Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project

Colorado Department of Health Care Policy & Financing

RFP # UHAA 2016000079
January 19, 2015

Technical Proposal
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January 19, 2016

Sarah Miller  
Department of Health Care Policy and Financing  
Purchasing and Contracting Services Section  
1570 Grant Street  
Denver, CO 80203-1818  
(303) 866-3782  

Dear Ms. Miller:

Rocky Mountain Health Maintenance Organization, Inc., doing business as Rocky Mountain Health Plans, is pleased to submit our proposal to the State of Colorado to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado, RFP # UHAA 2016000079.

The team assembled by Rocky Mountain Health Plans includes the expertise of Strive, Mind Springs Health (“Mind Springs”), Mountain Valley Developmental Services (“Mind Springs”), Community Options, Midwestern Mental Health Center (“Midwestern”), Foothills Gateway, Inc. (“Foothills Gateway”), and SummitStone Health Partners (“SummitStone”). Together, we have the expertise to implement an excellent Pilot Project in Mesa, Delta, Montrose, and Garfield Counties (in the Western Slope) and Larimer County (in the Front Range) to serve individuals with intellectual and developmental disabilities as well as behavioral health needs. Additionally, we have the expertise to conduct data collection and analyses that will generate important lessons for replication and sustainability to other regions of the state.  

Patrick Gordon will be the primary contact for any technical questions regarding the proposal, contract negotiations, and through the end of the contract. Mr. Gordon’s contact information follows: Patrick.Gordon@rmhp.org, 720-515-4129.

The Rocky Mountain Health Maintenance Organization, Inc. Federal Tax ID is: 84-0614905.

I affirm that I am authorized to sign for Rocky Mountain Health Maintenance Organization, Inc. and bind the firm contractually.

Thank you for the opportunity to bid on this very important work. We are confident that Rocky Mountain Health Plans and its partners can provide exemplary services on the project and we look forward to your decision in this matter.

Sincerely,

Michael Huotari  
Vice President, Legal and Government Affairs
Executive Summary

The Executive Summary must be factual and should succinctly cover the core aspects of Offeror’s staffing, methodologies and approaches to fulfill the Statement of Work within the solicitation. The name, phone number and e-mail address for the Offeror’s contact person for the Offeror’s proposal. Also include the Offeror’s CORE VSS number in the Executive Summary.

Rocky Mountain Health Maintenance Organization, Inc., doing business as Rocky Mountain Health Plans, is pleased to submit our proposal to the State of Colorado to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado, RFP # UHAA 2016000079. The contact person for this proposal is Patrick Gordon, who may be reached at Patrick.Gordon@rmhp.org or 720-515-4129. The Rocky Mountain Health Maintenance Organization, Inc. CORE VSS number is VC00000000061230.

The team assembled by Rocky Mountain Health Plans includes the expertise of Strive, Mind Springs Health, Mountain Valley Developmental Services, Community Options, Midwestern Colorado Mental Health Center, Foothills Gateway, and SummitStone Health Partners. Together, we have the expertise to implement an excellent Pilot Project in Mesa, Delta, Montrose, and Garfield Counties (in the Western Slope) and Larimer County (in the Front Range) to serve individuals with intellectual and developmental disabilities as well as behavioral health needs. Additionally, we have the expertise to conduct data collection and analyses that will generate important lessons for replication and sustainability to other regions of the state.

These partner organizations currently manage a solid crisis response system, set of services, and continuum of care that were developed and implemented quickly and that are providing excellent services. We have deep and collaborative relationships with each other and with other organizations in our communities. We have efficient and effective processes in place that we can replicate and we have strong relationships across the community and across sectors. This Pilot Project will support a new kind of partnership among all of the organizations that will help them provide even better support to individuals with an intellectual or developmental disability and their families and caregivers.

This Pilot Project will allow us to implement even stronger collaborative efforts to support individuals who are experiencing a behavioral health crisis – and work to prevent them in the future. This Pilot Project would allow us to bring experts in Intellectual and Developmental Disabilities (I/DD) immediately into crisis response efforts when such a disability is present, and allow cross-system and cross-disciplinary teams to work together to develop and implement follow-up care plans that are person-centered and responsive to the individual’s needs.

The Pilot Project will build on, and leverage, the existing behavioral health crisis systems that have been developed and implemented by Mind Springs and Midwestern in the Western Slope (as part of West Slope Casa) and by SummitStone in the Front Range, and that is collaboratively supported and utilized by Rocky Mountain Health Plans, Mountain Valley, Community Options, Strive, Mind Springs Health, Mountain Valley Developmental Services, Community Options, Midwestern Colorado Mental Health Center, Foothills Gateway, and SummitStone Health Partners.
Springs, SummitStone, and Foothills Gateway. This existing system has been successfully meeting the crisis needs of the Western Slope and the Front Range for 14 months (building on crisis services that had been provided for well over 20 years), including a successful mobile crisis system, site-based crisis respite, and follow-up support services for individuals experiencing a behavioral health crisis. The Pilot Project proposes to build from this existing system, by adding an additional continuum of services onto that existing system to provide enhanced and specific services for individuals with I/DD who have behavioral health needs and are experiencing a behavioral health crisis, and for their caregivers.

The system of care that will be developed and implemented for the Pilot Project will include the following eight elements:

1. Augmentation of the provision of the existing 24 hour a day, seven day a week timely response system that includes telephone and in-person availability for assessment by adding crisis responders with specific expertise in serving individuals with I/DD and with specific knowledge of services for individuals with I/DD.

2. Clinical treatment, assessment and stabilization services in the context of short term respite. These respite and support services will be available on an emergency basis as well as available as a planned support.

3. Development of an individualized cross-system crisis prevention, intervention, and follow-up services plan.

4. Provision of technical assistance to community partners to enhance their ability to serve individuals with I/DD and behavioral health needs.

5. Ensuring a highly trained workforce specializing in treating individuals with Dual Diagnoses (both behavioral health needs and I/DD).

6. Development of agreements with community partners about shared responsibility and clarification of roles to best serve individuals with a Dual Diagnosis.

7. Assessment of the population to monitor capacity and need.

8. Measurement of outcomes and continuous quality assurance and program modifications.

These elements are woven into the design of the model, and will guide the implementation and delivery of services. The main components of the model include:

1. Provision of a coordinated crisis response, assessment, reassessment, care planning, and follow-up services that include both a behavioral health crisis expert and an expert in I/DD.

2. In-home services that are focused on both the behavioral health needs and I/DD needs of the individual, and that are coordinated across these two systems.
a. **In-home supports would be provided to individuals with I/DD after a behavioral health crisis has occurred.** These services are essentially in-home supports offered for a period of time to assist the individual in remaining stable. These coordination and provision of these services would be led by the CCB with involvement from the CMHC behavioral health crisis staff.

3. **Mid-term to longer-term facility stabilization services** that are focused on both the behavioral health needs and I/DD needs of the individual, and that are coordinated across these two systems.

4. Provision of and linkage to coordinated, cross system follow-up services regardless of Medicaid enrollment status, whether an individual is enrolled in an HCBS waiver or not, and regardless of any other insurance status.

   a. This includes linkage to HCBS services, assistance in enrolling in Medicaid and/or an HCBS waiver, and provision of services to help prevent individuals from having future crises. This Pilot Project will allow us to provide additional, coordinated services to help individuals stabilize after the crisis and to prevent future crises. Coordination of these services will occur by utilizing the case manager as a “coordinator of coordinators”. The case managers have deep expertise in working with individuals with I/DD and their caregivers and providers, and are deeply familiar with community resources and Home and Community Based Services waivers. These services may include Medicaid-covered services, services typically provided through HCBS waivers, services typically provided through the capitated behavioral health system, and services provided through other funding sources and community-based organizations.

The Pilot Project will also provide education to providers and caregivers about the availability of crisis respite services, and the needs of individuals with both I/DD and behavioral health needs, as well as other services, to help increase utilization of services that may prevent future crisis. The grant will also increase access to new longer term respite. Additionally, our approach to collecting and using data will allow us to ensure that needed services are accessed, and that we gather lessons learned for program improvement and replication.

This proposal outlines our model, the services we propose to provide, and how we will collect data and information and provide that to the state to inform future replication of the best practices of this model.
W-9 (Appendix C)
Technical Proposal

Introduction

As noted in the Request for Proposal (RFP) to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado, issued by the Department of Health Care Policy and Financing (HCFP), many gaps exist in services for individuals with both an intellectual or developmental disability and a behavioral health issue. These gaps are well documented in a 2014 report from the University Center of Excellence on Developmental Disabilities at the University of Colorado, School of Medicine. In 2015, Colorado’s legislature passed House Bill 15-1368, which established the Cross-System Response for Behavioral Health Crises Pilot Project (Pilot) to help address these gaps. One strategy for addressing these gaps is a Pilot Project, designed to provide crisis intervention, stabilization, and follow-up services to individuals who have both an intellectual or developmental disability and a mental health or behavioral disorder and who also require services not available through an existing Home and Community Based Services (HCBS) waiver or covered under the Colorado behavioral health care system.

Rocky Mountain Health Maintenance Organization, Inc., doing business as Rocky Mountain Health Plans, with its subcontractor/partner organizations, Mind Springs, Strive, and Mountain Valley Developmental Services, Community Options, Midwestern Colorado Mental Health Center (Midwestern Colorado MHC) in the Western Slope, and SummitStone Health Partners and Foothills Gateway in the Front Range (the “partner organizations” or “the partners”) is pleased to submit our proposal to implement the Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project in Mesa, Garfield, Montrose, Delta (Western Slope) and Larimer (Front Range) Counties. The partner organizations are committed to helping the state continue to improve services for individuals with both I/DD and behavioral health needs, by developing and implementing a Pilot Project to provide crisis services, stabilization services, and follow-up services to these individuals. The partner organizations, location, and role on the project are provided below.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Type of Organization/Expertise</th>
<th>Location</th>
<th>Role on Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocky Mountain Health Plans</td>
<td>Regional Care Collaborative Organization (RCCO)</td>
<td>RCCO Region 1 - Western Slope and Front Range Larimer County</td>
<td>Lead Applicant and Fiscal Lead</td>
</tr>
<tr>
<td>Mind Springs</td>
<td>Community Mental Health Center and Colorado Crisis Response Lead for Western Slope</td>
<td>Western Slope – Mesa and Garfield Counties</td>
<td>Community Behavioral Health Services and Behavioral Health Crisis Expertise</td>
</tr>
<tr>
<td>Midwestern Colorado Mental Health Center</td>
<td>Community Mental Health Center</td>
<td>Western Slope – Montrose and Delta Counties</td>
<td>Community Behavioral Health Services and Behavioral Health Crisis Expertise</td>
</tr>
<tr>
<td>Strive</td>
<td>Community Centered Board</td>
<td>Western Slope – Mesa County</td>
<td>Expertise Serving Individuals with I/DD; Expertise with I/DD System and Services, including HCBS Services</td>
</tr>
<tr>
<td>Mountain Valley Developmental Services</td>
<td>Community Centered Board</td>
<td>Western Slope – Garfield County</td>
<td>Expertise Serving Individuals with I/DD; Expertise with I/DD System and Services, including HCBS Services</td>
</tr>
<tr>
<td>Community Options</td>
<td>Community Mental Health Center</td>
<td>Western Slope – Delta and Montrose Counties</td>
<td>Community Behavioral Health Services and Behavioral Health Crisis Expertise</td>
</tr>
<tr>
<td>SummitStone Health Partners</td>
<td>Community Mental Health Center and part of the Colorado Crisis Response team for northeast Colorado</td>
<td>Front Range – Larimer County</td>
<td>Community Behavioral Health Services and Behavioral Health Crisis Expertise</td>
</tr>
<tr>
<td>Foothills Gateway, Inc.</td>
<td>Community Centered Board</td>
<td>Front Range – Larimer County</td>
<td>Expertise Serving Individuals with I/DD; Expertise with I/DD System and Services, including HCBS Services</td>
</tr>
</tbody>
</table>
Map 1, below, shows the Pilot Project region and the locations of the Pilot Project Partner organizations.

**MAP 1: PILOT PROJECT PARTNERS AND COUNTIES**

The partners bring decades of experience to meet the requirements of this Request for Proposal, including deep expertise in and involvement with behavioral health, I/DD, existing services within Colorado’s behavioral health care system, existing HCBS services, and other community services. Two of the partners, Mind Springs and SummitStone, currently manage, implement and support the Colorado Crisis Response System for their respective regions, and will therefore be able to easily and effectively leverage and build upon that existing system to provide enhanced services to individuals with I/DD who are experiencing a behavioral health crisis. The partners will leverage existing behavioral health services that are part of the Crisis Response System, including existing mobile and walk-in crisis services, existing respite services, including in-home supports, site-based and facility-based supports, and mobile services in these counties. The partners will also leverage existing HCBS services and existing systems of care for individuals with I/DD, in which they are deeply involved. The partners will enhance existing services by providing cross-disciplinary, cross-
network, team-based, person-centered crisis services and follow-up services, and specific in-home and site-based therapeutic respite for individuals with I/DD.

The partners view this RFP as a significant opportunity to:

- enhance services for individuals with I/DD and behavioral health needs, fill critical gaps in services for this population, and provide more person-centered and I/DD specific services for individuals in crisis;
- demonstrate the value of an innovative cross-system and team-based model, both in terms of quality of life and health outcomes, but also in terms of reducing costs through avoidable hospitalizations, emergency room visits, and admissions to Regional Centers; and
- provide lessons learned and a model for other regions of the state to replicate.

This proposal leverages the behavioral health and community centered board developmental disability systems that are local and community based, and that are based on strong community relationships that have deepened over the years. It offers innovation and new best practices, and integrates crisis delivery for children and adults with an intellectual or developmental disability with behavioral health services, as opposed to being fragmented. It strengthens the level of integration through collaboration of behavioral health expertise with expertise serving individuals with I/DD.

Additionally, this proposal builds upon the well documented efforts of the partners around integration of behavioral health services, long term supports and services, and physical health care services. Mind Springs, Strive, Mountain Valley, Midwestern Colorado MHC, Community Options, Foothills Gateway and SummitStone all have strong relationships with the Medicaid Regional Care Collaborative Organizations (including RMHP, the lead on this proposal) and have been statewide proponents of integrated care, and all work collaboratively on a regular basis. For example, on the Western Slope, the Mesa County Health Leadership Consortium, which was created in 2009, brings together hospitals, clinics, public health, health plan providers, and other organizations to address relevant issues in Mesa County in an effort to improve quality and access to care, while reducing costs. The partners will also leverage the Community Crisis Group that meets in Mesa County to problem solve and identify solutions to close the gaps for very complex individuals in a crisis when existing systems and structures cannot fully meet those needs. This group will continue to serve as an advisory group to the Mesa County Pilot.

RMHP has extensive experience working closely with its partners on integrating behavioral health services, which it will leverage for this Pilot Project. For example, the Department approved a plan submitted by RMHP for a Medicaid payment reform initiative. This community-based approach brings together payment reform, population health management, behavioral health integration and whole person care. Additionally, the partners are involved in, and can leverage, the Western Colorado Executive Committee, which RMHP convened to provide direction and accountability for achieving aligned local, regional, state and federal policy directives. This committee convenes
experts in several critical domains – consumer experience, clinical care, payer, public health, technology and behavioral health. Mind Springs and Midwestern are among the leaders at the table.

On the Front Range, RMHP funds Community Care Teams in Fort Collins and in Loveland which have embedded behavioral health professionals along with nurses and community health workers. RMHP’s community based care coordination model is multi-disciplinary in order to address the full range of medical, behavioral health and social needs of its members in Larimer County. Also in the Front Range is the Larimer County Interagency meeting, which grew out of regular long-term placement meetings with Adult Protective Services. For the past 20 years, it has been called “the Interagency Group”, and has an expanded mission of responding to needs of area residents who utilize higher levels of care. The group plans for contact, safety, and placement for these high acuity individuals. Membership includes over 20 area agencies, including Adult Protective Services, law enforcement representatives from Loveland, Fort Collins, and Larimer County Jail, Banner and UC Health, North Range Behavioral Health ATU and detox, SummitStone, Larimer Community Center Board, Catholic Charities, Housing Authority, and Colorado State University, among others.

As another example of existing collaboration, in Larimer County, the Community Mental Health and Substance Abuse Planning Partnership began in August of 1999. The Partnership is a collaborative effort to restructure the system of mental health and substance abuse services and improve responsiveness to the needs of those individuals most affected by substance use disorders and mental illness in the community. The Partnership’s vision is for a well-coordinated, well-funded continuum of mental health and substance abuse services, which will achieve a maximum potential for meeting community needs and promote a healthier community through healthier individuals and families. The Partnership’s Steering Committee has 20-25 members who meet monthly to plan and direct the Partnership’s efforts. The Steering Committee includes directors from the city, county, criminal justice system, law enforcement, intellectual disability services, faith community, hospital, housing authority, mental health and substance abuse service agencies, school districts, university; as well as consumer advocates, private therapists, and a liaison from the state office on mental health and substance abuse. Subcommittees are composed of a broad representation from consumer and community agencies, both public and private. The Health District provides staffing and coordination for this Partnership.

In addition, Foothills Gateway and SummitStone have had an agreement for over 15 years for provision of psychiatric, consultation and therapy services to I/DD individuals with co-occurring diagnoses. Therapists from SummitStone are housed within Foothills Gateway to provide therapy and a psychiatrist and psychiatric nurse provide medication reviews and consultation on a twice weekly basis.

The partners know and understand all aspects of the Medicaid system, including the behavioral health system, Home and Community Based Waivers, as well as private insurance and Medicare, and have many years of expertise doing billing for services, including Third Party Liability billing.
The partners also know our communities, including the rural areas, which have unique challenges and needs. We know what works and what does not work in those communities, because we have been a listening partner and a part of the community. In turn, the communities we serve know us and they turn to us for help. Medical professionals, social services, law enforcement, and others in the community turn to when faced with a behavioral health crisis. We provide help with the full support of our many community partners, having built that hard-to-come-by trust on the Western Slope and Front Range over many years and collaborations.

The partners understand, and are fully prepared to expand, not only person-centered recovery-oriented services, but also the expanded continuum of care to reduce future crises and recidivism in the crisis system. We are excited about the opportunity to enhance services for individuals with I/DD, and to help demonstrate best practices for replication to other regions of the state.

The partners know the populations and the existing infrastructure in each of the regions in which we propose to conduct this Pilot Project. This knowledge allows us to build on what we know exists, and to quickly identify gaps so that we might fill those. We will be able to immediately enhance services for individuals with I/DD and behavioral health needs, and implement innovations that are informed by our experience and successes within our communities.

The partners hold the philosophy of valuing every individual’s behavioral health need as a core philosophy in all operations, and we work hard to help ensure that people receive care in the least restrictive environments possible. When individuals are in crisis, we help avoid them being referred to the emergency room, by offering walk in crisis at multiple sites in each county, and by offering mobile crisis response systems. Additionally, all of the partners work with the emergency rooms and law enforcement to find person-centered solutions at the lowest level of care.

The partners are in a unique position to most effectively conduct this Pilot Project. For decades, the partners have provided a full range of services to the regions, and this Pilot Project would allow us to seamlessly add and test an enhanced model of service for individuals with I/DD. This project would help meet previously unmet needs, further reduce fragmentation, and result in better services, improved health outcomes, and reduced costs to the state as more preventable hospitalizations, Regional Center admissions, and emergency room visits are avoided, and as avoidable interactions with law enforcement are reduced.

Each of the organizations is forward-thinking, innovative, and proven. As partners, we are collaborative and constantly moving toward greater levels of integration. We are passionately committed to recovery and resiliency, and to Coloradans with intellectual and developmental disabilities. In our following proposal you will find robust articulation of the shared principles of strong community relationships, use of evidence-based practices, innovation, and a truly integrated crisis response system for individuals with Intellectual and Developmental Disabilities.
Overview of the Project and Work Plan

The following provides a high-level overview of the proposed Pilot Project and proposed work plan.

Start-Up Period

First, within five days of the contract Effective Date, the team will submit a Start-Up Plan to the state. The Start-Up Plan will include a description of all of the steps, timelines, milestones and deliverables that the team will complete during the Start-Up Period, and which will ensure the team will be able to perform of the project work by the Operational Start Date. The Start-Up Plan will also include the names of all personnel who will be involved in the Start-Up Plan work, an operational readiness review for the Department to assess our readiness to begin performing the work, and a discussion of the risks associated with the Start-Up Plan and our team’s plans to mitigate these risks. Once the Start-Up Plan is approved by the Department, the team will implement the Start-Up Plan, and will update the Department weekly on the status of deadlines, timelines, and milestones.

During the Start-Up Period, the partners will also make needed changes to the Mind Springs’ Electronic Medical Record (EMR) and SummitStone’s EMR (described in more detail below), finalize the communications plan, the business continuity plan, and develop the final list of individuals who will be working on the project, in accordance with the requirements of the RFP.

Operational Period: High-Level Overview

During the Operational Period, the Pilot Project will be implemented as described in detail throughout this proposal. Here, we provide a high-level overview of the Pilot Project. The Pilot Project will build on, and leverage, the existing behavioral health crisis systems that have been developed and implemented by Mind Springs and Midwestern in the Western Slope (as part of West Slope Casa) and by SummitStone in the Front Range, and that is collaboratively supported and utilized by Rocky Mountain Health Plans, Mountain Valley, Community Options, Strive, Mind Springs, SummitStone, and Foothills Gateway. This existing system has been successfully meeting the crisis needs of the Western Slope and the Front Range for 14 months (building on crisis services that had been provided for well over 20 years), including a successful mobile crisis system, site-based crisis respite, and follow-up support services for individuals experiencing a behavioral health crisis. The Pilot Project proposes to build from this existing system, by adding an additional continuum of services onto that existing system to provide enhanced and specific services for individuals with I/DD who have behavioral health needs and are experiencing a behavioral health crisis, and for their caregivers.

The system of care that will be developed and implemented for the Pilot Project will include the following eight elements:

1. Augmentation of the provision of the existing 24 hour a day, 7 day a week timely response system that includes telephone and in-person availability for assessment by adding crisis
responders with specific expertise in serving individuals with I/DD and with specific knowledge of services for individuals with I/DD.

2. Clinical treatment, assessment and stabilization services in the context of short term respite. These respite and support services will be available on an emergency basis as well as available as a planned support.

3. Development of an individualized cross-system crisis prevention, intervention, and follow-up services plan.

4. Provision of technical assistance to community partners to enhance their ability to serve individuals with I/DD and behavioral health needs.

5. Ensuring a highly trained workforce specializing in treating individuals with Dual Diagnoses (both behavioral health needs and I/DD).

6. Development of agreements with community partners about shared responsibility and clarification of roles to best serve individuals with a Dual Diagnosis.

7. Assessment of the population to monitor capacity and need.

8. Measurement of outcomes and continuous quality assurance and program modifications.

These elements are woven into the design of the model, and will guide the implementation and delivery of services.
Western Slope and Front Range
Intellectual and/or Developmental Disabilities (I/DD)
Crisis Center Pilot Project

- Hospital
- CCBs, Service Agencies, Physicians, Law Enforcement
- Families/Individuals

Crisis Line Call (DD Suspected)

Face-to-Face / Phone Assessment

Safety Plan
Short Term Respite
In-home Respite
Psychiatric Hospital

If longer term, review of treatment needed

ART Team Support

Coordination and Provision of Follow-up Services

Call in DD Telehealth Professional to work with MHC Crisis Staff

Evaluation

Resolution

Face-to-Face / Phone Assessment

- Safety Plan
- Short Term Respite
- In-home Respite
- Psychiatric Hospital

If longer term, review of treatment needed

ART Team Support

Coordination and Provision of Follow-up Services
Western Slope and Front Range
Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project

Multi-Agency DD Assessment Response Team (ART) (Includes DD Crisis Telehealth Professional)

- Individual Placement
- DD Stabilization/Respite Facility
- Continued Phone/Teleconference Support
- Follow-up by ART

Permanent Placement with ART Support
Individuals will be served by the Pilot Project as follows:

1. An individual enters crisis system either through the state crisis hotline, which triages the need and links with a local response, or through walking in to local crisis access points developed through the Colorado Crisis Response System. Typically this will result in a mobile crisis response.

2. A local CMHC response to the crisis situation occurs within one hour in urban areas, and within two hours in rural areas, in alignment with the existing Crisis Response system. This immediate response includes assessment. For this Pilot Project, the partners will adapt and modify the assessment tool to include a specific assessment for an intellectual or developmental disability. If such a disability is suspected or detected, the behavioral health crisis responder immediately contacts the on-call CCB crisis responder with expertise in serving individuals with I/DD. Note that the initial assessment occurs with a person from both behavioral health (CMHC) and the I/DD (CCB) system involved once an intellectual or developmental disability is identified. By immediately bringing in experts in providing services for individuals with I/DD to work collaboratively and side-by-side with the behavioral health crisis experts, while the crisis is occurring, we will be able to more effectively help the individual and his or her caregivers, providers, and family members (if appropriate) with the immediate crisis.

