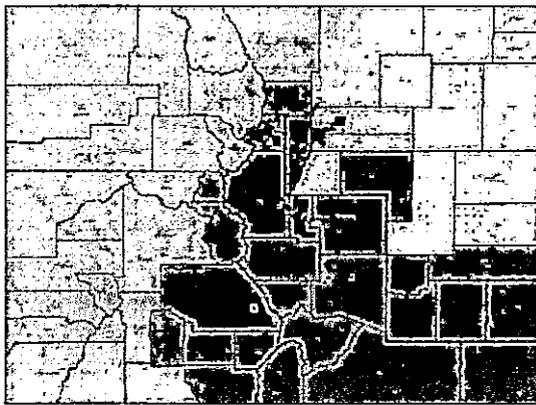
Healthy Communities Contact Information

Family Health Coordinators can help you apply for the Healthy Communities Program. To find your Family Health Coordinator in your region go to: <https://www.colorado.gov/pacific/hcpf/family-health-coordinator-list>

All Colorado citizens wanting to access public programs or those who are already eligible for public programs and are under the age of 21 or pregnant.

RCCO contact information

You are enrolled in a RCCO based on your home address. Check the map below to see which RCCO serves your county.



- RCCO 1 - Rocky Mountain Health Plans
- RCCO 2- Colorado Access
- RCCO 3- Colorado Access
- RCCO 4- Integrated Community Health Partners
- RCCO 5- Colorado Access
- RCCO 6- Colorado Community Health Alliance
- RCCO 7- Community Care of Central Colorado

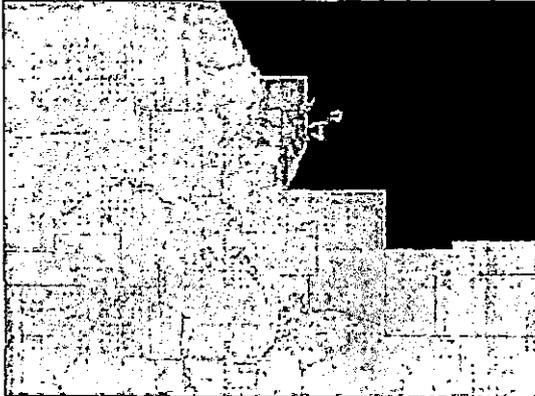
RCCO Region	Contact Information
RCCO 1 - Rocky Mountain Health Plans	970-254-5771, 800-667-6434 acc.rmhp.org/Home
RCCO 2- Colorado Access	303-368-0035, 855-267-2094 www.coaccess-rcco.com
RCCO 3- Colorado Access	303-368-0037, 855-267-2095 www.coaccess-rcco.com
RCCO 4- Integrated Community Health Partners	855-959-7340 www.ichpcolorado.com
RCCO 5- Colorado Access	303-368-0037, 855-267-2095 www.coaccess-rcco.com
RCCO 6- Colorado Community Health Alliance	303-256-1717, 855-627-4685 cchacares.com/en-us/home.aspx
RCCO 7- Community Care of Central Colorado	719-314-2560, 866-938-5091 http://www.mycommunitycare.org/

Resources

Up-to-date contact and RCCO regions can be found here:

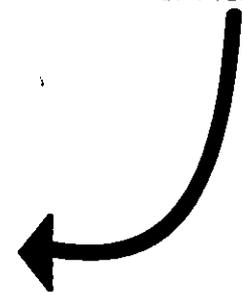
BHO contact information

You are enrolled in a BHO based on your home address. Check the map below to see which BHO serves your county.



- Colorado Access/Access Behavioral Care Northeast (ABC)
- Behavioral Health, Inc (BHI)
- Colorado Health Partnership (CHP)
- Foothills Behavioral Health Partners (FBHP)
- Colorado Access/Access Behavioral Care Denver (ABC)

If you need a mental health specialist call your BHO



BHO	Contact Information
Colorado Access/Access Behavioral Health Northeast (ABC)	(303) 751-9030 or (800) 984-9133 toll free www.coaccess.com/access-behavioral-care
Behavioral Health, Inc (BHI)	(303) 361-8100 www.bhicares.org/
Colorado Health Partnership (CHP)	(800) 804-5008 toll free www.coloradohealthpartnerships.com
Foothills Behavioral Health Partnership (FBHP)	(303)-432-5950 or (866) 245-1959 toll free www.fbhpartners.com/
Colorado Access/Access Behavioral Health Denver (ABC)	(303) 751-9030 or (800) 984-9133 toll free www.coaccess.com/access-behavioral-care

For detailed information on receiving mental health care or substance use disorder treatment turn to page xxx

5 Your Primary Care Doctor

The growth and development of a child is a complex process. To ensure that this process is following the right path your child should be regularly visiting their pediatrician or doctor. Pediatricians can track and monitor the health of your child as well as provide you with important information on any illnesses, immunizations, nutritional advice and physical fitness. Pediatricians will also monitor your child's behavior and emotions, including issues around his or her social and family life, schooling, and learning abilities.

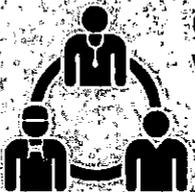
If you feel like your child is showing any abnormalities in their behavior, your pediatrician would be the first point of contact for care. They are usually the most knowledgeable on your child's health history since they have probably seen and tracked the health of your child through previous visits.

Your pediatrician will conduct an evaluation of your child's mental and developmental health as well as check for any substance abuse issues. The screenings are quick, simple and provide the pediatrician with an initial assessment of what is going on with your child. If the results of the evaluation are indeed a cause for concern, then your pediatrician will refer your child to a specialist for further evaluation.

Finding a doctor/pediatrician

Once you have Medicaid insurance you will be able to choose a doctor/pediatrician for your child. Your health professional must accept Medicaid for them to be able to see your child.

Find a Medicaid Provider



Click the link below and search for providers who live nearby you:

<https://www.colorado.gov/hcpf/find-doctor>

TIP

You can call your RCCO or the Healthy Communities program to help you find a nearby provider.

More information in Section 4

Remember that you should always check with the individual provider to find out if they're accepting new Medicaid patients. If you need additional help please go to page xxx and call or email the Medicaid Customer Contact Center.

Evaluating your child for health problems

It is important that your child has regular visits with a pediatrician in order to make sure that there are no problems with your child's health. These regular visits provide the pediatrician with opportunities to identify any potential health concerns that your child may have. The sooner they can identify problems, the lower the risk of your child missing typical developmental milestones.

Your pediatrician will check your child's health using different methods that are safe and effective. Below are some typical things that your pediatrician will check during your child's visits. Please note that depending on your child's age, your pediatrician will check for different things.

- Developmental delays
- Immunization status
- Body Mass Index (BMI)
- Cognitive abilities
- Blood level tests
- Oral Health

If the pediatrician believes that your child may have a mental health concern, they will refer you to a specialist. For more information on mental health specialists, turn to page xxx.

Resources

For a detailed list of what a pediatrician is checking during your child's life, please go to:

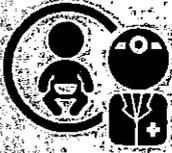
<http://kidshealth.org/en/parents/system/#catchcheckupsubcat>

TIP

Monitoring and tracking your child's health can help health professionals identify potential concerns. Try to answer the following question about your child. Don't worry if you can't answer these questions.

- Is your child's troubling behavior similar to the behavior of other children in his or her age group?
- How often does your child behave in a way that troubles you?
- How severe or extreme does your child's behavior seem to you?
- How long does each episode of troubling behavior last?
- Where does your child's troubling behavior occur?

Reminder: Well Child Visits



Children need to be regularly seen by their pediatrician or family physician to make sure that they are growing and developing normally. Your child's first well-child visit should be a couple of days after they are born and continue until they are 21 years old.

Your child's provider will conduct a number of tests that evaluates their overall health. Even if your child is healthy, well-child visits are effective in preventing your child from getting sick.

Information provided at a well-child visit

- Sleep
- Safety
- Childhood diseases
- What to expect as your child grows

Tools and resource kits for each well-child visit

<https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

Your child's provider will also talk about other wellness topics such as family relationship issues, school, and access to community services.

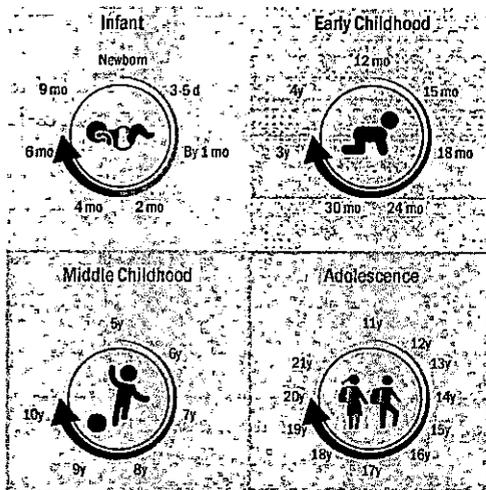
When should your child have a well-visit?

Before your child is born it is important to go to your doctor especially if:

- You are a first time parent
- Are a parent with a high-risk-pregnancy
- You have questions on issues such as breastfeeding, circumcision and general child health issues.

After your child is born they should be evaluated right after birth. The next visit should be 3-5 days after birth. Your provider should help you schedule these appointments and notify you whenever your child is due for a visit.

After these initial visits it is recommend that you take your child for well-visits at the following child's ages:



How can your RCCO coordinate your care?

Your RCCO has a close relationship with your doctor's office and can assist with coordination your child's care. It can often be confusing understanding all of the information that your doctor has given you. This is where your RCCO can assist you by explaining where you may need to go next to get the needed care for your child.

For example, you can contact your RCCO if you need to be connected to a doctor or if you need help finding transportation to your appointment. A RCCO will help you in contacting the right people so that your care happens in a timely and efficient manner.

Resources

For a detailed well-visit schedule please go to the Bright Futures

website: <https://www.aap.org/en-us/Documents/periodicity-schedule.pdf>

Referrals from your pediatrician/doctor to specialists

After your child's pediatrician/doctor has evaluated your child for any health concerns, they may refer them to a specialist if more evaluations are needed. Specialists are doctors who have completed advanced education and training in a specific area of medicine. Your child's pediatrician/ doctor will refer you to the right specialist based on their evaluation.

If you know what is wrong with your child, you can also go straight to a specialist. Your RCCO or doctor can provide you with the contact details of specialists in your area that accept Medicaid or CHP+.

Example of specialty doctors include:

- Addiction psychiatrist
- Adolescent medicine specialist
- Cardiologist
- Cardiovascular surgeon
- Colon and rectal surgeon
- Dermatologist
- Developmental pediatrician
- Endocrinologist
- Gastroenterologist
- Geriatric medicine specialist
- Gynecologist
- Infectious disease specialist
- Neurologist
- Obstetrician
- Oncologist
- Ophthalmologist
- Oral surgeon (maxillofacial surgeon)
- Orthopedic surgeon
- Pain management specialist
- Physiatrist

If your child has been referred to a health professional that specializes in mental health and substance use disorders, please go to page xx for more information.

6 Additional Resources for Families to get Care

Children's health is one of the most important investments for Colorado. Due to many different types of needs that children in Colorado may have, additional resources and programs are made available to safeguard their health and well-being. Some of these programs are automatically available the second your child is enrolled into Medicaid while others require that your child have a specific health condition or disability. The next following pages explain some of the additional resources your child may be eligible for.

Early and Periodic Screening, Diagnostic and Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a benefit that protects the health of your child by ensuring that they receive appropriate preventive, dental, mental health, developmental and specialty services. It is required by law that these services are provided for your child in order to keep them healthy.

Who qualifies?

Children and youth under age 20 as well as adults who are pregnant, are automatically protected by this benefit once they are enrolled into Medicaid. Children and pregnant women on CHP do not qualify for the EPSDT benefit.

Healthy Communities and EPSDT

The Healthy Communities program is mainly responsible for ensuring that your child receives EPSDT benefits and services. Family Health Coordinators from the program will make sure that you can access your EPSDT services and services as well as with help navigating the health care system. For more information on Family Health Coordinators turn to page xxx.

Information and support that you will receive from the Healthy Communities program on EPSDT:

- Information to all Medicaid-eligible individuals under age 20 and under, including adults who are pregnant, that
- EPSDT services are available and of the need for age appropriate screenings, well child visits and immunizations;
- Help with arranging and receiving screening services for your children;
- Help with arranging (through referral) corrective treatment as determined by child health screenings;
- Missed appointment follow-up;
- Refer for transportation assistance; and
- Outreaching your family for available EPSDT services
- Assisting you through the referral process if your child needs further evaluations or treatment.

What is medical necessity and how will it effect my child's benefit

Medical services and supplies must be medically necessary in order to be covered by Medicaid.

What does it mean for medical services and supplies to be medically necessary?

For children (0-20 years of age), medical necessity starts with looking at individual health care needs of a specific child. What may be medically necessary for one child may not be for another. This process starts with your doctor or other health care professional evaluating your child's needs and prescribing treatment or supplies if they have been determined to help improve or sustain your child's health. The medical professional should be able to find information on which orders/prescriptions need to receive prior approval by Medicaid.

Just because a doctor says something is medically necessary, however, doesn't automatically mean it meets Medicaid's rules for medical necessity. For the medical services and supplies to be medically necessary they also must be considered appropriate for the specific needs (sometimes referred to as normal course and treatment) and have a good chance of helping the condition addressed or at least prevent the condition from worsening. This also means the ordered treatment cannot be considered experimental by the medical community.

Medical necessity also requires that the treatment, etc., cannot be ordered solely for the benefit of a child's caretaker or health care provider. Respite care, for example, is to give a caretaker a break so it would NOT be considered medically necessary. However, some services such as respite may be available under a Medicaid Waiver program explained on page xxx.

