COLORADO DEPARTMENT OF HUMAN SERVICES

Office of Behavioral Health and Housing

Operational Plan for the Mental Health Institutes

February 15, 2002

Operational Plan for the Mental Health Institutes

Preface

The public mental health system in Colorado has undergone many changes in the past twenty years. This, coupled with aging physical structures, has led to a variety of changes for Colorado's two Mental Health Institutes (MHIs). The number of beds at the MHIs has decreased significantly while the number of persons served has increased and the average length of treatment has decreased. Most recently this change has been due to the capitation of services for Medicaid-eligible mental health consumers and the transfer of consumers to the most appropriate, least costly, and least restrictive setting. Additionally, with the introduction of atypical psychotrophic medications, more individuals who previously would have spent much of their lives in institutions are now able to live successfully in the community. Finally, following the recent Supreme Court decision in Olmstead v. L.C., we are challenged to continue improving the public mental health system by enhancing plans that promote access to home and community-based services, and maximize the dignity and autonomy of persons with disabilities, including mental illnesses.

The advancements in the mental health field have drastically impacted the types of people served by the Mental Health Institutes, as well as the services delivered to those individuals. Previously the MHIs served a significant proportion of inpatient consumers for extended periods of time. Currently, the MHIs continue to treat many individuals with long-term inpatient services, however they treat an increasing proportion of persons with the serious emotional disturbances and mental illnesses with brief hospitalizations, stabilizing these persons, treating the problem(s) that led to the admission, and then returning them to the community for follow-up services. The MHIs have restructured over time to respond to this dynamic environment by offering to provide new or different services, or by downsizing to reflect decreased usage. The Department of Human Services was in need of an operational plan to guide their future role in Colorado's public mental health system.

In August 2000, a contract was awarded to TriWest Consulting Group to produce this operational plan. This contractor reviewed and analyzed clinical, financial and program capacity information for the MHIs and the community mental health system. National and state-of-the-art data were included in this effort. Additionally, the TriWest Consulting Group conducted numerous focus groups with stakeholders from across the State to expand their information base for a comprehensive system analysis. The March 15, 2001 Plan developed by the contractor included written recommendations regarding the possible future configuration of the Mental Health Institutes. These recommendations were presented to the Department of Human Services for review, consideration and possible modification.

This project was overseen by a steering committee that included representatives from the Department of Human Services (DHS), the Governor's Office of State Planning and Budgeting, the Office of the State Auditor, community mental health providers, and family members of consumers with mental illnesses. Several of the steering committee representatives are also members of the Mental Health Strategic Planning Committee of the Mental Health Planning and Advisory Council. The report contained extensive recommendations in various areas. Some of the recommendations were immediately acted upon by DHS. With regard to a several other recommendations, DHS staff wanted to secure input from mental health constituents throughout the State.

In June 2001, Mental Health Services funded the TriWest Consulting Group to complete a complementary study, *An Assessment of Community Mental Health Resources*. This study identified available community resources as well as gaps in resources across the State needed to effectively serve persons with serious emotional disturbances and mental illnesses in the integrated community settings across Colorado. The information gathered through this assessment of community alternatives will be valuable as the State moves forward with its Operational Plan for the Mental Health Institutes and its Olmstead Plan.

In October of 2001, the Department of Human Services reconstituted and expanded the Steering Committee to host this input process and integrate the feedback. The Steering Committee membership included representatives from a wide array of organizations throughout the State. The Steering Committee's role was to listen to feedback, integrate the issues and provide their consensus (as possible) to DHS. Resource people were included to provide information, as needed. To assist the Steering Committee, DHS contracted with Marcy Balogh, M.A. (Solutions Resources) to facilitate the meetings of the Steering Committee and conduct the forums. Ms. Balogh contracted with Garry A. Toerber, PhD to assist with the process and provide analysis of the input. The Department of Human Services is very grateful of the time and effort of the Steering Committee.

It is with careful consideration of multiple complex issues that the Department of Human Services presents the Operation Plan for the Mental Health Institutes. The Department is very invested in the quality of public mental health services in Colorado. Therefore, comprehensive evaluation of system changes and the impact on persons with serious emotional disorders and mental illnesses, their families and our communities are critical aspects of this Plan.

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Colorado Department of Human Services
Office of Behavioral Health and Housing

