COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

COLORADO
Department of Public Health & Environment

4300 Cherry Creek South
Denver, CO 80246

COLORADO
Department of Human Services

1575 Sherman St.
Denver, CO 80203

November 1, 2019

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the response to the Joint Budget Committee's Request for Information #7 regarding the Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE).

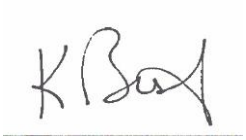
Multi-Department Request for Information #7 states:

Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1 of each fiscal year, the status of the implementation of Regional Center Task Force recommendations.

While the three Departments achieved some milestones quickly, some of the Regional Center Task Force recommendations and associated tasks have been ongoing and are being advanced by eight interrelated initiatives identified in this report. As of October 1, 2019, 75 percent of the tasks outlined in Appendix A are complete and the remaining 25 percent are supported in the interrelated initiatives.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz, at nina.schwartz@state.co.us or 303-866-6912.

Sincerely,



Kim Bimestefer
Executive Director
Department of Health Care Policy and Financing

Sincerely,

Jill Hunsaker Ryan
Executive Director
Department of Public Health and Environment

Sincerely,

Michelle Barnes
Executive Director
Department of Human Services

KB/JHR/MB

Enclosure(s): Health Care Policy and Financing FY 2019-20 Multi-Department RFI #7

CC: Representative Daneya Esgar, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Stephanie Ziegler, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

Regional Centers Task Force Implementation Update

Legislative Requests for Information for FY 2019-20
Requests Affecting Multiple Departments #7

November 1, 2019

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Human Services

COLORADO
Department of Public Health & Environment

Contents

I. Requests Affecting Multiple Departments #7

This report was developed in response to the Joint Budget Committee's Request for Information #7 – "Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1 of each fiscal year, the status of the implementation of Regional Center Task Force recommendations."

II. RCTF Overview

The Regional Centers Task Force (RCTF), created by House Bill (HB) 14-1338, was directed to develop recommendations regarding the future size, scope and role of Colorado's three Regional Centers serving people with intellectual and developmental disabilities (I/DD). The Task Force produced 10 recommendations, each with several associated tasks, and published the RCTF Final Report in December 2015. The recommendations include ambitious, broad system changes that involve the Colorado Departments of Health Care Policy and Financing (HCPF), Human Services (CDHS), and Public Health and Environment (CDPHE).

III. Infrastructure

CDHS, CDPHE, and HCPF (the Departments) agree that Colorado must provide effective and efficient, person-centered services in the most appropriate and least restrictive setting. At times, Regional Centers are the most appropriate and least restrictive setting – offering short-term treatment and stabilization programs for individuals whose acute or complex needs cannot be met in the community. As a result, the Regional Centers play an important role in the state's spectrum of care for people with ID/D."

IV. Recommendation Implementation and Satisfaction: Eight Inter-Related Initiatives

The Departments have taken considerable steps toward improving community system capacity and stability by increasing funding and eliminating barriers to accessing services for individuals with I/DD who require complex mental and behavioral health services. There are eight system initiatives underway to strengthen services, build provider capacity, and improve quality of services for individuals with I/DD that will provide increased opportunities for people currently served by the Regional Centers to be served by private providers in the community.

While much progress has been made, future work will be required to fully implement the significant systems changes proposed by the RCTF. This report identifies how the following initiatives collectively advance the RCTF recommendations and associated tasks:

A. Cross-System Crisis Response for Behavioral Health Pilot Program; Report of Best Practices and Recommendations
B. Targeted Case Management – Transition Services
C. Person-Centered Thinking Training Initiative
D. Quality Metric Initiative
E. Behavioral Health Task Force and Behavioral Health Entity – Implementation & Advisory Committee
F. Department of Regional Center Operations Transitions
G. Children's Habilitation Residential Program Waiver Expansion
H. Reimbursement and Ongoing Rate Review

Initiative A. Cross-System Crisis Response for Behavioral Health Pilot Program Report of Best Practices and Recommendations

HB 15-1368 established the Cross-System Crisis Response for Behavioral Health Pilot Program (CSCR Pilot) to address gaps in services for people with an I/DD and a mental health disorder experiencing a behavioral health crisis.

The CSCR Pilot Annual Report identified barriers to mental/behavioral health services within five general categories: diagnosis, training, crisis stabilization, care coordination, and collaboration. A series of best practices and recommendations was developed for serving individuals diagnosed with I/DD. Current emphasis is on implementing the recommendations and developing specialized trainings to benefit service professionals and providers specifically related to the diagnosis and assessment of mental health issues in individuals with I/DD.

HCPF is developing a plan to implement the CSCR Pilot recommendations that will include training for professionals to provide a deeper understanding of diagnosing and treating individuals with I/DD and behavioral/mental health diagnosis and offer a multifaceted professional toolbox to address the needs of individuals diagnosed with I/DD in Colorado to eliminate gaps in service.

Initiative B. Targeted Case Management – Transition Services

HB 18-1326 authorized HCPF to sustain transition services for individuals who live in nursing facilities or receive services from Regional Centers, and who choose to move into a community-based setting. The new transition service, Targeted Case Management – Transition Services (TCM-TS), was implemented on January 1, 2019.

TCM-TS provides a robust transition service (240 Units or 60 hours) of paid casework to coordinate a transition, which allows providers to offer a higher quality of transition service to individuals as they transition into the community. Accompanying TCM-TS, all adult Home and Community-Based Services (HCBS) waivers offer four services for individuals transitioning, including Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Set-Up.

Regulations for TCM-TS require that transition monitoring include a client satisfaction survey prior to discharge from a facility, and at the end of the transition period to evaluate the client's experience in service planning,

transition plan implementation, transition coordination process, level and adequacy of services provided, and overall client satisfaction.

Initiative C. Person-Centered Thinking Training Initiative

In 2016, HCPF entered into a collaboration with the Council on Quality and Leadership (CQL) to hold dozens of training events throughout Colorado to introduce the Person-Centered Thinking Initiative. The work has continued to grow both internally at HCPF and externally. There are five components to the Person-Centered Thinking Initiative:

- "Speaking Up" is a collaborative effort with University of Colorado-Colorado Springs to develop targeted curriculum for an array of training modules to be offered to individuals receiving services. The training curriculums are designed to help individuals be their own advocate as they learn to lead their own person-centered support planning process.
- HCPF has developed of a state-wide Person-Centered Thinking Training plan. Person-Centered Thinking Training is offered to build competency in three crucial workforces:
    - ✓ Case Management Agencies
    - ✓ Direct Care Support providers
    - ✓ Transition Coordination Agencies (TCAs)
- In collaboration with stakeholders, HCPF has developed a new Long-Term Services and Supports (LTSS) Assessment Tool and Person-Centered Support Plan Process for eligibility determinations, needs assessments, and support planning for all individuals seeking or receiving LTSS. The new processes will be person-centered, enhance self-direction, and facilitate greater coordination of services, as well as be equally applicable to adults with disabilities, and children.
- The Office of Community Living (OCL) recently became the recipient of an award from the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) granting technical assistance for person-centered planning, practices, and systems. The goal of NCAPPS is to "promote systems change that makes person-centered principles not just an

aspiration, but a reality in the lives of people who require services and supports across the lifespan." NCAPPS assists states, tribes, and territories to "transform their long-term care service and support systems to implement policy on person-centered thinking, planning, and practices."

Initiative D. Quality Metric Initiative

HCPF is developing a multifaceted system of quality metrics that directly translates into individuals receiving the services they want, when they want, and where they want.