In addition, once the medical services and supplies have been determined to be medically necessary for a child, Medicaid cannot impose arbitrary limits on how many or how often these medical services or supplies can be provided.

Benefits and Services

The following benefits and services are covered for your child if their needs have been determined medically necessary:

- Physician and nurse practitioner access
- Hospital services
- Speech/language services
- Occupational therapies
- Home health services
- Medical Equipment
- Mental health and substance use disorder treatment
- Hearing and dental coverage
- Prescription drugs
- Behavioral health services

Why is it important to use the EPSDT benefit?

Children should be screened for any potential health problems so that they can be quickly treated. The earlier the screening the faster health professionals can help your child and make sure that they stay on a correct path of growth and development. EPSDT ensures that children on Medicaid have access to these services to protect their health and well-being.

Breakdown of EPSDT



Assessing and identifying problems early.



Checking children's health at periodic, age-appropriate intervals. Colorado has adopted the American Academy of Pediatrics Bright Futures Periodicity schedule. To see the schedule turn to page xxx.



Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems. Screening Services included:

- Comprehensive health and developmental history
 - Comprehensive unclothed physical exam
 - Appropriate immunizations
 - Laboratory tests (including lead toxicity test)
 - Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)
-



Performing diagnostic tests to follow up when a risk is identified. Diagnostic tests should always be done if a problem has been identified during screening. These tests help find what the problem with your child may be and allow for the correct treatment to be given.



Control, correct or reduce health problems found. Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Medicaid Waiver Program

Medicaid Home and Community Based Waivers (HCBS) provide individuals who have special health care needs with services that help them remain in their homes and communities. Colorado offers 12 HCBS waiver programs that focus on different health conditions.

- Brain Injury Waiver 
- Children's Home and Community-Based Services Waiver 
- Children's Extensive Support Waiver 
- Children with Life Limiting Illness Waiver 
- Children With Autism Waiver 
- Supported Living Services Waiver 
- Children's Habilitation Residential Program Waiver 
- Developmental Disabilities Waiver 
- Community Mental Health Supports Waiver 
- Elderly, Blind, or Disabled Waiver
- Spinal Cord Injury Waiver 
- Persons Living with AIDS/HIV Waiver 

   Signifies which organization you need to apply through to be placed on the waiver program. More information below.

Who qualifies?

To qualify for any of these waivers, your child has to be "at-risk" of institutionalization in an intermediate care facility as well as meet financial, medical and care needs. Parental income is not considered for eligibility. Only the child's assets or income is considered.

Eligibility requirements differ for each waiver. Please visit the Colorado Medicaid website for detailed description and eligibility information for each waiver.

<https://www.colorado.gov/pacific/hcpf/programs-individuals-physical-or-developmental-disabilities#forchildren>

Apply for HCBS Waivers

Depending on which waiver you are applying for, you will have to go through the following agencies:



Community Centered Boards (CCBs) coordinate services to clients in the least restrictive setting possible with the goal of keeping them in their homes and communities as an alternative to institutional care. CCB contact information: <https://www.colorado.gov/hcpf/community-centered-boards>



Single Entry Point (SEP) Agencies provide case management, care planning, and make referrals to other resources for clients. To find the SEP Agency in your county, click on the link below: <https://www.colorado.gov/pacific/hcpf/single-entry-point-agencies>



County Department of Social/Human Services (DHS) administer certain waivers with the oversight of the Department of Health Care Policy and Financing. To find your local County Department of Social/Human Services click on this link: <https://nces.google.com/n/state/cous/humanservs/home/services-by-county>

If you have more questions about the HCBS waivers please contact the Medicaid Customer Contact Center
Toll Free: 1-800-221-3943 | State Relay: 711 | Fax: 303-866-4411

Resources

Additional programs for individuals who have/are:

- Physical or Developmental Disabilities
- Behavioral Health Needs
- American Indian Or Alaskan Native
- Veterans

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For your information

Each waiver has an enrollment and may have a waiting list. People can apply for more than one waiver, but can get services through one waiver at a time.

7 Navigating the Mental Health Care System

It can be difficult navigating the mental health care system, because of the many different pathways people can take to get care. Unfortunately, many of the paths may not get people the quick care and treatment that they need. To reduce the confusion of navigating the mental health care system, this guide will help you, your child or your family to access mental health and substance abuse disorder services.

The following pages explain the resources that are available to you and how they can connect you to mental health and substance use disorder services.

Accessing Mental Health or Substance Abuse Services for Children with Medicaid

If your child has Colorado Medicaid they are automatically enrolled into one of the five Behavioral Health Organizations (BHO) based on your county of residence. Your BHO will arrange behavioral health services for your child that include services for mental health and substance use disorders.

You do not need a referral from your primary care provider to receive mental health or substance abuse services. You can directly contact your BHO.

Your BHO has an extensive network of providers in your region. These providers can work at either a Community Mental Health Center (CMHC) or are from an independent provider network (IPN).

You can also directly contact your CMHC or IPN without the need of a referral from your primary care provider.

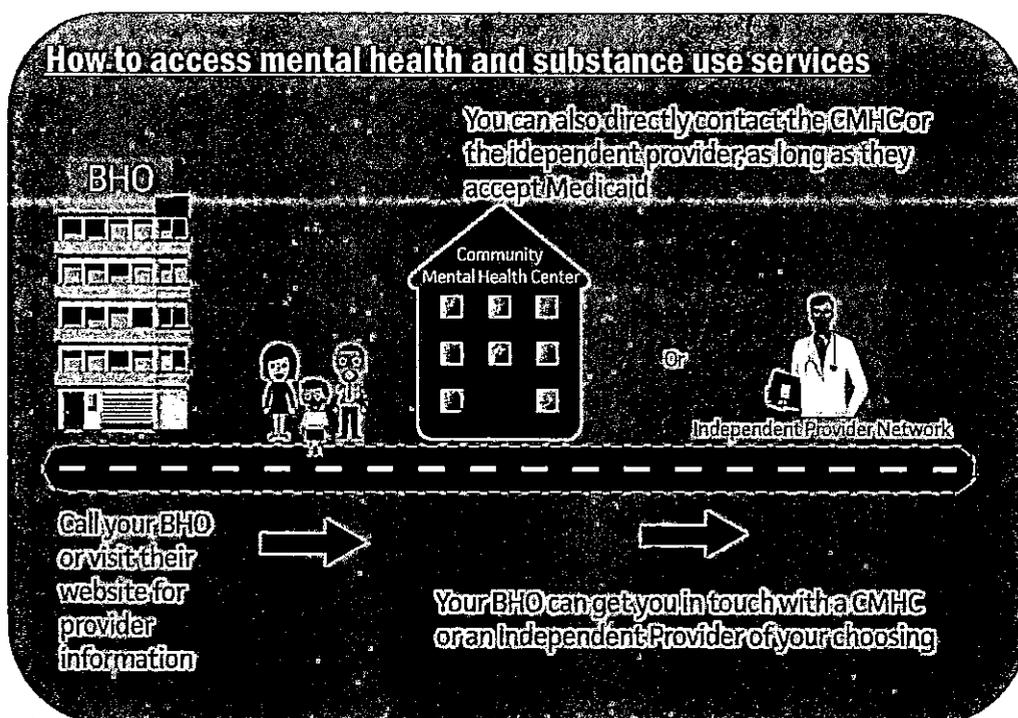
Mental Health Service Providers

Community Mental Health Centers- are non-profit providers of mental health and substance abuse services. There are 17 CMHCs, serving all areas of Colorado. Each CMHC has a number of mental health specialists that can provide treatment for various symptoms and diagnosis. Your CMHC will connect you to the right specialist that serves your needs

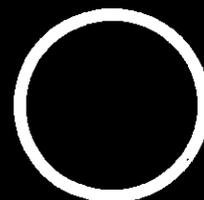
For a comprehensive list of services please contact your local CMHC.

<http://www.cbhc.org/find-help/find-a-community-mental-health-provider/>

Independent Provider Networks- are individual mental health and substance abuse providers. Your BHO can help you find the right provider that will serve your needs.



BHO Contact Information



If your child does not have Medicaid, please go to page xxx for instructions on how to sign up. The faster your child receives treatment, the faster their health can improve.

Accessing Mental Health or Substance Abuse Services for Children with Child Health Plan Plus

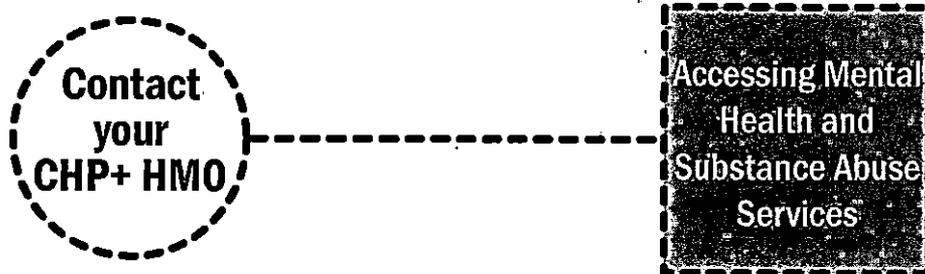
If your child is on a Child Health Plan Plus (CHP+) plan, they will have to join and seek services through a Health Maintenance organization (HMO). There are five CHP+ HMOs serving various parts of Colorado. To find which HMO is serving your county please click this link :

<https://www.colorado.gov/pacific/sites/default/files/Child%20Health%20Plan%20Plus%20HMO%20Chart.pdf>

Your CHP+ HMO has an extensive network of providers that will provide mental health and substance abuse treatments for your child. Please contact your CHP+ HMO to be connected with an appropriate provider.

You do not need a referral (approval in advance) from your Primary Care Provider (PCP) to get mental or behavioral health services from a specialist, hospital, or other provider that is in you CHP+ HMO network.

How to Access Services



CHP+ HMO	Contact Information
Colorado Access	(888) 214-1101 www.coaccess.com
Colorado Choice CHP	(822) 475-8466 coloradochoicehp.com
Denver Health Medical Plan	(303) 602-2100 denverhealthmedicalplan.com
Kaiser Permanente	(303) 338-3800 kp.org
Rocky Mountain Health Plans	(800) 346-4643 rmhp.org

If your child does not have CHP+, please go to page xxx for instructions on how to sign up. The faster your child receives treatment, the faster their health can improve.

Visiting your mental health professional

If your child is having emotional or behavioral problems, you should take them to a mental health professional for an evaluation. The results of the evaluation will help diagnose any problems with your child and connect them to the right mental health professional for treatment.

There are many different types of treatment option available for treating mental illnesses. Some of those treatment options include talk therapy, play therapy, and behavioral therapy. Your child's mental health professional will be able to determine what treatment or multiple treatments your child will need.

Some children may also require medication to treat their mental illness. It is important to remember that not all mental health professionals can prescribe medication or provide certain services. For a detailed list of mental health professionals and the programs and services that they provide please visit this website. <http://www.mental-healthamerica.net/types-mental-health-professionals>

If you, your child or family are receiving care at a Community Mental Health Center, then you have access to many different types of mental health professionals under one roof. The CMHC will make sure that you are connected with the right professional that can help you improve the health of your family.

How long will it take to get an appointment

As a Health First Colorado member, you have the right to get behavioral health services in a timely manner. When you call to make a first appointment, it is important to tell us or your provider if you have a special need. Some of our members may need special help to get the most from their behavioral health services. If you have a disability and need special assistance, please let us know when you call for an appointment. Also let us know if you need an interpreter for a non-English language or a sign language interpreter.

For Mental Health Services:

- When you call to make a first or routine care appointment, our providers will offer you an appointment within **7 days**.
- If you call about an urgent mental health problem, our providers will see you within **24 hours**.
- If you are calling with a mental health emergency, our on-call providers will see you within one hour if you live in a city. If you live in a rural area, they will see you within **two hours**.

For Substance Use Disorder Services:

- When you call to make a first or routine care appointment, our providers will offer you an appointment within **7 days**.
- If you call about an urgent substance use problem, our providers will see you within **24 hours**.
- If you have an emergency substance use problem, you should call 911 or go to the nearest emergency room. If you have a substance use provider, you may call them to ask about your treatment options.

Appointments for regular, ongoing therapy will be scheduled within **2 weeks** from when you had your first appointment with your provider. Regular ongoing therapy services include being assigned to a regular therapist, one-to-one counseling and group therapy

TIP

If you cannot be seen within the times mentioned above, call your BHO. They can help you get connected to a specialist or file a grievance if you are having difficulties accessing care.

What Mental Health and Substance Abuse Services are available for Children on Medicaid?

The table below explains your or your child's mental health benefits covered under the Behavioral Health Plan. Services that are not covered under the Behavioral Health Plan may be covered by your Medicaid insurance, but only if they are medically necessary. The EPSDT program for children requires that any services that are medically necessary be provided. For a definition of medically necessary please turn to page xxx.

Behavioral health benefits covered under the Behavioral Health Plan

Case Management Services	These are services you get in the community. They help you stay in the community. They include service planning, outreach, referral and coordination of services. Routine case management is part of the services provided by your care coordinator.
Emergency Care	Emergency care is the treatment of a substance use disorder that is life threatening. It is life threatening to the person who is having the crisis. Or, another person may think it is life threatening to you.
Inpatient Hospital	Inpatient services are those mental health services that need to be given in a hospital.
Medication Management	This is when a doctor, or other licensed prescriber, prescribes and monitors your psychiatric medications.
Outpatient Treatment	These are services you get in an office or other place in the community. Services include individual, brief, family, and group therapy.
Psychosocial Rehabilitation	Psychosocial rehabilitation programs help people with serious mental illness. They teach people the skills they need to live in the community.
Residential Treatment	A residential treatment program is a 24-hour living situation. It provides care when a person does not need to be in the hospital, but still needs help and structure 24-hours a day. Residential treatment can be for adults or children.
School Based Services	School-based services are for children and youth with special mental health care needs. They are provided in the school setting. Services may include smaller classrooms, specially trained staff, counseling, and other services to help the child succeed.