3. Results of the immediate assessment may be one of the following.

   a. The individual can be safety transitioned to their home environment, with coordinated follow-up services being provided through both the CCB system and the CMHC system.

   b. The individual enters into services that are already available through the existing Crisis Response System, but with the addition of specific supports for individuals with I/DD that will be coordinated with the CCB. The CCB staff and the CMHC staff will work together to build a care plan, coordinate care, and arrange for care, with the CMHC staff taking the lead in terms of executing decisions and arranging for care.

   c. If the individual is assessed to benefit from short-term respite, either in-home or site-based, these services are currently offered through the existing Crisis Response System throughout the Western Slope counties and in Weld County (which neighbors Larimer County) in the Front Range. This Pilot Project would allow for enhancement of these existing short-term respite support services by supporting the addition of I/DD-specific supports that will be supported by the CCBs. This allows individuals to be served at the lowest level of care because, without the CCB supports available at the time of crisis, the individual may have been placed at a higher level of care.
d. The individual may need more intensive supports, which would be provided via Transitions on the Western Slope, an existing Crisis Stabilization Unit, with a maximum length of stay of five days. This Pilot Project would allow for this existing support to be enhanced by making supports from the CCBs readily available. As with short-term respite, this allows individuals to be served at the lowest level of care because, without the CCB supports available at the time of crisis, the person may have been placed at a higher level of care.

e. The individual may need longer and more intensive supports, but not a psychiatric hospital stay. These services will be made available through Pilot Project funding that will allow us to rent space at the Grand Junction Regional Center, Mountain Crest Hospital in the Front Range, or individualized settings for children to provide intensive stabilization and site-based support services for up to 30 days.

f. The individual may need more intensive supports, requiring a psychiatric hospital stay. These services are also already available via the existing Crisis Response System, but this Pilot Project would ensure that I/DD-specific supports are also available, which will allow individuals to receive integrated care during the psychiatric hospital stay, which is likely to shorten the overall length of stay and result in more positive outcomes for the individual.

Once the immediate crisis is resolved, the new and enhanced services that would supplement and coordinate with the existing Crisis Response System services, and would be provided by this Pilot Project, include:

1. Additional in-home supports through services offered in collaboration by the CMHC and CCB.

2. Mid-term to longer-term facility stabilization services that are focused on both the behavioral health needs and I/DD needs of the individual, and that are coordinated across these two systems.

3. The “typical” services offered by the CCB and the CMHC and billed through their regular payment methods will also be available to help assure continued wellbeing.

During all of the above, the individual will be continuously reassessed collaboratively by the CMHC and CCB staff, combining their knowledge, experience, and strengths. Once an individual is ready to transition from one level of care to the next, a follow-up plan will be developed and in place, created jointly by CCB and CMHC to continue to offer ongoing supports collaboratively.

This model allows us to develop comprehensive care plans that take into account the individual’s behavioral health needs, as well as their needs that are related to their intellectual or development disability. On the Western Slope, plans will be developed and informed by the Multi-Agency Developmental Disabilities Assessment Response Team (ART) which will include: the crisis
In summary, the main components include:

1. Provision of a coordinated crisis response, assessment, reassessment, care planning, and follow-up services that include both a behavioral health crisis expert and an expert in I/DD.

2. In-home services that are focused on both the behavioral health needs and I/DD needs of the individual, and that are coordinated across these two systems.
   a. In-home supports would be provided to individuals with I/DD after a behavioral health crisis has occurred. These services are essentially in-home supports offered for a period of time to assist the individual in remaining stable. These coordination and provision of these services would be led by the CCB with involvement from the CMHC behavioral health crisis staff.

3. Mid-term to longer-term facility stabilization services that are focused on both the behavioral health needs and I/DD needs of the individual, and that are coordinated across these two systems.

4. Provision of and linkage to coordinated, cross system follow-up services regardless of Medicaid enrollment status, whether an individual is enrolled in an HCBS waiver or not, and regardless of any other insurance status.
   a. This includes linkage to HCBS services, assistance in enrolling in Medicaid and/or an HCBS waiver, and provision of services to help prevent individuals from having future crises. This Pilot Project will allow us to provide additional, coordinated services to help individuals stabilize after the crisis and to prevent future crises. Coordination of these services will occur by utilizing the case manager as a “coordinator of coordinators”. The case managers have deep expertise in working with individuals with I/DD and their caregivers and providers, and are deeply familiar with community resources and Home and Community Based Services waivers. These services may include Medicaid-covered services, services typically provided through HCBS waivers, services typically provided through the capitated behavioral health system, and services provided through other funding sources and community-based organizations.

The Pilot Project will also provide education to providers and caregivers about the availability of crisis respite services, and the needs of individuals with both I/DD and behavioral health needs, as well as other services, to help increase utilization of services that may prevent future crisis. The grant will also increase access to new longer term respite.
Evidence-Based Services/Model

All services will be based on, and will leverage evidence-based, person-centered, and trauma-informed care.

All of the partners utilize person-centered, trauma-informed, and strengths-based practices in all of their work, and the services to be provided as part of this Pilot Project will leverage these. A central and underlying model for this Pilot Project is the START model. The START model is based on Systemic, Therapeutic, Assessment, Resources & Treatment services. It was developed by the Center for START Services at the Institute on Disability/UCED at the University of New Hampshire. START is “a national initiative that works to strengthen efficiencies and service outcomes for individuals with intellectual and developmental disabilities (IDD) and behavioral health needs in the community” (http://www.centerforstartservices.org/). It was first implemented in 1988 to provide community-based crisis services for individuals with I/DD who were experiencing a behavioral health crisis. It is a person-center approach that is based on other evidence-based practices. It was cited as a model program in 2002 by the U.S. Surgeon General as a comprehensive model of services that supports independence, treatment and community living for individuals with I/DD that has proven results in terms of reduced utilization of the emergency room and inpatient hospital stays, as well as high satisfaction from individuals and their families, lower costs, and strengthened cross-system collaboration.

![Public Health Model & START: Numbers Benefitting from Intervention](image)
Additionally, services will be informed by the trauma-informed care services developed by Mind Springs. Mind Springs is one of 37 organizations nationwide chosen to be a part of The National Council for Behavioral Health’s 2013 Trauma-Informed Learning Collaborative. As part of this work, Mind Springs Health has pioneered the concept of trauma-informed care on the Western Slope. Research shows that 90% of community mental health clients have been impacted by trauma at some point in their lives, whether as a child or an adult. Mind Springs has implemented Trauma-Informed Response and Care initiatives in all of its work, and will implement these principals as part of the Pilot Project as well. This includes trauma-informed assessment, understanding trauma as part of stabilization and treatment, and as part of the development of follow-up services. It also includes helping all community partners, including medical and social services partners, to understand the importance of identifying past trauma as a part of current crises, and to include attention to these traumas in how individuals are supported.

**Funding and Paying for Services**

Pilot Project partners will ensure that payment for services is sought by the appropriate and applicable sources, including private insurance, Medicare, Medicaid state plan, HCBS waivers, and other sources. If no other payment sources are available, the Pilot Project funds will pay for services for the individual until the individual has other insurance, or becomes enrolled in Medicaid.

**Data and Lessons Learned**

All crisis services will be tracked using Midwestern/Mind Springs’ and SummitStone’s EMRs, which will allow for real-time sharing and reporting of data, including services provided and outcomes. In the Start-Up Period, changes to the EMR will be made to accommodate these new services and this new model, including the ability for the case manager to enter all case management and services data into the EMRs. This will allow the team to report easily and efficiently, and to develop project findings that will help support lessons learned, sustainability, and replication.

A number of metrics will be tracked to evaluate the impact of this Pilot Project. The goals of the Pilot Project are to provide enhanced cross-system, team-based, person-centered, and trauma-informed care that is coordinated across systems and agencies, which will result in better outcomes for the individuals. These improved outcomes include fewer future crises, reduced hospital admissions, reduced emergency department visits, and reduced admissions and readmissions to Regional Centers. Additionally, the Pilot Project intends to improve quality of life for the individuals being served and their caregivers, and reduce overall costs of care.

This includes tracking of both process and outcome measures, including: services provided, utilization of the emergency department and hospitalization, health outcomes, satisfaction with services, and quality of life. Through careful and thorough tracking of services that are included in care plans, and services that are accessed, as well as other data, the Pilot Project will gather information about continued gaps in services. We will use these data to develop lessons learned, including lessons regarding implementation, partnerships, and program structure, as well as about
outcomes of the Pilot Project, for use by the state in considering replication of the model and broad dissemination to other parts of the state.

Closeout Period

Within 30 days of the Effective Date of the contract, the team will submit to the Department a Closeout Plan, which will be updated each June 30th, and which will include all Closeout requirements, steps, timelines, milestones, and deliverables that will be needed to transition the services of the project to another contractor or to the Department at the end of the contract. This Closeout Plan will include details to support a smooth transition that will minimize the impact of the transition on the individuals being served by the project, on providers, and on the Department.

During the Closeout Period, the team will implement the most recent, Department-approved Closeout Plan, completing all steps, deliverables and milestones contained in the plan. Also during the Closeout Period, the team will provide all reports, data, systems, deliverables, and other information that are needed for a transition of the project and work. The team will also ensure that project responsibilities are transferred smoothly, and without interruption, to the Department or another contractor. Further, the team will notify any subcontractors of the termination of the project, and notify all involved parties (providers, members, and other stakeholders) that the team is no longer the Crisis Center Pilot Contractor. These notifications will be approved by the Department before they are delivered, and will be delivered at least 30 days prior to the end of the contract. The team will work with the Department to ensure that all Closeout requirements have been completed.

Organizational Experience (Offeror’s Response 1)

1. Provide a detailed description of Offeror’s organizational experience related to the Work. Specifically, address the Offeror’s experience within the last ten (10) years managing a program for persons with intellectual or developmental disabilities and/or for persons with a mental health or behavioral disorder. For each Program listed, describe the type of work performed, the type of services provided for the individuals, and the dates of when the work was performed.

The Partner Organizations

Rocky Mountain Health Plans, Mind Springs, Strive, Mountain Valley Developmental Center, Community Options, Midwestern, SummitStone Health Partners, and Foothills Gateway (together “the partners”) have come together to develop and implement this Pilot Project in Mesa, Montrose, Delta, and Garfield Counties in the Western Slope of Colorado and in Larimer County in the Front Range. These organizations have decades of experience serving individuals with I/DD and individuals experiencing a behavioral health crisis; providing follow-up services; making referrals to community partners; connecting individuals with Medicaid, Medicare, private insurance and other funding sources; and ensuring that individuals receive the services they need to avoid future crises. Together, the partners have the capacity and experience to implement a strong Pilot Project with a rigorous evaluation component, and the ability to provide important lessons about
successful implementation, sustainability and replicability for the whole state. Our past experience, both as individual agencies, and as partners to each other and to other organizations in our communities, is highlighted below.

**Past Experience with Similar Projects**

As organizations that have provided comprehensive mental health and substance use disorder services, and services for individuals with I/DD for decades, each partner has managed projects similar to the project described in this proposal, including crisis stabilization services, mobile crisis services, in-home and site-based respite and support services, and follow-up services for individuals with I/DD, including coordination with HCBS waivers. Examples of past projects are provided below.

**Experience with Similar Data Projects**

The partners have many years of experience in defining, measuring, monitoring, and managing mental health and substance abuse services, as well as crisis services, and have the ability to measure and report on outcomes that will be of interest for replication and sustainability of this Pilot Project, should the state pursue replication and/or expansion.

Over the years, each of the partners has developed sophistication in the collection and use of data. Each partner has quality management departments and staff who review and evaluate services in accordance with annual quality improvement plans, including the use of business intelligence software tools such as Tableau, which will be used for reporting in this Pilot Project. As an example of use of data in a targeted fashion to support program improvement, recently Mind Springs focused on access to psychiatric care and, based on a Plan-Do-Study-Act process, reduced the time to access a routine non-urgent or emergent, psychiatric appointment from 78 days to 21 days for adults, and from 86 days to 14 days for children and adolescents.

For this Pilot Project, the partners are leveraging Mind Springs’ existing quality dashboard software, and will create reports that are similar to those provided as part of that dashboard. Use of this reporting software will enable real time data review and will aid in joint quality improvement efforts.

All of the initial crisis response and stabilization services provided under this Pilot Project will be entered into either the Mind Springs EMR for the Western Slope and SummitStone’s EMR for the Front Range. Data from SummitStone’s EMR will be transferred to Mind Springs, using protected transfer protocols, where these data will be combined with Mind Springs’ data and reported to Rocky Mountain Health Plans. Follow-up services that are coordinated by the CCB partners will be entered into their web-based record keeping systems (Therap for Mountain Valley, and Strive; and in-house developed systems for Foothills Gateway and Community Options) and then transmitted for billing to HCPF through the state Colorado Contract Management System (CCMS). These systems allow for easy tracking of services, billing of services, and transfers of data. More details about the data collection plan are provided in Offeror’s Response 5.
While our experience and histories vary, the principles that underlie our work are the same. All of the partners provide services that are person-centered, trauma-informed, and based in the following principles.

- We Value Partnerships: We develop and maintain strong partnerships in the communities we serve, and work to collaborate, educate, and share resources.
- We value service: We believe in creating services that are accessible to all, regardless of payment ability.
- We Value Outcomes: We are outcomes-driven and focus on achieving positive outcomes for the individuals and communities we serve.
- We Value Responsible Financial Stewardship, Integrity and Accountability in all that we do.
- We Value People: We believe each person wants to be great and that everyone has the capacity to learn, grow, and change.
- We Value Excellence: We believe in striving for excellence in all that we do.
- We Value Stewardship: We believe in making the best use of our resources in carrying out our mission.
- We Value Innovation: We believe in having the courage to develop creative and adaptable ways to provide care and to conduct business.
- We Value Recovery: We believe in person-centered care that promotes hope and resiliency.
- We Value Diversity: We believe the uniqueness of each person brings strength and opportunity to our communities.
- We Value Principled and Visionary Leadership: We believe everyone can be a leader through mentoring, teamwork, humility and personal courage.

Services that would be provided as part of this Pilot Project follow these principles. More details about each organization, and examples of past projects, are provided below.

Rocky Mountain Health Plans

The lead agency on this project, Rocky Mountain Health Plans (RMHP), is a Colorado-based, not-for-profit health plan, with headquarters in Grand Junction and regional offices are in Denver, Colorado Springs, and Durango. For more than 40 years, RMHP has committed to improving the lives of our Members and the health of Colorado. RMHP currently serves the needs of more than 300,000 Members, offering one of the largest provider networks in Colorado with over 2,500 primary care doctors, 7,535 specialists, 6,647 non-physician specialty providers, 103 hospitals, 700 outpatient facilities, 870 pharmacies, and 88 ambulatory surgery centers. RMHP is one of the
Colorado health plans in which Medicaid clients may enroll for access to medical services on the Western Slope.

RMHP has been a leader in the field of community-based, health care delivery system integration since its founding in 1974. During this time, RMHP gathered extensive experience managing projects of a similar size and scope. Examples of similar past projects include the following.

**Project:** Accountable Care Collaborative (ACC) Program: Regional Care Collaborative Organization and ACC payment reform initiative pilot  
**Time Period:** 2011 - present  
**Funder:** Colorado Department of Health Care Policy and Financing  
**Project Description:** RMHP serves as the Regional Care Collaborative Organization (RCCO) for Region 1, which covers 21 counties along the Western Slope plus Larimer County. As RCCO, RMHP is responsible for ensuring that Medicaid Accountable Care Collaborative (ACC) members receive comprehensive, coordinated and patient-centered care. This means providing access to care at the right time and in the right setting, including improved access to medical and behavioral health services, long-term services and supports, human services and public health system services. RMHP and its partner community care teams work to ensure that care is coordinated across settings and during care transitions. The Colorado Department of Health Care Policy and Financing approved a plan submitted by RMHP to pilot an ACC payment reform initiative, called RMHP Medicaid Prime. Launched in September 2014, Medicaid Prime is a statutory pilot with a simple goal: Improve the health of individuals and the community while reducing costs and improving efficiency. This community-based approach brings together payment reform, population health management, and whole-person care in Western Colorado. It primarily serves adult Medicaid enrollees and a small number of children in six counties: Garfield, Gunnison, Mesa, Montrose, Pitkin and Rio Blanco. This initiative encompasses physical health, behavioral health and substance abuse services, with Mind Springs and Midwestern Colorado Mental Health Center among the community partners.

**Project:** Colorado Beacon Consortium (CBC)  
**Time Period:** 2010-2013  
**Funder:** Office of the National Coordinator for Health Information Technology (ONC)  
**Project Description:** Rocky Mountain Health Plans has a longstanding track record and organizational culture of supporting multi-stakeholder collaborations, the most prominent of which includes its role as the Prime Sponsor of the Colorado Beacon Consortium. RMHP and its partners, Quality Health Network, Mesa County Physicians IPA, and St. Mary’s Hospital and Regional Medical Center, were awarded a Beacon Community Agreement from the ONC. The Colorado Beacon Consortium worked to achieve the ONC’s stated goals of improving health care quality, cost efficiency and population health via advancing Health IT infrastructure.
Mind Springs

Mind Springs has been in existence since 1972. In 2009, the organization revised its corporate structure due to also operating a psychiatric hospital, which required a community based board. Today, Mind Springs, Inc. operates Mind Springs Health, Inc. and West Springs Psychiatric Hospital, Inc. We have 600+ employees, providing outpatient services, residential, detoxification, crisis services, and psychiatric hospital services. Mind Springs has a long history of providing both community mental health and substance use disorder treatment services, as well as crisis intervention and stabilization services, including mobile crisis response, psychiatric hospitalizations, and emergency room support for behavioral health crises. Mind Springs has been providing community-based mobile crisis services in hospitals, jails, clinics, and other community settings for decades; emergency on-call services 24/7 have been provided since the mid-1970s. Additionally, Mind Springs is a primary provider for Medicaid, and accepts Medicare and commercial insurance.

Mind Springs operates five detox facilities across the Western Slope and has been providing behavioral health crisis services for decades. Approximately 90% of face to face mental health crisis evaluations result in a safety plan, same/next day therapy or psychiatric appointment, and follow up and avoid an admission to any higher level of care. Engagement in outpatient treatment for Substance Use Disorder following a detox episode ranges from 23%-56%, which is significantly higher than is found in the literature or is required in the MSO contracts.

Mind Springs has 14 clinic sites across 10 counties - Mesa, Garfield, Eagle, Pitkin, Summit, Grand, Routt, Jackson, Moffat and Rio Blanco Counties - and is embedded in or has relationships with primary care clinics, CHCs, FQHCs, school-based health centers, and other community-based organizations from which crisis referrals are made, and to which post-crisis referrals are made for follow-up. Mind Springs has provided the full array of behavioral health services, including mental health services and substance use disorder services, to all ages for decades, in a variety of settings. These settings include community mental health center clinics, hospital emergency departments, school-based clinics, primary care clinics, and in the community (for crisis, intensive, and outreach services). Specifically, we provided services to any school across 10 counties for crisis as well as many other schools for outpatient services.

Services that Mind Springs provides include: Counseling and Therapy that ranges from intensive and contact multiple times a week to less intensive care, Peer Services and Outreach, myStrengths (a self-help web based tool), Crisis Evaluation and Intervention, Community Support, Psychiatric Care, Vocational Support, Substance Use Disorder Treatment, referrals and case management to community-based services and natural supports, Women’s Residential, Special Connections for Pregnant Women, Specialized Women’s Services, offender services (Strategies for Self-Improvement and Change), DUI Level I and Level II, a large variety of outpatient programs for adults and youth, and five detoxification centers. These services are responsive to people with mental health needs, substance use disorder needs, and to people with co-occurring disorders.
Mind Springs understands the different services needed for people with different combinations of needs, and services are tailored to meet these needs, including within crisis services. Mind Springs served approximately 21,000 people in the past fiscal year.

In addition to serving as the region’s community mental health center and providing Medicaid capitated behavioral health services, Mind Springs has the following specific project experience.

**Project:** Colorado Crisis System (Both Mind Springs and Midwestern)

**Time Period:** September 2014 – present

**Funder:** Colorado Department of Human Services, Office of Behavioral Health

**Project Description:** Mind Springs and Midwestern are partners with West Slope Crisis Access (WSCA), which is the Colorado Crisis System Contractor for the Western Slope of Colorado. As such, they provide crisis behavioral health services, including both mental health services and substance use disorder services, to the entire Western Slope region of Colorado, which includes 10 counties. These public community-based behavioral health services include the provision of crisis services that are evidence-based, culturally sensitive, and trauma-informed. WSCA provides these services throughout the region to all ages, regardless of payer. As part of this project, Mind Springs already has a crisis call system in place and assessments for walk in evaluations at 14 locations across 10 counties. Respite has been available in Grand Junction since 2010 through Mind Springs and, in partnership with Hilltop, Mind Springs has been providing child and adolescent respite services since 2009. Since 2014, Mind Springs has provide in-home peer respite services through this project. Mobile crisis services, residential crisis services, and follow-up services are provided to individuals who are experiencing a behavioral health crisis.

**Project:** Managed Service Organization

**Time Period:** 1998 – present

**Funder:** Colorado Department of Human Services, Office of Behavioral Health

**Project Description:** West Slope Casa, of which Mind Springs is a part, has served as a Managed Service Organization for decades. As such, Mind Springs has provided substance use disorder treatment services, including screening, outpatient, inpatient, and crisis services to individuals across the Western Slope. As part of this work, Mind Springs collects and analyzes data on services provided, satisfaction with services, and outcomes of services, and reports these to the state regularly. In the past year, Mind Springs/West Slope Casa earned all of the available Managed Service Organization (MSO) incentive funds from the Colorado Department of Human Services’ Office of Behavioral Health. Mind Springs monitors and collects data for, is a strong supporter of, and is actively engaged in the state’s C-STAT initiative. Mind Springs’s results are generally among the top tier of the C-STAT results. Mind Spring’s involvement in the C-STAT project provides evidence of Mind Springs’ experience conducting similar research projects.

**Strive**

Strive was incorporated 50 years ago as a non-profit Community Centered Board (CCB) under legislation authorizing the development of CCBs to identify, coordinate and provide services to all
individuals with developmental disabilities in Mesa County. The long-term name of Strive was Mesa Developmental Services, but was changed in 2012 to acknowledge the person-centered nature of the organization and reflect the autonomy of the individuals we serve. In 2012, Strive also received a 4-year accreditation from the Council on Quality Leadership (CQL), one of the national premier accrediting agencies for developmental disabilities. Strive is governed by a 15 member Board of Directors composed of community agency members, business owners, and family members as well as a person who receives our services.

Through our contracts with HCPF and CDHS, Strive has an extensive history of providing case management and crisis services through the Home and Community Based (HCBS) Medicaid waiver system, including the 24/7 Developmental Disabilities Medicaid waiver (DD waiver), the Supported Living Services Medicaid waiver (SLS waiver), the Children’s Extensive Support Medicaid waiver (CES), as well as the federally and state funded Early Intervention program. Within all of these waivers or for individuals on our waiting lists, Strive’s care coordination system assures appropriate resources are available to children and adults. This is accomplished through referral to a variety of approved service agencies such as Ariel, Mosaic, and Caprock as well as Mesa County Department of Human Services (MCDHS). Case management works with these agencies or with our internal service providers to help reduce further crises by obtaining the right program at the right place and in the right time and by providing periodic scheduled reviews.

On Strive’s service side, we have truly become the “provider of last resort” in Mesa County, taking on individuals in crisis. We do this by providing individualized, person-centered residential, vocational and behavioral programs. In the last year, we have done that for several individuals identified through the community crisis collaborative. Our service system is comprised of home-based services for children and adults, residential and vocational programs, and behavioral, nursing and occupational therapy. Strive touches the lives of over 1300 people each year in Mesa County.

A major initiative in which Strive engaged in 2009-2010 was our development of three group homes for 24 individuals from the Grand Junction Regional Center who were being displaced due to closure of their skilled nursing facility. The project management of building three homes, developing the program, staffing and licensure, all within 9 months illustrates Strive’s project management skills.

Other projects in recent years include the expansion of our services to work with individuals with autism and other neurodevelopmental disorders. Strive offers Applied Behavior Analysis services to children and adults with this disorder. With Strive’s Audyssey program, children with autism have local services and support to help them learn new skills for communicating, problem solving, social integration and coping. Adults are also assisted with skills of independence, job/career development, social skills, counseling and behavioral supports.
Most importantly, Strive has developed an autism and neuro-developmental Diagnostic Evaluation clinic composed of a multi-disciplinary team of psychologists, ABA certified staff, speech/language pathologist, occupational therapist, doctoral level nurse practitioner, advance practice nurse/care coordinator. This is truly a cross-system collaborative effort as it is made up of staff from JFK Center for Excellence in Denver, Colorado Mesa University, school district personnel, previous employees of the Grand Junction Regional Center and Strive staff. This clinic sees over 40 children and adults each year, with most of the referrals from community physicians, and is proactively addressing assessment and service delivery for individuals in order to avert crisis. The program is in Grant Junction and is the only diagnostic clinic between Denver and Salt Lake City where parents can bring their child for a diagnosis.