- HCPF administers the National Core Indicator (NCI) surveys to assess the quality of life and outcomes of people with disabilities who access publicly-funded services through Medicaid. Data is gathered yearly to measure the performance of states' LTSS systems and help state agencies with quality improvement initiatives, strategic planning, and legislative and funding.
- HCPF has worked with the stakeholder-driven Community Living Quality Improvement Committee (CLQIC) to develop a Quality Framework for Medicaid HCBS that incorporates NCI data alongside other performance measures to assess system performance.
- HCPF's OCL is working to incorporate elements of the Quality Framework as Key Performance Indicators for the Office to better track quality and program improvement opportunities.
- The Regional Center Task Force Operations Team is tracking transitions of individuals from Regional Center services for efficacy and analyzing transition data to identify key success strategies and determine what/if changes should be implemented to improve the transition process.

Initiative E. Behavioral Health Task Force and Behavioral Health Entity - Implementation & Advisory Committee

Behavioral Health Task Force

On April 8, 2019, Governor Jared Polis directed CDHS to spearhead Colorado's Behavioral Health Task Force (BHTF). The mission of the task force is to evaluate and set the roadmap to improve the current behavioral health system

in the state. This includes developing Colorado's "Behavioral Health Blueprint" by June 2020, with anticipated implementation of recommendations starting in July 2020. There are three subcommittees:

- **State Safety Net**: This subcommittee shall offer a roadmap to ensure that every Coloradan, regardless of acuity level, ability to pay, or co-occurring disabilities, can obtain appropriate behavioral health services in their community.
- **Children's Behavioral Health**: This subcommittee should develop a plan to address how we deliver and manage children's behavioral health and improve outcomes.
- **Long-Term Competency**: Consistent with a recent consent decree entered into by CDHS, this subcommittee should develop a comprehensive plan for individuals in the criminal justice system who have been found incompetent to proceed and future solutions to increase community interventions to reduce demand on forensic solutions to mental health.

Behavioral Health Entity – Implementation & Advisory Committee:

HB 19-1237 directed that minimum standards and rules be established and streamlined for behavioral health entities operating in the State of Colorado by 2024 that:

- Provide a single, flexible license category under which community-based behavioral health services can provide integrated mental health services and meet a consumer's continuum of needs, from crisis stabilization to ongoing treatment
- Provide a regulatory framework for innovative behavioral health service delivery models to meet the needs of both individuals and communities
- Increase parity in the oversight and protection of a consumer's health, safety, and welfare between physical health and behavioral health regardless of the payment source

- Streamline and consolidate the current regulatory structure to enhance community providers' ability to deliver timely and needed services, while ensuring consumer safety.

Initiative F. Division of Regional Center Operations Transitions

The Division of Regional Center Operations (DRCO) has developed a well-defined process for facilitating transitions from Regional Center services to private service agencies.

- In alignment with their goal of "supporting people in multiple ways so they have opportunity to live in the most integrated community setting", DRCO collaborates with HCPF, the Community Centered Boards (CCB), service agencies, advocates, and families to provide a person-centered, treatment-focused stabilization model.
- An interdisciplinary Transition Support Team (TST) provides guidance to the community team throughout the transition process and provides support as needed and requested for the first three months following a transition.

Initiative G. Children's Habilitation Residential Program Waiver Expansion

Per HB 18-1328, the Children's Habilitation Residential Program (CHRP) Waiver has been expanded to include children and youth age birth (0) to twenty-one (21) who have an I/DD and very high needs and are not in child welfare and added two new services. CHRP waiver services may be used to provide supports as youth transition into adulthood.

New services provide wraparound support and in-home learning opportunities to support the child or youth to remain in the family home or to return to the family home after out of home placement.

Initiative H. Reimbursement and Ongoing Rate Review

Per HB 18-1407, Access to Disability Services and Stable Workforce, a 6.5 percent increase in reimbursement rates for Direct Support Professionals for the following services in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), Supported Living Services (HCBS-

SLS) and Children's Extensive Supports (HCBS-CES) waiver was implemented March 1, 2019:

- Group Residential Services and Supports
- Individual Residential Services and Supports
- Specialized Habilitation
- Respite
- Homemaker Basic and Enhanced
- Personal Care
- Prevocational Services
- Behavioral Line Staff
- Community Connector
- Supported Community Connections
- Mentorship
- Supported Employment- Job Development and Job Coaching

Ongoing work to examine payment and rate reforms will be done through the Medicaid Provider Rate Review Advisory Committee (MPRRAC). The next review for HCBS-DD waiver rates will be in State Fiscal Year 2020-2021.

V. Dashboard

HCPF maintains a RCTF Recommendation Implementation Dashboard containing widespread, major action steps. As of October 1, 2019, the completion status of the 10 recommendations made by the Regional Task Force was 75 percent complete. The remaining tasks have been linked to the eight current initiatives detailed above that will directly influence their status toward completion. Figure 1 shows the progress of each of the five categorical themes listed in the RCTF Final Report.

- **Category 1:** Recommendations 1, 2, and 3. Invest to enhance the necessary community supports to enable more of the individuals of the Regional Centers and more persons with I/DD to live successfully in the community.
  - ✓ Of the 38 identified tasks in Category 1, only three remain unaddressed and those are moving toward completion by the Cross-System Crisis

Response initiative and the recently created Behavioral Health Task Force that are both aimed at increasing provider capacity, training, and collaboration to enhance community supports.

- **Category 2:** Recommendations 4 and 5. Enhance the transition, care coordination, and crisis intervention process.

  ✓ Of the 23 identified tasks in Category 2, 17 are complete and the remaining 6 tasks are currently being directly addressed by the Targeted Case Management – Transition Service, in conjunction with the Quality Metric Initiative.

- **Category 3**: Recommendations 6 and 7. Develop a flexible safety net provider system with the Regional Centers and select community providers, serving as crisis stabilization units and as a provider of last resort.

  ✓ All 8 of the unmet tasks identified in Category 3 are being carried forward by implementation of Colorado's Behavioral Health Task Force with its *State Safety Net* sub-committee directive of offering a roadmap to ensure that every Coloradan, regardless of acuity level, ability to pay, or co-occurring disabilities, can obtain appropriate behavioral health services in their community. The tasks of Category 3 are also addressed by the Short-Term Stabilization Model implemented by DRCO.

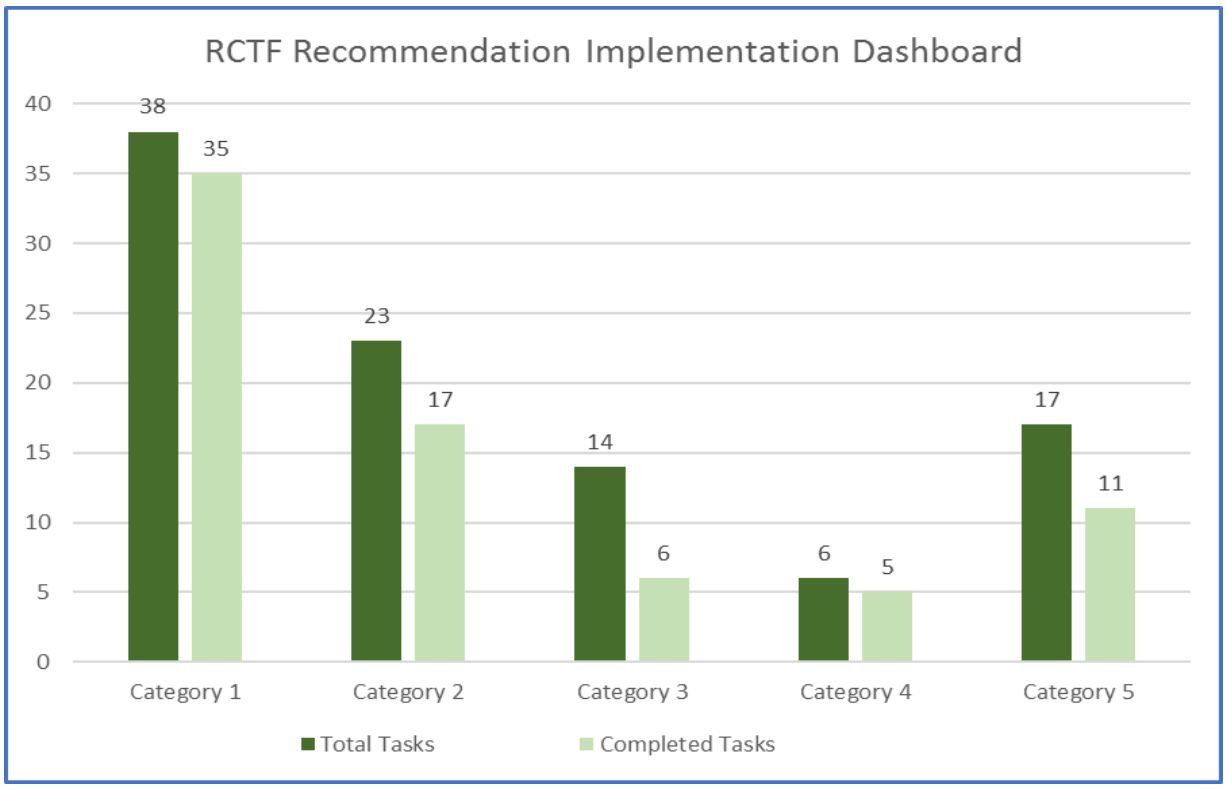
- **Category 4**: Recommendations 8 and 9. As the safety net provider system is established and demonstrated to be effective, concurrently act on consolidation and efficiency opportunities if client census naturally decreases.