Other required services that are covered under the Behavioral Health Plan

The following services may be offered in your community. To learn more, call your Behavioral Health Organization. The Behavioral Health Organizations contact numbers are listed on page xxx

- Vocational and employment services SUD
- Home-based services for children and adolescents SUD
- Intensive case management SUD
- Respite services SUD
- Drop-in centers SUD
- Clubhouses SUD
- Family support, education and training services SUD
- Multi-systemic therapy
- Peer services and support services
- Peer mentoring for children and adolescents SUD
- Assertive community treatment programs SUD
- Warm (telephone support) lines SUD
- Special services for adoption issues
- Early childhood intervention services
- Prevention services and early intervention activities
- Recovery services SUD
- Supported employment

SUD = Services also covered if you have substance use disorder

Substance use disorder services covered under the Behavioral Health Plan

The following table explains your substance use disorder benefits covered under the Behavioral Health Plan. (Note that inpatient and residential services are not covered services). If you or your child needs inpatient and residential services, they may be covered under Medicaid if they are medically necessary. All services must be medically necessary for your covered substance use disorder:

Case Management Services	These are services you get in the community. They help you stay in the community. They include service planning, outreach, referral and coordination of services. Routine case management is part of the services provided by your care coordinator.
Emergency Care	Emergency care is the treatment of a substance use disorder that is life threatening. It is life threatening to the person who is having the crisis. Or, another person may think it is life threatening to you.
Outpatient Treatment	These are services you get in an office or other place in the community. Services include individual, brief, family, and group therapy.
Social Detox Services	These are services that help people get clean and sober. They will monitor your vital signs, assess your motivation for treatment, provide your daily living needs and do a safety assessment.
Medication Assisted Therapy	These are services provided in an outpatient Substance Use Disorder setting. They include administration of Methadone or another approved controlled substance to a person who is opiate dependent in order to decrease or do away with dependence on opiates. It also may include counseling to help the person focus on their recovery without having to deal with the symptoms of withdrawal.
Psychosocial Rehabilitation	These are services provided by a recovery coach or a peer specialist. A recovery coach/peer specialist is someone who has had personal experience with a drug or alcohol addiction, is now sober, and has had special training to use his or her experience to help others in recovery. Recovery Coaches are part of a treatment team at the behavioral health center or substance abuse provider setting.

Resolving Problems with your Services

If you are unhappy with any part of your mental health or substance abuse service, you have the right to file a grievance (complaint). You also have the right to appeal any action (decision) that you disagree with. Each BHO has an Office of Member and Family Affairs (OMFA) that can help you with any grievance or appeal. You can also contact your BHO to start an appeal process.

Definitions

Action: An Action is when a BHO:

1. Denies or limits all or part of a requested service, including the type or level of service.
2. Reduces, changes or ends treatment that was already approved.
3. Denies payment in whole or in part for a service.
4. Does not provide services in a timely manner.
5. Does not act within approved time frames for grievances and appeals.
6. Denies a request to obtain treatment outside the network in rural areas.

Appeal: When you disagree with an Action by CHP and ask for a review of the Action. You may make your Appeal orally but must follow up in writing

Designated Client Representative (DCR): A person you choose to file a grievance or appeal for you. You must put this choice in writing. This person can be one of your providers, like a doctor or therapist. It can also be a friend or a family member

Grievance: A complaint about your mental health or substance use services, your provider or staff. You can file a Grievance if you are unhappy about any service or staff person. This includes things like the quality of your care, or failure to respect your rights. It could also include a provider or staff being rude to you. A Grievance can be oral (in person or by telephone) or in writing.

Notice of Action: This is a letter that CHP sends you explaining the Action it is taking and your Appeal rights.

State Fair Hearing Process: This is a hearing before a state administrative law judge. It is available for Appeals only.

How to file a grievance?

You have 30 calendar days from the date of the event to file a grievance. You may file your grievance on the phone, in person or in written form. The Client and Family Advocate at Mental Health Partners can help you with this.

How to file an appeal?

If you disagree with an Action that your BHO takes, you have the right to file an Appeal. You must make your appeal within thirty (30) calendar days from when we sent the Notice of Action. You can file an appeal by phone, in person or in writing. If you appeal by phone or in person, your BHO will consider that date as the date of your appeal.

Who can help me file a grievance or an appeal?

If you need help filling a grievance or an appeal, you can contact an Ombudsman to help you through the process. the ombudsman is an independent organization that provides free services to Medicaid managed care or BHO members.

Ombudsman for Medicaid Managed Care
1-877-435-7123 outside of Denver
303-830-3560 in the Denver Metro area
TTY 1-888-876-8864 for hearing impaired



Additional Information

BHO Member Handbook

Each BHO is required to provide member handbooks with detailed information on accessing services, filing grievances and appeals, and general information on member rights. The member handbook also includes contact information to various resources that can help you with any questions or problems that you might have regarding your care.

BHO Member Handbook Links

Colorado Access/Access Behavioral Health Northeast (ABC)	http://www.coaccess.com/documents/ABCNE-Member-and-Family-Handbook.pdf
Behavioral Health, Inc (BHI)	http://bhicare.org/wp-content/uploads/2014/01/member-and-family-handbook-1-1-2014.pdf
Colorado Health Partnership (CHP)	http://www.coloradohealthpartnerships.com/members/pdf/CHP_Member_Handbook.pdf
Foothills Behavioral Health Partnership (FBHP)	http://fbhpartners.com/members/
Colorado Access/Access Behavioral Health Denver (ABC)	http://www.coaccess.com/documents/ABCD-Member-and-Family-Handbook.pdf

8 Crisis Situations

Crisis Support Line

If you are in a crisis or in need of immediate mental health, substance use or emotional help for yourself or someone you know, contact the **COLORADO CRISIS SERVICES**. They provide confidential and immediate support, help manage an emergency situation, and connect you to further resources. They are available at any time of the day.



Call this toll-free number
1-844-493-TALK (8255)
or text **TALK** to **33255** to
speak to a trained
professional.

When you call Colorado Crisis Services, you will be connected to a crisis counselor or trained professional with a master's or doctoral degree. They offer translation services for non-English speakers, they engage in immediate problem solving, and they always make follow-up calls to ensure you receive continued care.

Crisis Walk-In Centers/Stabilization Units

You can also visit any of the Walk-In Crisis Services

if you are having a crisis or need help dealing with one. They are open 24/7, and offer confidential, in-person crisis support, information and referrals to anyone in need. If you need assistance when helping others with a crisis, you can always go to a walk-in center near you. Some locations provide crisis beds for 1-5 days, for either voluntary or involuntary treatment. Location of Walk-In Centers can be found below.

Mobile Care

If you cannot reasonably access the Crisis Service Walk-In Centers, a mental health professional can be sent out to your location to provide support if you are in need of face-to-face help. You will need a referral from a Crisis Service Clinician to have someone come out to your location. Call 1-844-493-TALK (8255) to learn more about how to access this service.

Respite Care

Respite care can only be initiated by a Crisis Services Clinician after an in-person meeting. Those needing safe, peer-managed stabilization and support can stay voluntarily for 1-14 days to get the help they need.

Metro Denver Region

Westminster Walk-In Crisis Services

2551 W 84th Avenue
Westminster, CO 80031

Lakewood Walk-In Crisis Services

12055 W 2nd Place
Lakewood, CO 80228

Littleton Walk-In Crisis Services

6509 S Santa Fe Drive
Littleton, CO 80120

Boulder Walk-In Crisis Services

3180 Airport Road
Boulder, CO 80301

Denver Walk-In Crisis Services

4353 E Colfax Avenue
Denver, CO 80220

Aurora Walk-In Crisis Services

2206 Victor Street
Aurora, CO 80045

Northeast Region

Fort Collins Walk-In Crisis Services

1217 Riverside Ave
Fort Collins, CO 80524

Greeley Walk-In Crisis Services

928 12th Street
Greeley, CO 80631

Southeast Region

Pueblo Walk-In Crisis Services

1302 Chinook Lane
Pueblo, CO 81001

Colorado Springs Walk-In Crisis Services

115 S Parkside Drive
Colorado Springs, CO 80910

Western Slope Region

Grand Junction Walk-In Crisis Services

515 28 3/4 Road
Grand Junction, CO 81501





COLORADO

Department of Health Care
Policy & Financing

Client & Clinical Care Office
1570 Grant Street
Denver, CO 80203

June 30, 2016

The following report was conducted as part of a Quality Improvement Project undertaken by Health Care Policy and Financing in partnership with the Colorado Department of Human Services-Division of Child Welfare.

Since completion of the report in the fall of 2015, several additional steps in the project have been implemented:

- Data analysis on behavioral health utilization for children on Medicaid that are also involved in Child Welfare is being completed by Colorado State University.
- A tool kit for families and child welfare staff to assist in navigating the complexity of the two systems is drafted and being vetted by community partners.
- BHO Directors have participated in Early Prevention Screening Diagnosis and Treatment (EPSDT) training. Several BHOs have subsequently invited department staff to train case managers and other staff on EPSDT requirements.
- A standardized training for Child Welfare Staff on EPSDT has been developed for the Child Welfare Academy.
- The Department continues to collaborate with the BHOs to develop improved processes for children and families involved in Child Welfare to get access to behavioral health services they need, either through their local Community Mental Health Center or a qualified Independent Practice Network.

Thank you to all of the focus group participants and community partners who have provided input and comments to the report.

Camille Harding, LPC
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1570 Grant Street
Denver, CO 80203





Quality Health Improvement Project - Improving Access to Key Services for At-Risk Children and Families

Colorado Department of Healthcare Policy and Financing

March 30, 2016

PCG | *Human Services*
Public Focus. Proven Results.

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INTRODUCTION

In the summer of 2015, Colorado Department of Health Care Policy and Financing (HCPF) contracted with Public Consulting Group, Inc. (PCG) to help identify strategies to improve access to behavioral health services for children and families. For the purposes of this report, behavioral health services include services to treat mental health and substance use disorders (SUD).

PCG has previously partnered with HCPF and other Colorado state agencies including the Colorado Department of Human Services' Division of Child Welfare (DCW) to address the needs of at-risk populations. The work performed for this report has its origins in a number of prior initiatives, including a summary assessment PCG completed for DCW in February, 2014. This 2014 assessment identified opportunities to expand support for children and families served by DCW by leveraging Medicaid funding for services/programs that are currently paid for with state revenues. The report that PCG submitted to DCW¹, included recommendations to expand the provider networks within the Behavioral Health Organizations (BHOs) and increase coordination with Regional Care Collaborative Organizations (RCCOs). Additionally, PCG recommended the continued expansion of the Dental Administrative Service Organizations, increased training/support for front-line staff, and revised cost allocation practices. A primary recommendation from this assessment was to further examine services through the County Core Services programs, which often finance behavioral health services for children and parents/caregivers that may be Medicaid-reimbursable.

Following that study, PCG, staff at HCPF and DCW continued to explore the opportunities noted in the 2014 report. In February, 2015, HCPF invited PCG to join a meeting of a statewide collaborative group to discuss challenges associated with access to behavioral health services for children and adolescents. The entities that participated in this collaborative meeting included HCPF, DCW, the Office of Behavioral Health, the state's Behavioral Health Organizations (BHOs), County Child Welfare departments, County Human Services Directors Association (CHSDA), Colorado Counties Inc. (CCI), and the Community Mental Health Centers (CMHCs). This meeting gave a variety of stakeholders the opportunity to provide perspectives on how children/families access behavioral health services and the capacity of the provider network to impact change within the current landscape.

During the Collaborative Group meeting, participants acknowledged that the systems landscape for accessing, providing and financing behavioral health services is complex. To help clarify the various entities involved in providing, authorizing, approving, and managing behavioral health services for families, we included an organizational glossary, outlining state/local agencies involved in development of the report. (Appendix 1 – Glossary of Organizations/Agencies Involved in Behavioral Health Services).

From a client and family perspective, navigating the behavioral health system is challenging. It has been discussed that a concerted state-local collaborative effort is needed to improve accessibility and strengthen service quality. It was identified that there was an overriding need to strategically organize systems to ease the burdens that hinder children and families from navigating the system for behavioral health services.

Some of the other key points identified by the Collaborative Group that support this need include, but are not limited to:

- Detailed crosswalk between BHO-contracted providers and DCW contracted providers
- Establishing data exchange between HCPF/BHOs and DCW
- Developing a "common language" and cross training between BHOs and DCW
- Designing care coordination processes to help children/families better access services
- Drafting protocols/strategies to help BHOs and DCW better leverage funding for needed services
- Better aligning the service planning between County child welfare caseworkers and BHO providers, as well as enhanced cross-training between the two entities.

¹ Colorado Department of Human Services: Medicaid Refinancing in Child Welfare, February 24, 2014

Based on recommendations from previous assessments, the meeting in February 2015, and other internal efforts within HCPF and DCW, the scope for completing this report was developed. The purpose of this report is to provide HCPF and state/local partners with analysis, stakeholder feedback, and recommendations to address key issues. This report will identify Colorado's major barriers and recommend strategies to improve access to services for at-risk children and families.