Strive has taken a lead role in the crisis management group initiated by Rocky Mountain Human Services two years ago. This group, composed of the majority of the human service agencies in the county, comes together when a person is in crisis, hospitalized far too long due to lack of appropriate placement, or at risk of homelessness. Many of the individuals who have come forth to this group are children and adults with developmental disabilities and our case management system has obtained resources for them and our service system has developed unique and individually designed ABA and/or residential programs for them.

Strive and Mind Springs have collaborated for many years in providing medication management to over 175 individuals with developmental disabilities in Mesa County. Mind Springs provides the psychiatric expertise and Strive provides administrative and nursing coordination of a clinic that is offered twice a week at Strive.

Strive also has been fortunate in developing a relationship with the city of Grand Junction to operate the Western Botanical Gardens. This has given us the opportunity to enhance vocational and work experiences for individuals we serve as well as to provide a venue for community activities (concerts, Easter Egg hunt, Sensory limited Santa experience). This endeavor supports our expertise in working collaboratively with government as well as illustrating our project management skills, given the multi-faceted nature of this project.

Strive has strong support from the community due to our expertise in working with individuals with developmental disabilities and our willingness to collaborate with other community providers to help individuals. We annually receive funding from the Mesa County Commissioners, United Way and other granting organizations.

Community Options
Community Options, Inc. provides and coordinates services and supports to people with intellectual/developmental disabilities. Community Options is one of 20 Community Centered Boards in Colorado and serves the Western Slope counties of Montrose, Delta, Gunnison, Hinsdale, Ouray and San Miguel. Community Options provide a variety of comprehensive services to over 450 individuals and their families who meet the eligibility criteria for Home and
Community Based (HCBS) Medicaid waiver system and live within the six county region. Community Options is continually working to expand the provider choices available for clients and families, with additional services currently provided by Mosaic, Six Points, Mountain Valley Developmental Services, Strive, and an ever-increasing number of Early Intervention, SLS, and CES providers and independent contractors. It has four locations, including two in Montrose, one in Cedaredge, and one in Delta.

Community Options is recognized and a statewide leader with its participation in the Case Management Directors’ Committee, the Chief Financial Officers Contracts/Audit Committee, the Alliance Early Intervention Workgroup, the Alliance Focus on the Future Project, the Division for Intellectual and Developmental Disabilities Allocation of Waiver, Enrollment Task Group, Waiting List Management Work Group, and Conflict Free Case Management Task Group, and numerous other Alliance committees. Community Options has also participated in a collaborative effort with three other Western Slope CCBs that resulted in 45 staff being trained in Person Centered Thinking.

Mountain Valley Development Services (MVDS) was founded in 1973 by a group of parents and volunteers and was incorporated as a non-profit agency in 1975. Located in Glenwood Springs, MVDS has since become an organization which provides a comprehensive array of services to children and adults with developmental disabilities.

MVDS has been designated by Colorado Department of Health and Human Services as the Community Centered Board responsible for Eagle, Garfield, Lake and Pitkin Counties. MVDS is accredited by CARF, the Rehabilitation Accreditation Commission, and approved by Colorado Departmental Disabilities Services. MCHS offers children and family programs, adult residential, recreation and leisure, and employment and vocational supports, as well as case management. Mountain Valley currently has eight licensed group homes in Parachute, Rifle, Glenwood Springs and Carbondale.

As the Region’s CCB, MVDS has administered and coordinated HCBS services to individuals with I/DD for four decades, including the HCBS-SLS waiver, the HCBS-DD waiver, the HCBS-CES waiver, and Family Support Services.

Midwestern Colorado Mental Health Center

The Midwestern Colorado Mental Health Center has been providing behavioral health services in Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel Counties since 1964. The communities served vary widely, including the ranching and mining towns of Somerset, Norwood, Delta, and Olathe, as well as the high profile resort towns of Crested Butte and Telluride. Populations range from 790 in Hinsdale County to 33,432 in Montrose County. Midwestern Colorado CMH is a 501(c)(3) organization and are governed by a board of directors representative of the area served.
Midwestern Colorado MHC’s treatment team includes psychiatrists, therapists, masters level clinicians, counselors, care managers, and advanced nurse practitioners who offer psychiatric services, individual and group therapy, peer services, support groups, medication management, intensive case management, and educational opportunities. People can access behavioral health care from Midwestern Colorado MHC in a variety of settings including: clinics in Delta, Gunnison, Montrose, Norwood, Nucla, and Telluride, in the school-based health clinic in Delta, through school-based services in nearly every school, alongside primary care at the Pediatric Clinic in Montrose and Delta and in the Federally Qualified Health Centers in Olathe and Norwood, at Western State College, in outreach locations in Hotchkiss, Lake City, Naturita, and Ridgway, and in senior care facilities, hospitals, and jails, and in the home when necessary.

Midwestern Colorado MHC provides services to roughly 6,400 people each year from every age group and all over the six-county region. It offers 24-hour emergency services in all six counties at no cost to anyone who needs help. Crisis intervention, suicide/homicide risk assessment, emergency mental health and alcohol commitments, and debriefings are among the services provided. In the last year, Midwestern Colorado MHC responded to over 2,500 mental health emergencies.

Foothills Gateway, Inc.
Foothills Gateway, Inc., designated as the Community Centered Board for Larimer County, Colorado, by the Division for Intellectual and Developmental Disabilities with the Colorado Department of Health Care Policy and Financing, functions to coordinate and provide services to citizens with intellectual and developmental disabilities. We believe in a life of opportunity, of choice, and of dignity for every individual, regardless of age or ability. Our mission is to advocate for and empower individuals with disabilities to lead lives of their choice.

Foothills Gateway, Inc. began in 1972 through a merger of the Foothills Activity Center in Loveland and the Easter Seals Gateway Center in Fort Collins, becoming Foothills Gateway Rehabilitation Center. Through the tremendous efforts of community members from both areas, a new facility was built at our present site located at 301 W. Skyway Drive, halfway between Fort Collins and Loveland. This location is centrally located within Larimer County and provides easy access to the most populated areas.

Today, Foothills Gateway, Inc. (renamed from Foothills Gateway Rehabilitation Center) continues to coordinate and provide services to over 2400 individuals with intellectual/developmental disabilities and their families. Services and supports are person-centered and provided through a variety of programs, including case management and direct services.

As the Region’s CCB, FGI has administered and coordinated HCBS services to individuals with I/DD for decades, including the HCBS-SLS waiver, the HCBS-DD waiver, the HCBS-CES waiver, and Family Support Services.
SummitStone Health Partners

SummitStone Health Partners is a private non-profit whose mission is to provide unsurpassed behavioral health prevention, intervention and treatment services. We serve individuals and families in our community who, based on income or lack of adequate insurance, are without other options for behavioral health care, which encompasses both mental health and substance use disorder treatment. SummitStone serves more than 9,000 clients each year, 35% of which are children, youth and young adults.

With 24 locations throughout northern Colorado, SummitStone Health Partners provides complete behavioral health care services that literally mean the difference between life and death for members of our community, building healthier individuals and families. More than 50 products and services allow SummitStone Health Partners to meet the individualized needs of consumers and their families through evidence-based, consumer-driven and patient-focused care. It provides mental health and addiction services to individuals and families in Larimer County, including Estes Park (1 location), Fort Collins (9 locations including a 24/7 walking-in crisis center), and Loveland (5 locations) communities. Services include 24 hour walk-in crisis centers, addiction treatment, anger management counseling, respite care, and dual disorder treatment.

Fees are charged on a sliding scale based on income and number of family members, and no one is turned away due to inability to pay. More than 85 percent of our consumers live in families with annual incomes under $25,000. SummitStone Health Partners is an actively engaged community partner with agencies ranging from school systems and social services to primary physical care practitioners and our criminal justice system – all of whom regularly serve individual in need of behavioral health treatment but lack the internal resources to adequately serve these individuals on their own.

While SummitStone Health Partners’ primary mandate is to serve individuals with Medicaid, we are also the safety net provider for people who are uninsured and without the means to pay for the treatment they need. SummitStone Health Partners has the goal of being a collaborative partner in a community where every individual who seeks treatment for a behavioral health disorder finds the care they need, in the place they need it, and at the exact time they need it. When we are successful, no one need die from an untreated mental illness or substance use disorder. Lack of insurance or funding would not prohibit someone from seeking and receiving the treatment he or she needs. The stigma that continues to surround these disorders would dissipate. No baby would be born addicted to methamphetamine or impacted by maternal alcohol abuse. Weekly suicides in Larimer County would no longer be the reality. Our jails, emergency rooms, and homeless shelters would no longer be overflowing with people who need treatment, not punishment.
Personnel (Offeror’s Response 2)

2. Provide a detailed explanation of how the Offeror will provide sufficient personnel to perform the Work, including all of the following:
   a. How the Offeror will provide Key Personnel that meets or exceeds the requirements contained in this RFP.

The organizations partnering on this project bring extensive expertise to the project, as well as extensive community partnerships and presence. The organizations will provide sufficient, and well-qualified personnel to perform the work of the Pilot Project. Project staff are experienced and very well qualified, as well as passionate about the work they do and the individuals they serve. Their expertise meets and exceeds all requirements contained in this RFP. Any new staff who are hired to work on the Pilot Project will meet the same qualifications in terms of expertise, experience, background, dedication and, if needed, licensure. Key personnel working on the Pilot Project include:

- Experts in community-based, in-home, site-based, and mobile crisis services
- Master's level (or higher) behavioral health experts, including Board Certified Behavior Analysts (BCBAs), Licensed Marriage and Family Therapists, Licensed Professional Counselors, Licensed Clinical Social Workers, Psychologists, and psychiatrists with many years of direct-supervision experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with developmental disabilities
- Bachelor’s level (or higher) behavioral health experts, including Board Certified Associate Behavior Analysts (BCABAs). Anyone not licensed will be supervised by a BCBA or other relevant licensed person.
- Experts in providing and coordinating home and community based services for individuals with Intellectual and Developmental Disabilities. Strive, Foothills Gateway, and Community Options are three of the 20 Colorado Community Centered Boards mandated through Colorado statute to coordinate services for individuals with developmental disabilities in specific catchment areas of the state. Strive, Foothills Gateway, and Community Options have been providing case management services for both children and adults through the HCBS Medicaid waiver programs since Colorado initially received Medicaid waiver funds in the 1980s. The attached resumes show the strength of our personnel in the areas of coordination of services and knowledge of the HCBS waivers. CPF and/or CDHS annually contract with these CCBs to administer case management and oversight of the HCBS Developmentally Disabled Medicaid waiver, Children’s Extensive Supports Medicaid waiver, Supported Living Services Medicaid waiver and the Early Intervention program.
These CCBs are the identified and exclusive experts in the areas of HCBS and case management in their specific catchment areas.

- Experts on Colorado’s HCBS waivers, including expertise in helping individuals enroll in waivers, receive services through the waivers, and in care coordination of waiver services with other services.

- Case management experts with decades of experience providing person-centered case management to individuals with Intellectual and Developmental Disabilities. STRIVE, one of the partners in this application, is accredited by the Council for Quality Leadership (CQL), one of the national premier accrediting bodies for person-centered practices. Strive is the only CCB in the state that has received this person-centered accreditation.

- Data collection and analytic experts

- Project management experts

- Experts in Cross-Agency Collaboration and Community Partnership

Because the partnering organizations have long and deep histories of collaboration and partnership, the staff who will be working on this project already know each other, work well together, and have deep respect for each other’s strengths and expertise. They are also eager to learn from one another, and work closely together as cross-disciplinary teams to provide the best crisis support and ongoing support to the individuals they serve.

Some staff will be existing staff, while others will be hired specifically for this project. Hiring for all new staff will begin as soon as an announcement of the award is made. Details about the expertise of existing staff are provided below, followed by details about staff training.
<table>
<thead>
<tr>
<th>Cassandra Williams</th>
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<tbody>
<tr>
<td>Janet Veatch</td>
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<td>Valita Speedie</td>
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<td>Christina Cruz</td>
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<td>Cheri McLaughlin</td>
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<td>Krista McClinton</td>
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<td>Janice Curtis</td>
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<td>Michelle Hoy</td>
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<td>Jacqueline Skramstad</td>
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<td>Dr. Mark Ramsey</td>
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<td>Sarah Johnson</td>
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<td>Joan Esther Levy</td>
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<td>Patti Foster-Hoffman</td>
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<td>Sharon Jacksi</td>
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<td>Lynn Simpson</td>
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<td>Lynda Wonders</td>
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<td>Kimberly Boe</td>
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<td>Elaine Wood</td>
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<td>Tom Turner</td>
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<td>Debbie Lapp</td>
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<td>Marla Maxey</td>
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b. How the Offeror will provide and train all Other Personnel so that the Work is completed accurately and in a timely manner. Additionally, include a listing of the position titles for each position related to the Contract, the general responsibilities of that position, the number of individuals filling that position and the numbers of hours each week the position will be dedicated to the Work.

Existing personnel who will be part of this project already have significant training in the provision of crisis services, behavioral health services, services for individuals with intellectual and developmental disabilities, case management, and data collection and analyses. Staff already provide many of the types of services that will be provided under this contract. The Pilot Project will allow for the implementation of a cross-disciplinary team approach, which will leverage and capitalize on the existing strengths and expertise within the staff. By working in these cross-disciplinary teams, not only will the individual be better served, staff will gain additional expertise to continue to serve individuals more effectively. For example, behavioral health clinicians will learn from I/DD experts about specific needs of, and approaches to working with, individuals with I/DD. Similarly, I/DD experts will learn from the behavioral health experts about crisis strategies that are rooted in best practices for behavioral health.

Prior to this “on the job” learning, however, all staff who have not received training will undergo training, as described in Offeror’s Response 5. Any training that is needed for new or existing staff, such as data training, project management training, or basic onboarding (for new staff), will be provided in accordance with each organization’s regular training and onboarding protocols.

The table below provides a listing of the position titles for each position related to the contract, the responsibilities of that position, the number of individuals filling the position, and the number of hours each week the position will be dedicated to the work.
### POSITION TITLES, RESPONSIBILITIES, NUMBER OF INDIVIDUALS, AND HOURS PER WEEK

<table>
<thead>
<tr>
<th>Position Title</th>
<th>Responsibilities</th>
<th>Number of Individuals</th>
<th>Hours per Week Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Director</td>
<td>Oversees program and administrative functions; serves as liaison with HCPF; coordinates between partners; assures financial compliance and billing</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Data Analyst</td>
<td>Develops data points for measuring outcomes; assures partners are imputing data accurately; aggregates and presents summary data of project</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>Supports administrative and program staff with clerical and informational coordination</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Accounting Technician</td>
<td>Invoices HCPF for charges; reconciles accounts payable and receivables</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Training staff</td>
<td>Assures staff receive training and education to implement programs effectively</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Behavior Consultant</td>
<td>Assesses, plans, implements and consults on the behavioral challenges of individuals in crisis and for longer term treatment development</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>Case manager who coordinates with MH, DD, family and individual to assure and maximize services</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Direct care in-home</td>
<td>Staff who implement respite and support services in the home of the individual in crisis</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>On-call</td>
<td>DD staff who are assigned to mental health crisis response system to assist in assessment and initial treatment safety planning</td>
<td>12</td>
<td>484</td>
</tr>
<tr>
<td>On-site direct care</td>
<td>Facility staff who implement treatment plans and serve individuals in the on-site facilities</td>
<td>4</td>
<td>160</td>
</tr>
<tr>
<td>Behavioral Line</td>
<td>Specially trained direct care staff who focus on the implementation of the behavior support plan for the individual, i.e., mentor, coach, role play</td>
<td>3</td>
<td>120</td>
</tr>
<tr>
<td>Facility Supervisor</td>
<td>Oversees operation and staff of the facility</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Nursing</td>
<td>Implement physician orders; respond to acute physical issues of individuals in site-based facilities</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Attends staffing and case reviews (not billable to insurance)</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Attends staffing and case reviews (not billable to insurance)</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

c. A plan for how the Offeror will replace all Key Personnel and Other Personnel so that the transition between personnel does not impact the ability of the Contractor to complete the Work.

As decades-old organizations with multiple staff and locations throughout the counties to be served by this Pilot Project, the partner organizations have multiple staff who can step in to provide services should a transition in personnel occur, including a transition in Key Personnel.
Should a transition in personnel occur that would have an impact on the team, all of the
organizations would be able to draw upon its staff across the regions to meet project needs,
and could hire additional staff if needed. These new staff would undergo the training described
in this proposal.

d. If the Offeror intends to use a Subcontractor, the Offeror shall provide a description of how
the Offeror will use Subcontractors and the portions of the Work that will be completed by
each Subcontractor. This description shall also include the anticipated positions provided by
the Subcontractor and the roles of those positions, as well as a plan for how the Offeror will
manage the Subcontractor and all Subcontractor personnel to ensure that the portions of the
Work assigned to the Subcontractor will be completed accurately and in a timely manner.

RMHP, as the lead agency on this Pilot Project, would subcontract the delivery of services to
Mind Springs, SummitStone, Midwestern Colorado MHC, Mountain Valley, Strive, Community
Options, and Foothills Gateway as described throughout this proposal. Behavioral health crisis
staff, I/DD experts, and case managers will be employed by and housed at the partner
organizations. RMHP, as the lead, will be the State’s point of contact and will be accountable for
managing the partners and ensuring that work is being conducted and services are being
delivered in alignment with the contract, that all expectations and deliverables are met, and
that data and reporting expectations are met.

RMHP will be the State’s point of contact and will be accountable for managing the partners
and ensuring that work is being conducted and services are being delivered in alignment with
the contract, that all expectations and deliverables are met, and that data and reporting
expectations are met. This also includes providing to the Department completed and detailed
records of all meetings, system development life cycle documents, presentations, project
artifacts and any other interactions or deliverables related to the Pilot Project. We will ensure
that all partner personnel have the training and experience needed to complete the work of the
Pilot Project. In cases when training is needed, we ensure that it occurs. Key Personnel and
Other Personnel at RMHP and Partners will be available for all regularly scheduled meetings
and as needed with prior notice of any additional meetings. We will respond to all telephone
calls, voicemails and emails from the Department within one (1) Business Day of being made
aware of them. Throughout the Pilot Project, RMHP with work directly with the person the
Department designates to sign transmittals on behalf of the Department to receive direction. If
there ever is an event when we receive direction from the Department from someone not the
Department's designee, we will contract the primary designee to obtain direction.

Throughout the course of the Pilot Project, RMHP will inform the Department of any current
trends and issues in the healthcare marketplace and provide information on new technologies
in use that may impact the its responsibilities. RMHP, during its regular calls with the Partners,
will provide opportunity to share information about trends, issues, and technologies in the field, so that RMHP can share this information with the Department.

RMHP is prepared and has capacity for working collaboratively with key Department staff, as well as any other staff of other Department contractors or State agencies as it relates to the Pilot Project, recognizing that if a conflict were to arise, it would respect the proposed resolution of the Department. Moreover, in the event that RMHP is privy to internal policy and contractual discussions, it will consider and treat all information as confidential and will only disclose upon approval from the Department. RMHP has extensive experience working with the Department, as part of its role as a RCCO, and so is well-equipped to manage this role and these requirements.

Staff at RMHP will review and approve materials prior to distribution or presentation to the Department to ensure that all deliverables meet the Department-approved format and content requirements, meeting the expectations for number of copies and media for each deliverable. RMHP will plan and manage the submission process of deliverables to the Department for review and approval from each of the Partners and ultimately, itself. If changes to a deliverable are requested, we will make changes within five (5) business days unless the Department provides a longer period in writing. RMHP is aware and willing to make changes that may include modifying portions of the deliverable, requiring new pages or portions of the deliverable, requiring resubmission of the deliverable or requiring inclusion of information that was left out of the deliverable. RMHP would be happy and willing to assist the Department in its review via a walkthrough of each deliverable, and recognize that a deliverable will only be deemed accepted until notified as such by the Department. An accepted deliverable permits implementation by RMHP of any changes to plans, policies, or procedures.

RMHP will assume ultimate accountability and responsibility for performance of all tasks related to the Pilot Project and will conduct careful review of the exact requirements of the Department. The designated Project Lead for the Pilot Project will monitor all phases of the project in accordance with work plans or timelines or as determined between RMHP and the Department, and will serve as the direct point of contact for the Department. She will also ensure the completion of all work in accordance with requirements, including, but not limited to, ensuring the accuracy, timeliness and completeness of all work. We acknowledge and welcome that at any time throughout the Pilot Project, the Department may request information necessarily for it to complete a performance review or evaluation of the Pilot Project. To ensure we are successful in these reviews, we have created a team of staff who meet high standards for expertise and qualifications, level of effort, contribution, capacity and reputation. RMHP will follow an established process to support project management activities and ensure the identification and prevention of deficiencies in quality of deliverables. Deliverables, documents, and calculations will be assessed regularly for completeness,
accuracy, comprehensibility and high quality. At a minimum, deliverables will be responsive to the specific requirements for that deliverable, organized into a logical order, contain no spelling or grammatical errors, formatted uniformly and contain accurate information and correct calculations. All documents and electronic files shared with the Department will be done so in formats compatible with the Department's systems.

RMHP will retain all draft and marked-up documents and checklists utilized in reviewing deliverables for reference as directed by the Department. No deliverable, report, data, procedure created by RMHP for the Department that is necessary to fulfilling responsibilities for the Pilot Project, as determined by the Department, is proprietary. RMHP reviews and approves materials prior to distribution or presentation and debriefs staff with the project manager regarding performance.

Within five (5) business days following the effective start date of the Pilot Project, RMHP will provide a list of names of the individuals assigned to the Pilot Project, including those at its Partner locations. In addition, RMHP would provide immediate notification regarding changes in any of the key personnel assigned to the Pilot Project. In the event of a personnel change, RMHP will seek approval from the Department and provide name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change within ten (10) Business Days following the our receipt of notice that the person is leaving employment. In the event that employees are required to have and maintain any professional licensure or certification issued by any federal, state, or local government agency, the RMHP will submit copies of each employee's current licenses and certifications to the Department within five (5) business dates of receipt of updated licensures or upon request by the Department.

Within ten (10) business days of the effective start date of the Pilot Project, RMHP will submit to the Department its Communication Plan that includes how the team will communicate to Members any changes to the services they will receive and how they are to be accessed throughout the Pilot Project. The Communication Plan will also include details on how RMHP communicates with its partners and providers. Methods may include email list, weekly phone calls, and newsletters. Any non-routine communication with any Member, any Provider, the media or the public will not occur without the prior written consent of the Department.

A fundamental component of the Communication Plan will be a detailed process to address urgent communications or crisis situations, including how the RMHP will increase staff, contact hours or any other steps if existing communication methods for Members or Providers are insufficient. The Communication Plan will include a listing of cell phone numbers and email address for one individual authorized to speak on record regarding the Pilot Project, one individual responsible for website and marketing efforts, and one individual designated as back up communication staff that can respond in the event that the other two individuals are
unavailable. RMHP will update the Communication Plan on an annual basis, and will submit to the Department by June 30th of each year. We understand that there may be interim changes to the Communication Plan. In the event that a revision is required, we will submit an interim communication plan within 10 business days of the Department’s Request, unless the Department permits for a longer time in writing.

Within ten (10) Business days after the effective start date of the Pilot Project, RMHP will submit its Business Continuity Plan that we will follow in order to continue operations after a disaster or other business interruption. RMHP will also ensure that its partners have business continuity plans. The Business Continuity Plan will include, at least, how we will replace staff that has been lost or is unavailable during or after a Business Interruption so that the Pilot Project can continue, how information gathered will be maintained and not lost, how it will minimize the impact on Members, how it will maintain communication with the Department, a description of both short term and long term back up facilities, and how a transition to back up facilities will take place. The Business Continuity Plan will be implemented immediately upon any disaster or other business interruption. The Business Continuity plan will be reviewed at least semi-annually and updated as needed. RMHP will submit an Updated Business Continuity Plan Semi-annually, by June 30th and December 31st of each year.

Cross-System Response and Collaboration Plan (Offeror’s Response 3)

3. Provide a draft Collaboration Plan

Our draft collaboration plan includes the following:

- A plan to collaborate and co-locate with the Colorado Crisis Response System, including helping the Crisis Response System expand to support individuals with I/DD
- A plan to leverage the Colorado Crisis Response System toll-free hotline
- A plan to provide a Comprehensive and Cross-System Response

Collaboration and Co-Location with the Colorado Crisis Response System

On the Western Slope and on the Front Range, the Pilot Project will be co-located with the Colorado Crisis Response System, and it will be fully integrated with that system, since Mind Springs and SummitStone lead and support the Crisis System Response in their regions. On the Front Range, the Pilot Project will be in a different location, but will have weekly meetings with the Colorado Crisis Response System. The meetings will assure consistency across sites on operationalization of the Pilot Project, accurate data capture and reporting, and meeting of service standards. The project manager for the grant will meet weekly, onsite, with the Project Managers of the Western Slope and Front Range crisis systems to assure overall coordination.