  ✓ All but one task identified in Category 4 are met, and that is an ongoing process to be addressed by Reimbursement and Ongoing Rate Review.

- **Category 5**: Recommendation 10. Establish cross agency governance to administer these recommendations and ensure ongoing monitoring of efficacy of services and programs.

  ✓ Of the 17 identified tasks in Category 5, there are 6 outstanding tasks that will be addressed by the Quality Metric initiative that is in line with the federal "Meaningful Measures Initiative" and aims to ensure quality healthcare service delivery in Colorado.

Figure 1. (As of October 1, 2019)



VI. Conclusion

The Departments have made significant investments to ensure access to community-based services, and continue to work toward implementing practicable, interrelated initiatives that directly support the RCTF recommendations. To date, 75 percent of the tasks contained in the Regional Center Task Force Recommendations have been implemented. The remaining 25 percent of tasks are being addressed by the inter-related series of initiatives listed. The intra-departmental Regional Center Task Force Sponsor Group and Operations Team will continue to monitor the implementation of the recommendations, and the Departments will continue to support people with I/DD to live as they choose.

VII. Appendix A - RCTF Implementation Timeline, November 1, 2019

Note: Grey rows indicate the recommendation (task) is excluded and therefore not included in the scope of work. The RCTF Sponsor Group restricted crosswalk inclusion to only those programs and initiatives having a direct relationship with the RCTF recommendations. The RCTF Sponsor Group also excluded duplicative and non-deliverable tasks as well as tasks that were not a good use of resources.

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
Recommendation 1	Leverage Medicaid waiver redesign efforts already underway pursuant to the requirements of H.B. 15-1318 and explore additional alternatives, ensuring that these efforts take into account the desire to provide more individuals with the opportunity to be served in a community setting.	Initiatives A - H	7/1/2016	6/30/2020
1.B.1	Utilize strategies identified and utilized in the Colorado Choice Transitions program to foster collaboration among the DRCO, providers, and families and guardians regarding transition planning.	Yes	7/1/2016	7/31/2017
1.B.2	Identify CCB case management agencies, I/DD behavioral health providers and BHOs/MHC staff to collaborate on each individual's transition based on where the individual will live. Suggested responsible party: case management agency. Date determined by the transition planning process. (Addressed fully in Recommendations 4 and 5)	Yes	7/1/2016	6/30/2018
1.B.3	Ensure a mental health clinician and I/DD behavioral specialist work together on each case. Suggested responsible party: case management agency. Date: TBD.	Yes	4/1/2018	1/31/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
1.B.4	Develop options to incentivize provider agencies, case management agencies, behavioral health providers and BHOs to ensure that each transition is successful. Possible incentives could include review of relative contracts, funding options or rules. Suggested responsible party: HCPF. Date: TBD. (Additional details are available in Recommendation 4)	Yes	7/1/2017	6/30/2019
1.B.4.a	Based on the person's needs, utilize the support level 7 process to fund a person interested in and choosing to transition from the Regional Center to a community-based placement.	Yes	7/1/2016	6/30/2017
1.B.4.b	Utilize an intensive case management model and rate to ensure robust service coordination and engagement during and after the transition.	Yes	7/1/2017	1/31/2019
1.B.4.c	Evaluate the behavioral units/caps and costs to address the needs of the person transitioning. Note: The Supports Intensity Scale (SIS) alone may not consistently reflect the support required for individuals with intense needs. The SIS assessment is currently being analyzed for effectiveness. The conclusions reached from this analysis should inform the evaluation recommended above.	Yes	7/1/2016	6/30/2017
1.B.5	Define person-centered standards of success for transition to the community from the Regional Center. Suggested responsible party: case management agency. Date: At least 45 days prior to planned transition.	Initiatives B, C, and D	7/1/2016	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
1.B.6	Track outcomes of each transition documenting successes and lessons learned, reporting back to DRCO and CCB. Suggested responsible party: case management director. Date: At 3 months, 6 months and 1 year following the transition. (Addressed fully in Recommendation 4)	Yes	7/1/2017	1/31/2019
1.B.7	Monitor this process and recommend actionable payment and rate reforms consistent with the waiver redesign, any alternative funding change, and capacity development. Suggested responsible party: HCPF. Date: Ongoing.	Yes	7/1/2018	6/30/2019
1.B.8	Address the lack of capacity to provide DD specific care in the mental health system through contract review, training, workforce development and capacity development. Suggested responsible party: HCPF. Date: Ongoing.	Yes	7/1/2016	6/30/2019
1.B.8.a	Develop and execute fiscal and actuarial studies to examine the potential fiscal impact of integrating people who have I/DD/Autism into the capitated mental health system funding (H.B. 15-1368)	Yes	7/1/2016	6/30/2017
1.B.8.b	The fiscal analysis should take into account current costs associated with inpatient hospitalizations, emergency department (ED) visits, first responders and other costs associated with behavioral/psychiatric crisis.	Yes	7/1/2016	6/30/2019
1.B.8.c	Examine bright spots of integrations of I/DD population occurring across the state, including Aurora Mental Health Center's Intercept program, Mental health Partners--Boulder,	Yes	7/1/2016	6/30/2017