TriWest Recommendation	Steering Committee's Position	Consultant's Position	Department's Position
Close the 10-bed unlocked adolescent unit at CMHI-Pueblo and using the savings to fund approximately $1.34 million in community-based adolescent alternative services. TriWest also considered an alternative model that maintains the unlocked adolescent unit and closes eight beds on the locked adolescent units. TriWest estimated this savings to be $390,000. They chose not to recommend this model because of the differential in savings between the two approaches.	The Steering Committee opposes the TriWest recommendation to close the unlocked 10-bed adolescent unit at CMHI-Pueblo.	The Consultant agrees with the Steering Committee position to oppose the closure of the 10-bed adolescent treatment team at CMHI-Pueblo. The author instead supports the alternative consideration of TriWest to reduce the size of locked adolescent treatment team at CMHI-Pueblo from 20 beds to 16 beds and to reduce the locked adolescent team at Fort Logan from 22 beds to 18 beds. Any savings be first used to develop local community-based services on the Western Slope.	The Department does not support closing the unlocked adolescent unit at CMHI-Pueblo. The Department does however; support closing four beds on the two locked adolescent units at the Institutes, one unit at CMHI-Pueblo and one unit at CMHI-Fort Logan. In addition, the Department supports closing two beds on the ten-bed unlocked adolescent unit at CMHI-Pueblo. Contingent on a positive evaluation of this effort, the Department will consider the further development of intensive community-based services for adolescents and the subsequent closure of additional Institute beds.
1) Develop local Institute alternative pilots in Northern and Western Colorado; and fund the two pilots with start-up transition funds, followed by savings from downsizing the three 32-bed CMHI-Pueblo adult inpatient units to 24 beds each. TriWest estimates that downsizing by 24 beds will result in $1.9 million in savings that would be available to fund intensive community-based services. 2) They also recommend that Colorado Psychiatric Hospital (CPH)) partner with the providers in the Northern Colorado to serve consumers from that region.	The Steering Committee strongly opposes this recommendation. The Steering Committee supports the need for pilot programs on the Western Slope but does not support the reduction of beds at the Institutes to fund the pilot programs given the current demand for beds at the Institutes.	The consultant supports the recommendation of the TriWest Study to develop pilot programs with new money on the Western Slope. However, does not support the recommendation to commit up front to reduce the beds available at CMHI-Pueblo to continue funding for the pilot programs in CMHI-Pueblo. Any reduction in beds at CMHI-Pueblo should occur only as a result of reduced demand for the CMHI-Pueblo inpatient beds.	The Department supports decreasing the three 32 bed adult units at CMHI-Pueblo to 24 beds each, resulting in a total of 24 fewer adult beds if the Department receives up-front funds to develop intensive community-based services through a proposal process. It is critical that the intensive community-based services be developed prior to any beds being closed at the Institute. The Department believes that CPH partnering with providers in N CO to serve consumers from that region may be useful as a future consideration, however in light of the current changes in organizational structure, it is not feasible to pursue this at this time. The Department supports greater admission flexibility to either of the CMHIs.

TriWest Recommendation	Steering Committee's Position	Consultant's Position	Department's Position
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 $25 million annually in State general funds, which can leverage $34.5 million and 695 treatment slots of community alternatives.	The Steering Committee opposes the TriWest recommendation # 3 to transition to community control 40% of the remaining adult capacity and 35% of remaining older adult capacity.	The consultant recommends the development of contracts with private hospitals on the Western Slope to provide inpatient care closer to the patient's home. These contracts should be for a certain number of beds rather than payment for the number of patient days used. This would provide "free" beds similar to the arrangement of beds at the Institutes and thus would remove the "profit" motive in use of inpatient services. The development of alternatives to inpatient services will need to be double funded until such time as the alternatives are available, evaluated, and found to provide the care patients now in the Institutes require.	Once the beds at the Institute are closed following the Department's action plan related to Recommendation #2, the Institute dollars that become available will be used to repeat the proposal process and continue the development of intensive community-based services and subsequent closing of additional beds at either of the Institutes. This process will further 'right-size' the Institutes while building the necessary community capacity. Alternatively, the Department could request time-limited start-up funding for this effort after returning the start-up funds from Recommendation #2 back to the State's general fund. The Department's goal is to incrementally reduce up to 40% of the adult capacity after #2 is implemented and 35% of the older adult bed capacity by FY 2011, if supported by ongoing evaluation findings, including year 3 benchmarks.
The TriWest Group recommends the initiation of an incremental monitored process to transition the Mental Health Institutes toward becoming a quasi-independent part of the University of Colorado Hospital (UCH). This recommendation is based on improving the ability of the Institutes to compete effectively in the current healthcare marketplace. TriWest did not address any fiscal savings from this initiative.	The Steering Committee opposes the recommendation to incrementally transition the Mental Health Institutes toward becoming a quasi-independent part of University of Colorado Hospital.	The consultant recommends that this issue be pursued but the review should only be pursued after the Department determines its plans related to some of the other issues discussed in the TriWest Study. This issue is a long-term proposal and UCH needs a stable organizational structure prior to any future discussion.	The Department agrees with the concerns of the Steering Committee and the Consultant regarding the recent changes in the organizational structure at the UCH. The Department agrees with the Consultants suggestion, that if this recommendation is pursued, that a committee of Department staff along with stakeholders in the system should be involved in these discussions. The Department recognizes the difficulties of such a merger as well as the complications the Forensics Program creates.

TriWest Group Recommendation #1: The TriWest Group recommends closing the 10-bed unlocked adolescent unit at CMHI-Pueblo and using the savings to fund approximately $1.34 million in community-based adolescent alternative services.

The **Steering Committee** opposes the TriWest recommendation to close the unlocked 10-bed adolescent unit at CMHI-Pueblo.