The following summary recommendations are made for HCPF's consideration:

- Focus on immediate, "quick win" efforts to strengthen communication between state agencies to align strategy and program operations.
- Realign current Medicaid programs and services to better meet the needs of children/families that are not directly accessing services through typical channels. Examples of this include: youth involved in the child welfare system; preventative services for families targeting social determinants of health; and enhanced coordination for children and families referred from other sources.
- Structure fiscal incentives and administrative processes to support enhanced provider networks for Medicaid service provision
- Complete a three-phased process with progressive action steps over an approximate two year period:
 - Phase I (6-9 Months):**
 - Implement quick wins with a particular focus on communications
 - Lay the foundation for significant system continuous improvement work at the state and local levels
 - Phase II (9-18 Months):**
 - Implement significant system improvements not requiring major new state appropriations, statutory changes, and/or Federal approval
 - Plan RCCO-BHO re-procurement and include targeted outreach for specific populations
 - Strengthen collaborations at the local level through data sharing, role clarification, joint communications, aligned service/treatment planning, and measurement strategies for outcome indicators
 - Align strategies of HCPF, DCW, and OBH
 - Phase III (18+ Months):**
 - Execute RCCO/BHO re-procurement
 - Fully implement Project COMMIT²
 - Implement significant system improvements requiring major new state appropriations, statutory changes, and/or Federal approval
 - Set up and begin using mechanisms for continuous improvement of policy, process, tools, and measures

² Project COMMIT refers to HCPF's process to replace its Medicaid Management Information System, which will redefine systems and business processes for the Colorado Medicaid agency. This process will replace the legacy MMIS and fiscal agent services with a service delivery model that is flexible and adaptable, with Business Intelligence and Analytics tools that will provide easy access to data and comprehensive reporting.

METHODOLOGY

The PCG project team completed its work through the following phases:

- a) Project Kick-Off and Initial Data Gathering;
- b) Conduct On-Site Information Gathering and Focus Groups;
- c) Gather Additional Feedback to Further Test Hypotheses;
- d) Compile Results and Final Summary Report(s).

a) Project Kick-Off and Initial Data Gathering

The project was initiated by a kick-off meeting, led by the PCG project team and HCPF staff. The meeting included representatives from HCPF and other key stakeholders (DCW State/County Offices, BHOs and/or RCCOs). During the project kick-off meeting, the overall scope of the project was clarified. In addition, there was also a facilitated discussion regarding the need to develop an action plan to address access to high quality services. The Project kick-off meeting helped shape the protocol PCG used to communicate the project and solidify key questions for on-site focus groups. The participants in the project kick-off meeting also helped to identify a detailed list of stakeholders to be a part of the project and key materials for the PCG team to review. The written materials collected/reviewed by PCG throughout the project are listed in Appendix 2 – Listing of Documents/Materials Collected.

b) Conducted On-Site Information Gathering and Focus Groups

The PCG project team conducted various key interviews and focus groups to understand how services are administered at the state and local levels. The primary goal of the meetings/activities in this phase were to identify barriers impacting families covered by Medicaid from front-line staff that have the most contact with the clients being served. The focus group meetings and document reviews also helped the project team explore opportunities to leverage more prevention services for children/families.

Focus group meetings included child welfare case workers and supervisors, CMHC case managers and clinicians, management staff from RCCOs, BHOs, CMHCs, and private providers from the following counties:

- o Mesa
- o Larimer
- o Pueblo
- o Logan
- o Weld

A number of focus group participants provided details about the broader regions and counties they work in including RCCO representatives with experience throughout multi-county regions and private providers from neighboring counties who traveled to take advantage of the opportunity to speak with the PCG team.

- Confidential conversations with foster parents involved with the child welfare system who struggled in obtaining needed services to address behavioral health needs of the adolescents in their care.
- Focused Interview with representatives from RCCO Region 6.
- Listed in Appendix 3 – Stakeholder participants that took part in our project meetings

In each focus group, participants provided a detailed description of how families currently access services. This included policy-related, structural, programmatic, and fiscal barriers that impact their ability to access services. Recommendations for HCPF and other partners could consider to improve access were also made. Each stakeholder session was guided by the protocol in Appendix 4 – Guiding Protocol for Focus Groups and included ad-hoc discussions in areas of importance to participants.

c) Gathered Additional Feedback via Survey

For counties or other individual participants unable to attend regional on-site focus groups, the PCG team also gathered additional responses from a survey which mirrored the protocol used in focus groups. The survey was provided electronically to all county office staff (caseworkers, supervisors, senior team members, etc.), Community Mental Health Centers (CMHCs), Behavioral Health Organizations (BHOs), Regional Collaborative Care Organizations, and other entities involved in providing care, coordination, case management, and/or direct services to children and families. The survey was available for a week (June 22 – 26), in which PCG team collected 178 responses. The eight-question survey gathered feedback regarding current provider networks, service timeframes, and general capacity. The survey results are summarized and discussed in the Findings section.

Below we include an aggregated breakdown of the participants. This includes categorical totals for the interviews/focus groups, as well as the feedback survey (which includes over 260 stakeholder encounters).

Organization/Entity	# of Interview or Focus Group Participants	# of Survey Participants
HCPF	12	
CDHS/DCW	6	
	7	28
	30	72
RCCO	7	6
BHO	3	4
CMHCs, BH Frontline & Supervisor Private Providers	16	5
Other	3 (Families, CASA, Guardian ad Litem)	63
TOTAL	84	178

d) Compiled Results and Final Summary Report(s)

The final report was drafted based on the findings from project. This includes the collaborative meetings with HCPF and state partners, focus groups, interviews, surveys, and documentation review. This report includes recommendations to improve access to services for at-risk children, adolescents, and families, strategies to better align the goals of DCW and Medicaid partners across the state, streamline program operations to simplify county Medicaid, and approaches to potentially reform services.

KEY PRINCIPLES

Throughout the project, the PCG project team noted key principles that were reiterated by stakeholders:

- 1) Message the rationale for and implications of changes effectively, openly, and honestly to all impacted state and county staff
- 2) Examine problems from the perspective of consumers
- 3) Where possible, streamline/simplify processes and procedures versus adding new processes and procedures
- 4) Connect/align new change initiatives with existing initiatives, under an umbrella of rationalized and simplified overall strategic priorities
- 5) Leverage this project to strengthen systematic collaboration between HCPF, DCW, and OBH on solutions both under this project and across a broader plane
- 6) Plan action steps for maximum likelihood of success and sustainability, including organizing them into a roadmap with priorities and phases and assigning accountabilities with attention paid to staff capacity and identifying and accomplishing quick wins early

FINDINGS

The following are key themes that emerged from our assessment of Colorado's state-supported behavioral health system. The information in the findings section incorporate the summaries for the stakeholder meetings, interviews, and focus groups.

Organizational Readiness for Change

Colorado is uniquely active in innovating both frontline practices and organizational practices which leads to both positive and negative impacts throughout the system. Medicaid covered behavioral health services generally require collaboration between multiple partners at both state and local levels and with multiple steps required before coordinated services can be delivered. This collaboration is hampered by staff turnover and a relative lack of coordination among numerous change initiatives.

Strengths:

- HCPF and DCW have worked successfully in the recent past on joint change efforts. These successful collaborations indicate the two organizations can work together to drive change.
- Both DCW and HCPF demonstrate strong alignment and clarity on core organizational values and priorities. DCW leaders and staff are committed to ensuring children/families are connected to a targeted and tailored set of services. HCPF's overriding focus is managing the administration of Medicaid programs, and providing consistent and fair services to all eligible recipients.
- Many staff members interviewed stated that key changes such as increased reimbursement for Medicaid-supported behavioral health services, and the Collaborative Management Program (CMP) which incentivizes county-level interagency coordination have been beneficial improvements.
- All staff members we interviewed expressed a strong desire to see the needs of vulnerable children, adolescents and families met. We found numerous examples of administrators and service providers at the local level advocating doggedly for the children and adolescents in their care. County DSS/DCW and RCCO administrators were found to be exploring creative options for relieving administrative burdens for Medicaid service providers. State HCPF administrators closely collaborate with DCW counterparts to understand and strengthen the ways Medicaid-supported services can be enhanced with other funding in integrated systems of care, frequently going beyond what was required in their roles to try to meet the needs of uniquely vulnerable populations.

Gaps:

- Public agency staff (state, local, etc.) and other stakeholders involved in the administration of Medicaid programs have reported struggling with the rate and volume of change. There is a multi-year pattern at both HCPF and DCW of frequent change in policies, procedures, and frontline practices needing the following:
 - Analysis as to how these changes impact the ability of staff to successfully implement the changes alongside all other work already assigned to them.
 - Prioritization of changes with respect to other initiatives being implemented at the same time.
 - Communication regarding how the changes build on those that have come before, align with other initiatives being implemented at the same time, and prepare the system for additional changes planned for the future.
- Staff members at both state and county levels and across all major organizational units whose staff we interviewed reported feelings of constant "churn" and confusion regarding priorities. County DCW leadership staff reported that they felt like they were constantly trying to explain how changes fit into an overall strategy, without having adequate tools or communication from the State to assist them. PCG also observed that a multitude of simultaneous initiatives were overarching and not well integrated into the overall DCW mission.

Local staff noted that the multiple strategic frameworks, reporting requirements, working groups, and measures are difficult to implement and can negatively impact day-to-day work. Some of these initiatives that are currently happening, or were recently implemented include Systems of Care, the Accountable Care Collaborative, Behavioral Health Transformation, the Collaborative Management Program (CMP), the Colorado Opportunity Project, The Two Generation Framework, Colorado's Title IV-E Waiver demonstration project, and C-Stat as well as numerous rollouts of evidence-based practices and legislative mandated initiatives. Many of these initiatives cross state agencies and provider organizations, however there is a lack of coordination amongst the State agencies impacted by these initiatives. This results in unintended barriers for front-line staff working directly with children and families, particularly with county DCW staff, BHO providers, and private providers.

- HCPF is actively engaged in Project COMMIT, a project to re-procure and enhance all aspects of the state's Medicaid Management Information System (MMIS), data analytics system, pharmacy benefits systems. This system manages the Medicaid program costs, operations of claims, and overall reporting for Medicaid services. Upgraded systems are scheduled to come online in a phased fashion over the course of 2016 and 2017. The key areas that will change include provider enrollment, current portals for billing and collecting clinical data, and updates to the case management system. While this is a potential strength from a data management and reporting standpoint, it also is one more major initiative taking staff time and energy to properly implement this large scale project.
- There is a multi-year pattern of high staff turnover among state staff and county service providers (e.g., child welfare caseworkers and CMHC therapists). This has led to gaps in knowledge and communication related to Medicaid-supported services and their administrative and programmatic requirements.
- OBH is very short staffed, which makes it hard for them to participate actively in the kinds of systemic and systematic continuous improvement efforts like the one generated in this report.

Service Quality and Access

Medicaid is underutilized for eligible behavioral health services, and particularly outside of the ten biggest counties in terms of population (the "big ten counties"). Some key reasons identified for this problem is an inadequate provider network experienced in treating children and families and the complexity of navigating families to services. There are not enough private providers accepting clients with Medicaid coverage, either because they have not been credentialed by the BHO to serve Medicaid clients or they choose to not accept clients with Medicaid coverage. It was also noted that many providers felt that the overall behavioral health system in Colorado is complicated and difficult to navigate. That said, unique features of Colorado's system (e.g., CMHCs, RCCOs) do provide children, adolescents, and their care givers with service options and access that exceeds those in many other states.

Strengths:

- Colorado's unique network of CMHCs, RCCOs, and Crisis Intervention Teams provide low income, at-risk children/families with service navigation and access to affordable mental health treatment services at levels beyond those available in many other states.
- Many RCCOs and County DHS/DSS offices are doing positive, innovative work to increase provider choice and quality for Medicaid clients. This includes helping private providers become credentialed and provide administrative supports to increase capacity to serve Medicaid clients. They are also leading continuous quality improvement efforts to streamline and strengthen communication and process flows between CMHCs, private providers, BHOs, and county DCW.
- In addition to federally-funded supports (e.g., Medicaid administrative funding, mental health and substance abuse disorder (SUD) block grants), Colorado's legislature and state agencies have provided counties with a uniquely flexible and broad array of funding to help counties meet the needs of particularly vulnerable populations. Examples include Core Services and Child Welfare Block Grant funds to help meet the needs of children and adolescents in child welfare. Also, there are specialized funds for incarcerated adults and juveniles, and twelve (12) Medicaid waivers to support home and community based services for children, adolescents, and adults with moderate to severe disabilities and mental illness.

- In some counties, child welfare administrators emphasized their increased attention and investment in trauma-informed services, signaling a potential shift towards preventing and immediately addressing underlying causes of trauma rather than focusing primarily on treating manifestations of past trauma later in childhood and early adulthood.