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	and Mind Springs Mental Health in Grand Junction.			
1.B.8.d	Survey current organizations (CMHC, CCBs) that are successfully providing mental health care to the I/DD populations in order to identify best practices.	Yes	7/1/2017	6/30/2019
1.B.8.e	Survey Mental Health Centers about barriers to billing/utilization outside the capitated rate.	Yes	7/1/2016	6/30/2017
1.B.8.f	Revise the relevant contracts to standardize and require best practices across the state in order to incentivize continued capacity development and integrated care. (Note: This is addressed fully in Recommendation 2)	Yes	12/1/2017	6/30/2019
1.B.9	Identify the costs associated with the elimination of the exclusionary diagnostic criteria for those with I/DD and Autism under the current mental health Medicaid system. (Addressed fully in Recommendation 2)	Yes	7/1/2016	6/30/2017
1.B.10	Secure funding to develop a model of training, consultation, and workforce development to enhance capacity of working with the I/DD population within the mental health/behavioral health system. (Addressed fully in Recommendation 3)	Yes	7/1/2017	6/30/2019
1.B.11	Reallocate funding to enhance the flexibility and responsiveness of the community providers to provide support for families as an integral element of treatment for a person with a dual diagnosis.	Initiatives A - H	6/1/2019	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
Recommendation 2	Fully include services for individuals with I/DD in the capitated mental health system by basing access and reimbursement of services on the presentation of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks.	Yes	7/1/2016	6/30/2019
2.B.1	Including people with behavioral health needs, regardless of the etiology of those needs, in the mental health Medicaid capitated program would centralize responsibility and integrate this special population into existing community services. Doing so would require BHOs to develop specialized I/DD providers either in-network, through the community mental health providers, or externally through third-party providers. This would eliminate screen-outs or denials that currently leave people under-served or without behavioral health services at all.	Yes	7/1/2016	6/30/2019
2.B.2	This recommendation acknowledges and addresses the issue that BHOs have not adequately developed the specialized provider networks as required by the HCPF contract. As a consequence, clients are screened away from community mental health centers and are not documented as being denied services, while assessments are performed by untrained clinicians, resulting in erroneous denials due to over attribution of behavioral problems to a person's developmental disability (diagnostic overshadowing).	Yes	1/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
2.B.3	This restructuring would require the coordinated work of the Colorado Department of Human Services, the Colorado Department of Health Care Policy and Financing, Offices of Behavioral health, Division for Developmental Disabilities, and will inevitably involve the Regional Care Collaborative Organizations (RCCO).			
2.B.4	Studies should be conducted to assess the funding needed to support the mental and behavioral health needs of people with I/DD in publicly funded services. CBHC, Alliance and existing providers can collect information from existing programs and providers. Such actuarial studies are necessary to determine the likely increase in costs (through potential additional care) or savings (though avoidance of long-term costs such as ED and hospital visits via early intervention) and must underpin any changes to the BHO contracts. H.B. 15-1368 authorizes and funds an actuarial study similar to what was done for integrating substance abuse treatment with mental health services.	Yes	7/1/2016	6/30/2019
2.B.5	The $65 million State Innovation Model (SIM) grant awarded to the State outlines a goal of integrated care for 80% of Coloradans by 2020. Coordinated work is already occurring with primary care practice along with a workforce group. This recommendation should be taken to the SIM committee and a plan developed to ensure that people with I/DD are not left out of this groundbreaking work.	Yes	7/1/2016	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
2.B.6	Given that the future plans for BHOs to be embedded within the Regional Care Collaborative Organizations are unclear and undefined, it is uncertain as to the timeframe in which changes to the BHO contract will take place. The current BHO contracts have been recently renewed for a period of one year, expiring on June 30, 201. As those contracts are reviewed, the above considerations should be embodied as practical.			
2.B.7	HCPF should begin an effort to analyze the BHOs to better understand:	Yes	7/1/2016	6/30/2019
2.B.7.a	Differences in business practices such as variation in fee-for-service billing by region/company;	Yes	7/1/2016	6/30/2019
2.B.7.b	Disparities in services provided;	Yes	7/1/2016	6/30/2019
2.B.7.c	Themes of success that can be replicated; and	Yes	7/1/2016	6/30/2019
2.B.7.d	Opportunities to carry these successes into future program and contract innovations.	Yes	7/1/2016	6/30/2019
Recommendation 3	Develop guidelines, training, and clinical tools for medical, behavioral and mental health providers to deliver effective services for the I/DD population.	Initiatives A - H	7/1/2016	6/30/2020
3.B.1	Provide funding support to develop an adequate workforce that is cross-trained in behavioral health treatment and techniques for teaching and working with individuals with I/DD. This will include new forms of treatment expertise such as behavioral analysis, functional assessment of behavior, and evidence based treatments that are not grounded in traditional psychotherapy models.	Yes	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
3.B.2	Develop and integrate effective networks of primary care medical providers and other health professionals that can positively impact health outcomes for persons with I/DD.	Yes	7/1/2016	6/30/2019
3.B.3	Develop and update guidelines for the general, physical, behavioral and mental health recommendations for adults with I/DD, especially for those conditions not screened for by routine health assessments of the general population that takes a comprehensive approach involving:	Yes	7/1/2017	6/30/2019
3.B.3.a	training primary care providers in the content and use of these guidelines;	Yes	7/1/2017	6/30/2019
3.B.3.b	developing clinical tools to help apply them; and	Yes	7/1/2017	6/30/2019
3.B.3.c	establishing clinical support networks that work in concert to increase the use of these guidelines.	Yes	7/1/2017	6/30/2019
3.B.4	Secure funding to augment recommendations and training efforts coming out of the SIM grant.	Yes	7/1/2017	6/30/2019
3.B.5	Develop strategic partnerships with university training programs across the state, as suggested in the Colorado Health Workforce Development report. (Note: The University of Colorado's JFK Center for Excellence is the federally designated agent to advance the education of professionals supporting people with I/DD.) Such partnerships could create a well-trained workforce and provide a "feeder" system for the state to ensure that future expertise will be available. This is important as the state moves toward integrated systems of care, in which cross-	Yes	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	training and expertise will be essential and foundational to the model's support.			
3.B.6	Actively engage people with I/DD in health awareness, self-advocacy, health literacy, and health promotion activities to enable them to participate in their own healthcare through improved access.	Initiative C	7/1/2018	6/30/2020
3.B.7	Add the current Regional Center designation of Psychiatric Technicians to CDPHE certification and determine which types of services these technicians would be authorized to provide.			
Recommendation 4	Enhance the transition planning process to include additional person-centered elements and improve outcome tracking.	Initiatives A - H	7/1/2016	6/30/2020
4.B.1	The transition process should be revised to include:			
4.B.1.a	Additional person-centered details: The enhanced transition plan must be a person-centered planning process reflecting what is important to, and for, the person receiving home and community-based services. It must address personal preferences and ensure health and safety. The plan must identify the person's strengths and	Yes	7/1/2016	6/30/2018

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	weaknesses, preferences, needs and desires.			
4.B.1.b	Risk factors: The plan should include risk factors for the person, as well as risk mitigation plans. CMS has made clear any reference to the person in the person-centered planning requirements include both the person and their legally appointed decision-making authority.	Yes	7/1/2016	6/30/2018
4.B.1.c	Enhanced communication with CCBs: Materials sent to community providers must include a complete representation of the individuals being considered for placement in the community.	Yes	7/1/2017	6/30/2018
4.B.1.d	An approach for resolving disagreements: The process must also include a way to address disagreements between providers, families and guardians, and any others involved in care delivery.	Yes	7/1/2016	6/30/2017
4.B.2	Each transition plan must include balanced set of outcome measures that indicate successful living for the client. The set of measures could be enhanced by following these steps:	Yes	7/1/2017	6/30/2019
4.B.2.a (i-ii)	Create a balanced set of core metrics. Care should be taken to design each metric so as to be measurable, traceable, and actionable over time. Categories of metrics might include: (i) Incident rates (e.g. ED visits, negative interactions with law enforcement, self-injurious behavior,	Initiatives B and D	7/1/2017	6/30/2020

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	elopements, involuntary change in residence, suicidal threats/attempts/completions, etc.); and (ii) Quality of life indicators (e.g. client/family/guardian satisfaction surveys, progress toward significant goals, employment rates, significant changes in health (positive or negative), etc.).			
4.B.2.b	Once such metrics are defined, HCPF, CHDS, and CDPH should collaborate to fill any gaps between the desired information and the currently available sources.	Initiatives A, B, D, and E	7/1/2017	6/30/2020
4.B.2.c	For each metric, the accountable departments(s) could establish actionable and reasonable goal thresholds to track quality performance. For example, the goal for the number of ED visits should not be set at zero but instead targeted to equal that of non-I/DD Medicaid population, or three visits per year per client.	Initiatives A, B, D, and F	7/1/2017	6/30/2020
4.B.3	Identifying lessons learned and trends from monitoring individuals could be used to drive best practice sharing and continuous improvement activities to improve the quality and efficiency of service for all persons with I/DD undergoing transition.	Yes	10/1/2017	6/30/2019

