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Brief Synopsis for Decision-Makers

This Operational Plan is the culmination of an eight-month study. It is preceded by a series of seven prior reports that form the foundation of the plan and that are included as appendices.

It is recommended that available services within the overall Colorado mental health system be increased and current Institute inpatient programs maintained until community alternatives are developed. Sixty percent (60%) of current capacity represents core Institute inpatient capacity that should not be provided in other settings. Other major recommendations include:

Adolescent Psychiatric Inpatient Services – 30% of current adolescent capacity is unused. Recommendations include funding $1.34 million in community-based adolescent alternative services by closing the 10-bed unlocked Open Adolescent Program at CMHI-Pueblo.

Adult Psychiatric Inpatient Services – Distances from Northern and Western Colorado to CMHI-Pueblo (ranging from 168 to 272 miles) negatively impact clinical care. Local Institute alternative pilots in Northern and Western Colorado are recommended to manage 24 of 33 current allocated beds. Funding would come from downsizing 24 beds at CMHI-Pueblo, resulting in approximately $2.7 million and 68 slots of community-based treatment.

Geriatric Psychiatric Inpatient Services –The same general observations regarding distance for adult services also apply to older adults. Expansion of Northern and Western Colorado pilots to include current geriatric inpatient capacity is recommended.

Financing Recommendations – These include:

- Enhancing Medicaid revenue by $5.1 million annually by changing to cost-based rates and obtaining an IMD waiver.
- Maintaining current funding levels over time through annual adjustments for inflation and population growth.
- Initiating a seven-year transition to community control of funding for 40% of remaining adult capacity and 35% of older adult capacity, resulting in $25.0 million annually in State General Funds, which can leverage $34.5 million and 695 treatment slots of community alternatives.

Governance Recommendations – Initiate an incremental, eight-year process to transition the Institutes toward becoming a quasi-independent part of University of Colorado Hospital (UCH) through five two-year steps (two of which are concurrent):

- Step 1 – Establish that Colorado Psychiatric Health (CPH) can manage and provide Institute services by including it in the Northern Colorado adult inpatient pilot, described above.
- Step 2 – Initiate a CPH/UCH management contract for CMHI-Fort Logan.

- Step 3 – Merge CMHI-Fort Logan operations into University of Colorado Hospital.
- Step 4 – Initiate a CPH/UCH management contract for CMHI-Pueblo civil and general hospital units (concurrent with Step 3).
- Step 5 – Merge CMHI-Pueblo civil and general hospital operations into University of Colorado Hospital.

Executive Summary

The purpose of this Operational Plan is to define the future role of the Colorado Mental Health Institutes (CMHIs or Institutes) in Colorado's public mental health system and guide the future operation of the Institutes. All major civil programs of both Institutes are included, encompassing adolescent, adult, and geriatric psychiatric inpatient programs, the residential treatment center at CMHI-Fort Logan, and the CMHI-Pueblo general hospital. This Operational Plan is the culmination of an eight-month study. The approach was predicated on an iterative, multi-method design. It included data collection, analysis, and development of a series of seven prior reports that form the foundation for the Operational Plan and are included as appendices to the plan.

I. Recommendations for the Ongoing Role of the Institutes

The basic stance of this plan is that changes in the system of care can help establish improved service availability within current levels of State General Fund appropriation, adjusted over time to keep pace with inflation and population growth. Five overall recommendations are offered:

- I-A – Available services within the overall Colorado mental health system should be enhanced through increased leveraging of federal funds (e.g., Medicaid), greater use of more cost-effective community-based programming, and raised funding availability overall. Needed additional funding for community alternatives is estimated at $35 to $43 million annually.
- I-B – Current Institute inpatient programs must be maintained until alternatives are developed, that are adequate in terms of both quantity and quality. The experience of the State of Oregon when it closed its state psychiatric facility in Portland provides a good example of this approach.

- I-C – A core Institute inpatient capacity should be defined as service to those most in need due to either (1) the long-term nature of their condition at a level of acuity needing intensive inpatient services; or (2) the severe acuity of their symptoms such that service in any other setting is not safe, regardless of the length of stay needed. Approximately 60% of current capacity is estimated to represent core capacity.