The **Consultant** recommends the alternative consideration of TriWest, to reduce the size of locked adolescent treatment team at CMHI-Pueblo from 20 beds to 16 beds and to reduce the locked adolescent team at Fort Logan from 22 beds to 18 beds. Any savings be first used to develop local community-based services on the Western Slope.

The Department of Human Services Plan

The Department does not support closing the unlocked adolescent unit at CMHI-Pueblo until intensive community-based services are developed. It is critical that intensive community-based alternatives be developed prior to the closure of Institute beds. The Department does however; support closing four beds on the two locked adolescent units at the Institutes, one unit at CMHI-Pueblo and one unit at CMHI-Fort Logan. In addition, supports closing two beds on the ten-bed unlocked adolescent unit at CMHI-Pueblo. Contingent on positive evaluation findings of this effort, the Department will consider the further development of intensive community-based services for adolescents and the subsequent closure of additional Institute beds. If this is feasible, the Department will use a four-year transition period to gradually transition additional adolescent services from the Institutes to the community. The Department will initiate this effort focusing on the service needs of the adolescents served on the unlocked adolescent unit. Efforts to develop alternative community services will focus on the areas of the State that routinely utilize these beds. Evaluation of clinical and system outcomes will be imbedded in this process to ensure that adolescents and their families are not negatively impacted and to maintain the safety net function that the Institutes provide for persons who cannot be safely and appropriately treated with intensive community-based services.

This approach results in ten fewer adolescent beds without impacting the admission flexibility that currently exists and without jeopardizing the clinical needs and safety of the adolescents served. The Department's decision to close two beds on the unlocked adolescent unit at CMHI-Pueblo is based on utilization patterns. The decision to decrease the size of these two locked units is based on the increased volatility of the patient mix because the physical design of these units does not adequately accommodate the larger number of patients. These factors impact the Institutes' ability to safely treat the number of patients for which they have assigned beds. Therefore, the Department proposes to 'right-size' these two units to more accurately represent the true current capacity of these treatment units. Additionally, the Department supports increasing the flexibility of admissions to any of the three adolescent units depending on the availability of appropriate beds and the wishes of the patient, family, guardian and decision makers. This optimizes the use of the adolescent beds while accommodating some of the transportation issues resulting from long commutes and increases options to address the clinical mix of patients.

The estimated annual savings from this bed reduction is $255,171, includes 8.0 FTE and is based on methodology used previously by the Joint Budget Committee Staff, however does differ from the original TriWest estimates. The budget reduction details follow the narrative section of Recommendation #1. The closing of these ten adolescent beds can occur within 30 days of a final decision.

As supported by the TriWest Report, Steering Committee and Consultant, the Department is invested in keeping current funding in the mental health system because of the need to further develop alternative services and expand Colorado's community mental health capacity for adolescents, as supported by the input from the public forums and the Steering Committee.

The Department also supports TriWest Group's recommendation to use a proposal process to develop intensive community-based services so that local communities can develop plans that address the needs and resources for their region of the State. Proposals developed on a regional basis, to serve persons from multiple community mental health centers will be encouraged. Additionally, the Western Slope region of the State has been identified by the Steering Committee and the Consultant as the highest priority for intensive community-based alternatives for the adolescent population.

The TriWest Group's Final Report to the Department completed June 18, 2001, *An Assessment of Community Resources,* provides detailed information regarding the existing capacity and gaps in intensive community-based services across the State. This information will assist the Department in determining the services needed in various regions of the State and provide supporting information for the proposal process.

Lastly, the Department supports the TriWest recommendation to focus the expansion of intensive community-based services on evidenced-based practices, whenever practicable.

Additional justification for not closing the ten bed unlocked adolescent unit at CMHI-Pueblo:

- Community Input at public forums and the DHS Steering Committee studying the Operational Plan for the Mental Health Institutes in Colorado March 2001 report do not support the closure of the 10-bed Open Adolescent Unit at CMHIP.
- CMHIP uses the Open Adolescent Unit to separate a younger more vulnerable population from older adolescents served in the CMHIP Locked Adolescent Unit. If the Open Adolescent unit at CMHIP is closed, CMHIP will not have the capability of separating their younger more vulnerable population from older adolescents. Combining young adolescents with the locked adolescent population is neither safe, nor clinically or behaviorally appropriate.
- Approximately 55% of admissions to Open Adolescent Unit are children age 14 and under experiencing their first psychiatric break needing hospitalization; or those who have failed in outpatient community programs. Combining these young adolescents with the locked adolescent population is neither clinically nor behaviorally appropriate for the following reasons:
  - Age, cognitive and developmental appropriateness
  - Vulnerability to emulating the behaviors seen at the Locked Adolescent Unit (gang related behaviors, criminal conduct and perpetrating behaviors)
  - First time admit patients would be exposed to higher levels of acuity of the locked patients
  - Vulnerability to sexual predators who are admitted to locked adolescent units

- Treatment approach of the locked adolescent unit is not clinically appropriate to this population