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4.B.3.a (i-ii)	There are two different systems in use for incident tracking for this population. For HCBS-DD waiver services, the provider agency sends the critical incident report (CIR) to the CCB for entry into the DDWeb application portal (formerly known Community Contract Management System or CCMS). For persons in an ICF-I/DD, occurrence reports (ORs) are entered into the Colorado Health Facilities web portal (also called the Occurrence Reporting Portal or System). (i) To track individuals in a Regional Center who transition to a community setting, future monitoring will need to integrate data from both tracking systems. Tracking these six categories will meet the task force's intention: (a) Abuse (b) Neglect (c) Exploitation (d) Serious injury (e) Missing person (f) Death (ii) Additional categories reported for HCBS but not ICF include: (a) Mistreatment (usually captured in abuse, as that category includes verbal as well as physical abuse) (b) Medical crisis (outside of serious injury, such as an emergency department visit for behavioral issues) (c) Medication error with an adverse health impact (when not a serious injury) (d) Unusual incidents (includes criminal offense by the person, not otherwise captured in the other categories)	Yes	7/1/2016	4/30/2018

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4.B.3.b	There is some disagreement over the effectiveness of the Transition Readiness Assessment Tool (TRAT) and the associated process in accurately determining readiness for transition. A re-evaluation should be conducted by a cross-functional team of experts to ensure that the assessment tool and method is balanced and multi-dimensional, and that it is a predictor of an individual's likelihood of succeeding in the community while performing tasks independently in less-restrictive settings.	Yes	7/1/2016	3/31/2018
4.B.4	Current funding mechanisms can present a barrier to successful transitions. In some instances, approving a temporary funding increase to SIS support level 7 is sufficient to provide the additional supports needed during transition. In other instances, an exception to the standard process of support level determination is needed. The departments should work with community providers to propose details of such exception funding and the process for accessing it. Considerations should include:	Yes	7/1/2017	6/30/2019
4.B.4.a	Behavioral supports: Staff within the Regional Centers who have experience with a given resident may be engaged to provide behavioral supports in the new provider's setting for a period after the transition. The RC staff may provide training to community provider staff on the specific behaviors, triggers, and strategies established to ensure the resident's safety and stability. This support will be critical to ensuring a smooth	Yes	7/1/2016	1/31/2019

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	transition and to prevent regression, and care should be taken to ensure that this funding is easily accessible and based on individual need (that is, not "unit-based").			
4.B.4.b	Onboarding funding: Residents transitioning between residential settings may need funding to meet one-time costs. This may include certain durable goods (furniture, housewares, etc.) that are needed to avoid barriers to transition.	Yes	7/1/2016	1/31/2019
4.B.5	Once the process is enhanced:			
4.B.5.a	An effort should be made to encourage families and guardians to engage in the enhanced process, though transitions should remain voluntary. Part of this effort should include activating "parent to parent" (or guardian to guardian) networks, conducting sessions with concerned guardians to share the experiences of guardians and individuals who recently undergone the transition process. These sessions should focus on lessons learned during the process, both positive and negative, and the progress of the individual with I/DD since the transition was effected. In some states, this has taken the form of a "peer mentor" process where families and guardians whose family member has undergone a transition volunteer to support	Yes	7/1/2016	6/30/2018

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	those who are contemplating a transition.			
4.B.5.b	Results of the transitions should be published to the degree possible given HIPAA constraints.	Yes	7/1/2016	6/30/2018
4.B.6	Implementation:			
4.B.6.a	Within 6 months, CDHS and HCPF should review the current transition process and enhance it to include the elements above (CDHS for planning, HCPF for tracking).	Yes	7/1/2016	6/30/2017
4.B.6.b	Each person engaging in an enhanced transition should have their case reviewed for lessons learned.	Initiatives B and D	7/1/2016	6/30/2020
4.B.6.c	These actions should be in concert with the implementation of care coordinators, which is described fully in Recommendation 5.	Initiatives A, B, D and F	7/1/2016	6/30/2020
Recommendation 5	Identify, authorize and fund an entity (or entities) to coordinate service delivery for those individuals with I/DD receiving services from multiple systems of care to optimize on-going access to services and provide support during emergencies, transitions and crises. Identify opportunities to reduce complexity across care delivery systems.	Initiatives A, B, D, E, and H	2/1/2018	6/30/2020

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5.B.1	Defining "Care Coordination" for purposes of this recommendation:			
5.B.1.a	Purpose: Care Coordination addresses interrelated behavioral, developmental, education, financial, medical, and social needs to optimize health and wellness outcomes. In ties of ongoing stability, care coordination is a person-and-family-centered, assessment-driven, team activity designed to meet the needs and preferences of individuals while enhancing the caregiving capabilities of families and service providers. in teams of emergency or crisis, the care coordination entity will work to coordinate the needed resources across systems of care to limit the severity and duration of the crisis.			
5.B.1.b (i-x)	Core functions: A care coordinator has both the responsibility and authority to work across the MH, BH, DD, physical and dental health systems and social services to support individuals receiving services from these entities and provide effective care coordination in times of stability and crisis. Specific functions include: (i) assess with the family and individual their strengths as well as unmet needs across life domains; (ii) identify all sources of referrals, services, and supports, facilitate connections with these sources, and manage continuous communication across these sources; (iii) identify desired outcomes and establish accountability and/or negotiate responsibility (e.g. who will perform which specific actions to achieve common goals); (iv)			

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	develop a comprehensive plan of care and services with the individual, family and provider(s) that includes a plan to utilize strengths and address unmet needs; (v) provide information around purpose and function of recommended referrals, services, and supports; (vi) reassess and modify comprehensive plan of care with the family, individual, and provider(s); (vii) support and facilitate transitions between residences as necessary, both in times of stability and crisis; (viii) share knowledge and information across systems, and facilitate communication, among participants in individual care; (ix) be available 24/7 and have access to real-time data from electronic health records or other similar systems in times of crisis; and (x) authorize increases in funding in times of crisis to allow staffing levels necessary for health and safety, development of an interdisciplinary team, specialist visits, medical transportation, etc.			

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5.B.1.c (i-iv)	Additional functions: Care coordination is necessary because care delivery systems are specialized and fragmented, requiring a skilled navigator to access the array of services to which a person with I/DD is entitled. In addition to providing this navigation service, the network of care coordinators should regularly: (i) document and refine the business processes for care coordination; (ii) analyze organizational constraints and barriers to service delivery; (iii) identify opportunities for enhanced communication, service integration and simplification; and (iv) provide this feedback to the legislature through the implementation structure established by Recommendation 10 through existing committees of reference.			
5.B.2	Implementation: There are four recommended actions to execute this recommendation:			
5.B.2.a	Within 1 year, identify existing funding authority and sources, conduct a gap analysis and make recommendations for additional sources of funding for contracted regional lead entities to handle care coordination.	Yes	2/1/2018	6/30/2019
5.B.2.b	Within 1 year, rewrite the exclusionary clause that prevents RCCOs from serving someone coming out of an institution for 12 months.	Yes	2/1/2018	6/30/2019
5.B.2.c	Within 2 years, HCPF, CDPHE and CDHS need to review existing rules to identify rules that act as a barrier to the creation of contracted lead entities for care	Yes	2/1/2018	6/30/2019

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	coordination; and then amend those rules.			
5.B.2.d	Within 3 years, HCPF needs to clearly define criteria for lead care coordination entities, related tiered rate methodology, and clearly identified data collection and implement outcome-based contracts with lead care coordinator(s).	Initiatives A, B, D, E, and H	7/1/2019	6/30/2020
Recommendation 6	Create contractual agreements with community-based providers across the state that include a no reject/no eject clause and have the Regional Centers serve as a safety net provider as necessary.	Initiatives A - H	7/1/2019	6/30/2020
6.B.1	Colorado should ensure that community-based services (least restrictive environment) are available for people with the most intense needs. This could be done through contractual agreements with providers of specialized services with "no reject" clauses while also preserving state-operated services for those individuals who cannot find a suitable placement with a community provider. Such as system would effectively create a hybrid system of "last resort".	Initiatives A - H	7/1/2019	6/30/2020
6.B.2	For such contracts to be successful and for the care provided to meet the needs of the diverse I/DD population, providers must meet specific criteria. Please see "Additional Information" below for these criteria, based on recommendations offered by providers with expertise in serving three common sub-populations of people with I/DD.	Initiatives A - H	7/1/2019	6/30/2020