- I-D – Populations outside of the core mission should be served only if necessary because there is no alternative or because it would be more cost-effective than other alternatives.

- I-E – Many current CMHI consumers could and should be served in more clinically appropriate and cost-effective settings. Analysis suggests that up to 40% of current capacity could be diverted to alternative settings, including acute inpatient and other community-based alternatives.

II. Recommendations for CMHI Program Development

Adolescent Psychiatric Inpatient Services – In the most recent period (7/1/01 through 12/31/00), 30% of the Institutes' 52 adolescent beds overall were unused on average. Extensive analysis of this trend over three years prior supports downsizing of the current 52-bed combined capacity. Recommendations include:

- II-A-1 – Close the 10-bed unlocked Open Adolescent Program at CMHI-Pueblo and use 100% of savings to fund community-based alternatives for adolescents.

- II-A-2 – Fund approximately $1.34 million in community-based adolescent alternative services. Evidence-based models of care should be required, including Multisystemic Therapy (MST).

- II-A-3 – Raise fees charged for third party payers, especially Medicaid.

Adult Psychiatric Inpatient Services – There is consistently high demand for the Institutes' 247 adult beds, with current combined average occupancy at 93.9%. For Northern and Western Colorado, the distance between the CMHCs and CMHI-Pueblo range from 168 to 272 miles. This distance to current Institute beds at CMHI-Pueblo negatively impacts care in multiple ways. Recommendations include:

- II-B-1 (a & b) – Develop local Institute alternative pilots in Northern and Western Colorado. These pilot programs should involve local CMHCs, MHASAs, and inpatient providers to manage 24 of 33 current allocated beds. For Northern Colorado, Colorado Psychiatric Health (the inpatient psychiatric component of University of Colorado Hospital) is recommended to be the inpatient partner, given the governance recommendations below.

- II-B-1-c – Fund the two pilots with start-up transition funds, followed by savings from downsizing the three 32-bed CMHI-Pueblo adult inpatient units (excluding the Circle Program) to 24 beds each (24-bed total downsizing). It is estimated that this will result in $1.9 million in State General Fund savings that could leverage approximately $2.7 million and 68 slots of community-based treatment.

- II-B-1-d – Develop the local Institute alternative pilots through a collaborative, multi-stakeholder proposal process. This should include demonstration of a credible, long-term commitment by local providers to carry out the historical mission of the Institutes, evidence-based approaches such as assertive community treatment (ACT), and specific performance standards.

- II-B-1-e – Fund the initial development of alternatives with one-time funding. A 54-month timeline would allow one-time funds to be repaid prior to full development of community alternatives, resulting in a cost-neutral process.

- II-B-2 – CDHS should work with metro area MHASAs and CMHCs to reverse the three-year trend of increasing percentages of adults with Medicaid served by CMHI-Fort Logan's adult inpatient units.

Child Psychiatric Inpatient Services – There is consistently high demand for the 16-bed Children's Unit at CMHI-Fort Logan, with current average occupancy at 90.6%. Higher rates of involuntary treatment and dangerousness suggest that the acuity level of child disorders treated is increasing. Recommendations include:

- II-C-1 – Increase training and support of staff commensurate with the increasing percentages of child consumers with involuntary and endangering treatment needs.

- II-C-2 – Increase the fees charged to Medicaid sources.

- II-C-3 – Increase collaboration with other child inpatient programs such as The Children's Hospital.

Geriatric Psychiatric Inpatient Services – There is consistently very high demand for the two 30-bed geriatric units at CMHI-Pueblo and the one 25-bed geriatric unit at CMHI-Fort Logan, with current combined average occupancy at 95.4%. The same general observations regarding distance can be made for older adult services as for adult services. The following recommendations are offered:

- II-D-1 – Expand Northern and Western Colorado pilots to include current geriatric inpatient capacity. Several additional issues will need to be addressed, including long-term placements for consumers with co-morbid medical conditions.
- II-D-2 –Increase fees and/or collections as needed for Medicaid recipients at the CMHI-Fort Logan geriatric program.