In both the Western Slope and Front Range regions, services under this Pilot Project would closely coordinate with services provided under the existing Crisis Response System. In fact, this
The Pilot Project will work collaboratively with the whole Colorado Crisis Response System. In fact, the entire model of the Pilot Project is predicated on working in collaboration with the Crisis Response System. Individuals can enter into the existing crisis system in two ways. One is by calling into the existing statewide crisis lines. The other is as a walk in to any of the six local office locations, including one each in Delta, Montrose, Mesa, and Larimer counties and two in Garfield County. In either event, contact with the local Crisis Response System occurs. If an individual calls the statewide crisis line, those responders conduct an initial phone assessment and then call the local crisis responders immediately for a mobile dispatch of crisis responders. This Pilot Project will collaborate with those state hotline staff by offering training and technical assistance (noted in more detail both below and in Offeror’s Response 5) on assessing for an intellectual or developmental disability, and by coordinating with these staff continually and throughout the Pilot Project.

As soon as the local behavioral health crisis responders are involved, they will follow the process and model detailed in this proposal. In short, the behavioral health crisis responder will assess for an intellectual or developmental disability and, if one is present or suspected, will contact the local on-call I/DD crisis expert from Strive, Mountain Valley, Community Options, or Foothills Gateway. From that point on, the crisis BH staff and the I/DD staff will work in tandem to support the individual in the immediate crisis situation and then to provide stabilization and follow-up services.

To support this collaboration, training will be provided to both the BH crisis staff and the I/DD staff, as detailed in Offeror’s Response 5. The training that will be provided will support the collaboration by helping both the BH and I/DD crisis responders, as well as the case managers and follow-up staff understand all aspects of the model, including assessing for the presence of an intellectual or developmental disability, supporting an individual during the crisis, developing appropriate transition plans and follow-up services for an individual after a crisis, and working together as a team. Through the trainings, and through working collaboratively with I/DD experts, over time, the Crisis Response staff will gain additional expertise in serving individuals.
with I/DD and experts on I/DD will gain additional expertise in helping individuals who are experiencing a crisis. Together, these teams will provide strong, ongoing, person-centered, and whole-person support by combining their strengths and sharing their expertise. This will support an expansion of the regions’ ability to serve this population more effectively, and will expand overall knowledge of services and supports available to individuals with I/DD.

Collaboration with the Colorado Crisis Response System will include the following steps:

- Within two weeks of signing the contract, the partners will meet with Colorado Crisis Response staff to share the model for the Pilot Project, which will include additional items to screen for an intellectual or developmental disability and bringing in an I/DD specialist as soon as an intellectual or developmental disability is uncovered for an individual in crisis.

- Also at the initial meeting, Pilot Project staff will begin to explore with Crisis Response staff any training that may be needed for staff who answer that hotline and who provide services, and will finalize the communication plans and processes for both identifying and I/DD and bringing in an I/DD specialist immediately, to work alongside the behavioral health crisis staff. Details about the proposed training plan is proposed in Offeror’s Response 5.

- Within four weeks of the beginning of the contract, Pilot Project staff who are I/DD experts will train crisis hotline and other crisis staff on screening for I/DD, additions to the screening tool that will support identification of an I/DD, and the protocol for reaching out to an I/DD on-call crisis staff if an I/DD is identified.

- Pilot Project staff will set up recurring meetings with Crisis Response staff, including local and state hotline staff. These meetings will likely be every other week for the first several months to finalize communications and training protocols and to ensure that the new processes are working well. These meetings will likely move to monthly meetings once all training has been completed and new protocols are in place. The monthly meetings will be used to trouble-shoot and refine processes as needed.

Collaboration and/or Co-Location with the Colorado Crisis Response System Toll-Free Hotline

As noted throughout the proposal, the partners will utilize and leverage the Colorado Crisis Response System toll-free hotline. As noted above, immediately upon signing the contract, the partners will meet with Colorado Crisis Response hotline staff to share the model for the Pilot Project, which includes screening for an intellectual or developmental disability and bringing in an I/DD specialist as soon as an intellectual or developmental disability is uncovered for an individual in crisis. Hotline staff will be trained to screen for I/DD and on how to outreach I/DD on-call crisis specialists immediately. Some individuals will enter the Pilot Project outside of the existing Crisis Response System and its hotline. The Pilot Project will work closely with the
existing Crisis Response System to avoid duplication of efforts and to ensure that activities are coordinated and streamlined.

At the end of the Pilot Project, training and technical assistance that have been provided to state hotline staff and to the Crisis Response staff will support sustainability of the model by ensuring that individuals who enter into the crisis system are assessed for an I/DD and that, if an I/DD is detected, the appropriate supports and services are provided, including bringing in I/DD experts as soon as possible and throughout the person’s transition out of crisis and follow-up services.

A Comprehensive and Cross-System Response
To provide a comprehensive and cross-system response, the partners will utilize and leverage its deep relationships across the communities. Our Cross-System Response will include the following.

Community-Based Mobile Support
Community Based Mobile Support is already provided by the Crisis Response System, but these supports will be enhanced by this project as needed and, for each individual with I/DD who is in crisis, the community based mobile response will include an I/DD specialist working side-by-side with the BH specialist as a result of the Pilot Project. The Community-Based Mobile Support currently functions primarily by responding to local hospitals, law enforcement offices, schools, and agencies such as the CCBs. Community based mobile supports allow the existing crisis teams to meet individuals in crisis "where they are at". It is often helpful to see an individual's environment and use the natural supports in that environment to help the individual in crisis deescalate or to assess if a higher level of care is necessary. Advice and direction offered by both an I/DD specialist and BH specialist will ensure for a good assessment and plan of care.

Stabilization
This Pilot Project will leverage and coordinate with stabilization resources that are already provided by the Crisis Response System, and will provide some new services that are not currently available but that are critically needed. In terms of coordinating and leveraging existing services, this Pilot Project will enhance existing in-home and short-term facility-based support, respite and stabilization services by including I/DD specialists who will work side-by-side with the BH specialist to help stabilize the individual, and support services that may be specifically needed by individuals with I/DD. Short-term site-based respite and support services will be enhanced with trained peer respite workers, led by CMHC staff and supported by staff with expertise serving individuals with I/DD. If an individual needs mid-term to longer-term stabilization, this Pilot Project will allow us to meet that need, which is currently a critical unmet need for this population. As an example, this Pilot Project funding will allow us to rent space at the Regional Center in Grand Junction to allow us to provide intensive, targeted, mid-term to longer-term stabilization services for the individual. In this case, the staff with expertise...
serving individuals with I/DD direct the services, with support from the CMHC system. Facilities or individualized settings will be developed for children and adults in both Larimer County and Mesa County.

**Evaluation**

Evaluation of individuals who are experiencing a behavioral health crisis is not a one-time occurrence. Rather, evaluation and assessment are ongoing activities. As an individual’s situation changes, it is critical to continue to evaluate and assess their needs. Assessments occur at the time of the call as well as when face to face contact occurs with the individual in crisis. Often a safety plan includes some type of check in with the crisis team as part of a reassessment for safety. If in-home or site-based respite and support services are used, each will also reassess for safety and needs of the individual on a continual basis. This will be accomplished both by asking the person being served (and their caregivers and family members) what they need and by using expertise from the CMHC and now the CCB to help determine what is needed.

**Treatment**

Because the partners are all deeply engaged in providing either behavioral health services or services for individuals with I/DD across the regions, the partners are already providing many aspects of the treatment services needed for the individuals who would be served by this Pilot Project. However, the level of collaboration and cross-system response will be tremendously enhanced by this model. As teams of I/DD experts and BH experts work together in crisis situations, developing treatment plans and follow-up support services plans, they will continue to learn more about resources available to support individuals. Treatment that is provided often includes, but is not limited to behavioral health counseling/therapy; medication evaluation, adjustment, and management; peer specialist services; and wrap around services. Behavioral health counseling may be individual or group. Medication management and adjustment is ongoing, including support to help with adjustment to new medications and reminders. Peer specialist services may be provided by a trained peer who has lived experience and who can provide in vivo support, wrap around intensive services, and a listening ear, hope for recovery, and an opportunity to practice new skills. Additional services may include referrals to additional outpatient services, and other community-based services. Treatment is evidence-based, and evidence-based practices (EBPs) include cognitive behavioral therapy, behavior reinforcement, group therapy, coordination of care, person centered planning.

**In-Home Therapeutic Support**

As noted throughout, some of the critical services the partners propose to provide as part of this Pilot Project are in-home therapeutic supports to individuals, their families, and caregivers. Individuals enter into the Pilot Project (via the mechanisms described elsewhere), and are stabilized. Once stabilized, they may return home, or they may enter a short-term, mid-term, or
longer-term support services setting for additional services. Once individuals return to their regular place of residence, whether that is their own home, a family home, a group home, or some other setting, in-home therapeutic support services can help keep them stable, increase their quality of life (as well as the quality of life of their families and caregivers), and reduce the likelihood of future crises. The partners will provide in-home therapeutic services that are both evidence-based from the behavioral health perspective and that are culturally competent (both in terms of demographics such as race, gender, and ethnicity, but also in terms of a person having an intellectual or developmental disability). These include one-to-one supervision, development of adaptive strategies for dealing with emotional or behavioral issues, modeling appropriate behavior for individual, and modeling appropriate interactions and interventions for staff or family members. These services will be provided in a cross-system fashion by leveraging the partnership between the CMCH and the CCB in each of the two regions.

**Site-Based Therapeutic Support**

Site-based therapeutic services and supports will also be provided as part of this Pilot Project. At each of the site-based settings, services that will be provided include one-to-one supervision, development of adaptive strategies for dealing with emotional or behavioral issues, modeling appropriate behavior for individual, modeling appropriate interactions and interventions for staff or family members, medication stabilization, and the development of enhanced treatment and follow-up plans for re-entry to the individual’s usual community setting.

**Follow-up Services**

A critical component of this Pilot Project is the cross-system and comprehensive provision of follow-up services. Too often, across all systems of care, individuals with complex needs face many barriers to getting the services they need to improve or maintain their health and quality of life, avoid higher levels of care, including hospitalizations and visits to the emergency department. These are both costly to the system, and bad for people. A key component of our model is the development and implementation of coordinated follow-up services that prevent future crisis, that provide support to the individuals and their caregivers and family members, and that help improve quality of life and health outcomes. We will do this by providing one case manager to each individual who enters the Pilot Project. That case manager will be an I/DD expert from the local CCB, and will be responsible for working with the individual, their caregivers and family members, the ART, and the behavioral health expert from the CMHC to develop and implement a follow-up care plan that incorporates behavioral health services, respite services for family members and caregivers, therapeutic and planned respite services, and wide variety of services, including those that are available through the HCBS waivers for adults with I/DD, including: residential, vocational, behavioral, therapeutic, respite, community connections, mentoring, and nursing and case management.
These will be provided in a cross-system, comprehensive fashion by leveraging the I/DD case manager’s expertise, their knowledge of and partnerships with community-based organizations, and their partnerships with the CMHC behavioral health staff.

Cooperative Agreements

To provide a truly cross-system response, the partners will leverage existing cooperative agreements, or develop new agreements, with the following: Colorado Crisis Services (already exist), Medicaid state plan services, Medicaid School-Based Health Services, Home and Community-Based Waiver Services, the capitated mental health system, and other community service providers, health care professionals and organizations whose specialization may be utilized in the treatment of individuals served in the Pilot Project.

The Partners will leverage existing cooperative agreements, memoranda of understanding, and contacts with providers and will develop and enter into new agreements as needed. Other partners with informal agreements jails, housing authorities, homeless shelters, and police and parole offices. Existing cooperative agreements and partnership arrangements include:

- Colorado Crisis Services
  - Mind Springs, Midwestern Colorado MHC, and SummitStone are part of the Colorado Crisis Services project for the Western Slope and Front Range regions

- Medicaid state plan services providers
  - Countless state plan services providers across the regions, including all provider types

- Medicaid School-Based Health Services
  - All school-based health centers in Delta, Montrose, Garfield, Mesa, and Larimer Counties
  - Additionally, Rocky Mountain Health Plans specifically has relationships with school-based health centers in RCCO Region One, as describe in the table below.

<table>
<thead>
<tr>
<th>Town</th>
<th>Clinics(s)</th>
<th>Open to</th>
<th>Medical Provider</th>
<th>Behavioral Health Provider</th>
<th>Current Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta</td>
<td>A Kidz Clinic</td>
<td>All children &amp; youth in Delta County from birth to 18 years</td>
<td>Pediatric Associates</td>
<td>Midwestern Colorado MHC</td>
<td>Contracted as RCCO PCMP</td>
</tr>
<tr>
<td>Rifle</td>
<td>Rifle Middle School</td>
<td>Students &amp; staff enrolled in any school in the district &amp; their siblings from birth to 19 years</td>
<td>Grand River Health</td>
<td>Mind Springs Health</td>
<td>Contracted as RCCO PCMP</td>
</tr>
<tr>
<td>Parachute</td>
<td>Grand Valley Center for</td>
<td>Students enrolled in any school in the district &amp; their siblings</td>
<td>Grand River Health</td>
<td>Grand River Health</td>
<td>Contracted as RCCO PCMP</td>
</tr>
<tr>
<td>Town</td>
<td>Clinics(s)</td>
<td>Open to</td>
<td>Medical Provider</td>
<td>Behavioral Health Provider</td>
<td>Current Relationship</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Montrose</td>
<td>Northside Child Health Center</td>
<td>Any child in Montrose County from birth to 21 years, as well as eligible parents</td>
<td>Pediatric Associates</td>
<td>Montrose County School District</td>
<td>Contracted as RCCO PCMP</td>
</tr>
<tr>
<td>Montrose</td>
<td>Day Treatment Program</td>
<td>Students 8 to 13 years of age at risk of out-of-home placement</td>
<td>Midwestern Colorado MHC</td>
<td></td>
<td>Contract in Process</td>
</tr>
<tr>
<td>Montrose</td>
<td>Vista Charter Alternative School</td>
<td>Students 9th through 12th grade</td>
<td>Midwestern Colorado MHC</td>
<td></td>
<td>Contract in Process</td>
</tr>
<tr>
<td>Fort Collins</td>
<td>Centennial High School</td>
<td>Students enrolled in high school &amp; siblings &amp; adolescent relationships from 14-21 years</td>
<td>Rocky Mountain Youth Clinics</td>
<td>Rocky Mountain Youth Clinics</td>
<td>Contract in Process</td>
</tr>
</tbody>
</table>

- **Home and Community-Based Waiver Services**
  Countless HCBC waivers services providers across all of the counties, including, but not limited to:
  - Foothills Gateway
  - Horizons Specialized Services
  - Mountain Valley Developmental Services
  - Strive
  - The Center for Mental Health
  - SummitStone Health Partners
  - Whole Health LLC Mind Springs
  - Hilltop Community Resources
  - Home Care of the Grand Valley
  - Interim Healthcare
  - Northwest VNA
  - Optimal Home Care
  - Community Options
  - Delta County Department of HHS
  - Montezuma County Public Health Department
  - Montrose County Department of HHSS
  - San Juan Basin Health Department
  - Volunteers of America (VOA)

- **Capitated mental health system:** Mind Springs, as the Community Mental Health Center in this region, is the primary provider of capitated mental health services for the
Western Slope region covered by this Pilot Project; SummitStone, as the CMHC for the Front Range, is the primary provider of capitated mental health services for Larimer County.

- Other community service providers, health care professionals and other organizations whose expertise may be utilized in supporting individuals served in the Pilot Project include, but are not limited to physicians and family practices, FQHCs, hospitals, psychiatric units, and many others.

**Final Collaboration Plan and Reimbursement Plan**

Within 10 days of the Effective Date of the Contract, RMHP and its partners will submit a Collaboration Plan that provides details about initial contact with the Crisis Response System (including the hotline), protocols, communications plans and strategies, frequency of meetings, and the staff who will be responsible for ensuring that the collaboration is effective and meets the needs of the individuals being served. RMHP and its partners will update the Collaboration Plan annually, incorporating lessons learned, noting any challenges in the collaboration, and making adaptations to the plans as needed.

Additionally, RMHP and its partners will ensure that community service providers are only billing the Pilot Project for services that are un-reimbursable by private insurance, Medicaid or Medicare. Within 10 days of the Effective Date of the contract, RMHP and its partners will create and send to the Department a Reimbursement Plan that describes how community service providers will be reimbursed once the Pilot Project funds have been depleted.

**Pilot Project Regions (Offeror’s Response 4)**

4. *Provide the number of geographically representative Regions, their names and location that the Offeror would focus on for the Pilot Project. In addition, explain why the Offeror proposes to focus the Pilot Project in those geographically representative Regions.*

The team proposes to conduct the Pilot Project in the following regions and counties:

- Mesa, Garfield, Montrose, and Delta Counties (Western Slope)
- Larimer County (Front Range)

These regions were selected for several reasons. First, the organizations have a strong presence in these regions, currently provide similar services in these regions, and they know that there is a need for these services. The team has deep local knowledge, including medical providers; community based organizations that provide supportive services, including food, housing, transportation, and other social services; the emergency response systems; local law enforcement; and local caregivers and caregiver support organizations, and many others. This strong local knowledge will allow us to tap into existing resources for individuals who come to the Pilot Project because they are in crisis, and who are served through the Pilot Project,
including individuals who are not enrolled in Medicaid and/or Colorado’s Home and Community Based Services (HCBS) waivers.

Second, the partnering organizations already provide services in these regions. Rocky Mountain Health Plans (RMHP) is the Regional Care Collaborative Organization (RCCO) for the Western Slope, and coordinates care for RCCO enrollees in these regions. Mind Springs and Midwestern Colorado MHC provide behavioral health services for individuals in these regions, and Mind Springs oversees and provides crisis services as part of the Colorado Crisis Response System. Strive, Community Options, and Mountain Valley Developmental Services are the Community Center Boards (CCB) for the Western Slope counties. SummitStone provides behavioral health services to Larimer County and is part of the Crisis Response System, and Foothills Gateway is the CCB for Larimer County. Together, the partnership of these organizations for this Pilot Project represents a unique and strong opportunity to develop and implement innovative, cross-disciplinary, team-based, person-centered crisis services to individuals with Intellectual and Developmental Disabilities who are experiencing a behavioral health crisis. Not only will the Pilot Project provide these critically needed services, it will test an innovative model of care, and collect data and information to support program improvement and replication.

Third, these regions have high need. First, target counties (Larimer, Garfield, Mesa, Montrose, and Delta) fell within the highest quartile category in terms of the number of Medicaid or CHIP beneficiaries among counties through the state.
MAP 2: ESTIMATED NUMBER OF MEDICAID AND CHIP BENEFICIARIES

Estimated number of Medicaid and CHIP beneficiaries
by Colorado County

- Lowest Quartile (165 - 1,407)
- Second Quartile (1,408 - 3,511)
- Third Quartile (3,512 - 9,678)
- Highest Quartile (9,879 - 200,046)

Data source:
U.S. Census, 2013 5-year estimate
CMS, 2015
email: alambarrinc@healthmanagement.com
Map 3 reveals that the number of individuals, 5 years of age and older, diagnosed with a cognitive disability fell within the highest quartile category when the population was divided equally into four classes.

**MAP 3: ESTIMATED NUMBER OF INDIVIDUALS 5 YEARS AND OLD WITH A COGNITIVE DISABILITY**

Estimated number of individuals 5 years and older with a cognitive disability by Colorado County

- Lowest Quartile (3 - 257)
- Second Quartile (258 - 494)
- Third Quartile (495 - 1,437)
- Highest Quartile (1,438 - 27,082)

Data source:
U.S. Census, 2013 5-year estimate
alimbartino@healthmanagement.com
Maps 4 and 5 reveal that these counties also have high rates of children who are eligible but not enrolled in Medicaid (Map 4) and CHIP (Map 5). The counties to be served by our Pilot Project score in highest quartiles on these indicators. This suggests potentially high unmet needs for services that could be met through this Pilot Project. While these indicators apply to children only, they may be reflective of similar trends for the adult population.

**MAP 4: ESTIMATED NUMBER OF CHILDREN 0-18 YEARS WHO ARE ELIGIBLE BUT NOT ENROLLED IN MEDICAID**
MAP 5: ESTIMATED NUMBER OF CHILDREN 0-18 YEARS WHO ARE ELIGIBLE BUT NOT ENROLLED IN CHIP

Number of children 0-18 years that are eligible but not enrolled in Medicaid by Colorado County

Data source:
Colorado Health Institute, 2012
alambertine@healthmanagement.com
Fourth, these counties and regions were selected because they provide an opportunity to test this innovative model in a variety of settings, from the Front Range to the Western Slope, and in high-density urban areas and rural and even frontier areas in these counties. By testing the innovation in different settings, it will be possible to explore where it works best, what adaptations need to be made for different settings, which community partners are most critical to the success of the model, and where gaps may still exist. This presents an excellent opportunity for the state to test the model, learn about what works, and learn about what it will take to successfully implement the model statewide.

Overall Evidence of Need, and How this Pilot Project will meet those Needs

Despite the efforts of all of the partner organizations, and many other community based organizations, and others, resources do not meet the needs for services on the Western Slope, nor in the Front Range. In Colorado, as with many states, significant gaps still exist in access to care for I/DD who also have a mental and/or behavioral health disorder. This problem becomes more acute when an individual requires crisis intervention and stabilization. Theoretically, people with a dual diagnosis of IDD and a behavioral health disorder have access to mental health center services. However, historically, these systems have experienced fragmentation, for many reasons. The state’s effort to work toward more effective integration through this Pilot Project is to be credited, and will help reduce that fragmentation. The Western Slope (including RMHP) and Larimer County (which is also a part of the RMHP region) is leading the state on integration and this Pilot Project serves as one more step toward the vision of integration and removing barriers to services.

Nationally, the estimate of how many individuals with I/DD who also have mental illness is approximately one third (30%–35%) of the I/DD population, as reported by The National Association for the Dually Diagnosed (NADD). A second, and similar estimate, is offered by the National Core Indicators Data which found that 43% of individuals with I/DD need some extensive support to manage self-injurious, disruptive and/or destructive behavior. The NCI data brief found that those individuals who had a specific mental illness diagnosis were much more likely to have support needs. Using the NADD data and the Colorado HCBS waiver adult enrollment, the number of adults (over 18 years) receiving or waiting for waiver services in Colorado who are likely to have a dual diagnosis is likely to be between 3,362 and 3,923 individuals. For children, using Colorado Department of Education data and NADD estimate, an estimated 5,487-6,401 students in Colorado may be impacted by dual diagnoses. This number represents approximately 0.7% of the total student population (aged 3-21 years) of 863,561 in Colorado in 2013.

2 National Core Indicators data brief, May 2014; [http://www.nationalcoreindicators.org](http://www.nationalcoreindicators.org)
The following heat maps use estimates from the National Association for the Dually Diagnosed of individuals with a dual diagnosis to estimate the demand for services in the Pilot Project regions. Map 4 demonstrates that the target counties (Larimer, Garfield, Mesa, Montrose, and Delta) fell within the highest quartile category when the range of dual diagnosis estimates among students (3-21 years) were divided equally into four classes.
MAP 6: INDIVIDUALS (AGE 3-21) WITH DUAL DIAGNOSES

Estimated number with a dual diagnosis of IDD and BH among the preschool through 12th grade population by Colorado County

First Quartile (4 - 55)
Second Quartile (56 - 135)
Third Quartile (136 - 358)
Highest Quartile (389 - 8305)
No data allocated (Broomfield)

Data source:
Colorado Department of Education, 2014
alanbertino@healthmanagement.com
Map 7 demonstrates that the target counties (Larimer, Garfield, Mesa, Montrose, and Delta) fell within the highest quartile category when the range of dual diagnosis estimates among adults (18 years or older) were divided equally into four classes.

For these individuals and their families, there are several barriers to accessing the right care. These barriers are described below:

1. Many of the individuals affected with a dual diagnosis are not able to access services due to **narrow eligibility criteria**. Thus, many of the individuals with a dual diagnosis are not likely to be eligible for services in the I/DD system as they meet neither the IQ nor the adaptive behavior criterion and, therefore, have even more limited access to mental health services. As a result, many individuals are turned away from care because they present with problems that are considered to be a result of an uncovered diagnosis, or because they lack of insurance, or due to providers already having a full caseload.
Meeting this Need: In response to this gap, our pilot program will work to connect individuals to services available via alternative funding streams.