- The Open Adolescent Unit (OAU) is an acute care facility admitting younger adolescents presenting 27-10 behaviors that are either a danger to themselves or others; but require a less restrictive setting than a 'locked' facility but needing more than a Residential Treatment Center or an outpatient setting. These persons generally do not have criminal charges requiring juvenile forensic assessment or services.
- The OAU provides a full complement of psychosocial, psychiatric/medication and medical assessments that is imperative to thoroughly and accurately assess the patient's presenting problems. Thorough assessments are what sets quality treatment direction. Brief hospitalization stays of 3-5 days normally seen in other hospital settings or in outpatient settings cannot accomplish this. Such brief stays contribute to recidivism as medications cannot be appropriately assessed for effectiveness and treatment/aftercare plans are not thoroughly or appropriately implemented.
- This alternate recommendation is in the best interests of adolescents who are experiencing mental illness and leaves the potential open for future growth based on a number of unanswered questions that were posed by the community during the public forums and concerns raised by the DHS Steering Committee.
  - The Steering Committee / public forums cited problems in getting patients into the adolescent beds at the Institutes, however the Institute beds are not filled to capacity. The relationship between the community perception, the low census and the MHASAS needs to be explored.
  - The Steering Committee / public forums cited concern for the ability of the private sector to serve the population if the number of beds at the Institutes were reduced. Private facilities traditionally treat short-term adolescent patients and are not experienced nor do they specialize in treating the longer-term patients who have traditionally been treated by the Institutes. The Institutes need to maintain the ability to increase capacity for treating the longer-term patients if they cannot be served in the private sector.
  - The Steering Committee / public forums cited concern that adolescent patients now served at the Institutes may end up in jails, correctional facilities or even forensics. This potential needs to be tracked and the Institutes need to maintain the ability to increase capacity to treat this population if necessary.
  - Speakers at the Grand Junction forum cited concerns about transporting patients, particularly adolescents, over the mountains especially during winter months. They emphasized the need for local resources with Institute beds only being used as a last resort.
  - The Institutes believe that adolescents should be admitted to any of the three adolescent units depending on the availability of appropriate beds and the wishes of the patient, family, guardian or other decision maker for the adolescent.

Reduce 4 beds of locked unit in CMHI-Pueblo, 4 beds of locked unit in CMHI-Ft Logan and 2 beds of unlocked unit in CMHI-Pueblo

1. Uses the same method for calculating the FTE reductions as in the staffing decision item request.
   - Ft Logan shows a staffing need of 34.7 FTE for a 22 Bed Unit and 32.1 FTE for a 18 Bed Unit
   - Assumes a reduction of 2.5 FTE for Ft Logan.
   - Calculation of needed staff for Pueblo shows a decrease of 5.6 FTE for both units for the reduced bed size.
   - Assumes a reduction of 5.5 FTE for Pueblo.
2. Uses the same cost for FTE reductions used in the last year's staffing decision item.

3. Since no Units are closed, assumes no reduction in housekeeping, dietary, or psychiatry costs.
4. Operating reduction is based on year to date operating costs in the Pueblo 10 bed unlocked unit.

Conclusion: There is a reduction of 8.0 FTE and an annual cost reduction of $255,171

CMHI Adolescent Beds	Current Beds	Beds Within 30 Days of Decision
CMHIFL - Locked	22	18
CMHIP- Locked	20	16
CMHIP - Unlocked	10	8
TOTAL	52	42

As noted earlier, the Department will assess the feasibility of repeating this approach including reinvesting the $255,171 annually, over a four-year period, to develop additional intensive community-based services. This effort will focus first on addressing the potential closure of the eight beds that will remain on the unlocked unit at CMHI-Pueblo. Savings from closing Institute beds will be used to support intensive community-based services. However, if evaluation findings at any time indicate that this transition process is not achieving desirable outcomes, Institute beds will not be closed.

Adolescent Unit Reductions

Number of months	12							Total Request		
		Pueblo			Ft Logan					
Personal Services	Salary	FTE	Cost		FTE	Cost		FTE	Cost	
Lic Pract Nurse	1,810	(1.0)	(21,720)		0.0	0				
Mental Health Clin I	1,954	(1.0)	(23,448)		0.0	0				
Nurse I	3,730	(0.5)	(22,380)		0.0	0				
Psychiatric Techs I	1,724	(3.0)	(62,064)		(2.5)	(51,720)				
Subtotal salaries		(5.5)	(129,612)		(2.5)	(51,720)		(8.0)	(181,332)	
PERA	9.90%		(12,832)			(5,120)				
Medicare	1.45%		(1,879)			(750)				
Subtotal P.S.			(144,323)			(57,590)			(201,913)	
Total Personal Services			(144,323)			(57,590)			(201,913)	
<u>Operating</u>										
Nutritional Services				(4,048)			(2,698)			(6,746)
Pharmaceuticals				(5,281)			(3,520)			(8,801)
General Operating		500		(2,750)			(1,250)			(4,000)
Annual Lan Infrastructure		0		0			0			0
Computer Purchase		0		0			0			0
Subtotal operating				(12,079)			(7,468)			(19,547)
Total MHI				(156,402)			(65,058)			(221,460)
EDO										
Shift				(6,249)			(2,366)			(8,615)
Health, Life, and Dental		$ 260.66		(17,204)			(7,820)			(25,023)
Short-term Disability		0.04%		(52)			(21)			(73)
Total EDO				(23,504)			(10,206)			(33,711)
Total Request			**(5.5)**	**(179,906)**		**(2.5)**	**(75,265)**		**(8.0)**	**(255,171)**