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6.B.3	The State of Colorado (at an existing RC location or at other locations) would serve as the "fallback" safety net in cases where no other community-based (or privately-operated) option is available for a person with I/DD. This could include people with I/DD coming out of correctional institutions, hospitals, or those who experience crisis situations where immediate access to a community provider is not available in a timely enough fashion to ensure health and safety. The state-operated system would have established processes in place to work with community-based safety net providers to enable individuals to have access to less restrictive services as quickly as possible. "Quickly" in this context is not measured in days and weeks but in months or even years due to the extended process for stabilizing people with I/DD. There is a distinction between providing buildings and delivering services. It may be that the state's physical infrastructure could be low while still providing services across Colorado's geography. Such a "super CCB" design would enable provision of services to people where they live while maintaining low fixed costs.	Initiatives A, B, E, and F	7/1/2019	6/30/2020
6.B.4	Actions to implement this hybrid system include at least:			
6.B.4.a	The departments should work together to design the details of such a contract, working with community providers to understand their receptivity to such arrangements.	Initiatives A, B, C, and E	7/1/2019	6/30/2020

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6.B.4.b	The legislature should specify in statute the need for a safety net system that includes community-based providers as the primary service provider and the State as the fallback provider.	Initiatives A, B, E, and F	7/1/2019	6/30/2020
6.B.4.c	Once the first two actions have completed, the departments could establish both the contractual arrangements and the funding criteria for "no reject" community-based safety net providers for these populations.	Initiatives A, B, E, F, and H	7/1/2019	6/30/2020
Recommendation 7	Formalize the role of Regional Centers and certain community providers as a statewide crisis stabilization system for individuals with I/DD and/or co-occurring serious and persistent conditions.	Initiatives A - H	7/1/2016	6/30/2020
7.B.1	Defining crisis stabilization for I/DD:			
7.B.1.a	Purpose: Promote recovery for individuals with I/DD who are struggling with co-occurring disorders and need intensive interventions. An individual can receive treatment at a Regional Center crisis stabilization unit. However, in times of crisis, entry into a crisis stabilization program should not be the first option. A care coordination entity (and a team directed by that entity) must first attempt to resolve the crisis (Recommendation 7).			

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7.B.1.b (i-iv)	Goals: Enhance and expand behavioral health services to increase access as well as provide service alternatives to inappropriate systems of care in order to: (i) increase access to appropriate behavioral health services; (ii) decrease utilization of systems of care that do not have DD expertise (e.g. emergency departments, etc.); (iii) utilize an interdisciplinary team to address crisis situations and circumstances; and (iv) increase rates of satisfaction by families and care recipients.			
7.B.2	Details of crisis stabilization units:			
7.B.2.a (i-vi)	Defining emergency admissions and crisis stabilization: The criteria for entry into, and operation of crisis stabilization units require additional analysis. A team representing experts from CDPHE, CDHS and HCPF should conduct a review on this topic, including at least the following actions: (i) complete a compliance review of current emergency admissions in light of the admissions policy and relevant regulations. Use the findings to inform future RC emergency admissions; (ii) explore and analyze other states' approaches to meet the need for crisis stabilization; (iii) clarify the federal requirements and limitations regarding active treatment and other relevant regulations regarding usage of ICFs as emergency placements; (iv) align the current statutory requirement of Imposition of Legal Disability (ILD) for those entering /living in the Regional Centers with the	Yes	7/1/2016	6/30/2019

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	requirements of the Final Rule and other relevant policies. Explore the need and continued functionality of ILDs specific to the Regional Centers and utilize them only when legally necessary. Include in this effort a policy or process to address circumstances when an individual with I/DD is unable to make an informed consent and does not have a legal guardian who can perform this task in their stead. Explore statute change or other steps to produce alignment; (v) explore the development of Acute Treatment Units specifically designed to serve the needs of those with I/DD and function as stabilization and step-down environments as needed. This enhances system wide capacity and integration of mental health and I/DD services; and (vi) define the criteria for admission into a crisis stabilization unit, and determine where these criteria should be housed (rule, policy, etc.). Care should be taken that admission criteria be based on need, not diagnoses or condition or I/DD status.			

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7.B.2.b	Number and locations of beds: In the near-term, both the WRRC and GJRC could apportion a number of vacant ICF beds to crisis stabilization, assuming this is deemed permissible by the review described above. As community capacity is increased over the coming years, the location of crisis stabilization beds may shift at CDHS' discretion as consolidation options emerge. The task force feels strongly, however, that regionalized solutions be maintained to not pose an undue burden on the families of those persons with I/DD that suffer a crisis. To ensure delivery of crisis stabilization services in locations most advantageous to the I/DD population, CDHS and HCPF should explore utilizing contracts to establish crisis stabilization unit providers within the community, provided these contract providers could deliver suitable service at an acceptable cost. The departments should also contemplate delivery of service by using a cadre of state employees designated to provide stabilization services in situ rather than moving the individual in crisis from their primary residence.	Initiatives A - H	7/1/2019	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.2.c	Duration of a crisis stabilization: The length of stay in a crisis stabilization unit will vary as individuals with I/DD often require longer periods for stabilization. The task force recommends a design for crisis stabilization that is relatively short-term rather than indefinite while still acknowledging the specific needs of the person. Regional Center staff report that there are times when individuals require more than the acute 90-120 day placement for assessment and stabilization. This will likely remain true, as individuals with complex co-occurring challenges often require additional time in assessment, planning, and treatment design. A potential method for balancing this reality with the goal of reducing individual time within the Regional Center setting is to engage a standardized process for reviewing cases and maximizing expertise and strategy for improving care and rapid return to the community. For example, developing a review committee comprised of Regional Center professional staff as well as external expertise that conducts a second review of the case. The purpose is not to scrutinize the primary team's work or progress on each individual's transition. Rather, the goal is to have an external support team for the primary care team in thinking carefully about individual needs and strategies for the most effective treatment approach. It can also serve as a second opinion when progress is slower than hoped. In this way, the	Yes	7/1/2017	6/30/2019