Gaps:

- While there are numerous innovative services and programs available to children/families throughout Colorado, Colorado's behavioral health system is highly complex and difficult to navigate for customers and service providers. At the state level, there are behavioral health programs administered by various offices and departments in both the Department of Human Services (e.g., DCW, OBH) and HCPF (e.g., DIDD, Health Programs Office, Long Term Supports and Services), which each issue their own regulations and guidance to county staff and behavioral health stakeholders. At the local level, BHOs, RCCOs, CMHCs, private providers, county DCW, and Community Centered Boards (CCB's – local boards legislatively mandated to coordinate local services for individuals with disabilities) all play important roles in connecting individuals and families with needed behavioral health services, including screening and referral, determination of eligibility, documentation of services, provision of services, planning and coordination of services, funding of services, and claiming reimbursement for services.
- Throughout this effort, the PCG project team has sought clear narratives that describe how customers navigate through the system. These paths differ depending on what the child's presenting needs are, what their income levels are, and other factors. It has been the team's aim to gain a holistic understanding of how the system is supposed to work. The team instead found descriptions of individual behavioral health programs with inadequate reference to how they fit into an overall system: Conversations with state and local stakeholders (e.g., focus group, interview, and working group participants) about how the system works and is supposed to work surfaced differing perspectives regarding, e.g., organizational roles, eligibility for programs and funding support, and funding hierarchy (e.g., which funding source should be tapped first for which service, and under which conditions).
- There are multiple definitions and interpretations of "medical necessity". Medical necessity is the main basis on which children are approved or denied behavioral health services for Medicaid reimbursement. There is a specific definition of medical necessity for children/youth within federal rule. However, many BHOs are not considering this guidance, and have their own applied definitions. BHOs and hospitals appear to interpret medical necessity more narrowly than other stakeholders, causing conflict and multiple inadequate courses of treatment. For example, we were cited multiple instances of a child/adolescent/family member having a course of mental health treatment disrupted. In these cases, therapists considered the course of treatment not yet successfully completed, but the BHO determined that treatment has progressed to a point at which it was no longer medically necessary and therefore no longer eligible for Medicaid reimbursement. BHOs do not need to publish or otherwise disclose the criteria used to determine Medical necessity – these are considered protected, proprietary intellectual property. As a result, approval of therapies and courses of behavioral health treatment for Medicaid reimbursement varies from BHO region to BHO region.
**There are current efforts across the state (led by HCPF) to create a single, uniform definition of Medical Necessity for all programs, rules, and Department contracts. The development of a single Medical necessity definition is ongoing and is still in its interim stages at the time of this report.*
- HCPF includes EPSDT language within its contracts (with BHOs, RCCOs, services providers, etc.), however it is not consistently followed. Outside of interviews with HCPF staff, the EPSDT (Early Prevention, Screening, Diagnostic, and Treatment) program was not discussed. It appears to be a lack of awareness/understanding about the EPSDT program, even though it is federally mandated methodology for Medicaid clients under the age of 21 and wrapped into HCPF contracts.
- There is a perception among local stakeholders, and particularly child welfare administrators and workers, that opportunities for consistent, timely, appropriate, and high-quality behavioral health care are more limited through Medicaid, leading case managers to opt for service referrals for non-Medicaid providers. This seems to show that Medicaid is not understood by child welfare staff or local providers of services.
- Some common complaints of Medicaid funded services that we heard include:

- Longer wait times between intake, assessment, and initiation of services. For example, the project team was told specific examples of children who waited weeks or even months for specialized services. This includes mental health treatment, intensive community based services for youth, and other developmental delay and disability assessments. As another example, county staff noted that initial intake appeared to generally take place in a timely way and in accordance with contractual and statutory requirements. However, what constituted intake (e.g., assessments administered) varied widely from county to county and service provider to service provider, ranging from a screening, or basic medical history and demographics history to a wide- ranging, comprehensive assessment. Additionally, frequency of therapeutic sessions, with intervals between sessions ranging from every two weeks to once a month that do not align with a child's developmental stage of development for making behavioral changes do not seem to be considered.
 - Limited provider choice, due to few providers outside of the CMHC contracted with BHO/Medicaid, and experienced providers able to work with families presented with histories of intergenerational trauma, SUD and risk factors.
 - Less well coordinated care: Examples provided include confusion about clinicians able to participate in county child welfare-led Family Engagement Meetings or other staffing after having been told that BHO/Medicaid reimburses only for therapeutic sessions.
 - Less continuity of care due to high turnover of therapists at CMHCs, inadequate and inconsistent interpretation of what services Medicaid will pay for, and the role the BHOs play in determining medical necessity. (for example, EPSDT and maintenance of therapeutic sessions)
- The project team observed numerous examples of confusion among both state and local level administrators and front line service providers about what BHO/Medicaid reimburses. HCPF maintains a list of Medicaid-reimbursable interventions. This list changes annually in response to changes in federal rules and regulations, benefit changes. HCPF staff are contacted frequently (sometimes several times per day) with inquiries about Medicaid-reimbursable services.
 - Case management and therapeutic services for adolescents (12+) dominated focus group discussions while resources for the early childhood (0-8) population were minimally discussed, suggesting a focus on triage/crisis response versus prevention.
**Throughout the focus groups and interviews, there was not any mention of the Early Childhood Mental Health (ECMH) partners stationed at each CMHC, who are paid by CDHS. The ECMH providers appear to be ideal partners in providing more preventative services to families with younger children before issues escalate into serious problems for adolescents.*
 - There are county/local concerns about gaps in key services, some of which varied across localities. The key gaps that focus group participants and interviewees noted are:
 1. Intellectual and Developmental Disabilities
 2. outpatient substance use disorder treatment services for adolescents (ages 12+)
 3. early childhood (ages 0-8) treatment
 4. intensive substance use disorder treatment
 5. resources/programs directed at the middle childhood population (ages 8-12)
 6. trauma informed care that is adequate for families

Fiscal Oversight

The behavioral health services provided by HCPF does not sufficiently target children and families involved with other state systems such as Child Welfare. The availability and flexibility of alternative funds appear to have a generally negative impact on the utilization of Medicaid services. Alternative ways to pay for services, results in potentially duplicative payments due to fewer administrative requirements and less complexity in alternative funding sources. The complexity of the system has also led to confusion about funding hierarchy. Additionally, the way HCPF contracts for local Medicaid care coordination and fiscal administrative services appears to create barriers to efficient local

collaboration.

Strengths:

- Colorado's counties have a pool of funding for behavioral health services generally broader and more flexible than those in many other States. This pool includes funds from DCW (Child Welfare Block Grant and Core Services), OBH (Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant) and HCPF (Medicaid Administration Funds).
- HCPF's contracts with RCCOs and BHOs provide some leverage to increase collaboration amongst local behavioral health stakeholders, and the project team heard examples of some collaboration to strengthen provider networks and close local gaps in service.
- HCPF has recently raised reimbursement rates to levels comparable to other third-party payers.

Gaps:

- At the local level, the variety and flexibility of funds available to pay for behavioral health services provides a viable alternative to strongly pursue Medicaid reimbursement for services. This fact combines with a substantial community of local stakeholders -- most notably county child welfare administrators and private providers -- that perceive Medicaid as carrying an excessive administrative burden not adequately compensated through current Medicaid reimbursement rates. As a result, county child welfare administrators and staff routinely utilize funding allocated by the State for child welfare wrap-around services for many behavioral health services that are reimbursable by Medicaid. As a result, these funds are diverted from wrap-around and/or prevention services not reimbursed by Medicaid, with negative impacts on the speed and breadth of implementation of evidence-supported prevention work (e.g., trauma screening and treatment). The project team was told that counties are, for example, paying up to \$120 per hour for mental health therapeutic services, which is well beyond reimbursement rates for Medicaid or other third party payers, which allows providers reduced administrative burden.
- There appears to be local confusion regarding which funding sources should be used in what sequence to help at-risk children, adolescents, and families pay for behavioral health services.
- The HCPF contracts with RCCOs and BHOs although they differ significantly in tone and emphasized priorities. BHO contracts read like traditional managed care contracts with major accountabilities focusing on responsible stewardship of public funds and key initiatives (reimbursement, rate capitation, and efficiency). The contract language for RCCOs focus major accountabilities on community collaboration, holistic and integrated care, and expansion of Medicaid service provider networks. The difference in contracting has led to contrasting posture toward local partnerships, day-to-day communication, and differing administrative priorities.

Data and Information Systems

Many at-risk families are receiving behavioral health services administered by multiple state agencies and local offices. This means that data needs to be integrated across information systems to effectively coordinate and track service delivery. Data sharing is currently inadequate at both state and local levels for coordinating care for key populations. Due to minimal state-level interoperability, local staff members are frequently expected to double-enter data for numerous cases, which appears to happen inconsistently and inadequately. HCPF's COMMIT Project represents a major investment of funds and energy with the potential to have a significant positive impact on data analysis, sharing, and reporting capacity.

Strengths:

- The State currently has information systems with useful information regarding client demographics and behavioral health service delivery for data analysis and reporting, including DCW's Statewide Automated Child Welfare Information System, Trails, Colorado Client Assessment Record (CCAR) and HCPF's Business Utilization System (BUS).
- The project team found a number of examples of manual work being required to create services reports for key populations. These reports were generally used for oversight and management decision-making. For example, CDHS recently implemented referral guidelines to counties for all children under the age of 3

being served to be referred to Early Intervention for screening/intervention. This is one of the key populations being monitored and measured at CDHS.

- At the local level, a number of formal mechanisms exist to share information about plans related to behavioral health service delivery for children and adolescents in foster care. This includes county child welfare staff-facilitated Family Engagement Meetings and regularly scheduled case coordination meetings between CMHC therapists, county child welfare workers, and supervisors from both organizations.
- At the state level, there are mandated programs that can be used to share data to better coordinate services for children/youth. Specifically, EPSDT data is required to be collected under Center for Medicare and Medicaid Services (CMS) guidelines, which is broken into child welfare categories that could be useful for CDHS purposes (more informed assessments, joint service planning, and C-Stat measures).

Gaps:

- At the local level, data regarding service provision for adults (parents of the children in treatment) and children/adolescents is generally not integrated, even within individual CMHCs. As a result, service providers to children and adolescents often do not know what, if any, services are being provided to the adults in the same family and vice versa.
- State IT systems have places to enter case information regarding mental health and behavioral health services, but these systems are cumbersome and underutilized:
 - Mental and behavioral health data needs to be entered manually by case workers versus auto-populating (e.g., from provider systems, from each other's systems);
 - The systems are generally complex to navigate. For example, the project team witnessed an IT/Trails expert taking close to ten (10) minutes to navigate to wrap-around screens in Trails. County child welfare staff with access to BUS report that it is complex to navigate as well.
 - County child welfare workers generally do not have clerical support, leading the full burden of behavioral health service documentation to fall on them;
 - Data reports/trends/etc. are not routinely reported to the county child welfare case workers who are expected to double enter information about behavioral health service provision to children and adolescents in foster care, leading them to see limited benefits in their own work from time spent entering data.
 - Screens and fields related to mental and behavioral health are generally not mandatory and/or linked to prompts (e.g., pop-ups, automatic emails) that would keep data entry in the worker's awareness.
 - Clinicians in the CMHCs are required to populate a CCAR (Colorado Client Assessment Record) which includes demographic and clinical data on the overlapping population of DCW and OBH clients, as well as Medicaid covered children.
 - The project team saw evidence in Trails of missing and incompletely entered data, which the team attributes to the factors noted above. Due to the time-limited nature of the project, the team did not have the chance to review sample records from any other systems, including BUS.
- Key populations (e.g., uniquely vulnerable populations like children and adolescents with Intellectual and Developmental Disabilities in the foster care systems) do not appear to have staff assigned to monitor care trends (e.g., from critical incident reports), creating risk that major gaps in care may go undetected and/or unaddressed.

Communication and Coordination

The way organizational stakeholders communicate about and coordinate services for families greatly influences how

services are accessed. Local families, administrators, front-line caseworkers, therapists, and other service providers strongly noted that there are gaps in understanding how to navigate the state's system of care to obtain needed services. Due to the high number of stakeholders that impact service provisions for families; frequent and strategic communications are needed to coordinate and administer appropriate services to children, adolescents, and families in need.

Strengths:

- As noted above, most counties have at least some formal mechanisms for stakeholder dialogue related to coordination of care, including Family Engagement Meetings between frontline workers, families, and natural supports for families and CMHC-DCW staff dialogues and case worker/supervisor/therapist monthly meetings to discuss cases and care trends. The project team also heard about numerous examples of RCCOs brokering community dialogues.
- Among administrators, in participating counties (which currently includes more than half of the State's 64 counties) the Collaborative Management Program appears to have not only sparked dialogues between local government agencies, but also formal and informal dialogue between county DCW leadership, RCCO, CMHC, BHO, and other (e.g., schools, Private Providers) key local behavioral health stakeholders.
- Communication between key state staff (within DCW and HCPF, and between the two agencies/departments) is currently relatively strong, due to:
 - A couple of key DCW positions explicitly devoted to DCW-HCPF coordination (e.g., related to Systems of Care, Individuals with Intellectual and Developmental Disabilities, and a new staff member devoted to Alternative Courts)
 - Regular meetings and discussions between senior-level and mid-level (to a limited degree) DCW and HCPF staff
 - Co-location in the same building of DCW staff (e.g., child welfare licensing/monitoring staff and other key DCW staff) and HCPF staff (e.g., staff newly moved into the 12th floor of the main administration building), respectively
 - Inter-personal relationships between administrative staff
- There appears to be solid potential for strengthened DCW-HCPF collaboration even further:
 - DCW and HCPF both expressed to the project team an interest in strengthened collaboration, both related to strategy and day-to-day operations
 - Cross-departmental initiatives (e.g., Colorado Opportunity Project, Systems of Care, and the Cross Agency Collaborative) that can provide an impetus for more systematic collaboration and coordination
 - Consolidation of key HCPF staff in one building versus spread across several buildings
 - Regular meetings at senior administrator levels with expressed interest in sponsoring coordinated efforts among mid-level staff

Gaps:

- Staff and families report that local behavioral health stakeholder groups generally do not appear to be on the same page about how to best provide services and how to best leverage Medicaid. When they ask the same question (e.g., regarding what services Medicaid will help pay for and who to turn to help get connected with services), they get different answers.
- Communication between key state staff at DCW and HCPF has never been formally instituted, due to departmental silos within agencies that impact children receiving behavioral health services (e.g.,

Placement Services vs. Medicaid Waiver Administration vs. Office of Behavioral Health). Key staff are located on different floors and/or in different buildings, there have not always been routine/systematic mechanisms for inter-departmental communication, and staff turnover at mid- and senior-levels has been high.

- As noted above, local misconceptions (described as “myths” by a number of people interviewed) regarding Medicaid rules and regulations are pervasive, e.g., restrictions on frequency and nature of Medicaid-supported behavioral health services (“no more than one therapy session every 2-4 weeks”, “Medicaid doesn’t pay for participation in Family Engagement Sessions”). These restrictions appear to result from CMHC local decisions (e.g., as evidenced by the differences in restrictions imposed from county/region to county/region) versus state/ federal regulations.
- At the local level, agencies do not adequately communicate with each other regarding availability of services, options for navigating families to services, and strategies to maximize continuums of care for children with special circumstances.
- Formal processes for communications from the state level to counties are currently inadequate. Strengthened processes may help dispel some of the misconceptions regarding Medicaid rules and regulations.
- There are misunderstandings between local/county knowledge of Medicaid rules, and state formation of Medicaid rules.