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Short-term Disability	0.04%		(52)		(21)		(73)
Total EDO			(23,504)		(10,206)		(33,711)
Total Request		**(5.5)**	**(179,906)**	**(2.5)**	**(75,265)**	**(8.0)**	**(255,171)**

TriWest Group Recommendation #2: Develop local Institute alternative pilots in Northern and Western Colorado; and fund the two pilots with start-up transition funds, followed by savings from downsizing the three 32-bed CMHI-Pueblo adult inpatient units to 24 beds each. They also recommend that Colorado Psychiatric Hospital (CPH)) partner with the providers in Northern Colorado to serve consumers from that region.

The **Steering Committee** strongly opposes this TriWest recommendation. The Steering Committee supports the need for pilot programs on the Western Slope but does not support the reduction of beds at the Institutes to fund the pilot programs given the current demand for beds at the Institutes.

The **Consultant** supports the recommendation of the TriWest Study to develop pilot programs with new money on the Western Slope. However, the consultant does not support the recommendation to commit up front to reduce the beds available at CMHI-Pueblo to continue funding for the pilot programs in CMHI-Pueblo. Any reduction in beds at CMHI-Pueblo should occur only as a result of reduced demand for the CHMI-Pueblo inpatient beds.

The Department of Human Services Plan

The Department supports decreasing the three 32 bed adult units at CMHI-Pueblo to 24 beds each, resulting in a total of 24 fewer adult beds, by receiving up-front funds to develop intensive community-based services. It is critical that the intensive community-based services be developed prior to any beds being closed at the Institute.

The Department will use a proposal process to determine which regions of the State will receive funding. Agencies responding to the proposal process will need to demonstrate that not less than two community slots will be developed for each Institute slot and the proposal must include an appropriate number of intensive residential slots. The annual direct cost for an adult inpatient at CMHI-Pueblo is $98,147, based on a direct cost per day of $268.90. Therefore, the total up-front funds needed by the Department are $2,355,529 per year, for a two-year period, allowing sufficient time for the development of intensive community-based services, evaluation of the effectiveness of such services, and to free up the current occupied beds. Assuming that the Department requests funds in FY 2003 and these are appropriated beginning FY 2004, the Department intends to gradually close the adult beds, closing all 24 by the end of FY 2005. However, if funding for the development of intensive community-based services begins in FY 2003, the Department will begin transitioning services from the Institutes to the community beginning January 2003. The closure of adult beds will be based on the success of this initiative as demonstrated by a decrease in the utilization of Institute beds and an evaluation of the clinical outcomes of the persons served in the community mental health system. If the Institute bed census is not reduced in relation to the community resources that are developed, the funding for intensive community services would cease at the end of the two-year period.

Additionally, the Department believes that baseline data and evaluation of any changes in the service delivery system are important and must include the perspectives of multiple stakeholders including persons with mental illnesses, family members, advocates, Institute and community providers and other service systems that may be impacted by mental health system changes. The results of evaluation studies will address the appropriateness of

intensive community-based services without compromising the clinical outcomes of the persons served.

The TriWest Group also recommends that Colorado Psychiatric Hospital (CPH)) partner with the providers in the Northern Colorado to serve consumers from that region. The Department believes this may be useful as a future consideration, but in light of the current changes in organizational structure involving both CPH and the University of Colorado Health Sciences Center, it is not feasible to pursue this at this time.

However, the Department does believe that there should be greater admission flexibility, enabling referring agencies to admit to either of the Institutes, based on geographic proximity, patient and family preference and clinical factors.

Detailed fiscal data are not available at this time, however will be completed by the Department prior to any requests for funding. Additional justification for this Departmental decision is included with TriWest Recommendation #3.

TriWest Group Recommendation #3: 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 $25 million annually in State general funds, which can leverage $34.5 million and 695 treatment slots of community alternatives.

The **Steering Committee** opposes the TriWest recommendation # 3 to transition to community control 40% of the remaining adult capacity and 35% of remaining older adult capacity.

The **Consultant** recommends the development of contracts with private hospitals on the Western Slope to provide inpatient care closer to the patient's home. These contracts should be for a certain number of beds rather than payment for the number of patient days used. This would provide "free" beds similar to the arrangement of beds at the Institutes and thus would remove the "profit" motive in use of inpatient services. The development of alternatives to inpatient services will need to be double funded until such time as the alternatives are available, evaluated, and found to provide the care patients now in the Institutes require.