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	treatment process can be improved for individuals with more complex needs. When individuals need more time for medication trials or environmental adaptation, the review committee can provide validation of the primary team that additional time is required and/or provide linkage to additional community services.			
7.B.2.d	Roles and responsibilities: The division of responsibility will need to be clarified within the service system for members of interdisciplinary crisis management teams, care coordinators **(Recommendation 5)**, CCB case managers, BHO care coordinators, and the case managers at the Regional Centers.	Yes	8/1/2016	6/30/2019
7.B.3	Measuring success:			
7.B.3.a	It is recommended that community and RC stakeholders participate in "lessons learned" sessions to clarify role division and document improvements of the process after a specific number of crisis stabilizations.	Yes	7/1/2016	6/30/2019
7.B.3.b	Outcome measures include the average cost and length of stay related to individuals that require inpatient hospitalization, individuals served by local emergency departments, and individuals incarcerated compared to those served by the crisis stabilization center(s).	Yes	7/1/2016	6/30/2019
7.B.4	Implementation: The initial actions to execute this recommendation would include:			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
7.B.4.a	Within 1 year, HCPF and CDHS clearly define criteria for admission into crisis stabilization units, length of stay, and compensation for services provided, establish clearly identified data sources and collection methods to accurately measure outcomes and costs, and draft new policies and promulgate rules as needed to implement these changes.	Yes	7/1/2016	6/30/2019
7.B.4.b	Within 3 years, establish the relationships and changes in service to enable the delivery of crisis stabilization services as recommended above.	Initiatives A - H	7/1/2016	6/30/2020
Recommendation 8	Conduct an accurate cost analysis of both community and Regional Center HCBS beds related to compliance with the 2014 Centers for Medicare and Medicaid Services (CMS) Final Rule to guide future decisions on the number and location of state-operated HCBS waiver beds. In addition, provide funding and support needed to successfully transition residents, who desire to transition and are deemed ready to transition, to community placements and consolidate these beds as successes allow.	Initiatives A-H	7/1/2016	6/30/2019
8.B.1	Goals			
8.B.1.a	Increase options for persons with I/DD o reside in less restrictive living situations.			
8.B.1.b	Increase rates of satisfaction by families and care recipients.			
8.B.1.c	Decrease total Regional Center resident costs to enable reinvestment in additional community supports for the entire I/DD population.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.2	Impending Changes and Analysis			
8.B.2.a	Changes will be required to both residential services and day programs and potentially other aspects of HCBS service in the community and at the Regional Centers.			
8.B.2.b	CDHS should evaluate the gaps between current Regional Center operations and the guidance provided by the Final Rule and develop an estimate of the costs to come into compliance.	Yes	7/1/2016	6/30/2018
8.B.2.c	HCPF should evaluate the costs of compliance to the community providers. The punitive costs of failing to comply should also be investigated. This evaluation report should be directed by the cross-agency operational team described in Recommendation 10 and provided to departmental leadership and the legislature in keeping with the processes also outlined in Recommendation 10.	Initiatives A - H	7/1/2018	6/30/2020
8.B.3	Condition-based consolidation			
8.B.3.a	Consolidation of Regional Center HCBS beds could begin with a focus on relocating residents currently living in homes that are below their target census into a single home operating at the target number of beds. This may yield efficiencies in staffing and eventually allow disposition of unneeded infrastructure. Funds gained from this consolidation could be used to further develop community supports.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.3.b	As community supports are enhanced, it is anticipated that there will be a natural decline in the number of long-term residents of HCBS waiver beds. As these numbers fall, consolidation will become desirable, as the per-resident costs will grow significantly as infrastructure and staffing costs will be distributed over fewer residents.			
8.B.3.c	The task force recommends that the decision to consolidate facilities be based on conditions rather than on a timeline. The target date of March 2019 does not establish a goal of eliminating state operated HCBS homes. Instead, it simply creates a timeframe by which conditions should be in place to allow people to safely transition to community placements, if they choose to do so, and according to the transition process described earlier in this report.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.3.d (i-iv)	Below are four conditions that, together, would indicate that transition of a significant number of residents is likely to be successful. The task force recommends pursuing a target of March 2019, not with the goal of eliminating HCBS beds from Regional Centers, but as a means for providing a goal-date for the community. The four conditions are: (i) The residents with I/DD have met their recommended progress goals; (ii) Availability of a sufficient number of community beds to accommodate the number of residents being transitioned; (iii) A proven no reject/no eject contract with a safety net provider (or network) of providers within the resident's region that has the required facilities and staffing to accommodate the resident's needs (e.g. the specific needs of a medically complex resident v. a resident displaying high behaviors v. a resident with both characteristics); and (iv) The documented enhanced transition planning process has proved successful (as defined in Recommendation 4).			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.3.e	Some residents of HCBS waiver beds may struggle to find a suitable community placement for reasons of their conditions or due to inadequate funding to allow a community provider to meet their needs. For these residents, ICF services may be an option for long-term care but a process must be followed prior to ensure this is a correct placement. For these residents, the department must first try to modify their service plans. If this is not successful, an ICF placement may be an alternative. For those who do not meet he requirements for ICF placement, another financing option must be sought. The intention of this task force is to support the highest number of community-integrated placements while not compromising individual safety or the sustainability of the overall program by lowering the criteria of ICF placements. The task force is opposed to a system-wide, broad movement of individuals from HCBS waiver placements to ICFs merely to accommodate the CMS Final Rule.			
8.B.4	Measuring success: The success measures for these transitions will be the same as those recommended in Recommendation 4 regarding transition planning.			
8.B.5	Implementation: The initial actions to execute this recommendation would include:			
8.B.5.a	within 12 months, the departments complete and publish a gap analysis (to inform the cost analysis) and full cost analysis for the community HCBS and Regional Center HCBS to	Yes	7/1/2016	6/30/2018

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	become compliant with the 2014 CMS HCBS Final Rule;			
8.B.5.b	within 3 years, establish safety net provider contracts in each region, each with no-reject/no-eject clauses;			
8.B.5.c	implement an enhanced transition process per Recommendation 4; and			
8.B.5.d	as part of the normal budget process, departments request funding for a transition contractor.	Yes	7/1/2016	7/31/2017
8.B.6	Funding for transition contractor: To ensure successful, person-centered transitions for individuals who desire to transition and are deemed ready to transition, the following action steps are recommended:			
8.B.6.a	CDHS and HCPF develop a cross agency workgroup (Transition Workgroup) to handle the process of transitions.			
8.B.6.b	Transition workgroup establishes a timeline for enhanced transition, based on recommendations of RCTF.			
8.B.6.c	HCPF identifies enhanced rate structure to transition individuals to community with enhanced rates to cover additional staffing as needed, increased behavioral services and supports, and pre-screening/assessment for potential home health services to be provided as needed and appropriate at the provider location through Medicaid Sate Plan.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.6.d	CDHS and current Inter Disciplinary Team (IDTs) work with families and guardians and representatives from the CCB to conduct comprehensive assessments of Regional Center residents who are interested and deemed ready to determine the residents' transition support needs. (Note: Assessments are used to develop the transition checklist. The enhanced process and tools outlined in Recommendation 4 can serve as a starting point).	Yes	7/1/2016	6/30/2018
8.B.6.e	Assessments are provided to the Transition Workgroup (including placement experts from CCBs) to develop service needs and costs.			
8.B.6.f	HCPF and Transition Workgroup identify enhanced rate structures needed to support transitions. (Note: If Support Level funding is sufficient for these transitions, the timeline for this recommendation will be shorter, and the administrative workload will be less than if waiver redesign is a required predecessor.			
8.B.6.g	HCPF develops budget request based on enhanced rate structure, and assessment of number of people needing enhanced rates and enhanced services.			
8.B.6.h	Transition workgroup develops scope of work for transition coordinator. Scope of work would need to take into account RCTF recommendations. Could be a specific, detailed plan, or could be a two stage RFP that include a request for contractors to develop a plan and then re-bid on the implementation of the plan.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
8.B.6.i	Transition workgroup investigates potential funding sources for funding a transition coordinator (or these are provided via FY 2016 supplemental appropriation in Long Bill or FY 2017 Long Bill appropriation).			
8.B.6.j	Transition Workgroup develops a RFP with input from key stakeholders to solicit bids from entities to serve as the transition coordinator.			
8.B.6.k	HCPF develops a RFP for transition coordinator after investigating best practices from other states. Coordinate with CDHS as required.			
8.B.6.l (i)	Onboard the transition coordinator(s). (i) Transition Workgroup meets with transition coordinator frequently to track process/progress against key milestones.			
Recommendation 9	Once no-reject/no-eject contracts with community providers are established, implement a fully-funded transition process to place residents, who desire to transition and are deemed ready to transition, in the community, and over time reduce the number of state-run ICF beds as successes allow.	Yes	7/1/2017	6/30/2018
9.B.1	Goals			
9.B.1.a	Increase options for persons with I/DD to reside in less restrictive living situations.			
9.B.1.b	Increase rates of satisfaction by families and care recipients.			
9.B.1.c	Decrease total Regional Center resident costs to enable reinvestment in additional community supports for the entire I/DD population.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.2	Conditions affecting the future number and location of ICF beds:			
9.B.2.a	Changes in population demographics, community support development, and the pace of voluntary transition to the community make it impossible to establish a fixed number of ICF beds required at the Regional Centers;			
9.B.2.b	current facilities, particularly the GJRC, have facilities whose maintenance needs are, or may soon be, so great that it will be cheaper to develop new facilities;			
9.B.2.c	certain residents, particularly those with Problematic Sexual Behavior (PSB), require facilities designed specifically to address their conditions;			
9.B.2.d	it is anticipated that state-operated Regional Centers will maintain a certain regional footprint of beds to act as crisis stabilization units (Recommendation 7) while also reducing the number of long-term residents; and			
9.B.2.e	when combined, the dynamics above may require a reduced footprint with changes in facility design and staffing to accommodate the needs of the residents that will be served in the future.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.3	Compliance evaluation: HCPF, CDHS, and the State Architect should conduct a compliance review of the operational practices at Kipling Village. This review should identify gaps and issues and prescribe corrective actions to ensure compliance with federal standards and licensing requirements. This evaluation report should be directed by the cross-agency operational team described in Recommendation 10 and provided to department leadership and the legislature in keeping with the processes also outlined in Recommendation 10.	Yes	7/1/2017	6/30/2018
9.B.4	Condition-based consolidation and redesign:			
9.B.4.a	The task force recommends that the decision to consolidate and/or redevelop facilities be based upon conditions rather than on a timeline. The target date of March 2019 does not establish a goal of eliminating state operated ICF beds. Instead, it simply creates a timeframe by which conditions should be in place to allow people to safely transition to community placements, if they choose to do so, and according to the transition process described earlier in this report.			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.4.b (i-iv)	Below are four conditions that, together, would indicate that transition of a significant number of residents is likely to be successful. The task force recommends pursuing a target of March 2019, not with the goal of eliminating HCBS beds from Regional Centers, but as a means for providing a goal-date for the community. The four conditions are: (i) residents with I/DD have met their recommended progress goals; (ii) a sufficient number of community beds exist o accommodate the number of residents being transitioned; (iii) a proven no-reject/no-eject contract with a safety net provider (or network) of providers is in place within the resident's region that has the required facilities and staffing to accommodate the resident's needs (e.g. the specific needs of a medically complex resident versus a resident displaying high behaviors); and (iv) a documented enhanced transition planning process has been determined o be effective (as defined in Recommendation 10).			
9.B.5	Measuring success: The success measures for these transitions will be the same as those in Recommendation 4.			
9.B.6	Implementation: The initial actions to execute this recommendation include:			
9.B.6.a	within 3 years, establish safety net provider contracts in each region, each with no-reject/no-eject clauses;			
9.B.6.b	implement an enhanced transition process per **Recommendation 4**; and			