2. While the current Colorado Crisis Response System is working to close the gap in services, there remains a gap in prevention and intervention services for families, especially those with a family member with an intellectual or developmental disability. As a result, families turn to first responders, law enforcement, and hospital emergency departments for support during a behavioral crisis. All too often, these support staff lack crisis intervention training and inadequately meet the crisis needs of the family and, importantly, are also unable to offer follow-up services. Services that can help a family learn techniques to predict, and perhaps change, problematic behavior, prevent crisis, and provide appropriate follow-up supervision and care are needed. Additionally, there is a shortage of both outpatient and inpatient behavioral treatment options for children and adults. Traditional treatment approaches (i.e. group therapy) often are not suitable for individuals with I/DD. There is a need for therapeutic respite where holistic assessment and treatment occurs, including functional behavior plans that can be implemented by the caregiver.

Meeting this Need: In response to these gaps, our pilot program creates a model that incorporates adequate training of response staff regarding both the behavioral health needs and the needs related to the developmental disability. It also provides the follow-up services, care management, and education needed by families to effectively prevent and, when necessary, intervene in a crisis.

3. There is a need for cross collaboration among systems to meet the complex needs of people with co-occurring diagnoses, especially at the time of a crisis. Currently, inadequate reimbursement and inflexible funding streams create barriers to cross collaboration. Similarly, collaboration between and among community providers of I/DD services and behavioral health providers can be difficult due to the regulatory and reimbursement complexities of both systems. Due to the exclusion of I/DD from the Colorado Medicaid Community Mental Health Service Program, many clinicians feel they are required to segment their treatment according to different payment mechanisms. Providers report being exhausted and discouraged by their inability to meet the needs of people with dual diagnoses. Care coordination, in collaboration with the primary care physician, lacks the authority to develop a plan to treat, in a holistic manner, the identified functional needs regardless of reimbursement system.

Meeting this Need: In response to this gap, our pilot will work to develop individual cross-system crisis prevention and intervention plans and leverage partnerships with organizations that acknowledge and understand the existing challenges. Together, the effort will create pathways for individuals, families and providers to meet the complex
needs of people with co-occurring diagnoses. Care managers familiar with the various funding streams and reimbursement structures will coordinate this aspect to ensure that payment for services is sought by the appropriate and applicable sources, including private insurance, Medicare, Medicaid state plan, HCBS waivers, and other sources.

4. **Professional expertise and workforce capacity to serve the population is lacking**, creating a significant barrier to effective and coordinated treatment. Multiple disciplines of professionals and care providers are needed to serve people with dual diagnosis. Across the board, there is a need for specialized training in serving individuals with I/DD.

**Meeting this Need:** In response to this gap, our pilot will work to develop a much more highly train workforce, specializing in treating individuals with Dual Diagnoses, including both behavioral health needs and I/DD.

5. There is a need for **enhanced community resources and process to support the movement toward more truly home and community based services**. Several national and Colorado-specific forces are moving the system toward providing truly home and community based services, and working to develop community capacity to prevent the need for institutional care. These include the Centers for Medicare and Medicaid Services’ Home and Community Based Settings Rule, changes to Regional Center admissions, and a cultural shift toward more approaches to care that are authentically person-centered.

**Meeting this Need:** This Pilot Project works to test the effectiveness of a new and innovative model of care that combines the best of two worlds – the most experienced behavioral health crisis supports with the most experienced I/DD staff – and works to help prevent higher levels of care, including Regional Center admissions, hospital and psychiatric admissions, and the use of emergency rooms and law enforcement in times of crisis by working to effectively stabilize individuals with I/DD who are experiencing a behavioral health crisis and provide the follow-up services to prevent future crises.

Because the partner organizations are so well-positioned to leverage the existing crisis response system and because the needs are so great, the proposed Pilot Project will not only help meet many of these needs, it will also help uncover important lessons about how best to implement these types of services and this model of care.

**Pilot Project Region Report**

Within 30 days of the Effective Date of the Pilot Project, the partner organizations will submit a final Pilot Project Region Report, which will include final details about the region, the organizations with whom we will work and collaborate, and the staff with whom we will work and collaborate. Provided here are some details about the proposed Pilot Project Regions.
Draft Colorado Crisis Services Training Plan (Offeror’s Response 5)

5. **Provide a Draft Colorado Crisis Services Training Plan.**

The following is our draft Colorado Crisis Services Training plan. It builds on existing trainings for behavioral health crisis staff and existing trainings for I/DD staff. For this Pilot Project, specific staff (both behavioral health staff and experts in I/DD) will be provided both sets of trainings. In other words, I/DD staff will receive the trainings that have been designed for and implemented with BH staff (as well as their own trainings), and the BH staff will receive trainings that have been designed for and implemented with I/DD staff. In this way, from the very beginning, the Pilot Project will work to develop capacity of clinicians and experts from both BH and I/DD, and provide opportunities for cross-system learning and engagement. These trainings will support enhanced skills for all staff, will also serve to break down historical silos, and will ultimately support the provision of better services for individuals with an intellectual or developmental disability who are experiencing a behavioral health crisis.

All trainings begin the first week of employment for new employees. For existing employees, the cross-training will be implemented over the course of six months after the Effective Date of the Contract. All staff who provide crisis services or case management services will be provided the trainings.

**Existing Training for Site-Based Behavioral Health Support Staff**

Training for both new and existing behavioral health crisis staff, including staff who are serving individuals at a facility, is based on basic learning theory. Learning is developmental and repetition is important. The training happens in an order that allows the new employee to learn how to work with individuals from the time they enter our care to the time they leave our care. The training allows for multiple learning opportunities on each subject so that as employees learn, grow and have new experiences on the job, they can understand the learning point in a new, different and deeper way. Our training plans ensure that all staff are well-versed in providing evidence-based, trauma-informed and person centered care. Our trainings reflect our ideals of helping the whole person, building upon their strengths to help encourage their recovery and support their resilience. Details about training for these staff are provided below.
<table>
<thead>
<tr>
<th><strong>Initial Training for Crisis Stabilization Staff</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Week 1: Topics</strong></td>
<td>Training is provided by middle management</td>
</tr>
<tr>
<td>Crisis Prevention and Intervention (CPI),</td>
<td>Supervisors, the Director of Nursing and</td>
</tr>
<tr>
<td>De-Escalation, Electronic Medical Record</td>
<td>the manager for the department of the new</td>
</tr>
<tr>
<td>Documentation, Reporting, Groups, Shadowing</td>
<td>employee. CPI is taught by a certified</td>
</tr>
<tr>
<td>Employees, On-The-Job Training, Patient</td>
<td>CPI instructor and consists of 16 hours of</td>
</tr>
<tr>
<td>Safety, Building Orientation, HIPAA</td>
<td>training. The first week of training is</td>
</tr>
<tr>
<td>Training, Blood Born Pathogens, Vitals,</td>
<td>approximately 36 to 40 hours. All new</td>
</tr>
<tr>
<td>Infection Control, Cultural, Emergency</td>
<td>employees receive a Skills Book to use</td>
</tr>
<tr>
<td>Medical Treatment and Active Labor Act</td>
<td>as a resource guide for basic facility</td>
</tr>
<tr>
<td></td>
<td>operations. It is a helpful collection of</td>
</tr>
<tr>
<td></td>
<td>general information for job reference,</td>
</tr>
<tr>
<td></td>
<td>including explanation of potential unusual</td>
</tr>
<tr>
<td></td>
<td>patient behaviors, diagnosis,</td>
</tr>
<tr>
<td></td>
<td>documentation, running groups,</td>
</tr>
<tr>
<td></td>
<td>safety, etc.</td>
</tr>
</tbody>
</table>

| **Week 2: Topics**                          |  |
| Job Shadowing, CPR/Basic Life Support,     | Shadowing begins in Week 2 and occurs for  |
| 27-65, Pharmacy, Trauma Informed Care,     | approximately 6 shifts (up to 72 hours) or  |
| Documentation                              | until the new employee and supervisor feel |
|                                            | comfortable that the employee is ready to  |
|                                            | work independently. The new employee       |
|                                            | shadows a current employee who performs    |
|                                            | the same job requirements, including:      |
|                                            | case managers, Clinician I's, II's or     |
|                                            | III's, RN's, Providers, Ward Clerks.      |
|                                            | Competency is achieved when the new       |
|                                            | employee is successfully able to          |
|                                            | demonstrate and perform the functions     |
|                                            | shown to them during the position         |
|                                            | shadowing. Safety training is on-going.   |

| **Week 3: Topics**                          |  |
| Belongings Check-In, Valuables, Safety,    | Training and learning is ongoing. Training |
| Food Handling, Visitation, Infection       | is provided by the employee in the        |
| Control, Milieu Management                 | department already performing the duties.  |
|                                            | Training is approximately 36 to 40 hours.  |
|                                            | Competency is achieved with the new       |
|                                            | employee can demonstrate understanding of  |
|                                            | and can perform the duties shown to them  |
|                                            | during the position shadowing.            |

Competency standards for staff meet Department of Regulatory Affairs standards and all Colorado licensing standards, as applicable. To ensure that staff meet competency standards, the partners hire staff that meet the competency standards or can meet them after undergoing initial new employee training, or supplementary training if needed. Competency requirements are position based. All staff receive training in Crisis Prevention and Intervention, taking blood
pressure, use of medical devices, and equipment appropriate to their position. Competency is continuously assessed, and retraining is provided as needed or on a yearly basis. All new employees are provided with a Skills Book to use as a resource for ongoing training and learning.

**Ongoing Training**

For site-based support staff, ongoing, routine, in-person trainings will be provided to include topic such as: suicide assessment, verbal de-escalation, body language, milieu management, psychiatric illnesses and diagnosis. An Employee Skills Day event will be held annually. Additional details about ongoing in-service trainings are provided below.

<table>
<thead>
<tr>
<th>Ongoing Training for Crisis Stabilization Unit Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Prevention and Intervention/Basic Life Support, Emergency Medical and Active Labor Act, 27-65 Involuntary Commitment Statute, Skills Day with Competencies</td>
</tr>
<tr>
<td>Crisis Prevention and Intervention training is an annual training provided by a certified CPI instructor, with 'refresher' courses offered semi-annually. Emergency Medical Treatment and Active Labor Act training is provided annually as required by the state of Colorado. Training is provided through the Quality Department. 27-65: Involuntary Commitment training is provided annually by the Quality Department as required by the State of Colorado. Skills Day is offered once a year and is conducted by the Quality Department in conjunction with the Director of Nursing. Skills Day booths are set up and staff move from one booth to another to practice competencies such as blood draws, preparation of portable blood draws, vital signs such as blood pressure, weights, oxygen saturation levels, documentation, use of common medical equipment. Skills day is offered for 10 hours one day per year and is an annual refresher/competency opportunity for staff.</td>
</tr>
</tbody>
</table>

Site-based Support staff benefit from well-established, comprehensive policies and procedures for providing clinical supervision and performance evaluation. A licensed clinician provides direct supervision and support to all staff in site-based support facilities, coupled with training and oversight from a Medical Director from the associated partner organization. Performance evaluations occur after the first 90 days of employment and once per year after the end of the calendar year.

During their first three months of employment, clinical supervision is provided to licensed/certified and unlicensed/uncertified staff in individual weekly sessions of at least 30 minutes, and one group session of at least 30 minutes. It is anticipated that additional clinical supervision and support will be needed for staff providing crisis services, and that the need for this support will vary as the number and intensity of crisis services that are provided varies. The
partners have extensive experience and policies in providing clinical supervision and performance evaluation, both on a regular basis and on in crisis situations, and is well-prepared to provide these services for staff providing all crisis services and follow-up supports. An open door policy by supervisors who are on site is a major component of the supervision model for the crisis team.

CPI training will be required for staff and this training will support them in their ability to handle difficult situations and feel confident in their decisions. Any critical incident may result in a debriefing or Root Cause Analysis which also supports staff. Local supervisors will provide “in the moment” support as well as regular and scheduled supervision which assists staff in their comfort and confidence.

All site-based staff will have intensive and ongoing training in the initial months of employment. This includes the supervisory structure addressed above and the trainings noted above. All supervisors have an open door policy, as do program directors and regional directors for advice as needed on an emergent, urgent or routine basis. Supervisory staff have cell phones and staff can contact them as needed. The partners have administrators and/or clinical supervisors on-call for all non-work hours that any staff who needs assistance can contact. This is in addition to local supervisors and directors who can also be contacted. Staff are actively encouraged to seek supervision when they need it regardless of time of day. All staff have multiple contacts available to them at any time of day.

Training for Community-Based Mobile Crisis Staff

Upon hire of a new community-based mobile crisis staff member, a multi-week training plan is followed between the supervisor and clinician. New staff members are trained in motivational interviewing, brief intervention strategies and substance use and co-occurring disorders. All staff are trained in care for both mental illness and substance use disorders. Additionally, the new staff are trained in all company policies, are provided Crisis Response Training, and are provided Crisis Prevention and Intervention training. New staff are trained, then shadow an experienced staff member for a designated period of time, then performs assessments and provides services under the supervision of a licensed clinician, and then is allowed to work alone with written documentation monitored.

Our training for both new and existing staff is based on basic learning theory. Learning is developmental and repetition is important. The training happens in an order that allows the new employee to learn how to work with individuals from the time they enter our care to the time the individual leaves our care. The training allows for multiple learning opportunities on each subject so that as the employee learns, grows and has new experiences on the job, they can understand the learning point in a new, different and deeper way.
Our training plans ensure that all staff members are well-versed in providing evidence-based, trauma-informed and person centered care. Our trainings reflect our ideals of helping the whole person, building upon their strengths to help encourage their recovery and support their resilience.

<table>
<thead>
<tr>
<th>Training for Community-Based Mobile Crisis Response Team Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Week 1 Topics</strong></td>
</tr>
<tr>
<td>Organizational Norms/Culture; 27-65 Law; EMR Training; Law Enforcement Interactions; Client Treatment Rights; De-Escalation; Risk-Safety-Protective Factors; Shadowing</td>
</tr>
<tr>
<td><strong>Week 2 Topics</strong></td>
</tr>
<tr>
<td>HIPAA; Trauma Informed Care; 27-65 Designated Facilities; Safety Planning; Community Resources &amp; Partnerships; Use of LOCUS and CALOCUS; Shadowing and Practicing Interactions with a Mentor</td>
</tr>
<tr>
<td><strong>Week 3 Topics</strong></td>
</tr>
<tr>
<td>Co-Occurring Diagnosis; Special Populations (Children, People with TBI, Individuals with Developmental Disabilities, Dementia, and Others); Safety; CCAR Completion; Practicing Phone And Face To Face Evaluations With Mentor; Cultural Competence</td>
</tr>
</tbody>
</table>
Training for Community-Based Mobile Crisis Response Team Staff

<table>
<thead>
<tr>
<th>Week 4 Topics</th>
<th>Week 5 Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service; Advanced Training on Trauma Informed Care; Differential Assessment of SUD and Medical Issues and Use of Detox, Physical Health, and Hospital Partners; Begin Performing Evaluations with Consultation from Mentor</td>
<td>Client Grievance and Advocacy Procedures; Critical Incident Procedures; Mandatory Reporting; Understanding Continuum Of Care Options within Community; Safety Planning; EMR Review and Competency Validated on all Necessary Crisis Tools</td>
</tr>
<tr>
<td>During this week, new employees continue with online training via Relias, including: &quot;Anatomy of a Good Call&quot;; &quot;Customer Relations&quot;; Trauma Informed Treatment for children with Challenging Behaviors</td>
<td></td>
</tr>
</tbody>
</table>

Ongoing Training for Mobile Crisis Staff

In addition to initial training, ongoing training is provided. Yearly trainings are provided to all staff for Emergency Procedures. Additional training on screening and assessment, suicide assessment, etc., are addressed during the first 90 days of hire. The clinician shadows and then is evaluated while performing a crisis assessment. Cultural and sensitivity trainings, consumer rights, standards of care, community resources, mandated reporting, 27-65 statues, customer service, documentation, treatment planning are all included in the training plan and provided annually at a minimum. Additionally, regular staff meetings provide a place for training to occur on a regular basis. At least monthly individual supervision occurs to provide opportunities for training related items as well. Additionally, Essential Learnings is an offering that we have
available to all staff at all times as well. It is an online program that allows us to assign and track what courses staff are taking. This is used at least twice a year to cover mandatory trainings as well as chosen trainings based on job duties for staff. Additional details about annual and ongoing training activities are provided below.

<table>
<thead>
<tr>
<th>Annual and Ongoing Training and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Prevention and Intervention/Basic Life Support, Emergency Medical and Active Labor Act, 27-65 Involuntary Commitment Statute</td>
</tr>
</tbody>
</table>

Training for In-Home Therapeutic Support Services
All staff receive Mental Health First Aid, motivational interviewing, verbal de-escalation and brief intervention strategies training. All of these are nationally recognized curriculum for providing services to persons with mental illness and/or substance use disorders. Staff are trained to take vitals and to recognize issues with these measures. On the first experience for in-home therapeutic support staff, efforts will be made to include two new employees to train both at the same time and to provide initial support. As staff become more experienced, new staff will shadow experienced staff until competent to be reversed shadowed and then allowed to work with patients on their own. Peers may provide of these in-home therapeutic services. Before providing any services, peers are provided 80 hours of training in the Georgia Peer Specialist curriculum, which is evidence based, as well as other curriculum that provides a basis/education for the work they will do. All of the other training noted below begins after this 80 hours of training has occurred. Additional details about training for in-home therapeutic support staff are provided below.
Training for Respite Staff

<table>
<thead>
<tr>
<th>Week 1: Topics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational norms/culture; Electronic Medical Record training; Law Enforcement interactions; Client Treatment Rights; De-Escalation; Risk-Safety-Protective Factors; Shadowing</td>
<td>All new employees receive orientation to the agency including human resources, information technology and organizational culture. This is a minimum of 8 hours of training.</td>
</tr>
<tr>
<td>Week 2: Topics</td>
<td></td>
</tr>
<tr>
<td>HIPAA; Trauma Informed Care; Safety Planning; Community Resources and Partnerships; Shadowing; Mental Health First Aid</td>
<td>All Respite team members shadow experienced team members for one respite episode and then are shadowed by a team members for one additional episode before independently managing a respite episode. Respite workers receive approximately 40 hours of training.</td>
</tr>
<tr>
<td>Week 3: Topics</td>
<td></td>
</tr>
<tr>
<td>Safety; Cultural Competence; Qualified Medication Administration Person (QMAP); Critical Incidents; Grievance procedures; individual and Family Strengths</td>
<td></td>
</tr>
</tbody>
</table>

Competency requirements are, and will continue to be, position based. Upon hire, all residential/respite staff will receive training listed above. Competency will be continually assessed, and retraining provided as needed or on an as-needed and/or annual basis.

Competency standards already exist for most positions, and these standards meet Department of Regulatory Affairs standards, where applicable, American Nurses Association, and Joint Commission Accreditation Standards, Certified Addiction Counselor standards, and all Colorado licensing standards, as applicable. To ensure that staff meet competency standards, the partners hire staff that meet the competency standards or can meet them after undergoing initial new employee training, or supplementary training if needed. For those positions that do not currently exist (and so do not have competency standards), these will be developed during the 90 day planning period. Staff will be evaluated by supervisors at the 90 day mark, and then at least every six months on these competencies. Additionally, direct observation of clinical work will be utilized to evaluate skills. All clinical documentation is monitored, read and cosigned for up to 90 days.
Ongoing Training
The in-home therapeutic support staff will have a yearly review of essential trainings. These include assessing and awareness of suicide prevention and managing people with a mentally illness (possibly including portions of Mental Health First Aid). Each year, staff review and take training in sensitivity, consumer rights, abuse and neglect, and cultural competency. Standards of care training is included in the group of required trainings. Some of these trainings are provided through web based training. The others are reviewed with staff as needed. Additional details about annual and ongoing training are provided below.

<table>
<thead>
<tr>
<th>Ongoing and Annual Training and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis Prevention and Intervention/Basic Life Support, Emergency Medical and</strong></td>
</tr>
<tr>
<td><strong>Active Labor Act, 27-65 Involuntary Commitment Statute</strong></td>
</tr>
<tr>
<td><strong>Crisis Prevention and Intervention training is an annual training provided</strong></td>
</tr>
<tr>
<td><strong>by a certified CPI instructor, with ‘refresher’ courses offered semi-annually.</strong></td>
</tr>
<tr>
<td><strong>Emergency Medical Treatment and Active Labor Act training is provided annually</strong></td>
</tr>
<tr>
<td><strong>as required by the state of Colorado. Training is provided through the Quality</strong></td>
</tr>
<tr>
<td><strong>Department. 27-65: Involuntary Commitment training is provided annually by the</strong></td>
</tr>
<tr>
<td><strong>Quality Department as required by the State of Colorado.</strong></td>
</tr>
</tbody>
</table>

Training for Intellectual and Developmental Disabilities Staff
New employees at Strive and Foothills Gateway receive two full weeks of training before beginning to provide any services. These include trainings on the organization, its history and philosophy, its mission, on organizational resources available to the staff, and on basic organizational processes and protocols. Trainings are provided on HIPAA compliance and confidentiality, and the privacy complaint process. Trainings are provided on infection control, and communicable diseases, as well as physical safeguards for employees and the individuals we serve. A full set of training is provided on the rights of individuals, including right to privacy, right to communication, and right to a safe and secure environment. A major emphasis throughout training is on person-centered practices and the autonomy of the individual. A full day of crisis prevention intervention (CPI) is provided as well. On the third day of training, new employees “shadow” experienced staff to begin some “on-the-job” training and to provide new staff with an opportunity to learn in a more experiential fashion. The last two days of the initial training include a half day of medication certification training, and a half day of incident reporting. Wound care training is provided, as well as medication documentation and reminders. New staff receive more training on the values of the organization at this time as well. Transportation training is provided, to teach new staff the protocols for assisting individuals with transportation, including individuals who use wheelchairs.
In the second week of training, new staff receive training on behavioral health services that are available to the individuals we serve. Staff are trained on the values that underlie person centered care, and on the rights and responsibilities of the individuals we serve. Staff receive First Aid and CPR training, as well as training on taking vital signs and providing oxygen when needed. Staff also receive the MANE (Mistreatment, Abuse, Neglect, Exploitation) Prevention training. Additionally, new staff are required to take online trainings that include: Emergency Preparedness, Falls Prevention, Agency Overview, Hazardous Communications, Back Care and Lifting and Bloodborne Pathogens, and Therapy Services.

Existing CCB staff will receive the behavioral health trainings, and behavioral health staff will receive the trainings in working with individuals with I/DD. All new staff members will receive all of the trainings noted above. Once a staff member has completed all of the in-person and online trainings, the staff member begins “on the job” training with the crisis teams, on the crisis stabilization unit, on-site respite/support units, and/or in the residential or vocational sites, and will learn to develop and implement enhanced treatment plans for individual in order to ameliorate new crises. This training occurs continuously and is person-centered towards any individual being served in the Pilot Project and includes chart review, observation and interaction with the person according to identified guidelines, and implementation of new treatment regimens as defined by the person’s multidisciplinary team. This allows staff members to become comfortable with the services, with each other, and with working with staff from other agencies, as well as learn the protocols of each partner organization. This training period will support the development of strong cross-systems team-based relationships, which will be key to this project’s success, as team members are more and more able to rely upon and utilize each other’s expertise to serve the individual.

Additional Supports for All Staff

The partners all have well-established, comprehensive policies and procedures for providing clinical supervision and performance evaluation to all staff, including clinical staff and substance abuse staff. Additionally, RMHP has clear guidelines for coordinating care, as do the CCBs and the Community Mental Health Centers. The CCBs and CMHCs also follow state regulations and guidelines, which will be followed for this project as well. In addition, RMHP has a strong integrated care coordination systems supported with technology, which will be used to ensure that the individual’s care plan and follow-up services are well coordinated across systems. These policies and processes will be utilized throughout the project, and staff will be trained in these before beginning work on the project. Work performed as part of this project will utilize all of these existing policies and procedures to ensure that the provision of clinical supervision is consistent across all clinical staff who provide crisis stabilization services, mobile crisis services, and site-based and in-home therapeutic support services. Practices for providing clinical supervision for licensed/certified staff, unlicensed/uncertified staff, and staff providing
substance use disorder treatment services adhere to Colorado Mental Health Practice Act (C.R.S. 12-43-801) and the Colorado Office of Behavioral Health’s requirements for Clinical Supervision of substance use disorder staff. Administrators on call are licensed and provide backup/supervision of all crisis response teams.

For the majority of the partners, formal and informal performance evaluations occur after the first 90 days of employment and then at least once per year. For SummitStone, a formal evaluation occurs annually. These are conducted by the direct supervisor for each staff.