The Department of Human Services Plan

The Department agrees with the TriWest recommendation to transition up to 40% of the adult bed capacity and 35% of older adult bed capacity from the Institutes to the community, even though this did not receive the support of the Steering Committee. The implementation of this is contingent upon the successful implementation and evaluation findings of the previous recommendation. Supporting information regarding the Department's position on this issue follows.

The Department is considering two approaches to address this issue.

1) Based on the evaluation findings related to the implementation of Recommendation #2 and the closure of the 24 beds, the Institute dollars that are saved from the previous bed closures will be used to repeat the proposal process and continue the development of intensive community-based services and subsequent closing of additional beds at the Institutes. The Department believes that this process should be used for adults and older adults simultaneously. The Department will repeat this proposal process until the public mental health system has reached its optimum balance of Institute and community services. This process will, in essence, define the appropriate size of the Institutes, since the community mental health system will not be able to adequately serve all of the persons who use the Institute beds and there is strong support to preserve the viability of the Institutes to serve as a safety net for the State.

2) Alternatively, if the start-up funds from the implementation of Recommendation #2 are returned to the general fund, the Department could request time-limited start-up funding to reduce additional adult inpatient beds. If the Department receives this funding it will support the development of additional intensive community-based services through a proposal process. Following the development of these intensive community-based services, savings resulting from the reduction in Institute beds will be transferred to the communities to provide ongoing support for the new services, thereby freeing up the start-up funds. This alternative will be staged so that the transition occurs in different regions until all of the State is included.

With this approach, the Department intends to utilize the same methodology that was used for Recommendation #2 to determine the dollar amount for the up front funding of this request. The Department will complete this calculation based on updated costs prior to initiating the request.

TriWest recommends a five-year transition process, after allowing two years for the implementation of Recommendation #2. This allows time to prevent upsetting the continuum of Institute and intensive community-based services by evaluating each step before proceeding with further transitions of funds and services. The Department plans to use a six-year transition process, to allow greater time for evaluation based on concerns expressed in the public forums and by the Steering Committee. As Institute beds are closed, the dollars associated with these beds will be used to replace the up front funding received by the Department to continue the intensive community-based services and to free up the general fund dollars appropriated for this transition process.

Evaluation efforts will include the impact of system changes on the patients remaining at the Institutes as well as persons receiving intensive community-based services. The Department is committed to maintaining the quality of inpatient and community-based services throughout this transition process.

Regardless of the approach implemented, the Department agrees with the staging of this transition in order to:

- Allow areas of the State that are better prepared to begin this process;
- Learn from the experiences of the leading areas;
- Review the evaluation findings to determine if desirable outcomes are being attained or if modifications to the Department's plans are indicated; and
- Allow subsequent areas of the State to prepare for their transition.

The end target for the Department is to reduce up to 40% of the remaining adult bed capacity, after the 24-bed reduction, and 35% of the older adult bed capacity over a six-year period from FY 2006 through FY 2011. However, the Department plans to reduce the adult bed capacity by 20% from FY 2006 through FY 2008 and if supported by evaluation benchmarks, an additional 20 % from FY 2009 through FY 2011. Similarly, the Department plans to reduce the older adult bed capacity by 15% from FY 2006 through FY 2009 and if supported by evaluation benchmarks, an additional 20% from FY 2009 through FY 2011. If evaluation findings indicate that the community mental health system is not able to absorb a 40% adult bed reduction without compromising clinical outcomes, the Department plans to reconsider the 40% adult bed reduction based on the current 217 adult beds, before the initial 24 bed reduction at CMHI-Pueblo, discussed in Recommendation #2. The table below illustrates this staged approach for both of the Institutes and indicates a range for the adult beds based on the 40% reduction including the initial 24-bed closure and not including this closure. These bed reduction targets may change based on evaluation findings during the transition process and external factors such as the impact of population growth on the public mental health system.

Adult and Older Adult Six Year Bed Reduction Plan

	FY 2002-03	FY 2004-05	FY2006-08	FY 2009-11
CMHIFL Adult Beds	121	121	97	73
CMHIP Adult Beds	96	72	58	43
Total Adult Beds	217	193	155-174	116-130
CMHIFL Older Adult Beds	25	25	21	16
CMHIP Older Adult Beds	60	60	51	39
Total Older Adult Beds	85	85	72	55

Detailed fiscal data are not available at this time, however will be completed by the Department prior to any requests for funding.

Justification in addition to the TriWest Study recommendations for the Department's position to reduce the adult and older bed capacity of the Institutes (TriWest Recommendations #2 and #3) include the FY 1998 Open Case Evaluation as well as the State's Olmstead planning efforts. Below is supporting information for the Department's decision.

OPEN CASE EVALUATION OF STATE INSTITUTE AND HIGH RISK COMMUNITY CONSUMERSTHE POTENTIAL FOR BED AND RESOURCE ALLOCATION: EXECUTIVE REPORT, Colorado Mental Health Services, January 14, 1998

Colorado Mental Health Services (MHS), as the state mental health authority, has the responsibility to assure that the scarce resources available for public mental health services and treatment are allocated and used in the most efficient and effective ways possible. Allocation decisions are made in the context of two broad principles:

- Treatment and services should be community focused, consumer centered, minimally intrusive, and promote positive outcomes;
- Intensive, high effort, high security and high management services should be available, as needed, for the protection of the consumer, and for the safety of the public.