Survey Results

As a part of the assessment of access to services for at-risk families, a survey was distributed across the state to gather feedback on the current network of services available and general timeframes for accessing these services. The survey included six (6) multiple-choice questions and two open-ended questions. Multiple-choice questions were generally answered using a four-point scale, ranging from “Agree Strongly”, “Agree Somewhat”, “Disagree Somewhat”, and “Disagree Strongly.” To further our findings regarding Colorado families’ access to services, the survey results are summarized below (which includes 169 responses from various stakeholders).

Listed in Appendix 4 – Detailed Survey Results, the responses to each question are compiled and reported.

1. How many responses did we receive from stakeholders? How does our response group represent the community of entities/providers that serve children and families?

The survey received 169 completed responses from approximately 42 of the 64 counties. This group of responses includes the larger and smaller counties (in terms of geographical size, funding, and population served). There is also a strong mixture of personnel that responded to the survey, as approximately 28% of the responses came from caseworkers, with sizeable representation of county management and supervisors.

2. What appears to be an area of relative gap(s)?

Many of the survey question responses showed gaps in children/families having the appropriate access to mental/behavioral health services. The biggest gaps appeared to be families accessing services in a timeframe that meets their needs, as over 70% of respondents felt that this area was not adequate (Question 4 in Detailed Survey Results, combined between “Disagree Strongly” and “Disagree Somewhat”). This likely refers to the concerns with service coordination at the local level, as many children have to wait on services in search of Medicaid providers with open slots and/or confusion about how to access services. Many children/families are instead navigated to non-Medicaid providers due to timeliness of care (which is funded through Core Services dollars). This gap aligns with responses from other survey questions, which showed that approximately 15% of respondents noted children/families getting services from Medicaid providers within two weeks. However, 34% of respondents noted that children/families get services from non-Medicaid providers within two weeks.

3. What appears to be an area of relative strength(s)?

An area covered in the survey that showed promise relates to information sharing amongst

mental/behavioral health providers in communities. Approximately 45% of respondents agreed that information is shared between community partners (includes responses for “Agree Somewhat” and “Agree Strongly”). It is important to note that information sharing was noted numerous times as one of the things working well in helping families’ access services, and also noted strongly in things not working well to help families’ access services. It appears that the level of information shared between providers (county offices, health care providers, RCCOs, BHOs, etc.) varies by county, as some counties have found methods to be more successful at it than others. A potential strength could be using the models from successful counties and implementing these with counties that are not adequately exchanging information.

4. What are the things that seem to be working well and not working well in families accessing mental/behavioral health?

In response to the open-ended questions, respondents reported the following success factors and struggles to helping families access mental/behavioral health services.

Things Working Well (Success Factors)

- Increased collaboration and coordination amongst providers (ie.integrated care)
- Enhanced communications, specifically with caseworker staff
- CMHC involvement in family engagement meetings
- Convenient locations of services providers (in-house with county DCW offices, in schools, etc.)

Things Not Working Well (Struggles)

- Inadequate provider network (lack of resources and providers that accept Medicaid)
- High turnover rates (therapists and caseworkers)
- Major gap areas (minimal respite services, lack of bi-lingual services, substance use treatment)
- Long time periods before children can receive services and access to intensive services to stabilize children and adolescents in their home and community,
- Behavioral health systems not responsive to the needs of children and adolescents in the child welfare system

5. What are the major takeaways from the survey?

The survey helped to confirm that there are issues with the structures and systems that impact how children/families can access services. Even though there are some local examples of success stories, the overall responses showed that it is difficult for families involved in the child welfare system to obtain Medicaid services in a timely manner to address mental/behavioral health needs. The key barriers include administrative requirements for utilizing Medicaid services, developing and maintaining the needed provider network to serve this population, and ensuring the families can access actual services in a timely manner (from their initial entry point of involvement with the system).

RECOMMENDATIONS

The following recommendations flow from the project team’s analysis of the findings noted above as well as our experience helping health and human services agencies across the United States plan and implement change processes. We propose a three-phased process with the major progressive action steps unfolding over approximately two years. Our recommendations concern both *what* HCPF and its partners may wish to consider doing, and *how* they may wish to consider doing it:

What

Phase I (6-9 months)

Identify and implement “quick wins” while building a foundation for phase II and III action steps requiring advanced planning and resource mobilization:

- 1) Explore options and implement “quick wins” for lowering the administrative burden on local Medicaid and OBH-supported service providers and DCW staff:
 - a) Review Medicaid program business processes and associated documentation requirements for potential streamlining/simplification/greater alignment. (HCPF/OBH)
 - b) Provide local service providers and child welfare administrators with tools to review their current local

Medicaid administrative practices against what is required in order to identify potential efficiencies (HCPF, with OBH and DCW)

- 2) Review clinician's reimbursement for Medicaid service provision, ensuring general consistency/equity across the state. Strive for parity with reimbursement rates by other third party payers like private insurance companies. (HCPF)
- 3) Strengthen training and communication with county staff and stakeholders (e.g., child welfare, CMHC, BHO, RCCO). Leverage existing statewide opportunities and prioritize clarification of state and federal rules. For example, what Medicaid will pay for, including local Family Engagement Meetings, treatment planning, and frequency of therapy sessions that are allowable.
 - a) Identify topics to focus on and key audiences for each topic, including the following:
 - i) Guidance for private providers interested in becoming credentialed to service Medicaid clients – benefits to the Provider, how to become credentialed, administrative requirements, available supports
 - ii) Guidance for Medicaid clients and frontline staff (e.g., child welfare workers, therapists) - clarification of key terms (e.g., Medical necessity, EPSDT) and why they matter. Additionally, identification of key local and state organizations, Medicaid reimbursable services in general terms, step-by-step guide to getting the help you need. Also consider including core values and/or a client "bill of rights".
 - iii) Guidance for "the expert" (i.e., BHO and RCCO staff)-Develop a funding hierarchy for CMHC, county child welfare, and private providers. Documentation of Medicaid reimbursable services in specific terms, options for ensuring continuity of care. For example, how to use non-Medicaid funds to ensure continuity of care for children and adolescents coming into foster care who already receive behavioral health services from non-Medicaid providers. Additionally, leveraging EPSDT Medical necessity definitions, strategies to avoid interruptions in care, how to bill and get reimbursed for services, how to stay current (e.g., with Medicaid billing codes), administrative policies and procedures
 - b) Inventory training/communication materials across all Medicaid waivers and Medicaid services and look for opportunities to align, streamline, and/or enhance them (e.g., with easy-to-use desk aids, graphics on such topics as funding hierarchy and preferred/typical client flows). Consider using local staff and stakeholders (e.g., county HCBS waiver program administrators, RCCO and BHO liaisons to HCPF) as-reviewers of drafts to ensure that communication tools meet local needs.
 - c) Have HCPF staff collaborate with the child welfare training academy staff to prepare to integrate key content specifically about Medicaid- and OBH-supported services into the training academy.
 - d) Leverage regular meetings with HCPF contractors and partners (e.g., Collaborative Group, RCCOs) to disseminate updated training/communication materials. Consider additional training options for BHO, RCCO, CMHC, and local child welfare staff, including joint regional training sessions with all key stakeholder groups represented in the room to generate a potential boost to local collaboration.
 - e) Review regular process and timeframes for:
 - i) Communicating changes to Medicaid rules and regulations (e.g., available billing codes, documentation requirements)
 - ii) Periodic updating of communication/training materials to keep documentation current.
- 4) Communicate an expectation and incentivize RCCO and BHO staff to report jointly to HCPF on shared plans and progress to make a "no wrong door" policy a day-to-day reality.
 - a) Data sharing to ensure that providers have a comprehensive picture of behavioral health services received by all members of a family.
 - b) Coordination of services for clients with multiple diagnoses and service needs such as sharing of service plans.
 - c) Standardize communication with clients to ensure consistent answers to common questions.
- 5) Prepare for DCW and HCPF senior leader joint work to streamline and rationalize strategic frameworks and set shared priorities.
 - a) Identify a joint group of senior leaders to meet regularly on issues of shared strategic importance
 - b) Identify champions of DCW-HCPF collaboration to serve as co-chairs of the group
 - c) Draft a short, written charter to frame and guide the joint work of this group
 - d) Begin discussions toward identifying shared priorities, including ultimate outcomes and key populations
- 6) Identify ways to strengthen data sharing and reporting in counties, with a particular focus on connecting records regarding mental and behavioral services to children, adolescents, and adults within the same families.
 - a) Review barriers due to privacy regulations (particularly HIPAA and 42 CFR) and identify ways to overcome them.
- 7) Identify ways to strengthen joint DCW-HCPF reporting pending phase III implementation of the COMMIT

Project. Priorities for enhanced reporting may include:

- a) Sharing of Individual level service data across programs with a focus on identifying and troubleshooting major gaps in services
 - b) Identification of key services being provided to target populations and what outcomes these services are generating.
 - c) Explore how public funds invested in programs and practices compares with documented outcomes. Utilize data to prioritize and focusing investments on interventions that work.
- 8) Identify local behaviors that HCPF, DCW, and OBH want to incentivize. Review RCCO, BHO, CMHC, and county child welfare reporting requirements and performance measures and explore alignment of incentives to drive outcomes.
- 9) Explore opportunities to augment local capacity to provide:
- a) Administrative support to local DCW case workers and/or local DCW staff member experts on wrap-around services, with a particular focus on Medicaid clients.
 - b) Administrative support to private providers interested in becoming Medicaid providers.
 - c) Align and leverage case management and assessment services for specialized populations (e.g., children and adolescents with Intellectual and Developmental Disabilities or adolescents with a SUD diagnosis.)
- 10) Inventory and communicate promising care coordination practices across the state.
- 11) Explore options for limiting the negative impact of differing regional medical necessity determinations on access and continuity of care:
- a) Define and communicate in more specific terms guidance regarding application of "medical necessity" in federal rules for EPSDT and BHO application of medical necessity in determining Reimbursement.
 - b) Study states and localities that have succeeded in defining involvement with the child welfare system as medical necessity (e.g., Milwaukee, WI; New Jersey)
 - c) Prioritize continuity of care. Explore development of service and billing manual for children and adolescents involved with DCW. There are opportunities to require a Family Engagement Meeting with participation by the contracted BHO therapist before it is determined that a child does not meet medical necessity criteria.
 - d) Ensure access in all counties to information regarding the process to appeal denials of coverage on the grounds of medical necessity. Improve the understanding of EPSDT medical necessity defined as "... to correct or ameliorate defects and physical and mental illnesses and conditions. This allows consistency of medical necessity to assure a level of coverage sufficient to treat an already-existing illness or injury, but also to prevent the development or worsening of conditions, illnesses, and disabilities.
 - e) Train DCW staff and providers to document child and adolescent needs with a focus toward making a case for medical necessity.
- 12) Leverage the COMMIT Project to identify existing business processes and the extent to which these business processes will need to change. Where possible, influence system design to support effective administration of Medicaid behavioral health programs and interoperability with DCW systems.
- 13) Identify options for closing key gaps in service, including:
- a) Incentives and supports for service providers to provide
 - i) long-term residential and intensive treatment options for children and adolescents with severe mental illness;
 - ii) residential and intensive outpatient SUD treatment programs for adolescents;
 - iii) services targeting the unique needs of children ages 8-12; and,
 - b) Explore innovative ways to strengthen supports for family members and other care givers (e.g., foster parents, guardians) of children and adolescents with severe behavioral health needs, and particularly those outside of the "big 10" counties. Consider enhanced use of telemedicine and peer support models (e.g., parent2parent) to reach families across the state while limiting burdens on both families and medical professionals.
- 14) Identify options for closing key gaps in timely screening and assessment, including in particular:
- a) Screening of young children (0-8) for developmental delays and/or trauma and social determinants of health
 - b) Specialized assessment to determine medical necessity for specific service needs like Autism or other IDD
 - c) Screening of adolescents and parents for SUD
- 15) Consider incentivizing service providers based in "big 10" counties to travel on a regular schedule to rural counties on the Western Slope, in the Northeast, and in the Southern regions of the state.

- 16) Identify options for strengthening fiscal incentives for county child welfare to use Medicaid versus State general funds to pay for reimbursable behavioral health services.
- 17) Develop an action plan for implementing changes needed in phase II and III.

Phase II (9-18 months)

Begin implementing the action plan developed in Phase I, with particular attention paid to roles, relationships and communications. Continuously improve the action based on regular monitoring of progress, impact, and lessons learned:

- 1) Investigate options for lowering the administrative burden on local Medicaid and OBH service providers.
- 2) Explore reimbursement methodologies for Medicaid service provision.
- 3) Further strengthen training and communication with county staff and stakeholders.
- 4) Strengthen data sharing and reporting in counties.
- 5) Update reporting requirements and performance measures with stronger incentives for desired local stakeholder alignment that would not requiring state statutory changes and/or federal approval of changes to waiver provisions and/or Medicaid State Plan.
- 6) Incentivize promising care coordination practices across the state.
- 7) Identify actions to close key gaps in timely assessment.
- 8) Examine options for strengthening fiscal incentives for county child welfare to use Medicaid versus State general funds to pay for reimbursable behavioral health services.