During their first three months of employment, clinical supervision is provided to licensed/certified and unlicensed/uncertified staff in individual weekly sessions of at least 30 minutes, and one group session of at least 30 minutes monthly. After the first three months of employment, individual supervision is provided at least monthly for at least 30 minutes, along with group supervision at least monthly for a minimum of 30 minutes. Written documentation of both group and individual supervision activities is generated and signed by the supervisor and supervisee. Clinical supervision is provided by licensed clinical staff, including:

- A physician licensed to practice medicine in the State of Colorado.
- A psychologist licensed in the State of Colorado.
- A clinical social worker with a masters or doctoral degree in social work who is licensed in the State of Colorado.
- A nurse with a master’s degree in psychiatric nursing and licensed in the State of Colorado.
- A person with a master’s degree in counseling, psychology or a field relevant to mental health and licensed in the State of Colorado.
- Any other person with a professional education, training and/or experience in a mental health related field, deemed equivalent and proficient by the organization.

It is anticipated that additional clinical supervision and support will be needed for staff providing services, and that the need for this support will vary as the number and intensity of crisis services that are provided varies. All of the community mental health centers involved in this proposal have extensive experience providing clinical supervision and performance evaluation, both on a regular basis and in crisis situations, and are well-prepared to provide these services for staff providing crisis stabilization, mobile crisis, and crisis residential and respite services. The CCBs have extensive experience providing support to their staff members in a similar fashion. Supervision for staff providing substance use disorder treatment services includes the development of an initial supervisory agreement by supervisors and supervisees that includes information about the roles and responsibilities of each party; identification of the supervisee’s core competencies, needs, and goals; a continued competency plan; and a timeline.
for future review of the agreement. The frequency of supervisory sessions is agreed upon at this time, and supervision is provided in accordance with this agreement, with additional support provided as needed.

An open door policy by supervisors who are on site is a major component of the supervision model for the crisis team. Being available to help as needs arise and to support and assist teammates is important. We also have team leaders on each shift who are licensed clinicians with experience to support team members.

Supervisors are on call at all times to provide assistance during difficult situations. Psychiatric consultation and peer support is also available. Formal debriefings are held after difficult crisis events to provide continual learning and performance improvement.

Addition training for new and existing staff that will be provided includes:

1. training on the cross-system goals of the Pilot Project;
2. training for BH staff on how to assess an individual for I/DD, including how to use the current assessment tool, which will be adapted to assess for an I/DD, and how to do both telephone and face-to-face assessments; and
3. training on communication and outreach processes if an individual in crisis has an I/DD.

Continuing training will be provided to all crisis and follow-up staff (including the Behavioral Health staff and I/DD staff) that includes:

1. case reviews to determine what worked well and what could be done better in the future;
2. “just in time” training as challenges are uncovered; and
3. Additional training on collaboration or cross-system training as needed.

There is also training available in Larimer County, as described in the table below. The Colorado Crisis Services contract outlines what trainings staff in the crisis system are to have and by what time-frame (see table below). In addition, the Northeast Crisis Response System has set four months of employment as a minimum timeframe for which all ongoing topics must be covered at least to some extent in a staff’s employment. As such, at least one training for each special population in contract (I/DD, Native American, Veteran, Dementia, Age-related (youth, elderly, etc.), among others listed, must be reviewed by this timeframe.

A record of each staff member’s completed trainings is kept on file for each center where proof or verification of training with date and signature (e.g. sign in or certificate of completion) can be produced if asked.
**Orientation Checklist and Procedure Used to Ensure All Necessary Training and Orientation is Complete**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Facility-Based Support</th>
<th>Mobile Crisis</th>
<th>Respite Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>WITHIN 72 HOURS OF HIRE ALL STAFF:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete a thorough orientation to emergency procedures for the facility/team</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>WITHIN THE FIRST TWO WEEKS OF EMPLOYMENT:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSHA training regarding blood borne pathogens</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency protocols and procedures including fire and disaster response</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PRIOR TO WORKING INDEPENDENTLY, ALL STAFF:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency personnel processes and procedures</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Shadow staff of same designation for observation and orientation to community and processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Peer Specialists Training (40 hours - peers only)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Trauma-Informed Care (4 hours initial training)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Oriented to team and agency policies, procedures and processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Oriented to the Electronic Medical Records and other paper and computer documentation processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cultural awareness and responsiveness including use of translation services (4 hours)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assess for and manage Emergency and Involuntary Commitments</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessing for and managing the 27-65 process including assessment processes, requirements and necessary clinical processes and documentation of short and long-term certifications</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying and reporting critical incidents</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>De-escalation techniques; CPI (8 hours)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Seclusion and restraint processes as appropriate to staff scope of practice and relevant locations (i.e. CCC in Fort Collins will not do Seclusion, but will have restraint capability) (8 hours)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and management of co-occurring disorders including substance use disorders, developmental disorders, dementia, and traumatic brain injury</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Managing individuals with medical concerns and recognizing medical emergencies</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Recognizing and managing withdrawal symptoms and risks</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provision of crisis and clinical assessment, treatment planning processes and discharge planning processes</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and crisis intervention for child, adolescent and family situations</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment techniques for adult populations</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical approaches, assessment techniques and protocols, and crisis management processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
## Orientation Checklist and Procedure Used to Ensure All Necessary Training and Orientation is Complete

<table>
<thead>
<tr>
<th>Training Requirements</th>
<th>Facility-Based Support</th>
<th>Mobile Crisis</th>
<th>Respite Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community resources and emergency protocols throughout the region</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation system and assessing for least restrictive needs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Recovery principles and use of evidence based practices</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Role of Peer Specialists/Family Support</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CPR (8 hours) and First Aid</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>QMAP</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

## Ongoing Training and In-Service Topics Include (at least some training in each topic by 4 months employment)

<table>
<thead>
<tr>
<th>Training Topics</th>
<th>Facility-Based Support</th>
<th>Mobile Crisis</th>
<th>Respite Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>27-65 requirements</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Suicide Assessment/Intervention</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Alcohol/Drug Commitment requirements</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer rights / rights restrictions processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Critical incident reporting</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Refresher Trauma Informed Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fire safety, evacuation and disaster procedures</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Paperwork requirements</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Universal Precautions</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Refresher for de-escalation, seclusion and restraint</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cultural competency training</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Best Practices</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Management of difficult and aggressive behaviors</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Awareness training for special populations including: Veterans and Native American populations; and others as identified</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessment/management of co-occurring substance abuse, developmental, cognitive, brain injury and dementia disorders</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Other training as identified by audit, quality improvement processes and/or management, or offered through OBH</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Training is provided on the Western Slope and available to Larimer, just as Larimer’s trainings are available to the Western Slope. Within 45 days of the Effective Date of the contract, we will submit a final Colorado Crisis Services Training Plan to the Department.
In-Home Therapeutic Support (Offeror’s Response 6-9)

6. **Provide a list of the proposed In-Home Therapeutic Support Team members with current licensing information for each including the type of license the proposed team member possesses and the licenses’ expiration date.**

The In-Home Therapeutic Support Team members will be hired immediately upon signing of the contract for this Pilot Project. Team members will include Bachelor’s and Master’s level (or higher) behavioral health experts, including Board Certified Behavior Analysts (BCBAs), Licensed Marriage and Family Therapists, Licensed Professional Counselors, Licensed Clinical Social Workers, Psychologists, and psychiatrists with many years of direct-supervision experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with developmental disabilities. Other team members will include Bachelor’s level (or higher) behavioral health experts, including Board Certified Associate Behavior Analysts (BCABAs), and Bachelor’s level staff with expertise working with individuals with I/DD. Anyone not licensed will be supervised by a BCBA or other relevant licensed person. Additional team members will be trained and experienced peers. Staff will undergo the training detailed in Offeror’s Response 5. The partners will use their well-established and successful methods of recruiting new staff in their regions and counties, and will also recruit from existing staff and peers where appropriate. The In-Home Therapeutic Support Team staff will be supervised by existing, very experienced staff at the partner organizations.

7. **Provide a detailed description of how the In-Home Therapeutic Support Team will operate.**

Every individual who comes into the Pilot Project (via any of the mechanisms described) will receive an assessment, either by phone or face-to-face. This assessment will include an exploration of potential intellectual or developmental disabilities. If the individual has an intellectual or developmental disability, the individual will begin to be served via the Pilot Project. This means that an expert in I/DD from Strive, Mountain Valley, Community Options, or Foothills Gateway will be brought in immediately, and the behavioral health crisis staff and the I/DD staff will work side by side from that point forward to assist the individual.

Staff will use the program options already in place through the behavioral health crisis system, such as safety contracting, in-home respite and support, or site-based crisis stabilization and support facilities that provide up to a five day length of stay. After the individual has gone through the BH crisis assessment and service system and received short-term supports coordinated by DD and BH staff, they may still require longer-term services. These services will be provided either through In-Home Therapeutic Support or Site-Base Therapeutic support for up to a 30 day period. See the model graphic in the first section of this proposal.
The development and implementation of care plans will be guided and supported by a support team. On the Western Slope this support team is called the DD Assessment, Response, Treatment team (ART team). This team (and a similar team in the Front Range) will be composed of the grant’s care manager, the BCBA, a RN, the HCBS case manager, the primary care physician or designee, and relevant direct care or therapeutic staff, as well as county department of human services staff as needed, the psychiatrist/nurse practitioner from the behavioral health provider and the family/guardian/individual. This team’s role will be to develop and implement a plan to assist the child or adult in changing their environment, learning new adaptive skills, or engaging in counseling/behavioral interventions to further stabilize them emotionally and behaviorally and decrease the frequency and duration of future behavioral crises. Medication management and stabilization will also be an integral part of the program and will be coordinated with the behavioral health provider. A similar multi-disciplinary team will be utilized in the Front Range.

Based on the team’s assessment of types and amounts of in-home support needed, this delivery of service will begin as soon as the person transitions from the crisis response system. Implementation of the support will be primarily implemented by DD behavioral support staff. Revision of strategies will be a continuous process by the team until a treatment regime stabilizes the person for return to their usual activities. This program will be conducted in the person’s home or in a community facility, if that has been their home prior to the crisis.

In order to prevent future crises, the team will follow the person at least monthly during the first three months the person has transitioned out of the pilot by contacting the person and their caregiver to find out how they are doing. As issues arise, the team will further revise the person’s protocol and provide additional staff support as needed in order to avert a crisis. The follow-up after the first three months will be determined on an individual basis. Specific follow-up services will include status reviews of individuals’ stability, quarterly medication monitoring, and monthly HCBS case manager monitoring of the service plan (if the individual is on an HCBS waiver). Individuals who have used the pilot project will be tracked to ensure that issues that resulted in the crisis have not re-occurred.

8. **Provide a detailed description of how the In-Home Therapeutic Support Team will assure that follow-up appointments are monitored and met.**

The In-Home Therapeutic Support Team will assure that follow-up appointments are monitored and met in several ways, with the primary Case Manager leading this effort. First, the care plan and all follow-up services will be tracked in the CCB’s existing tracking tool (Therap or in-house software). The primary case manager will have easy access to details about which services have been recommended, what referrals have been made, and whether these referrals have resulted in services being delivered. Second, the case manager will have ongoing contact with the
individual, and will be able to gather additional information about use of recommended services. Additionally, the case manager’s access to the EMR and CCB service data, and their ongoing contact with the individual and his or her caregivers will provide that case manager with information about whether the services are having the intended impacts – including improved stability and improved quality of life for both the individual and his or her caregivers, reduced number of crises, reduced use of the emergency room, reduced hospital admissions, and other outcomes. Direct care professionals may be assigned to physically assist the person to the appointments as needed.

9. **Provide a detailed description of how the Offeror would coordinate with Members’ current Service Providers and main caretakers.**

The Pilot Project case manager at each site is responsible for coordinating with the individual’s other service providers and caregivers. During the time the individual is engaged with this Pilot Project, the case manager/care coordinator will involve ART team members, current service providers, and family/guardians in the development and implementation of the crisis response and stabilization plan. The case manager will do this through shared communication access, staff meetings and phone calls. Additionally, the case manager facilitates the development of a written plan that is agreed to by all members of the team working with the person.

Within 45 days of the Effective Date of the Contract, RMHP and its partners will submit a final In-Home Therapeutic Support Plan to the Department.

**Site-Based Therapeutic Support (Offeror’s Response 10)**

10. **Provide a Draft Site-Based Therapeutic Support Plan.**

The Pilot Project will provide site-based therapeutic support for individuals with I/DD and behavioral health needs at designated facilities that will provide therapeutically-planned and professionally staffed services 24 hours a day and seven days a week. These services will be provided at two different levels. The first is a 2-5 day transitions-type stay, which can be used as part of an immediate plan to ensure an individual’s safety. The second is a mid-term to longer-term site-based stay, which would be used to develop and implement a new treatment and services plan for an individual to not only help them transition out of crisis, but to help prevent future crises. Facilities that will be used for both the short-term (2-5 day stay) and the mid-term to longer-term (up to 30 days stay) will provide services to individuals who do not need inpatient hospital care, but need more intensive and individualized services than are available in an outpatient setting, including stabilization and crisis management. These facilities will also support individuals as they “step-down” from hospitalization as needed.

All of the partners utilize person-centered, trauma-informed, and strengths-based practices in all of their work, and the services to be provided as part of this Pilot Project will leverage these.
A central and underlying model for this Pilot Project is the START model. The START model is based on Systemic, Therapeutic, Assessment, Resources & Treatment services, and is “a national initiative that works to strengthen efficiencies and service outcomes for individuals with intellectual and developmental disabilities (IDD) and behavioral health needs in the community” (http://www.centerforstartservices.org/). First implemented in 1988 to provide community-based crisis services for individuals with I/DD who were experiencing a behavioral health crisis, it is a person-center approach that is based on other evidence-based practices. It was cited as a model program in 2002 by the U.S. Surgeon General as a comprehensive model of services that supports independence, treatment and community living for individuals with I/DD that has proven results in terms of reduced utilization of the emergency room and inpatient hospital stays, as well as high satisfaction from individuals and their families, lower costs, and strengthened cross-system collaboration.

Additionally, services will be informed by the trauma-informed care services developed by Mind Springs. Mind Springs is one of 37 organizations nationwide chosen to be a part of The National Council for Behavioral Health’s 2013 Trauma-Informed Learning Collaborative. As part of this work, Mind Springs Health is pioneering the concept of trauma-informed care on the Western Slope. Research shows that 90% of community mental health clients have been impacted by trauma at some point in their lives, whether as a child or an adult. Mind Spring has implemented Trauma-Informed Response and Care initiatives in all of its work, and will implement these principals as part of the Pilot Project as well. This includes trauma-informed
assessment, understanding trauma as part of stabilization and treatment, and as part of the development of follow-up services. It also includes helping all community partners, including medical and social services partners, to understand the importance of identifying past trauma as a part of current crises, and to include attention to these traumas in how individuals are supported.

For this Pilot Project, as noted elsewhere, any individual who enters into the existing crisis system, and is determined to have an intellectual or developmental disability will become part of the Pilot Project. If their assessment determines that they need site-based therapeutic support, the individual will be supported by the behavioral health expert and I/DD expert (working together) in making the transition to the site-based therapeutic support setting.

**Short-Term Site-Based Support**

For this Pilot Project, the partners propose to utilize several existing facilities. One facility, based in the Western Slope is called “Transitions”. Transitions is an unlocked, 11-bed facility associated with Mind Springs and is located at 515 28 ¾ Road in Grand Junction. The facility is currently utilized primarily for individuals of all ages who are experiencing a behavioral health crisis. Programming in the Transitions Crisis Stabilization Unit is focused on helping the patient identify the precipitating events and “triggers” for the crisis episode they are experiencing, develop or strengthen tools to cope with difficulties, and heightened awareness of their triggers. Identification of social supports, systems supports available for their use when difficulties arise, and a structured aftercare and follow up plan is constructed. Psychiatrists, physician assistants, psychiatric and family nurse practitioners, peer specialists, therapists, nurses and case managers along with other staff members, work in groups and individually with Transitions patients to accomplish as much as possible in a three to five day length of stay. The current utilization of Transitions averages 2.9 days, with a maximum stay of five days.

Through this Pilot Project, the partners propose to add additional capability to serve individuals with I/DD with support from the local CCB and to provide more services that may be needed by those individuals. Additional support includes the designated Pilot Project case manager and other staff who will come to the facility for team meetings, to provide support and services, and to conduct discharge planning, including coordination with HCBS services, if the individual is enrolled in an HCBS waiver. If the individual is not enrolled in an HCBS waiver, staff will support them in enrolling if appropriate and/or assist them in getting the services they need through the Pilot Project and/or other community services. If, at the end of the five-day stay at Transitions, or at any time during their stay, the individual worsens, the individual may be transitioned to a psychiatric hospital. Individuals in the Western Slope will go to West Springs Hospital and individuals living in the Front Range will have a similar program like Transitions and a hospital. If the individual has stabilized at the end of the five days (or sooner), the individual will be supported by his or her team to return to their place of residence, if
appropriate, or to another residential setting if it is determined (collaboratively with the individual and his or her caregivers) that this will be a more stable and supportive place of residence.

**Mid-Term to Longer-Term Site-Based Support**

If, after the initial crisis response assessment and services implementation, it is determined that an individual needs site-based therapeutic support beyond that offered in the BH system, the individual will be offered I/DD site-based services and the ART/cross-disciplinary team will mobilize to provide these services. This Pilot Project will utilize several options, depending on age of individual, environmental structure the individual requires, and the availability of beds. The main type of sites available for adults are a 1-2 bed home, a bed in one of many existing HCBS Medicaid Waiver group homes, Personal Care Alternatives (PCAs), and host homes. For children, the sites available are a 1-2 bed home authorized through Ariel Clinical Services (in Grand Junction and Delta) to serve children, their children’s residential group home, or a therapeutic foster home. For adults, these sites will be available at all pilot locations and for children will be available in select locations. In Larimer County, Foothills will be developing 3-bed facilities for children and adults.

The primary leased facility-based sites to be used will be either a vacated group home owned by STRIVE and/or a vacated Grand Junction Regional Center (GJRC) group home operated by CDHS. Initially, the site-based services will be offered through the options indicated above, until CDHS and HCPF have developed a leasing process for the state-owned group home. Partners in this grant application have been in contact with Mark Wester, CDHS Director of CDHS’ Office of Community Access and Independence, whose group is responsible for the state-operated group homes. Use of a CDHS property was outlined in the legislation authorizing this Pilot project. The facility will not be locked but will have alarms on the doors and windows. For individuals with AWOL issues, 1 to 1 staff ratios will be provided.

This site-based program will be staffed by a Board Certified Behavioral Analyst, behavioral direct support professionals (B-DSPs), and the Pilot Project care manager. The B-DSPS will be on-site 24/7 and a staff/ client ratio appropriate to the needs of the individuals will be used never to exceed more than one staff to three individuals. Most frequently, a 1 to 1 or 1 to 2 ratio will be in effect. The professional services will be provided by trained, certified, licensed staff. The BCBA and care manager will be on-site daily for varying amounts of time, depending on staff and individual need for support and/or consultation. Medical staff, including physician, nurse, nurse practitioner, psychiatrist and psychiatric nurse practitioner will be on-site weekly, when a case review on each individual in the pilot project will be conducted.

The function of the site-based service will be to develop and implement a treatment and program plan that can be transitioned to the community to allow the person to function as adaptively as possible and decrease crisis events. The strength of this program is that it will
involve a multi-disciplinary team that will also include family and current caregivers, in order that a useful and user-friendly program for the person can be developed; this will help ensure the success of the treatment plan.

Within 45 days of the Effective Date of the Contract, RMHP and its partners will submit a final Site-Based Therapeutic Support Plan to the Department.

**Community Based Mobile Support Teams (Offeror’s Response 11)**

11. **Provide a Draft Community Based Mobile Support Team Report.**

Within 45 days of the Effective Date of a contract, the partners will finalize and submit a Community Based Mobile Support Team Report. The following is a draft of the report, including:

- an overview of how the community based mobile support teams and the model will operate;
- how the team will be staffed 24 hours a day, seven days a week;
- descriptions of the staff that will be assigned to the teams, including licensing information; and
- descriptions of how the teams and the organizations will interface with police departments, schools, hospitals, emergency rooms and Colorado Crisis Services to be advised when a crisis is occurring and how the communication will occur.

The partner organizations will provide Community Based Mobile Support Teams of trained individuals who have the capacity to respond quickly, at any time (24 hours a day, seven days a week) when an individual with I/DD is experiencing a behavioral health crisis. These teams will provide mobile crisis services in the homes and residences of individuals with I/DD, in emergency room, in police stations and jails, in outpatient mental health clinics, schools, and other locations in the community. Behavioral Health mobile crisis teams from Mind Springs and SummitStone already provide these services in these counties, and the Pilot Project will add the capacity for an expert in I/DD to respond with the behavioral health team to ensure that services are cross-disciplinary and supportive of individuals with I/DD. The current teams include licensed and certified therapists and psychologists, and the teams under the Pilot Project will continue to include (and be led by) these certified and licensed experts.

**Staffing**

In all of the counties to be covered by this Pilot Project, medical and psychiatric staff consultation is available 24/7 for emergent issues that may arise during mobile crisis situations, including psychiatrists, psychiatric nurse practitioners and/or physician assistants, and family nurse practitioners. Mobile response staff will be available 24/7 in all counties included in the
Pilot Project. Depending on access to qualified personnel in outlying areas, telehealth options may be used in order to provide the I/DD professional support in initial crisis response.

All mobile response staff who conduct formal crisis evaluations must have a minimum of a master’s degree in a counseling field. Other mobile crisis staff may be trained peers or Certified Addictions Counselors (CACs). There are many criteria for selecting staff to serve as part of mobile crisis teams, including educational background, years of experience, type of experience, approach, and ability to establish rapport quickly and handle crisis situations in a calm, empathetic, and supportive manner. The hiring process includes resume and/or application review, as well as an interview process. The interview process allows for the evaluation of a candidate’s capacity for empathy, respect, and the ability to establish rapport quickly. The hiring manager assesses candidates’ ability to respond to questions and possible situations, and how the candidate would handle those situations.

All staff with expertise with individuals with I/DD must have at least a bachelor’s degree in a human service field and have worked with individuals with I/DD for at least three years. Master’s level therapists and BCBAs will be used as available.

Additionally, candidates must undergo employment pre-screening and background checks. All job offers at all of the partner organizations are contingent upon acceptable results of employment pre-screening and background checks. Human Resources reviews all results of the background checks and notifies the hiring manager of the results. The existence of any negative information does not constitute automatic rejection. The partners are especially sensitive to this issue as it pertains to the hiring of peers. Persons with serious offenses, including assault or child abuse, may be disqualified or terminated from employment.

Background checks include the following. E-Verify program is used to confirm work authorization with the Social Security Administration and, if necessary, the Department of Homeland Security. Professional References are called to confirm previous employment and provide additional information pertaining to their work history. A Criminal Background Investigation and Education Checks are conducted by human resources staff. The Colorado Department of Human Services Background Investigations Unit checks data or information related to child abuse or neglect contained in the TRAILS database for new employees who may interact with children under the age of 18 in any employment capacity. The Colorado Department of Regulatory Agencies is consulted for information about individuals who have Clinical Licensure or Certified Addictions Counselor (CAC) Certification in the State of Colorado, and the status of such certification. Upon hire and on a monthly basis, Human Resources checks the Office of Inspector General Exclusion Program on all employees for convictions specific to program-related fraud, patient abuse, and licensing board actions. This check is also completed for volunteers, student interns, board members and contracted individuals. Motor Vehicle Reports are run as needed, when driving is an essential requirement of the position.
Descriptions of the Staff

Mind Springs Health, Rocky Mountain Health Plans, Strive, Community Options, Mountain Valley Developmental Center, Foothills Gateway, and SummitStone have decades of experience providing behavioral health (BH) services and services for individuals with an intellectual or developmental disability (I/DD) throughout Mesa County, Montrose County, Delta County, and Garfield County (as well as across the Western Slope) and in Larimer County in the Front Range. Mind Springs Health and SummitStone have many years of experience providing mobile crisis services in their respective regions, and both are the Colorado Crisis Response contractors for their regions. Rocky Mountain Health Plans, as the Regional Care Collaborative Organizations (RCCO) for the region, has decades of experience coordinating care and meeting the physical health care needs of individuals in the region. Strive, Mountain Valley, Community Options, and Foothills Gateway have worked with individuals with I/DD and their families and caregivers, coordinating services and ensuring the provision of services, for decades as well. All of these organizations have long-standing and deep relationships within the communities they serve.

With this Pilot Project, the partners have the ability to leverage the existing mobile crisis system and enhance it to fully meet the needs of individuals with I/DD.

Currently, our existing system is strained by a growing demand for services. For example, since 2013, the number of unduplicated clients served by Crisis Services by Mind Springs alone has increased by 10% to 2,342. This is more than 78% higher than in 2012. Currently, WSCA has a 90% rate of keeping people out of higher levels of care following a face to face crisis contact and a 96% rate following a crisis call.