These principles may at times appear to be in conflict. The conflict is resolved, however by viewing both principles from the following perspective:

- Match Level-of-Care with Level-of-Need; and,
- Attempt to neither under- nor over-serve.

If resources are allocated carefully there is every reason to hope for and to expect positive outcomes and satisfaction along with cost efficiency and effectiveness. System and individual needs, treatment protocols and procedures, technology and community structure all change over time. As such, periodic assessment of service needs and alternative strategies are needed to maintain a balanced, equitable, efficient and effective system. This report focuses on a study designed to provide information to support decisions regarding the critical balance between state hospital system resources and community system resources for the care and treatment of **adult consumers** within the mental health system.

Colorado 1993 Integrated Plan. In 1993, MHS (then the Division of Mental Health) produced a report entitled, *Long-Range Plan for Colorado's Public Mental Health System: Integrating Hospital and Community Programs*. Known as the **Integrated Plan**, the report was stimulated by:

- MHS' goal to develop community based systems for delivering mental health services to persons with severe mental illnesses and serious emotional disorders;
- The Joint Budget Committee of the Colorado General Assembly encouraging with the 1993 Long Bill, the transfer of funds from the Institutes to support community program development; and,
- The Legislative Audit Committee's April 1993 recommendation that MHS develop a comprehensive plan for system reform that would address the possibility of redirecting resources from Institutes to the community.

At the core of this report, special studies were conducted that evaluated child, adolescent, and adult *Open Cases* – consumers who were receiving treatment at a specified point in time – at both the Institutes and within the community system. The community sample focused on high-risk individuals who potentially might be admitted to one of the Institutes. While primary policy recommendations from the Integrated Plan did not include recommendations regarding adult beds, as part of the analysis there was a complete assessment of adult Institute beds. This analysis suggested that a range of 31% to 54% of 1993 adult Institute beds (26% to 50% of 1997 adult Institute beds) might be considered for future bed reallocations decisions.

Summary and Recommendations:

- Information from this study clearly indicated that the Safety Net provided by state Institutes involving the medium to long-term treatment for adults with high security needs and management issues, is a necessary and essential component of Colorado's system of mental health care.
- There is a need to assess specific regional and community needs and service availability in order to locate and develop needed alternatives both effectively and efficiently. (The TriWest Group's, *An Assessment of Community Mental Health Resources* was completed June 18, 2001.)
- Planned changes should be evaluated and include both pre-change and post-change perspectives from key stakeholders, including consumers, advocates, providers, and community key informants.
- If the plan calls for a shift in beds from the Institute system to the community system, the shift needs to be planned carefully. Alternative community and regional resources need to be designed and implemented so that the demand for Institute beds decreases concomitantly with increased community capacity.
- If reallocation is planned, avoid unplanned cost-shifts with concomitant increases of negative outcomes by developing needed alternatives before shifting resources.

MENTAL HEALTH FY 2002 OLMSTEAD INPUT DOCUMENT CONSIDERATIONS:
(Lifted directly from the document.)

On June 22, 1999, the United States Supreme Court found in *Olmstead vs. L.C.* that unnecessary segregation of individuals with disabilities in institutions might constitute discrimination based on disability. Referring to the *Americans with Disabilities Act* (ADA), the *Olmstead* decision holds states accountable for providing community-based care whenever appropriate, rather than placing individuals with disabilities in institutional settings. The decision reinforces the premise that, with adequate resources, many individuals with mental illnesses or other disabling conditions can successfully live in the community.

The *Olmstead* decision makes it imperative that states remedy any unnecessary segregation by creating comprehensive, effectively working plans for moving individuals from institutional settings to integrated community treatment. Although there was initially no mandate requiring states to respond to the *Olmstead* decision, the Colorado Department of Human Services (CDHS) and Colorado Department of Health Care Policy and Financing (HCPF) determined an Olmstead plan was in the State's best interest. In July 2000, HCPF and CDHS communicated to the Governor's Office their interest in developing a plan. More recently, on June 18, 2001, President Bush signed an executive order requiring States to provide community-based alternatives for individuals with disabilities in compliance with the terms of the *Olmstead* U.S. Supreme Court decision.

The Court's interpretation of Title II of the ADA under the *Olmstead* decision obliges states to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of the qualified individuals with disabilities." This is known as the "integration regulation".

The ADA defines disability as:

a) A physical or mental impairment that substantially limits one or more of an individual's major life activities (not based on age alone);
b) A record of such an impairment; or
c) Being regarded as having such impairment.

Examples of major life activities that might be impaired include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks and learning, as well as basic activities as thinking, concentrating, interacting with others, and sleeping. To be a "qualified" individual with a disability, the person must meet the essential eligibility requirements for receipt of services or participation in a public entity's programs, activities, or services.