Medical / Surgical Service (MSS) Unit Inpatient Services – Although usage is up somewhat in the last six months of 2000 for the 20-bed general hospital program at CMHI-Pueblo, occupancy was only 45.6% for that timeframe. Total medical costs on a per civil bed day basis at CMHI-Pueblo were 247% higher than at CMHI-Fort Logan in 1999-00. DOC bed days are down 23% and same day surgeries for DOC consumers are down 77%. The following recommendation is therefore offered:

- II-E-1 – Undertake a zero-based budget development process to include only necessary costs and to develop a budget which reduces costs to levels more comparable to those of CMHI-Fort Logan (adjusted for any documented differences in medical patient severity). The review also should examine the relationship of the MSS Unit to DOC.

Mountain Star Residential Treatment Center (RTC) Services – Use of the 20-bed program at CMHI-Fort Logan has been consistently high since it came up to full capacity in 1997-98. Occupancy was 94% in 1999-00. The following recommendation is offered:

- II-F-1 – Raise fees charged (especially to Medicaid) to better match costs.

III. Financing Recommendations

Key financial findings include an estimated need for approximately $35 to $43 million in additional community spending statewide. Capitation as a mechanism for moving control of Institute funding to the community seemed to have only limited applicability. In addition to the specific subsidies of Medicaid services by State General Funds noted above in every area of Institute psychiatric programming examined, two current CDHS strategies to enhance federal Medicaid revenue were examined. The following recommendations are offered:

- III-A – Enhance Medicaid revenue by an estimated $5.1 million annually through the following mechanisms:
  - III-A-1 – Change Medicaid fees to be based upon a cost-based methodology, as proposed by the Institutes. CDHS estimates that this could increase annual federal revenue and free up $1.4 million in State General Funds for community alternatives.
  - III-A-2 – Continue to pursue an IMD waiver to allow Medicaid payment for some adult inpatient services. CDHS estimates that this could increase annual federal revenue and free up $3.7 million in State General Funds for community alternatives. If the current waiver request is denied, it is recommended that a waiver request be resubmitted modeled on Arizona's recently successful IMD waiver request.
- III-B – Prevent Institute safety net funding from eroding further by maintaining current funding levels over time through annual adjustments for inflation and population growth.
- III-C – Initiate a seven-year transition to community control of funding for 40% of remaining Institute adult capacity and 35% of remaining older adult capacity, resulting in a combined $25.0 million annually in State General Funds. This 129-bed additional reduction would leverage approximately $34.5 million and 695 treatment slots of community-based alternatives.

IV. Administrative and Governance Recommendations

Administration – Of the 27 states for which data were available, Colorado ranked 21st in the ratio of indirect (administrative) FTE to beds, with a ratio of 0.56 staff to each bed. Additionally, Colorado is one of only two states in which oversight of the state psychiatric hospital is not integrated with oversight of the mental health system. The following recommendation is made:

- IV-A – CDHS should study the split of Institute and mental health system oversight and look for opportunities to consolidate state government authority over the overall mental health system with authority for the Institutes (or any ensuing contract with non-state governmental entities to provide some proportion of current CMHI services).

Governance – The plan's analysis and recommendations regarding administration focus primarily on the governance of the Institutes into the future. There was considerable consensus that a quasi-governmental authority model is needed in order for the Institutes to be able to compete effectively in the current health care marketplace. Such a model provides the advantages of operating outside of the state budgeting system, state personnel system, and state procurement system, as well as the advantages of being able to retain governmental immunity as a quasi-governmental structure (limiting insurance costs), incur debt (by issuing revenue bonds), and undertake joint ventures and mergers.