Begin work on remedying the most challenging barriers to effective administration of Medicaid services to vulnerable children and adolescents:

- 9) Identify and work toward opportunities for DCW-HCPF interoperability, including integrated case records for the children, adolescents, and adults in vulnerable families and reporting to support implementation of a new, integrated strategic framework.
- 10) Explore options for incentivizing counties to use Core Services funds for services that Medicaid does not reimburse, including changes to statutory guidelines for how these funds are disbursed and administered.
- 11) Facilitate DCW and HCPF senior leader joint working sessions to streamline strategic frameworks and set shared priorities for vulnerable children, adolescents, and families in Colorado. Align values/guiding principles and develop a logic model from major programs/funding streams through outputs to outcomes, and a performance dashboard of a key shared performance measures.
- 12) Work to influence system designs as part of the COMMIT Project to support effective administration of Medicaid-supported behavioral health programs.
- 13) Prepare for RCCO and BHO joint re-procurement using a performance-based contracting model:
 - a) Study performance-based contracting models and experiences from other states/sectors
 - b) Develop array of output and outcomes measures, including those with meaningful annual results and others requiring the full life of the contract to show an impact
 - c) Identify consistent ways to report on and track output and outcomes measures
 - d) Identify and incorporate opportunities for:
 - i) defining Medical necessity in greater detail and with more consistency
 - ii) incorporating EPSDT more systematically into the day-the-day planning and administration of Medicaid-supported behavioral health services
 - iii) growing the Medicaid provider network

- iv) Incentivizing innovative care coordination practices that have shown to be effective, and incentivize continued experimentation/innovation
- v) hardwiring continuous improvement of business processes
- e) Identify payment structures that both reward performance exceeding benchmarks and penalize performance below benchmarks

Phase III (18+ months)

- 1) Continue implementing the action plan developed in Phase I and continuously improve based on lessons learned from Phase II, including implementing options requiring statutory changes, new funding appropriation requests, changes to current appropriations, and/or Federal government approval for desired changes.
- 2) Begin implementing and continuously improving an updated and simplified, joint DCW, HCPF, and OBH strategic framework for vulnerable children, adolescents and families with associated logic path, performance measures, and target populations.
- 3) Support implementation of the COMMIT Project, with a particular eye toward strengthening Medicaid waiver program administration, DCW, HCPF, and OBH interoperability, and reporting to support implementation of the newly integrated strategic framework.
- 4) Seek ways to strengthen joint reporting/interoperability between DCW, HCPF, and OBH.
- 5) Implement options for incentivizing counties to use Core Services funds for services that Medicaid does not reimburse.
- 6) Implement RCCO and BHO joint re-procurement using a performance-based contracting model.

How

- 1) Overall, PCG recommends that HCPF and its partners at DCW – the steering group that has overseen the development of this report – and OBH move from recommendations to an implementable action plan:
 - a) Prioritize recommendations and identify a final set of action steps that the group will recommend to DCW, OBH, and HCPF senior leadership for implementation
 - b) Identify a lead staff member charged with overseeing implementation and continuous improvement of agreed to action steps (e.g., a “Child and Adolescents Behavioral Health Improvement Manager” as described in *what* recommendation #3 above)
 - c) Identify lead staff people for each action step approved by senior leadership
 - d) Have the lead staff people identify more discrete action steps and timeframes for completion of Phase I action steps
 - e) Combine these discrete action steps into a Phase I action plan and begin implementing, monitoring the plan regularly for progress, impact, and lessons learned; adjust the plan as needed in response to evolving lessons learned
 - f) At completion of Phase I, develop and begin implementing a Phase II action plan, repeating steps a-d
 - g) At completion of Phase II, develop and begin implementing a Phase III action plan, repeating steps a-d
- 2) Changes with an impact on county staff and other stakeholders will have the highest likelihood of success and sustainability if they:
 - a) improve communication and make work easier/more streamlined
 - b) are well explained, with a clear rationale
 - c) feel “co-owned” by county stakeholders through use of state-county working groups and/or multiple feedback loops prior to statewide rollout
- 3) Phase II and III will be made slightly easier if DCW, HCPF, and OBH can find and implement a few Phase I “quick win” opportunities. These opportunities could help align DCW, HCPF, and OBH strategic priorities and clarify state and county accountabilities, priorities and performance expectations.

- 4) Review/strengthen communication with counties about ALL available Medicaid- and OBH-supported services for child welfare, and ideally non-Medicaid supported wrap around services as well.
- 5) Any change that may be perceived by stakeholders shifts in resource investment and should ideally be communicated as part of a "package" of changes that also includes perceived "value adds".
- 6) Physically locate HCPF staff members knowledgeable about Medicaid-supported services for child welfare at DCW for a portion of each week (e.g., two regularly scheduled days, so DCW staff knows when/where to contact him/her/them).
- 7) Leverage a portion of HCPF staff time at DCW to also strengthen connections and collaboration with OBH staff.
- 8) Look for opportunities to engage OBH actively in implementation efforts going forward.

Appendix 1 – Glossary of Organizations/Agencies/Programs Involved in Behavioral Health Services

- BHO – Behavioral Health Organization
- CASA – Court Appointed Special Advocates
- CCI – Colorado Counties Inc.
- CHSDA – County Human Services Directors' Association
- CMHC – Community Mental Health Center
- DCW – Colorado Department of Human Services, Division of Child Welfare
- DHS County – County Offices that Administer DCW Services
- DIDD – Division of Intellectual and Developmental Disabilities
- EPSDT³ - Early Periodic Screenings, Diagnosis, and Testing
- GAL – Guardian Ad Litem
- HCPF – Colorado Department of Health Care Policy and Financing
- MHASA – Mental Health Assessment and Service Agency
- OBH – Office of Behavioral Health
- RCCO – Regional Care Collaborative Organization

³ The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a mandatory service under Medicaid that provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The EPSDT Program was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. These services were expanded in section 1905 (r) (5) of the Social Security Act (the Act) to require that any medically necessary health care service listed in section 1905 (a) of the Act be provided to an EPSDT beneficiary even if the service is not available under the State Plan.

Appendix 2 – Listing of Documents/Materials Collected

- **HCPF Provider Bulletin, May 2015:** The periodic update released to inform the provider community on upcoming initiatives/events related to Colorado's Medicaid programs
- **Child Welfare SubPac – Developmental Disabilities Task Group Meeting (March 27, 2014):** Policy Advisory committee notes regarding rule changes, statutory changes, and policy issues
- **Interim Report from the Policy and Finance Task Group (October 2012):** Overview of the study, conclusions, and funding model methodology to best serve youth with developmental disabilities in the child welfare system
- **Themes from Gap Analysis Community Meetings and Survey:** Summary of Colorado Collaborative for Autism and Neurodevelopmental Disabilities Options (CANDO) to build a responsive system for coordinated services, crisis prevention, management, and stabilization for people with neurodevelopmental disabilities
- **Behavioral Health Care for Children in the Child Welfare System – A Vision for Colorado:** Interagency report on the vision for an "ideal" behavioral health system for children
- **Improving Behavioral Health Outcomes for Children and Youth in the Child Welfare system:** Notes from a series of regional forums hosted by the Office of Behavioral Health in Pueblo, Brighton, and Glenwood Springs (July/August 2014)
- **Behavioral Health Needs Analysis:** Study conducted for the Human Service's Office of Behavioral health regarding an analysis of Colorado's needs for behavioral health services
- **Center for Health Care Strategies, Inc. – Making Medicaid Work for Children in Child Welfare: Examples from the Field (June 2013)**
- **State Policy Advocacy and Reform Center – Child Welfare Funding Opportunities: Title IV-E and Medicaid**
- **State of Colorado, House Bill 13-1314**
- **Pueblo County Department of Social Services Strategic Plan for Child Welfare Division**
- **Foothills Behavioral Health Partners – county Department of Human Services Staff Survey Report (3/17/2015)**
- **Form CMS-416: Annual EPSDT Participation Report (Fiscal Year 2013)**
- **National Institute of Disability and Rehabilitation Research, United States Department of Education and the Center for Mental Health Services – Things People Never Told Me**
- **Behavioral Health Organization Contracts and Performance Measurement Scope Documents (HCPF Website, www.colorado.gov/hcpf)**

Appendix 3 – 2015 Stakeholder Register

(Name, Position, and Department/Agency):

- Camille Harding, Quality and Health Improvement Unit Manager, HCPF
- Gina Robinson, Program Administrator, HCPF
- Lenya Robinson, BH and Managed Care Program Section Manager, HCPF
- Christian Koltonski, Quality and Health Improvement Unit, HCPF
- Melinda Cox, Core Services and Prevention Programs Administrator, DCW
- Crestina Martinez, Government Relations and Partner Outreach, HCPF
- Heidi Walling, Quality Unit, HCPF
- Gretchen Russo, Permanency Unit Manager, DCW
- Andrew Johnson, Youth Services Manager, DCW
- Robert Werthwein, Director, DCW
- Les Cowger, Finance Manager, DCW
- Claudia Zundel, Family and Children's Programs Director, DCW
- Jennifer Martinez, HCBS Supervisor, HCPF
- Candace Bailey, Children's Waiver Specialist, HCPF
- Jed Ziegenhagen, Deputy Medicaid Director, HCPF
- Lori Thompson, Deputy Division Director, HCPF
- Sheila Peil, Children's Program Specialist, HCPF
- Christina Chavez, HCPF Systems, HCPF
- Randi Wilson, HCPF rates, HCPF
- Mesa DHS County Office
- Larimer DHS County Office
- Pueblo DHS County Office
- Logan DHS County Office
- Weld DHS County Office
- Mindsprings Health
- Rocky Mountain Health Plan
- Colorado Access
- Touchstone Health Partners
- AspenPointe
- Other State Partners (Regional Collaborative Care Organizations, Community Mental Health Centers, Behavioral Health Organizations, Service Providers, etc.)
- Survey Participants from over 42 Counties

Appendix 4 – Guiding Protocol for Visioning Sessions

I. OVERVIEW

A. Brief Overview and Purpose

As a part of PCG's support for the Quality Health Improvement (QHI) project, PCG is preparing to provide consultation and expertise to the Colorado Department of Health Care Policy and Financing (HCPF). This support will help HCPF, as well as other service entities in the state, improve access to key services for at-risk families. PCG's support activities include the facilitation of collaboration meetings, key informant interviews, focus groups, and other related tasks. This document will serve as the guide for all support activities.

PCG will use a collaborative approach to provide HCPF a comprehensive report, outlining recommendations to better engage Colorado stakeholders and improve system access/coordination of services for at-risk families. An additional support offering includes the provision of technical expertise for Colorado State University in matching child welfare data (obtained directly from DCW – Colorado Department of Human Services) with Medicaid claims information.

The following DHS county offices were targeted to participate in the QHI support activities:

- Northern Region – Larimer County
- Eastern Region – Logan County
- Southern Region – Pueblo County
- Western Region – Mesa County

PCG aims to conduct six (6) interviews and at least four (4) focus groups with a range of leaders, staff, and other stakeholders within Colorado's provider network (HCPF, DCW, County DHS Offices, and the Behavioral Health Organizations). During these meetings, participants will discuss methods to leverage available provider services (specifically county DHS offices and BHOs) for at-risk families, identify opportunities for "quick wins" that can make an immediate impact on current services, and longer-term considerations for policies, system integration, and stronger collaborations.

B. Schedule

Below is tentative schedule of the QHI support activities and dates:

QHI Support Activity Schedule	
Activity	Date
Identify the 4 counties targeted for participation in focus group forums (HCPF)	5/13/15
Make initial contact with 4 targeted counties (HCPF)	5/28/15
Conduct Stakeholder Kick-Off Meeting (PCG/HCPF)	5/28/15
Distribute agendas to all 4 counties (PCG/HCPF)	6/3/15
Set schedules for onsite visits (PCG/HCPF)	6/3/15
Onsite visits (PCG/HCPF)	6/8 – 6/11/15
Colorado materials review (PCG)	5/28/15 – 6/11/15
Submit Draft Report (PCG)	6/30/15

II. QHI Support Activities

A. Material Review

The stakeholders targeted to participate in the focus groups and interviews will provide the PCG team with any written materials that will help to inform the provider network review plan and final reform recommendations. Materials should include but not be limited to any prior surveys, organizational assessments, strategic plans, data reports, strategic communications, and meeting notes that would give the PCG team additional insight and a deeper understanding of the stakeholder's current strategy, approach to work, and communications with other organizations.

B. Targeted Focus Groups and Individual Interviews

For this specific assessment, the PCG Team plans to conduct interviews with senior leaders and focus groups with a representative sample of staff across each organization or regional office. The PCG Team generally targets key individuals with disproportionate influence over the organization/office (e.g., directors, program managers, board members, and executive leadership) for one-one interviews or, where it makes most sense, small focus groups (with no more than three individuals at once), with each interview lasting approximately 45 minutes.

In addition, for focus groups we target a representative cross-section of staff and other stakeholders able to provide insight into the organization's service provision and front-line interactions with children and families. Our ideal is focus groups 1.5 hours long and consisting of 6-12 participants per session, though we have conducted focus groups with larger numbers.

We recommend meeting with supervisory staff separately from individual contributors. For individual contributor staff, we propose integrated focus groups that include staff members from different programs in the same room together. Ideally, we meet separately with staff who share similar roles (e.g., caseload-carrying staff, data team members, administrative, etc.). However, if scheduling does not permit this separation, we can also accommodate staff sessions with a mix of roles represented. Our number one priority is to provide staff with valuable insights, maximum opportunity to participate, and the ability to work with lead staff to develop customized schedules and groupings that work best for the organization/office.

C. Logistics

For interviews, we need a space where confidential conversations can take place and seating arrangements that allow for relaxed dialogue between people positioned as equals (e.g., seated at a table versus across the interviewee's desk). We ideally need a table of some kind to allow for comfortable note taking.