Mind Springs, as part of the Colorado Crisis Response team for the Western Slope, knows how to manage and control access to crisis diversionary services and offers same day appointments to therapy, peer supports, and self help tools such as myStrength. In the Front Range, SummitStone has similar expertise. While not available same day, psychiatry is quickly accessed for the individual. The partners hold a philosophy of services at the lowest level of care and all of the partners leverage natural and community resources to support people at the lowest level of intervention possible. With this funding, enhanced capacity to serve individuals with I/DD who are experiencing a behavioral health crisis will result in the ability to serve anyone who identifies themselves as being in a behavioral health crisis and who has a intellectual or developmental disability, with no barriers.

By providing a cross-disciplinary crisis response team and a cross-disciplinary care planning team, as well as the ability to track all crisis services within the CMHC’s EMRs and follow-up services in the CCBs’ IT systems, outcomes and experience of care will be improved, and costs will be lower as a result of preventing hospitalizations, emergency room visits, and Regional Center admissions. Importantly, because the partners already have the infrastructure and relationships in place, enhanced services and integration can begin immediately.
All individuals with I/DD across the region who need services will be able to access mobile crisis services in a multitude of ways. Specific details about how mobile crisis services will be provided to specific populations are provided below. The partners hold the belief that people in crisis are just that: people in need of assistance, regardless of diagnosis or etiology, and we are committed to serving this population.

**Individuals Served**

**Ability to Pay, Place of Residence, and Ability to Pay**

Everyone who is believed to have an I/DD and is in crisis will be served, regardless of their ability to pay, and mobile crisis services are provided to all individuals, regardless of where they live. Many people travel to the Western Slope and Front Range and we serve any person in need of crisis supports. Mobile crisis services will be provided equally for all age groups, and mobile crisis teams are trained on providing crisis services to all ages. All of the partners have experience and expertise working with individuals of all ages, and providing behavioral health services, including crisis services, across the life span.

**Individuals Presenting with Aggressive Behaviors**

An important part of providing crisis services is being able to help de-escalate crisis, including de-escalating aggressive behaviors. Existing mobile crisis teams are trained in managing people who present with aggressive behaviors through verbal de-escalation. Crisis team members are also taught to recognize signs and triggers that could cause an explosive episode. Crisis Prevention Intervention (CPI) or Crisis Intervention Training (CIT) is provided to all crisis staff and teaches verbal techniques designed to de-escalate rising aggressive behaviors, and how to most effectively respond to each behavior to prevent the situation from escalating. Staff can effectively use verbal and nonverbal techniques to defuse hostile behavior and resolve a crisis before it becomes violent, using Principles of Personal Safety taught in the Crisis Prevention and Intervention training or other self-developed program to teach verbal de-escalation techniques (which all staff complete) to avoid injury if behavior becomes physical.

Only as a last resort, law enforcement support will be engaged to help appropriately serve people who present with significant aggressive behaviors, and we will help law enforcement engage in ways that do not endanger the person needing assistance. Mind Springs, Strive (and the other partners) have a strong history of working with law enforcement and supporting Crisis Intervention Training (CIT) or Crisis Prevention and Intervention (CPI) training. If, during mobile crisis activities, it is determined that an individual needs Crisis Stabilization Unit (CSU) intervention, the CSU will be able to provide emergency medications to assist individuals in decreasing their aggression as there will be a psychiatrist and pharmacy available 24/7.

**Individuals with Co-Occurring Medical Needs**

As noted above, the partners hold the belief that people in crisis are just that; people in need of assistance, regardless of diagnosis or etiology. A behavioral crisis requires intervention
regardless of etiology. Mobile crisis staff members are trained in providing crisis services to people with co-occurring medical needs. All individuals receiving mobile crisis will be screened for any medical conditions that may need immediate attention or that may be contributing to the crisis episode. If there are immediate issues which may require emergency care, local Emergency Departments will be utilized.

**Individuals with Substance Use Disorders**

At times, behavioral health symptoms with developmentally disabled as well as the general population are due to a medical condition or are substance-induced, precipitating a crisis. Mobile crisis staff will utilize established protocols for transport, medical clearance and substance use testing, where these issues are suspected, before determining the appropriate intervention.

**Accessing the Mobile Crisis System and Collaboration with the Existing Colorado Crisis System**

The current mobile crisis system on the Western Slope, which Mind Springs manages, works closely with the statewide call line awardee to design a seamless system for dispatch. The narrative below describes how dispatch currently works. Mind Springs currently has 24/7 crisis lines with the capacity to dispatch mobile crisis services across Mesa and Garfield Counties to respond to schools, hospital emergency rooms, jails, primary care offices, and other business locations, as well as respond to a scene as requested by law enforcement or an individual’s home. Additionally, all of the counties currently work with the statewide crisis hotline and have established protocols. The same is true of SummitStone in the Front Range. As the contractor for that region’s Colorado Crisis Response project, SummitStone already works closely with and collaborates with that initiative and the statewide crisis line. As noted elsewhere in this proposal, the partners will collaborate closely with the statewide crisis line as part of this Pilot Project.

Mind Springs has an 800 number for crisis calls in the counties it serves, including the counties (Mesa and Garfield,) that would be part of this Pilot Project. All calls are routed to the Mesa County 24/7 call center. Any local crisis numbers are also routed to the Mesa call center. That call center is able to dispatch all mobile response needs across all 10 counties 24/7 as well as serve walk in crisis. For the counties served by SummitStone and Foothills Gateway, calls are answered 24/7 by an answering service that routes calls to Master’s level clinicians, who respond within 15 minutes to the crisis call. All face to face or telehealth responses are one hour or less in urban areas (Mesa and Larimer) and in all other areas (Delta, Montrose, and Garfield counties), the response time is two hours or less.

In the rare instances when weather or other environmental conditions prohibit mobile teams from responding to a crisis situation immediately, or for crises in Montrose, Delta, and Garfield Counties, Mind Springs and Midwestern Colorado MHC already use telehealth capacity or provides telephone assistance until the mobile crisis team is able to respond to the location.
Additionally, mobile crisis teams work with community partners, such as acute care hospitals, to provide assistance, including identifying and using appropriate local resources, until a mobile crisis team is able to respond.

Mind Springs, SummitStone, and Midwestern Colorado MHC have more than 50 trained clinicians who can and do respond to crises in Larimer, Mesa, Garfield, Montrose, and Delta Counties, and have vehicles that assist with providing mobile crisis services in these counties. These vehicles allow crisis teams to provide alternative transportation to individuals who would otherwise be transported by ambulance or police, both of which are traumatic for individuals and more costly for the system.

All requests for mobile crisis services, including those received by the statewide hotline vendor, have a response. In the event of multiple calls or requests at one time, imminence, safety and impact to the community are the primary factors considered in a triage process. The prioritization process determines how teams are dispatched to respond to the multiple calls. Multiple mobile crisis teams and increased staffing are available during high volume times to ensure that all calls can be responded to in a timely manner.

The first order of business is engaging and assessing the individual. Using a person-centered approach, staff are trained to engage people in crisis and to simultaneously assess for risk. Often by using engagement skills first, a crisis is diverted and the person shifts to a different emotional state. This allows for lower levels of intervention to be the most successful. This focus on engagement supports the individual and contributes to their recovery. Next, each individual is assessed for an intellectual or developmental disability. If such a disability is present or suspected, the crisis staff will immediately outreach the I/DD staff and the I/DD staff will join in supporting the individual immediately.

**Services Provided as Part of Mobile Crisis**

For the current mobile crisis services system, individuals who are experiencing a behavioral health crisis are in a state of need and must have a response regardless of where the call for assistance originates from. This will remain the same, as will many of the processes. However, critical additions and enhancements are planned to serve individuals in crisis who also have an intellectual or developmental disability. Both the current system, and the enhancements are described below.

Once a contact is made, the crisis provider conducts an initial assessment. If it is determined or suspected that the individual may have an intellectual or developmental disability, the crisis provider immediately contacts the developmental disabilities specialist, who will join the BH crisis provider in all next steps, working collaboratively as a team. Both the BH and the I/DD specialist work together to conduct additional assessment and evaluation and help determine needed next steps for the individual.
If face to face mobile crisis services are requested or indicated, a mobile team is dispatched, which includes both a BH specialist and a I/DD specialist. Time to response is tracked as is the number of mobile dispatches, disposition, and the referral source requestor. This team then assists with linking the individual with community supports and creates a plan for utilizing those services and supports. Same day/next day appointments with therapists and peers are available, as are home and community services (regardless of whether the individual is enrolled in Medicaid or an HCBS waiver). Additionally myStrength, a self-help web based tool, is available and provided throughout the region for anyone who needs it, at no cost. We understand this tool may not be utilized by the individual with I/DD depending on their abilities, but that myStrength can also be used by individuals in the supports system, such as parents, caretakers and other professionals, as a resource for self-care and learning coping strategies.

Any crisis response starts with engagement and meeting the person “where they are at”. Sometimes people present due to a personal trauma or triggers and successful engagement can be effective at de-escalating the crisis intensity.

In the intervention process, the following stages occur, again including both the I/DD and the BH specialist: engagement, strengths assessment, personal supports assessment, identification of the major concerns, dealing with feelings and provide support, lethality and safety needs assessment, exploring possible alternatives, formulation of an action plan and follow up measures. A focus is always on preventing a hospitalization and using natural strengths and supports. If it is determined through the assessment that a more intensive level of care is needed, the team will arrange for the care needed and remain with the individual in crisis until that level of care is accessed.

During the interview, many different evidence-based strategies are utilized to best engage clients in the process, including Motivational Interviewing, which recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. It is non-judgmental, non-confrontational and non-adversarial. The approach attempts to increase the individual’s awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. A person in crisis needs to be empowered, given choices, options and resources, encouragement and hope. Some of the skills and best practices to accomplish this involve active listening, encouragement, paraphrasing, reflecting, emotional labeling, validating, reassurance and waiting.

Another evidence-based practice upon which this model is predicated is that START model. As noted previously, the START model is based on Systemic, Therapeutic, Assessment, Resources & Treatment services. Cited as a model program in 2002 by the U.S. Surgeon General, START provides a comprehensive model of services that supports independence, treatment and community living for individuals with I/DD that has proven results in terms of reduced
utilization of the emergency room and inpatient hospital stays, as well as high satisfaction from individuals and their families, lower costs, and strengthened cross-system collaboration.

Another evidence-based strategy that will be utilized (in addition to the entire process and approach being person-centered) is client-centered therapy, also known as person-centered therapy, which is a non-directive form of talk therapy. These interventions seek to understand the individual in his/her unique circumstances and how that individual’s personal preferences and goals can be maximally incorporated into the crisis response plan. Additional evidence-based strategies that will be utilized include problem-solving, use of Dialectical Behavior Therapy (DBT) skills, and the development of safety plans. Following a crisis experience, the case manager, who has specific expertise working with individuals with I/DD will work closely with the individual and his or her caregivers to assure transition and follow up as well as to offer support. This way we assure no one “falls through the cracks”.

The partners hold the following principles at the center of the work:

- All people are eligible to receive crisis services
- Engagement and strength building is the first response
- There is a focus on hospital diversions
- The crisis staff remains as a support with the person until full disposition is achieved
- Following a crisis experience, the Pilot Project case manager works closely with the individual to assure continuity, assess further needs, and assure good transition and follow up services.

Screening

The partners will enter all crisis services provided into Midwestern Colorado MHC/Mind Spring’s or SummitStone’s EMR and therefore use the same protocols for assessing a crisis situation. The current mobile crisis system has a standard screening form, which will be adapted to include specific items that will be most relevant for individuals with I/DD, including assessing whether individuals have received assistance from organizations such as (or similar to) Strive, Mountain Valley, Community Options or Foothills Gateway, received special services while in school, or have had previous access to personal assistance services. The screening tool also includes a specific suicide screen, and a brief medical screen. Mental health and substance abuse concerns are both inquired about and collateral information from friends or family members is also taken into consideration. Information about an individual’s developmental or intellectual disability may also be gathered from caregivers and/or family members or others who are involved with the individuals existing care plan, if one exists. A standard Crisis Assessment tool is currently used, and will be adapted to include assessment for I/DD. The current tool is part of the CareLogic Electronic Medical Record, and the adapted tool will be
part of this EMR as well. Both the face-to-face version and the phone version are provided, as
Attachments A and B. For this Pilot Project, data on every individual who is served will be
entered into the Qualifacts, Carelogic Electronic Medical Record (EMR) or SummitStone’s EMR,
using these tools. History of violence and trauma are evaluated. The tool that is currently used
is the WSEBICAT: West Slope Evidence-Based Integrated Crisis Assessment Tool, which is
included as Attachment C.

Mobile crisis responders will provide screening and triage to all individuals presenting in crisis,
to include screening for I/DD, suicidality, the potential for violence, and experiences of and
exposure to trauma. Additionally, as appropriate, the Level of Care Utilization System (LOCUS)
and CALOCUS (Child and Adolescent Level of Care Utilization System) level of care tools will be
used to validate the interview process and level of care placement decisions (Attachments D
and E).

In addition, behavioral health staff members are trained in Maslow’s hierarchy of needs and
Trauma Informed Care concepts and utilize these concepts when conducting triage, screening,
and assessment. Additionally, the Primary Care Post Traumatic Stress Disorder (PC PTSD) 4-
question trauma assessment tool may be used. After the individual has been stabilized and the
initial crisis has been resolved, the DD experts will determine whether the ULTC 100.2 and
Supports Intensity Scale (SIS) have been used with the individual to help develop a care plan for
the individual and to determine needs.

Peers
The integration of consumers, peers, and family members in the delivery of crisis services is
critical because they are often better able to connect with individuals experiencing a behavioral
health crisis since they may have gone through similar events themselves or with a loved one.
With this connection, they can help calm and reassure the individual, as well as facilitate
transitions of care and ensure that individuals connect with needed resources later.

In all of the counties that would be served by this Pilot Project, peers, consumers, and family
members are already integrated into the mobile crisis response process in a variety of ways. For
example, Mind Springs has a team of peer specialists that are utilized in the referral and
planning processes for individuals experiencing a behavioral health crisis. The partners currently
integrate peers in services provided to individuals in hospital settings, in outpatient programs,
and as part of case management planning. Family members are included in care planning,
safety planning, and identification of supportive resources. The individuals experiencing a
behavioral health crisis are at the center of care efforts, and are an active part of their own care
and planning.
Additionally, peers and family members will be utilized even more in this Pilot Project. Peers will be part of the site-based and in-home support teams, as part of the transportation process, and in discharge planning from an inpatient facility.

De-Escalation
An important part of providing crisis services is being able to help de-escalate crisis. The Crisis Prevention and Intervention (CPI) training on de-escalation (a 16-hour training) or Crisis Intervention Training, which is completed by all staff, are the primary trainings provided, and include not only verbal de-escalation, but other techniques to defuse a crisis. These techniques include, but are not limited to, the use of comfort foods, gliders/rockers or music, which can elicit soothing feelings; allowing the person in crisis to have safe, alone, quiet time; empathy and reflection; and problem-solving during immediate crisis.

Crisis team members are also taught to recognize signs and triggers that could cause an explosive episode and how to respond to aggressive behavior. Through CPI training or CIT, crisis staff are taught how to verbally de-escalate rising aggressive behaviors, and how to most effectively respond to each behavior to prevent the situation from escalating. Staff can effectively use verbal and nonverbal techniques to defuse hostile behavior and resolve a crisis before it becomes violent. Crisis staff are also taught the Principles of Personal Safety to avoid injury if behavior becomes physical.

If, during mobile crisis activities, it is determined that an individual needs site-based support services, the facility-based staff will be able to provide needed interventions to decrease aggression, including emergency medications. Seclusion rooms, while required to be built for licensure, are the absolute last resort for managing aggressive behavior. A specific philosophy is to not use “force” in a crisis situation.

Service Coordination and Referral Plans
Because mobile crisis teams, DD staff, BH staff, and the case managers for this Pilot Project live and work in the regions in which they provide services, these teams and staff are intimately familiar with and connected to resources in the community. They have clear channels of communication with community resources and are able to link individuals with needed supports.

After triage, screening and assessment have been completed, the crisis team will connect the individual with a case manager who is specifically part of this Pilot Project. This case manager will work with the individual, his or her caregivers and other supportive individuals, and with existing providers to assess ongoing needs to prevent future crisis. The ART will be brought in at this point to assist with development of the most appropriate and useful plan. Service plans may range from a plan to stay in the community with connections to peers, family members, and other natural supports and community resources and follow-up by the case manager;
referral to more intensive BH and DD services (same or next day appointments are available); transfer to site-based therapeutic support services or in-home therapeutic support services, or, if needed, to a psychiatric hospital.

Telehealth capacity is available in all of the counties and would be utilized to support the delivery of crisis services, respite services and therapy services, as appropriate. Secure Telehealth provides a high-quality, web-based, encrypted, video conferencing service to the behavioral health community using cloud computing. With this vast array of telehealth equipment, many services would be offered via this network. These services include crisis evaluations, psychiatric assessments, follow up therapy (with a covered provider or preferred provider) consultation and psychiatric consultation. Many hospitals and emergency rooms in the region have telehealth capability as well so these services are offered for persons in crisis in those facilities also.

Interface with Police Departments, Schools, Hospitals, Emergency Rooms, and other locations

Community Partners

Because of the long history these organizations in the counties in which they provide services, many of the local community partnerships and resources needed to provide supports and services are already in place. This includes relationships with Emergency Departments of local hospitals, law enforcement, jails, Departments of Human Services, FQHCs, rural Health Clinics and schools, HCBS service providers, and others.

In order to ensure that needed resources continue to be identified, and to continue to build and strengthen relationships with community partners, the partners will continue the outreach activities in which they already participate, and will continue to build new relationships. Examples of the processes that are used to identify local community partners and resources include Mind Springs’s participation in monthly community Task Force meetings with local partners, including law enforcement, area hospitals, Veterans services, probation and parole, County Attorney’s offices, healthcare providers, and others. As another example, Mind Springs, RMHP and Strive participate in the Mesa County Health Leadership forum. The informal Mesa County Crisis Collaborative composed of Strive, Ariel Clinical Services, Hilltop Institute, RMHP, MCDHS, and Mind Springs meets monthly to discuss individuals who are in crisis or who appear to be moving towards crisis. This group makes specific assignments to agencies to help resolve these problems. This group will be acting as an advisory group to this Pilot Project.

In all of the counties, the partners have strong relationships and partnerships with local resources with they will leverage to effectively provide the expanded and enhanced services proposed as part of this Pilot Project. Each of the partners has relationships with multiple community partners with which it will collaborate in order to ensure that needed resources can be accessed for individuals with I/DD who are experiencing a behavioral health crisis, who need crisis stabilization services, and who are being discharged from crisis stabilization services.
<table>
<thead>
<tr>
<th>Type of Resource</th>
<th>Purpose of Partnership</th>
<th>Examples of Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Crisis Hotline/Warm Line</td>
<td>Coordinate crisis calls, ensure efficient/effective dispatch of appropriate crisis stabilization resources in a timely way</td>
<td>Colorado Crisis Services</td>
</tr>
<tr>
<td>Statewide Crisis Marketing Entity</td>
<td>Share information to ensure that people in crisis are aware of services available</td>
<td>Cactus Marketing</td>
</tr>
<tr>
<td>Primary Care Providers</td>
<td>Address and meet co-occurring behavioral health and medical needs</td>
<td>The partners have well established partnerships with primary care and FQHCs across the region. See letters of support for details.</td>
</tr>
<tr>
<td>Behavioral Health Providers</td>
<td>Provide behavioral health services to help prevent crises, to help people in crisis, and upon discharge from CSU, residential/respite, other facilities</td>
<td>Mind Springs, SummitStone, Private providers</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>Coordinate assistance to people experiencing behavioral health crisis, transportation to appropriate services, and reduce additional trauma to people in crisis</td>
<td>The partners have established relationships with local police departments and sheriff’s offices in counties across the region.</td>
</tr>
<tr>
<td>Hospital Emergency Departments</td>
<td>Coordinate assistance to people experiencing behavioral health crisis, facilitate transportation to appropriate services, reduce additional trauma to people in crisis</td>
<td>The partners have well established relationships with the hospitals in the counties.</td>
</tr>
</tbody>
</table>

**Specific Community Resources that will be Leveraged**

**Emergency departments**

There are Emergency Departments (EDs) in all of the counties. The partner organizations have good working relationships with these EDs, and are contracted by the hospital and accustomed to providing support to people in crisis in EDs. Additionally, there is a Level 1 Trauma Center in Grand Junction that serves the entire region and the Front Range is served by Poudre Valley Hospital. Formal contract agreements are currently in place with the hospitals, and these allow the partner crisis teams to evaluate those individuals in need and then work collaboratively to establish a treatment plan.

**Police, sheriff and emergency medical services**

There is established law enforcement presence in all of the counties, including police, sheriff and emergency medical services, and the partners work with them regularly. Longstanding, collaborative relationships have been formed between every local law enforcement department as well as all county Sheriff’s Departments and the partners. These relationships include collaborative Front Line Intervention teams, assistance during crises, partnerships in Detox Collaboratives, and CIT training. The partners provide training to all law enforcement
personnel in Mental Health First Aid, as well as in trauma-informed practices. Partnerships also
exist with Emergency Medical Services (EMS) teams. These teams provide education and
training to detox personnel, crisis teams, and mental health center staff. They also attend
collaborative community meetings for detox and Front Line Intervention teams. There are
emergency response plans in place with these agencies. Emergency Medical Services are
accessed throughout the region via “911” in all counties, Emergency Departments are available
throughout the region, and the partners work closely with these Emergency Departments.

Physical healthcare providers
Each of the partner organizations has established working relationships and shared staff with
Federally Qualified Health Centers (FQHCs) and other health clinics. Mind Springs has
behavioral health staff in all of the FQHC settings in the counties. Additionally, the partners also
have staff in many primary care offices. The Midwestern Colorado MHC, for example, has staff
in nine primary care offices and two hospitals.

Additionally, Rocky Mountain Health Plans offers one of the largest provider networks in
Colorado, with the following:

- 2,542 primary care doctors
- 7,535 specialists
- 6,647 non-physician specialty providers
- 103 hospitals
- 700 outpatient facilities
- 870 pharmacies
- 88 ambulatory surgery centers

For individuals who are experiencing a behavioral health crisis, but who also have physical
health needs, these existing relationships will help with coordinating care and ensuring that
people get the care they need across the continuum.

School and university health systems
Mind Springs and SummitStone have provided crisis line, mobile crisis services and other
behavioral health services for decades, including services to students from all of the schools in
the counties. These relationships will help provide strong linkages for individuals in the region’s
schools and universities who may need mobile crisis and other crisis services. Midwestern
Colorado MHC offers services in three schools in Delta and Montrose, including a day treatment
program and a school based health clinic. Additionally, RMHP has relationships with the schools
listed in the table in Offeror’s Response 3.

Child welfare and child protective services
There are established Department of Human Service (DHS) agencies in all of the counties. The
partners work closely with these agencies and have existing contracts for core services that
could be utilized upon discharge. The partners maintain strong, collaborative working relationships and contracts with Child Welfare and Child Protective Services in all of the counties. In addition, the partners participate in DHS adult and child protection teams, have contracts with family drug courts, and provide day treatment services.

Aging and adult protective services
There are established Department of Human Service (DHS) agencies in all of the counties. The partners work closely with these agencies and have existing contracts for core services that could be utilized upon discharge. Mind Springs has strong relationships with Adult Protection Teams in the counties in the Western Slope, and with the region’s Areas on Aging, as well as with nursing homes and assisted living facilities. The Midwestern Colorado MHC also works with its region’s Areas on Aging. SummitStone has equally strong partnerships in Larimer County. The partners all participate on Adult Protection Teams.

Coordination with Other Services

Insurance/Medicaid benefits
Individuals receiving mobile crisis services who need to apply for Medicaid, HCBS waivers, or other insurance benefits will be supported in completing applications once they have been stabilized. If an individual who is experiencing a behavioral health crisis is transported to a crisis stabilization unit (CSU) or to residential or respite services, those staff will encourage individuals to apply for Medicaid or insurance benefits, and will assist them with applications. We are committed to billing insurance/Medicaid/Medicare as available.

Other benefit/assistance programs
Individuals who need to apply for other benefits or assistance programs will be able to do once they are stabilized, and the case manager will provide support.

Psychiatric hospitalization
If psychiatric hospitalization is needed, that option exists within the region’s continuum of care. The mobile crisis team would refer the individual to the Mind Springs psychiatric hospital (West Springs Hospital), or another facility on the Front Range (Mountain Crest Hospital) if necessary.

Substance abuse treatment providers
If substance use disorder treatment services are needed, the mobile crisis team would help link the individual with these services, and make referrals as necessary. Mobile crisis staff would also provide follow-up services to ensure client has engaged in services. Additionally the partners offer detox sites in the counties, which offer outpatient substance use disorder treatment.