Creating a new hospital organization and associated administrative entity would not be the most efficient use of funds. Merger with an existing quasi-independent authority offers an alternative that avoids the costs of creating a new authority. The University of Colorado Hospital Authority, with its statewide mission and experience transitioning from state government, offers a viable vehicle for such a change. Given this, the following recommendations are offered:

- IV-B – Initiate an incremental, monitored process to transition the Institutes toward becoming a quasi-independent part of University of Colorado Hospital (UCH). This is a substantial and possibly controversial recommendation that nevertheless appears to offer the best path to balance the many issues confronting the Institutes. The components of this recommendation offer a multi-step plan that involves additional, detailed planning, evaluation, analysis, and implementation over an eight-year timeframe. Each of the five steps takes two years (steps 3 and 4 are concurrent), and they are contingent upon ongoing analysis and planning. If at any point alternative directions are identified or data emerge suggesting small or major changes to the plan, these should be integrated into the plan and the plan changed accordingly, up to and including its termination. The five steps include:
    - IV-B-1 – Step 1 – Determine that Colorado Psychiatric Health (CPH) can manage and provide Institute services through the Northern Colorado adult inpatient pilot, as described above. (Years 1–2).
    - IV-B-2 – Step 2 – Initiate a CPH/UCH management contract for CMHI-Fort Logan. This second step would involve a management services contract for CMHI-Fort Logan

including executive leadership and certain administrative functions (e.g., billing), contracted to CPH/UCH. (Years 3–4).

- IV-B-3 – Step 3 – Merge CMHI-Fort Logan operations into University of Colorado Hospital as part of the quasi-independent governance structure of CPH, with appropriate steps to incorporate the historic mission of the Institutes. (Years 5–6).
- IV-B-4 – Step 4 – Initiate a CPH/UCH management contract for CMHI-Pueblo civil and general hospital units. This fourth step would occur concurrent with step three (IV-B-3). Given CMHI-Pueblo's combined civil and forensic mission, incorporating its civil inpatient operations into CPH/UCH poses a unique set of challenges. (Years 5–6).
- IV-B-5 – Step 5 – Merge CMHI-Pueblo civil and general hospital operations into University of Colorado Hospital as part of the quasi-independent governance structure of CPH, with appropriate steps to incorporate the historic mission of the Institutes. (Years 7–8).

V. Direct Care Staffing Recommendations

Despite ranking in the middle (14th) of 28 states surveyed, Colorado's actual ratio of 1.32 FTE of direct care staff per bed falls in the bottom third of the distribution of the 28 ratios surveyed. To move up to the middle (median) of the range of ratios, Colorado would need to increase staffing by 0.35 FTE per bed, an amount comparable to the current CDHS request to increase by 0.37 FTE per bed. The following recommendations are offered:

- V-A – The CDHS FY2001-02 request for 61.0 additional FTE is endorsed.
- V-B – The dynamic staffing model developed by CDHS is endorsed.

VI. Oversight and Evaluation Recommendations

Oversight Recommendations – The following recommendations are offered to provide dedicated oversight and support from the CMHI management team:

- VI-A-1 – Appoint a commission to oversee implementation of the Operational Plan.

- VI-A-2 – Fill the currently vacant superintendent position for CMHI-Fort Logan to support the Operational Plan.

Evaluation Recommendations – Evaluation should be integrated with each step of the Operational Plan implementation process, in order to determine the advisability of moving to later steps and to further inform and refine the planning process for subsequent steps. Key recommendations related to evaluation include:

- VI-B-1 – CDHS should contract with a single independent evaluator for the entire Operational Plan.
- VI-B-2 – Orient the evaluation toward decision support, not research.
- VI-B-3 – Major points of focus for the evaluation should include development of community alternatives, effectiveness of ongoing Institute programs, and effectiveness of governance changes.
- VI-B-4 – Principles for evaluating Operational Plan implementation should include: multi-modal assessment of implementation effects; multi-method evaluation approaches; stakeholder involvement in multiple components of the study; required participation of involved providers in the evaluation; a multi-year evaluation; targeting the evaluation to specific steps of the Operational Plan; development and incorporation of performance standards and benchmarks; formal mechanisms for the provision of ongoing feedback; and support of ongoing monitoring by CDHS.