For focus groups, we need a space to comfortably accommodate all participants. Our preference is for an "open u" or boardroom-style room set-up that allows all participants to see each other's faces while being oriented toward a space for the facilitator to occupy. We need at least one flipchart with markers, an easel, and adhesive for sticking paper to the wall (i.e., either "self-sticking" flipcharts or masking tape). If possible, facilitators should be able to get into the room for focus groups at least 15 minutes prior to the beginning of the session.

For all interactions that the PCG team will have with stakeholders, we want to ensure that the reason for this scope is clearly explained and understood by all participants. To this end, we will use the following language for written and verbal communications to introduce all HCPF assessment and planning activities:

"The Colorado Department of Health Care Policy and Financing (HCPF) and Public Consulting Group (PCG) are working together to develop strategies that improve access to key services for children and families. PCG has almost 30 years of experience helping health, human services, and education agencies improve services and outcomes for individuals and families in need of public assistance.

PCG's support aims to help HCPF and other Colorado stakeholders improve outcomes for youth receiving services from multiple providers. Our support activities include a materials review, on-site interviews and focus groups, remote conference calls with key stakeholders, and a summary report with actionable recommendations. The summary report will aggregate any feedback obtained through interviews and focus groups into cross-cutting themes; at no time will input provided be tied directly to any individual.

Our focus is on how the state's systems (Medicaid system and Child Welfare system) work together in ways that either help or make accessing services more difficult for children and their families. Our focus is NOT on funding allocation or budget reductions, but solely on improving the access and provision of services."

D. Interview/Focus Group Questions

Below is a short menu of the questions that may be asked of the group/interviewees. The focus and energy of the group/interview will determine which specific questions will be chosen:

**Current set of questions are written specifically from the perspective of County DHS Offices.*

1. What was your best day on the job in the past year? Why?
2. To what extent are DHS children/families getting services (Medicaid/BHO services) they need? In a timely manner? Of desired quality? Do the youth and families you serve agree with this? To what extent do feel they are getting timely and quality care and treatment? And how do you know?
3. How do you see the difference and relationships between the Behavioral Health Organization (BHO), Accountable Care Collaborative (ACC), and Community Mental Health Center (CMHC) in your community? How and how frequently does your organization interact with each entity (how frequently, at what levels of the respective organizations, etc.)?
4. Do you know that other providers are available under the BHO network outside of the CMHC? Do you know what primary care offices also include behavioral health so that families have access to a one stop shop? Do you know how to locate a therapist that has been trained in trauma care?
5. What is the general cultural makeup of the community your agency services? What specific efforts are made to ensure that children and families receive culturally competent mental and behavioral health services?
6. Describe the protocol DHS county staff utilizes to access Medicaid/BHO services:
 - Have children/families ever been denied services? If so, are there clear reasons and is there an appeals process?
 - To what extent are these services included in case plans?
 - In what ways do you help families' access services when a child is placed outside of your county and/or in the catchment area of a different BHO or ACC?
7. Describe any case-specific collaborative experiences between DHS and BHOs. For example, have there been children/youth/families that have benefited from joint planning between DHS and BHOs? If yes, how did that go? If no, why not?
8. More generally, what is currently going well in terms of collaboration with Medicaid/BHO providers in your region? What is not going as well? Why do you think that is, and what could help make things better?
9. Think about a family's typical experience in navigating the system to access available resources (both DHS-related and health-related):
 - Can you think of specific examples of positive experiences? What went well with those specific cases?
 - Can you think of specific examples of experiences that were not as positive? What did not go as well with those specific cases?
 - What helps DHS staff most in helping families achieve successful outcomes?
10. What, if any, other kinds of information (child-specific data, materials, family records, etc.) would help you better connect children/families with health interventions/treatments? Are there improvements that can be made to the information you already get?

11. What is your understanding of what constitutes "medical necessity"? To what extent do you feel that you can identify medical necessity?

12. What doesn't Medicaid pay for that you generally use Core Services dollars to cover?

Appendix 5 – Detailed Survey Results

2. Please select your position type.

Answer Options	Response Percent	Response Count
DCW County Staff - Management	15.8%	27
DCW County Staff - Supervisor	10.5%	18
DCW County Staff - Caseworker	28.1%	48
Community Mental Health Center Behavioral Health Organization	2.9%	5
Regional Collaborative e Care Organization	2.3%	4
Other	3.5%	6
	36.8%	63
answered question		171
skipped question		0

3. Please select a response to the following: Children/Families are generally able to access the quality mental and behavioral health services that meets their needs.

Answer Options	Response Percent	Response Count
1 - Disagree Strongly	24.0%	41
2 - Disagree Somewhat	38.0%	65
3 - Agree Somewhat	33.3%	57
4 - Agree Strongly	4.7%	8
answered question		171
skipped question		0

4. Please select a response to the following: Children/Families are generally able to access quality mental and behavioral health services in a timeframe that meets their needs.

Answer Options	Response Percent	Response Count	
1 - Disagree Strongly	35.7%	61	
2 - Disagree Somewhat	35.1%	60	
3 - Agree Somewhat	25.7%	44	
4 - Agree Strongly	3.5%	6	
	answered question		171
	skipped question		0

5. Please select a response to the following: The Medicaid provider network in the community(ies) you serve generally meet the needs of children/families served by the County Department of Human Services

Answer Options	Response Percent	Response Count	
1 - Disagree Strongly	25.7%	44	
2 - Disagree Somewhat	32.7%	56	
3 - Agree Somewhat	33.9%	58	
4 - Agree Strongly	7.6%	13	
	answered question		171
	skipped question		0

6. Please select a response to the following: Information is generally shared effectively between mental/behavioral health providers in your community(ies) (Departments of Human Services, physical health care providers, the Regional Collaborative Care Organizations, and Behavioral Health Organizations, private providers)

Answer Options	Response Percent	Response Count	
1 - Disagree Strongly	22.2%	38	
2 - Disagree Somewhat	32.7%	56	
3 - Agree Somewhat	36.3%	62	
4 - Agree Strongly	8.8%	15	
	answered question		171
	skipped question		0

7. What is the typical length of time from intake to first receipt of mental/behavioral health services (e.g., first therapy session) from Medicaid providers for children/families served by the County Department of Human Services?

Answer Options	Response Percent	Response Count
1 - One week or less	2.9%	5
2 - 1-2 weeks	11.7%	20
3 - 2-4 weeks	40.9%	70
4 - 5-10 weeks	15.2%	26
5 - More than 10 weeks	2.9%	5
6 - Unknown	26.3%	45
answered question		171
skipped question		0

8. What is the typical length of time from intake to first receipt of mental/behavioral health services (e.g., first therapy session) from non-Medicaid providers from children/families served by the County Department of Human Services?

Answer Options	Response Percent	Response Count
1 - One (1) week or less	12.3%	21
2 - 1-2 weeks	21.1%	36
3 - 2-4 weeks	19.9%	34
4 - 5-10 weeks	11.7%	20
5 - More than 10 weeks	1.8%	3
6 - Unknown	33.3%	57
answered question		171
skipped question		0



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MEMORANDUM

June 14, 2016

TO: Members of the Legislative Oversight Committee and Task Force Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems

FROM: Amanda King, Senior Research Analyst, 303-866-4332
 Amanda Hayden, Fiscal Analyst, 303-866-4918

SUBJECT: Overview of the Legislative Oversight Committee and Task Force Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems

Summary

This memorandum provides an overview of the 2016 membership of the Legislative Oversight Committee Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems (MICJS), the charge of the MICJS committee, the charge of the MICJS task force, the bill limits, the request deadlines applicable to the legislative oversight committee, and information regarding the legislative oversight committee staff and website.

2016 Committee Membership

The six members of the Legislative Oversight Committee Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems (MICJS) are appointed by legislative leadership as outlined in state law. The chair and vice-chair are designated by either the President of the Senate or the Speaker of the House of Representatives, alternating on an annual basis. The 2016 MICJS legislative oversight committee members are:

Representative Jonathan Singer, Chair	Senator Beth Martinez Humenik, Vice-Chair
Representative Stephen Humphrey	Senator Linda Newell
Representative Pete Lee	Senator Laura Woods

Meeting Dates

The MICJS legislative oversight committee is statutorily required to meet at least three times annually, but can meet more often as it deems necessary. In 2015, the committee met three times. The committee last met on March 18, 2016. The committee is scheduled to meet again on June 23, 2016, at 1:30 p.m. in House Committee Room 0112.

The MICJS legislative oversight committee members may receive per diem and reimbursement for attending meetings held outside of the legislative session.

Committee Details and Charge

The six-member MICJS legislative oversight committee was created to oversee the work of the 32-member advisory task force. Senate Bill 14-021 reauthorized both the MICJS legislative oversight committee and the task force until July 1, 2020. Article 1.9 of Title 18, C.R.S., establishes and outlines the duties of both the MICJS legislative oversight committee and task force.

Task force appointments. According to Colorado law, four members of the MICJS task force are appointed by the Chief Justice of the Supreme Court, and the remaining 28 members are appointed by the chair and vice-chair of the MICJS legislative oversight committee. Generally, the chair of the MICJS task force or the departments who are represented on the task force identify people who are willing to serve as task force members and suggest them for appointment. In making the appointments to the task force, the appointing authorities are to ensure the task force membership reflects the ethnic, cultural, and gender diversity of the state, and includes representation of all areas of the state.

Legislative recommendations. The MICJS legislative oversight committee reviews the MICJS task force's findings and may recommend legislative proposals. The MICJS legislative oversight committee brought forth one bill during the 2015 interim. Senate Bill 16-039, which was postponed indefinitely, would have clarified which mental health professionals must be included in a memorandum of understanding establishing a collaborative management team. The bill also would have required the memorandum of understanding to contain a provision specifying that the child's parent may be present at any meeting of the collaborative management team that concerns his or her child.

Annual report. The MICJS legislative oversight committee is required to submit an annual report to the General Assembly by January 15 of each year, regarding recommended legislation resulting from the work of the MICJS task force. The annual report is prepared by Legislative Council Staff. The most recent report may be found at: <http://1.usa.gov/202z5Sb>.

Task Force Detail and Charge

Charge. The MICJS task force is directed to examine the identification, diagnosis, and treatment of persons with mental illness who are involved in the state criminal and juvenile justice systems, including an examination of liability, safety, and cost as they relate to these issues. On and after July 1, 2014, the task force is required to study the following issues:

- housing for a person with mental illness after his or her release from the criminal or juvenile justice system;
- medication consistency, delivery, and availability;
- best practices for suicide prevention, within and outside of correctional facilities;
- treatment of co-occurring disorders;
- awareness of and training for enhanced staff safety, including expanding training opportunities for providers; and
- enhanced data collection related to issues affecting persons with mental illness in the criminal and juvenile justice systems.

Meeting requirements. The authorizing legislation requires the MICJS task force to meet at least six times per year, or more often as directed by the chair of the MICJS legislative oversight committee. The current practice of the task force is to hold meetings on the third Thursday of each month. To fulfill its charge, the MICJS task force is required to communicate with and obtain input from groups throughout the state affected by the issues under consideration. The MICJS task force is not precluded from considering additional issues, or from considering or making recommendations on any of the issues listed above at any time.

Reporting and legislation requirements. The MICJS task force must submit a report to the MICJS legislative oversight committee by October 1 of each year. The report must identify:

- issues to be studied in upcoming MICJS task force meetings and their respective prioritization;
- findings and recommendations about issues previously considered by the MICJS task force; and
- legislative proposals that identify the policy issues involved, the agencies responsible for implementing the changes, and the funding sources required for implementation.

Typically, this is given as an oral report at one of the MICJS legislative oversight committee meetings.

Committee Recommendations to Legislative Council

Bill limits. The MICJS legislative oversight committee may report up to five bills or other measures to the Legislative Council, unless the Executive Committee of the Legislative Council approves a greater number. Bills approved by the Legislative Council do not count against a member's five-bill limit for the regular legislative session.

Requirements for bill drafts. Committee members must request bills during a single committee meeting set for requesting legislation. If the request is approved by a majority of the committee, the request is submitted to the Office of Legislative Legal Services (OLLS) for drafting. The last day for committees to meet to request legislation is September 1, 2016.

There must be at least 35 days in between the meeting at which legislation is requested and the meeting at which it is approved. To allow time for Legislative Council Staff to prepare the fiscal analysis of the proposal, there must be 14 days between the date the proposed bill is finalized with OLLS staff and the date of the meeting to consider the proposed bills. The last day to finalize bill drafts with OLLS staff is September 22, 2016, and the committee must meet and vote on the bill drafts by October 6, 2016. All proposed interim committee bills must be presented to and approved by the Legislative Council prior to introduction in the next legislative session.

Legislative Council review. The Legislative Council must meet by October 15, 2016, to approve draft legislation. Bills not approved by Legislative Council may be introduced during the regular session, but such bills will count against a member's five-bill limit. Interim committee bills must have prime sponsors prior to consideration by the Legislative Council. Legislative Council Staff will apprise the committee of the date of the Legislative Council meeting once it is confirmed.

Committee Staff and Website

The Legislative Council Staff and OLLS are charged with assisting the MICJS legislative oversight committee in its activities. Additionally, the Legislative Council Staff acts as a liaison between the MICJS legislative oversight committee and the MICJS task force. If you have any questions or would like any additional information about the MICJS legislative oversight committee or issues concerning the committee, please contact:

- Amanda King, Senior Research Analyst, amanda.king@state.co.us, 303-866-4332;
- Amanda Hayden, Fiscal Analyst, amanda.hayden@state.co.us, 303-866-4918; or
- Jane Ritter, Senior Attorney, jane.ritter@state.co.us, 303-866-4342.

The MICJS task force provides its own support staff to prepare any minutes, reports, or other documents.

Additional information about the MICJS legislative oversight committee and the task force can be found on the committee's website at: <http://www.colorado.gov/lcs/MICJS>.