The *Olmstead* decision suggests that a state could establish compliance with Title II of the ADA if it demonstrates it has:

- A comprehensive, effectively working plan for placing qualified individuals who desire community-based services in least restrictive settings; and
- A waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated.

The Court emphasizes that nothing in the ADA suggests that individuals should be moved from institutional settings if unable to handle or benefit from community settings. Rather, states are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." Fundamental alteration of a program takes into account three factors:

1. The cost of providing services to the individual in the most integrated setting appropriate;
2. The resources available to the state; and
3. How the provision of services affects the ability of the state to meet the needs of others with disabilities.

TriWest Group Recommendation #4: The TriWest Group recommends the initiation of an incremental monitored process to transition the Mental Health Institutes toward becoming a quasi-independent part of the University of Colorado Hospital (UCH).

The **Steering Committee** opposes the TriWest Recommendation #4 to incrementally transition the Mental Health Institutes toward becoming a quasi-independent part of University of Colorado Hospital (UCH).

The **Consultant** recommends that this issue be pursued but the review should only be pursued after the Department determines its plans related to some of the other issues discussed in the TriWest Study. This issue is a long-term proposal and needs a stable organizational structure prior to any future discussion.

The Department of Human Services Plan

The Department agrees with the concerns of the Steering Committee and the Consultant regarding the recent changes in the organizational structure at the UCH. Now that Colorado Psychiatric Hospital (CPH) is required to become totally integrated into the UCH organizational structure, this could lead to a loss of control of mental health funding to the needs of persons with physical health illnesses and needs. Additionally, a change in the organizational structure of CPH and the Mental Health Institutes will not allow access to Medicaid funding for the Institutes and will likely preclude CPH from securing Medicaid funding for its own services.

The Department agrees with the Consultant’s suggestion, that if this recommendation is pursued after some of the other issues are resolved, a committee of Department staff along with stakeholders in the system should be involved in any discussions. The Department recognizes the difficulties of such a merger as well as the complications the Forensics Program creates.

The Four Primary recommendations of the TriWest Group's *CMHI Operational Plan Study: Operational Plan for the Mental Health Institutes* in Colorado; March 15, 2001 were the focus of the Steering Committee and Consultants review. Listed below are the other TriWest recommendations with a brief statement providing the current status of each.

Complete a proposal process to develop adolescent alternatives.

This process will not proceed until there are savings identified from changes in adolescent services at the Institutes resulting in the transfer of funds from the Institutes to the community or until new funds become available. The Department is invested in the development of intensive community-based services for adolescents, utilizing evidenced-based practices whenever feasible.

Raise third-party rates, especially Medicaid rates to cost-based methodology, for all patient populations including the RTCs.

The Department has proceeded with this recommendation in order to recapture the full cost of care of each category of clients and anticipates that it will soon be completed, retroactive to October 1, 2001, or possibly earlier.

Plan Western and Northern Colorado adult pilots with up-front funding for community alternatives.

Planning will proceed when there are savings identified from changes in adolescent services at the Institutes resulting in the transfer of funds from the Institutes to the community or until new funds become available. The Department supports the development and expansion of intensive community-based services for adolescents in Western and Northern Colorado, utilizing evidence-based practices whenever feasible. Additionally, as a mechanism to decrease the travel time for some of their consumers who need Institute services, the Department supports increasing the flexibility for Northern Colorado to admit to either of the Institutes.

Complete a zero-based budget for CMHI-Pueblo Medical/Surgical Services.

CMHI-Pueblo continues to work on this project and expects to have it completed by April 2002.

Continue to pursue Institute for Mental Disease (IMD) waiver.

In the Waiver Renewal Application for the Capitation Program, the State proposed to obtain federal matching funds to pay for inpatient services for adults in IMDs. The Centers for Medicare and Medicaid Services (CMS) rejected this proposal saying that this would be an illegal use of federal funds.

The State then explored the possibility of allowing consumers in IMDs to retain their Medicaid eligibility, so that they may get necessary physical health care services through the Medicaid Program, rather than through State General Fund dollars. This effort is currently on hold due to a recently released report from the Office of Inspector General (OIG) that addressed this same practice in Texas. The OIG is requiring the State of Texas to pay back nearly a half million dollars in federal funds for physical health care services provided to IMD clients, and to discontinue the practice of using federal funds to pay for these services in the future.

Integrate the oversight of the Mental Health Institutes and Mental Health Services.

The oversight of the State Institutes and Mental Health Services were integrated in a July 1, 2001 Department of Human Services restructuring effort. These service systems were under separate offices from 1994 until July 1, 2001 and now they are both part of the Office of Behavioral Health and Housing.

Appoint a commission to oversee the transition recommended in the Study.

The Department supports this concept, however does not support the development of a new body to fulfill this role. Instead, the Department will determine the feasibility of assigning this role to an existing body.

Contract with a single, independent evaluator to assess the transition.

The Department concurs with this recommendation, if contractual dollars become available. As an alternative, the Department will use the commission concept to oversee the system transitions to also have oversight responsibility for internal evaluation efforts.