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
9.B.6.c	within 12 months, the departments complete and publish a full cost analysis for the community ICF and Regional Center ICF services.			
Recommendation 10	Establish an ongoing monitoring, assessment, and reporting structure to ensure that recommendations are implemented and evaluated for impact.	Initiatives A - H	7/1/2016	6/30/2020
10.B.1	A cross-agency operational team will be assembled to coordinate implementation across agencies and meet at least quarterly to share progress and address implementation issues.	Yes	7/1/2016	9/30/2016
10.B.1.a	This team or a sub-set of this team may initially and during periods of higher activity need to meet more frequently to advance progress on assigned issues.	Yes	7/1/2016	9/30/2016
10.B.1.b	It is recommended that the meetings be offset from the reporting requirements to allow for timely delivery of reports to the JBC and the General Assembly.	Yes	7/1/2016	9/30/2016
10.B.2	The team will deliver a report quarterly to a group of executives from HCPF, CDHS, and CDPHE and to the JBC (Note: The team must work with the JBC to align on specific reporting dates that align with the JBC's quarterly meeting to review economic forecasts and other matters). At the discretion of the JBC, members of this team may be requested to join the JBC meetings to make presentations or answer questions.	Yes	7/1/2016	7/31/2016
10.B.3	The team will also deliver a status update to the General Assembly at least once per year, as a part of the SMART Act hearings in the November-January timeframe and	Yes	11/1/2016	1/31/2017

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	the beginning of the legislative session in January.			
10.B.4	Reports should include, at a minimum: overall progress per specific recommendation (dashboard), specific actions taken and actions needed, any special considerations, risks and mitigation plan, as well as any decisions made/required.	Yes	7/1/2016	7/31/2016
10.B.5	As it is fundamental to many changes included in this report, HCPF should report on the progress of waiver redesign activities and interactions with CMS regarding waivers per the requirements of section 25.5-6-409.3, C.R.S. (2015).	Yes	7/1/2016	7/31/2019
10.B.6	Potential members of such an operational team should include: CDHS representatives (1 for transitions and 1 for operation/finance), HCPF representatives (one for funding, one for waiver administration/client services), one CDPHE representative (focused on licensure and compliance) plus additional operation members as required.	Yes	7/1/2016	9/30/2016
10.B.7	This operational team could be led by an executive-level program manager with knowledge of the complex systems involved and the authority to drive results as well as a project manager who would build and maintain an integrated project plan containing timing, dependencies and resource requirements and coordinate activities across initiative sub-	Yes	7/1/2016	11/30/2016

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
	teams. Funding would need to be appropriated for these roles.			
10.B.8	An advisory committee of family members, advocates and providers could be established to engage with the operational team twice annually to provide feedback and insight. Committee members could also be on-call to provide expertise as requested by the operational team.	Yes	7/1/2017	7/31/2017
10.B.9	Twice annually, the operational team should publish a summary of progress to the broader community concerned with I/DD issues (families, guardians, advocacy groups, providers, etc.) and hold open forum meetings (in-person and teleconferences) to answer questions and gather feedback.	Yes	7/1/2016	12/31/2017
10.B.10	The team should establish a comprehensive measurements system, tracking both cost and performance measures on both an individual and system-wide level. Implementation steps could include:	Initiatives A - H	7/1/2018	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
10.B.10.a (i-iii)	Establishment of a balanced set of core measures that indicate the effectiveness and efficiency of the system of care. Care should be taken to design each metric so as to be measurable, traceable, and actionable over time. Categories of metrics might include: (i) incident rates (e.g. ED visits, negative interactions with law enforcement, self-injurious behavior, elopements, involuntary change in residence, suicidal threats/attempts/completions, etc.); (ii) quality of life indicators (e.g. client/family/guardian satisfaction surveys, progress toward significant goals, employment rates, significant changes in health (positive or negative), etc.); and (iii) cost for like services (inclusive of payments for all facets of services, regardless of the funder or payment vehicle).	Initiatives A - H	7/1/2018	6/30/2020
10.B.10.b	Once such metrics are defined, HCPF, CHDS, and CDPH should collaborate on performing a gap analysis between the desired information and the currently available sources (e.g. National Core Indicators, incident reporting systems, etc.). An analysis should be performed to confirm the efficacy of available measurement systems and to identify additional data requirements.	Initiatives A - H	1/1/2019	6/30/2020
10.B.10.c	Action should be taken to gather additional data as necessary.	Initiatives A - H	1/1/2019	6/30/2020

Recommendation (Task) Number	Recommendation (Task) Text	Complete	Target Start Date	Target End Date
10.B.10.d	For each metric, the accountable departments(s) could establish actionable and reasonable goal thresholds to track quality performance. For example, the goal for the number of ED visits should not be set at zero but instead targeted to equal that of non-I/DD Medicaid population, or three visits per year per client.	Initiatives A - H	1/1/2019	6/30/2020
10.B.10.e	Once such a system of metrics is established, cross-system comparisons on cost, outcomes, incident rates, etc., can be made by HCPF. Disparities in performance can be used to drive best practice sharing and continuous improvement activities with the goal being to improve the quality and efficiency of service for all persons with I/DD.	Initiatives A - H	1/1/2019	6/30/2020