Physical and medical services
The partners have solid partnerships, awareness of services and agencies and relationships that will allow us to make the appropriate referrals and connections with the right physical and
medical services at the right time. These include relationships with FQHCs and other clinics throughout the region, as well as hospital emergency departments and primary care providers. Mobile teams will be able to do basic assessments of individuals for medical needs and connect with the appropriate medical providers if needed.

Peer/family services
Peer specialists will be an integral part of the range of crisis services. In terms of mobile crisis services, peers will be utilized to help with transporting individuals, and will be available at respite and residential sites, as well as crisis stabilization units, to help individuals who are transferred there, to help ease transitions, and build engagement and connections. WSCA believes strongly that family needs to be involved and that often involvement of family can prevent a hospital admission.

Natural supports
The partners believe strongly in helping individuals identify and use the natural supports in their environment, and helping individuals build these supports. This belief is core to our service delivery, as it speaks to our belief in the individual as a person who has strengths that can and should be utilized in their recovery. Our collaborative discharge/safety planning processes reflect that and allow for each individual who is utilizing mobile crisis services to be able to have their voice and their wishes considered as an integral part of their plan. Family, friends, work, school, and favorite activities are all part of potential natural supports that would be utilized and valued in helping individuals return to their daily lives and find recovery.
Follow-Up Services Plan (Offeror’s Response 12)

12. Provide a detailed description of how the Contractor will assure that follow-up appointments are monitored and met.

The partners in this Pilot Project have extensive experience and expertise working with individuals, their caregivers and their family members to develop and implement comprehensive service plans, and ensuring that follow-up appointments are met and that needed services are delivered. Strive, Mountain Valley, Community Options, and Foothills Gateway have been coordinating services and ensuring that services are delivered to individuals with I/DD for decades.

This Pilot Project will meet several unmet needs in terms of follow-up services and appointments. First, the ART/cross-disciplinary teams will support the development of a cross-system service plan that provides behavioral health services and support services that are fully informed by the full spectrum of the individual’s needs – both their behavioral health needs and their needs related to their intellectual or developmental disability. Second, the involvement of both the CCB and the CMHC means that the resources that are brought in to support the individual will be more comprehensive, because the organizations together can rely upon the other’s knowledge and expertise. Third, the Pilot Project will provide funding to provide services and resources to individuals who are not enrolled in Medicaid and/or an HCBS waiver, and who do not have private insurance (or whose insurance does not cover the needed services).

The Pilot Project will enhance and create new resources to support cross-network care coordination during a crisis. Once the crisis is resolved, follow-up services are provided to ensure that people get what they need, including access to new or different HCBS waiver services. The coordination and management will be supported and monitored via EMRs and the CCBs IT systems.

If any individual appears to be experiencing a crisis or about to go into crisis, and before an assessment has occurred, the Pilot Project will test and implement a new Emergency Enrollment process. Specifically, to ensure that the needed services are provided and that follow-up appointments are monitored and met, the partners will implement a number of steps.

1. First, an assessment will be made to determine whether an individuals has insurance coverage or is enrolled in Medicare and/or Medicaid and the appropriate HCBS waiver. If so, that insurance, Medicare and/or Medicaid will be utilized as a payer or services, to the degree possible. If not (or if the individual has insurance that does not cover the needed services), the case manager (who will be employed by the CCB, and will work as part of the ART Team and the individual’s care team) will work to determine what the
individual is eligible for and needs and, if appropriate, will work to enroll the individual in Medicaid and the appropriate HCBS waiver.

a. This will include:

i. working with the individual to complete and submit a Medicaid application;

ii. completing the ULTC 1000.2 form which includes a Physician’s Medical Information Page signed by a physician. This alerts CDHS that the individual needs a functional assessment under the HCBS-Mental Illness Medicaid, which results in an assessment within 48 working hours of the referral; and

iii. working with CDHS to complete a financial eligibility assessment and complete the functional assessment eligibility. During this time period, which can be up to 30-45 days, the Pilot Project will pay for needed services. Also during this time period, the Pilot Project may pay the individual’s rent, while working to determine the individual’s social security (SSI or SSDI) status.

a. This may also include “Emergency Enrollment” process that will expedite enrollment. If an individual is in need of an emergency enrollment we have a multi-step process, which can be completed within a 3-4 week period if everything needed is provided and available. This includes immediately conducting the Developmental Disability Determination (which requires documentation that demonstrates disability prior to 22 years of age; a Medical diagnosis- of a neurological condition; needs that are not due solely to mental health; and an IQ or Adaptive assessment that meets state criteria). If the individual meets criteria, we will then immediately send a request to the state to approve an immediate emergency slot, which would only be approved if there is high risk to self or others. Once approved, the CCB will then conduct the two assessments: the Supports Intensity Scale and the ULTC 100.2 to speak to the level of need and strengths of needs of the individual. Throughout this Emergency Enrollment Process, the individual will be receiving services through the Pilot Project.

2. Next, the ART/cross-disciplinary team, which will include the case manager, will work with the individual, and his or her caregivers and family members, to ensure that the care plan that is developed is comprehensive, person-centered, and supportive of the individual.
3. Next, the case manager will coordinate all services, including non-Medicaid services, to include: psychiatric resources, medical resources, social resources, educational resources, and other resources that the individual may need.

4. All services will be tracked in the EMR, and will be reviewed by the case manager on an ongoing basis to ensure that services are being delivered and resources are being utilized. If services are not being utilized, the case manager will conduct immediate outreach to the individual and his or her caregivers to determine whether this is because the resource is truly not needed, or if there are barriers to it being delivered. If there are barriers to utilization, these will be explored with the individual, his or her caregivers, and the providers of the services to determine solutions.

5. Case managers will provide ongoing monitoring, case management, and support to individuals. For individuals who are enrolled in an HCBS waiver, case managers will continue to monitor individuals after stabilization to ensure that the crisis causing issues continue to be addressed. Monitoring includes regular psychological review meetings, with more frequent meetings as needed. Monitoring medication use is another key function of stabilization, and medications are monitored via the EMR and by case managers who will go to an individuals' residence to make sure they are taking their medication. Case management typically occurs via both in person and telephonically, with face to face contacts at least monthly for individuals who are stable. Changes to the service plan are made based on progress and status in programs the person attends, upon request of individual or family and if the case manager becomes aware of an issue to be addressed. Families, service providers and the monitoring the case manager regularly does alert them to potential crises.

6. All services that may be billed to insurance carriers, Medicare, and Medicaid will be billed. For services that cannot be billed, the partners will utilize Pilot Project funds. Case managers will continually monitor each individual’s eligibility for and enrollment in insurance, Medicare and/or Medicaid and will utilize those payers as they become available.

7. Case managers will also continually monitor individuals to determine whether and when they may be discharged from the Pilot Project. This will generally occur when the person’s goals have been met and they are able to return to their usual community or when they can receive all their services through another payer.

The Pilot Project will protect any individual from being denied services, especially if they do not have access to an HCBS waiver. In every case, case managers will work to find the right resources, do warm handoffs to other agencies, and make sure they are getting the resources they need.
Within 45 days of the contract Effective Date, the partners will provide to the Department a formal description of its Follow-up Process, which will include:

- a description of the follow-up process the partners will implement and use to assure that I/DD individuals are receiving the follow-up care necessary to avoid a future crisis;
- a full description of follow-up services that are available to be used including medical, social, education and psychiatric resources;
- how all resources will be billed and tracked; and
- how case management services will ensure cross-system collaboration and ensure that appointments are monitored and met, and that all needed services are provided and utilized.

Service Gap Data Collection (Offeror’s Response 13-14)

13. Provide a detailed description of how the data required in Section 5.9 will be collected.

How the Data will be Collected

The partners understand that a key goal of this project is understanding and measuring the impact of a new model of behavioral health crisis services for individuals with an intellectual or developmental disability. Data to be collected for this Pilot Project include, but are not limited to:

- all individuals participating in the Pilot Project and receiving services;
- the support types and services types provided to each individual;
- the cost of providing these services with a cost offset;
- the number and demographic profile of people who are unable to qualify to service billing either through the BHO or the CCB waiver programs. This will help inform HCPF what barriers to treatment exist.
- the length of stay in which crisis situation stabilized;
- the follow-up care each individual required after the initial crisis situation was resolved; regardless of whether the services were utilized; and
- the delivery system for services.

The partners will gather all of the data required in the RFP, primarily through EMRs already used for the state’s crisis system, and the CCB’s IT systems. Much of these data are already collected as part of the Colorado Crisis Response System initiative, including all behavioral health crisis and follow-up service data (including facility-based care), cost data, and reimbursement data. The CCBs already collect data for all of the services that they currently
provide through the waiver, and an analysis of both systems cost and utilization will be completed as it applies to people in crisis. This will include cost data, and data indicating the payer, whether Medicaid, Medicare, private insurance, the Pilot Project, or some other source.

In the first several weeks of the project, adaptations may be made to the existing crisis EMRs to capture the collaborative crisis response possible by this grant. This will assure the strengths of both the existing crisis system and the CCBs are available to people with co-occurring needs at the time of crisis. Also in the first several weeks of the project, Mind Springs and SummitStone will provide training to CCB staff on data collection and entry of crisis response data into their respective EMRs and will provide ongoing support and technical assistance as needed to ensure data are captured accurately and in a timely fashion.

All crisis service data are entered into the EMRs at the time of the service. Follow-up data will be entered into the CCBs’ service tracking systems. Data will be transferred from EMRs and other service tracking systems to Mind Springs, who will collate weekly.

As part of its existing Crisis Services Response Project, Mind Springs has created a dashboard of analytics that it uses to conduct rapid-cycle evaluation of its services, using the data to make program improvements, and that it uses to report process and outcome data to the State. The dashboard utilizes Tableau, a business intelligence software that allows for easy connections to data, and the ability to visualize and create interactive, sharable dashboards and reports. A sample of the existing dashboard for the Colorado Crisis Service project is provided below, and the full dashboard may be viewed at: [http://www.westslopecasa.com/WSC-Reporting/](http://www.westslopecasa.com/WSC-Reporting/).
The dashboard currently includes reporting on the number of respite, mobile crisis, and crisis stabilization visits; referrals made, referrals kept, decrease in suicidality; timeliness; engagement in treatment and planning; voluntary engagement; critical incident tracking; previous contacts within 15, 30, 60 and 90 days; client satisfaction; and the percentage of kept referrals. It is anticipated that reports will be generated for this project that are similar to those in the dashboard for the Crisis Services Project.

14. Provide a detailed description of how the Offeror will suggest changes that may be required to provide better services to I/DD Members in crisis.

To develop a strong understanding of changes that may be required to provide better services to individuals with I/DD who are in crisis, and to make suggestions about changes that may be required, the partners will collect and analyze all of the data noted above. In addition, the partners suggest a rigorous, mixed-method evaluation of the Pilot Project that will allow us to:

1. make suggestions for changes that may be required to the model to make it as effective and efficient as possible;
2. develop and enhance best practices; and
3. support the state in developing lessons learned to support replication and sustainability as well as to identify policy barriers.

To fully explore the impacts of our model and address these goals, our evaluation would work to answer the following evaluation questions. Following the list of evaluation questions is a list of data sources, methods, and proposed analyses.

**Process Evaluation Questions**

1. How was the model implemented? What were the primary challenges in implementation and how were these overcome?
2. What can we learn about how the model was implemented that will support future implementation, replication, and sustainability?
3. What differences were there in implementation between the Front Range and the Western Slope? What difference were there between rural and urban settings? What did we learn from implementation that will support efforts to implement a model in these settings in the future?
4. How many people with I/DD were served by the Pilot Project, and in which regions? How were they served and what services were provided to them?
5. To what degree were services well-coordinated for individuals?
Outcome Evaluation Questions

Overall Outcomes

1. What were the outcomes of the crisis intervention efforts for individuals served?
   a. What percentage of individuals who received crisis services were able to return to their home without needing site-based support or higher levels of care? What percentage of individuals transitioned to short-term site-based support, mid-term or longer-term site-based support, or to a psychiatric inpatient hospitalization?

2. Among the individuals who entered the Pilot Project and received services, what percentage had additional behavioral health crisis and when did these occur?

3. To what degree are health care outcomes being impacted by the Pilot Project?
   a. Using EMR data for individuals who are served by the Pilot Project over a longer time period (six months or longer), to what degree have individuals’ health outcomes changed since being served in the Pilot Project?

4. To what degree are overall health care costs being impacted by the Pilot Project?
   a. Using EMR data for individuals who are served by the Pilot Project, has their utilization of hospital, emergency department, and other high cost services changed?

Services and Best Practices Questions

1. Which services were most useful for individuals? Which were perceived to be least useful?

2. Which services are most critical and valuable for preventing future crisis?

3. Where are there gaps in services that still need to be met?
   a. What are recommendations for meeting these?

4. What best practices are emerging from this work? What evidence do we have that these are effective?

Collaborative Questions

1. Are the collaborations between individual I/DD and behavioral health crisis team members strong and effective?

2. Are the collaborations at the system level strong and effective? To what degree do they support the activities of the Pilot Project?
   a. Where are there areas of weakness in the collaborations?
Satisfaction and Quality of Life

1. To what degree do individuals report high satisfaction with services, including crisis services, stabilization services, in-home and site-based support services, and follow-up services?

2. To what degree do family members and caregivers report satisfaction with services?

3. Do services provided through this Pilot Project have an impact on quality of life for individuals, their families and their caregivers?

Financial and Return on Investment (ROI) Questions

1. What were the costs of providing the services that were provided through this Pilot Project?
   a. What were the costs to private insurance, to Medicaid, to Medicare, to other funding sources, and how much funding for services came from this Pilot Project?

2. What can we estimate to be cost savings that were generated by the activities of the Pilot Project, either via reduced unnecessary Emergency Room utilization/costs, hospitalizations and costs, Regional Center admissions and costs, or via reduced costs due to improved physical health?
   a. What data do we have to suggest that Pilot Project activities may have contributed to cost savings?

Sustainability Questions

1. To what degree is this model sustainable and replicable?

2. What resources are needed to make the model sustainable over time?

3. What policy barriers should be considered and addressed to support sustainability?

As with the data required by the RFP, a primary data source to answer some of these evaluation questions will be the Mind Springs’/Midwestern’s EMR and Summit Stone’s EMRs, and follow-up service data that will be tracked in the CCBs’ systems.

To explore whether the project has an impact on health outcomes and costs, we propose a study design that would analyze utilization and health quality measures for all people served by the Pilot Project in the Western Slope, by linking individuals’ Pilot Project service and cost data with Rocky Mountain Health Plans data on their health care utilization and quality measures. Two options exist for analyzing these data and generating findings. One would utilize health care utilization, cost and quality data for those individuals served in the Pilot Project, comparing their utilization prior to the launch of the Pilot Project to their utilization and costs once the Pilot Project is launched. Using interrupted time series analyses, we could explore changes in
trends and the impact of the Pilot Project, controlling for many threats to internally validity, such as regression to the mean. This analysis would allow us to explore the impact of the Pilot Project on reducing ED visits, hospitalizations, other institutional care, and other high cost services, but also assess the impact of the project on reducing crisis incidences and on improving health outcomes. Alternatively, another approach (which could be used in addition to the interrupted time series analyses of pre and post utilization and cost) is to compare Pilot Participants’ utilization, costs, and outcomes to those of a group of individuals who are known, but are not served in the Pilot Project would make up a comparison group. By comparing utilization and costs of the individuals served in the Pilot Project with a similar group that did not access services, it is possible to explore the impacts of the project on costs and utilization. RMHP and its partners will use HIE resources to match individuals. To select one of these two described approaches, the Pilot Project partners will consult with the Department, subject matter experts and community stakeholders about which approach produces an evaluation that is of the greatest value to the Department.
## Table of Evaluation Questions and Data Sources

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<th>Evaluation Question</th>
<th>Area of Interest</th>
<th>Data Sources</th>
<th>Frequency of Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>How was the model implemented? What were the primary challenges in implementation and how were these overcome? What can we learn about how the model was implemented that will support future implementation, replication, and sustainability?</td>
<td>Process</td>
<td>Interviews with staff and document review</td>
<td>Quarterly</td>
</tr>
<tr>
<td>What differences were there in implementation between the Front Range and the Western Slope? What difference were there between rural and urban settings? What did we learn from implementation that will support efforts to implement a model in these settings in the future?</td>
<td>Process</td>
<td>Interviews with staff and document review</td>
<td>Quarterly</td>
</tr>
<tr>
<td>How many people with I/DD were served by the Pilot Project, and in which regions? How were they served and what services were provided to them?</td>
<td>Process</td>
<td>EMR and CCB data</td>
<td>Monthly</td>
</tr>
<tr>
<td>To what degree were services well-coordinated for individuals?</td>
<td>Process</td>
<td>Interviews with staff, caregivers, and EMR data</td>
<td>Bi-annually</td>
</tr>
<tr>
<td>What were the outcomes of the crisis intervention efforts for individuals served?</td>
<td>Outcome</td>
<td>EMR data</td>
<td>Monthly</td>
</tr>
<tr>
<td>What percentage of individuals who received crisis services were able to return to their home without needing site-based support or higher levels of care? What percentage of individuals transitioned to short-term site-based support, mid-term or longer-term site-based support, or to a psychiatric inpatient hospitalization?</td>
<td>Outcome</td>
<td>EMR data</td>
<td>Monthly</td>
</tr>
<tr>
<td>How do these numbers compare with previous years, before the Pilot Project was implemented?</td>
<td>Outcome</td>
<td>EMR data</td>
<td>Bi-Annually</td>
</tr>
<tr>
<td>How do these numbers compare with previous years, before the Pilot Project was implemented?</td>
<td>Outcome</td>
<td>EMR data</td>
<td>Bi-Annually</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Area of Interest</td>
<td>Data Sources</td>
<td>Frequency of Data Analysis</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Among the individuals who entered the Pilot Project and received services, what percentage had additional behavioral health crisis and when did these occur?</td>
<td>Outcome</td>
<td>EMR data</td>
<td>Quarterly</td>
</tr>
<tr>
<td>How do these numbers compare with previous years, before the Pilot Project?</td>
<td>Outcome</td>
<td>EMR data</td>
<td>Quarterly</td>
</tr>
<tr>
<td>To what degree are health care outcomes and costs being impacted by the Pilot Project?</td>
<td>Outcome</td>
<td>EMR and RCCO data</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Using EMR data for individuals who are served by the Pilot Project over a longer time period (six months or longer), to what degree have individuals’ health outcomes and utilization changed since enrolling in the Pilot Project, compared with health outcomes and utilization (especially ED usage, hospital stays and other high cost services) prior to the Pilot Project?</td>
<td>Outcome</td>
<td>EMR and RCCO data</td>
<td>Bi-Annually</td>
</tr>
<tr>
<td>Which services were most useful for individuals? Which were perceived to be least useful?</td>
<td>Outcome: Services and Best Practices</td>
<td>Regular, existing focus groups help by each of the partners</td>
<td>Annually</td>
</tr>
<tr>
<td>Which services are most critical and valuable for preventing future crisis?</td>
<td>Outcome: Services and Best Practices</td>
<td>Interviews with individuals served, caregivers and family members; interviews with key staff</td>
<td>Annually</td>
</tr>
<tr>
<td>Where are there gaps in services that still need to be met? What are recommendations for meeting these?</td>
<td>Outcome: Services and Best Practices</td>
<td>Analyses of EMR service data compared with care plans; Interviews with individuals served, family members, caregivers, and key staff</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Area of Interest</td>
<td>Data Sources</td>
<td>Frequency of Data Analysis</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>What best practices are emerging from this work? What evidence do we have that these are effective?</td>
<td>Outcome: Services and Best Practices</td>
<td>Synthesis and review of all of the above data</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Are the collaborations between individual I/DD and behavioral health crisis team members strong and effective?</td>
<td>Outcome: Collaboration</td>
<td>Interviews and/or focus groups</td>
<td>Annually</td>
</tr>
<tr>
<td>Are the collaborations at the system level strong and effective? To what degree do they support the activities of the Pilot Project?</td>
<td>Outcome: Collaboration</td>
<td>Interviews and/or focus groups</td>
<td>Annually</td>
</tr>
<tr>
<td>Where are these areas of weakness in the collaborations?</td>
<td>Outcome: Collaboration</td>
<td>Interviews and/or focus groups</td>
<td>Annually</td>
</tr>
<tr>
<td>To what degree do individuals report high satisfaction with services, including crisis services, stabilization services, in-home and site-based support services, and follow-up services?</td>
<td>Process and Outcome: Satisfaction and Quality of Life</td>
<td>Focus groups and/or interviews</td>
<td>Annual</td>
</tr>
<tr>
<td>To what degree do family members and caregivers report satisfaction with services?</td>
<td>Process and Outcome: Satisfaction and Quality of Life</td>
<td>Focus groups and/or interviews</td>
<td>Annual</td>
</tr>
<tr>
<td>Do services provided through this Pilot Project have an impact on quality of life for individuals, their families and their caregivers?</td>
<td>Process and Outcome: Satisfaction and Quality of Life</td>
<td>Focus groups</td>
<td>Annual</td>
</tr>
<tr>
<td>What were the costs of providing the services that were provided through this Pilot Project?</td>
<td>Outcome: Costs and ROI</td>
<td>EMR data</td>
<td>Monthly</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Area of Interest</td>
<td>Data Sources</td>
<td>Frequency of Data Analysis</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>--------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>What were the costs to private insurance, to Medicaid, to Medicare, to other funding sources, and how much funding for services came from this Pilot Project?</td>
<td>Outcome: Costs and ROI</td>
<td>EMR data</td>
<td>Monthly</td>
</tr>
<tr>
<td>What can we estimate to be cost savings that were generated by the activities of the Pilot Project, either via reduced unnecessary Emergency Room utilization/costs, hospitalizations and costs, Regional Center admissions and costs, or via reduced costs due to improved physical health?</td>
<td>Outcome: Costs and ROI</td>
<td>EMR data</td>
<td>Monthly</td>
</tr>
<tr>
<td>What data do we have to suggest that Pilot Project activities may have contributed to cost savings?</td>
<td>Outcome: Costs and ROI</td>
<td>All of the above data</td>
<td></td>
</tr>
<tr>
<td>To what degree is this model sustainable and replicable? What resources are needed to make the model sustainable over time?</td>
<td>Outcome: Sustainability</td>
<td>All of the above data</td>
<td></td>
</tr>
</tbody>
</table>
Using all of the data noted in this section, the partners will create and submit to the Department annually, a Service Gaps Report that will note where service gaps exist, and recommendations for solutions to eliminate those gaps. Our analysis will include geo-mapping of where individuals reside and where services were provided, as well as where service providers are located, to continue to shed light on where services may be limited geographically. Additionally, our analysis will examine types of services and assess where there may be gaps, by examining differences in service plans and actual service utilization. Where there are discrepancies, we will conduct interviews with case managers, individuals served and their family members and caregivers to determine whether services were not utilized because they were not needed, or if they were not utilized because they were not available or there was a utilization barrier such as distance to the provider, lack of a cultural competent provider, lack of timely response, or other issue. As gaps are identified, key Pilot Project staff will work together to identify resources in the community that may be brought forward to meet the gap. If no resources can be found, the Pilot Project staff will work with the state and with local community leaders to identify solutions.

The partners are aware of several current, known service gaps, and the Pilot Project is designed to fill these. First, one current, known service gap is that crisis response lacks the immediate supports accessible by the CCB system. Essentially, there are two different systems responding to a behavioral crisis. This Pilot Project will immediately close this gap by assuring a joint response as appropriate. A second gap is that individuals sometimes “get lost between agencies” and don’t know who to turn to. The Pilot Project will be working to fill this gap by providing this cross-system, collaborative, and coordinated model of crisis response and provision of follow-up services, and by providing more intensive tracking of referrals to follow-up services, which case managers will be able to do, with the support of the team and the integrated EMRs. A third known, current service gap is that individuals and their caregivers and family members are often unaware of services that are available to them to prevent crisis, support individuals during crises, and support them after a crisis episode to help develop skills and supports needed to prevent future crises. The Pilot Project will be working to meet that gap by developing stronger cross-system collaboration that will help inform providers and individuals being served about the full range of resources available to them within both the behavioral health system and the system of care for individuals with I/DD. Fourthly, a known gap is the lack of adequate services to support individuals with I/DD who are nonverbal and are experiencing a behavioral health crisis. By working together as a team, the behavioral health crisis responder and the I/DD expert will be able to rely on each other’s strengths and expertise in these situations and will, therefore, be more equipped to support individuals with these needs.
Every year, by June 15, the partners will develop and submit to the Department as Best Practices Report that identifies methods for establishing best practices that can be duplicated throughout the state. These reports will be based on the data, evaluation and lessons learned described above, and will support the state in its efforts to sustain and replicate this most effective components of this Pilot Project.
Attachments

Attachment A: Face to Face Crisis Assessment Tool
Attachment B: Phone Crisis Contact Tool
Attachment C: WEBSICAT
Attachment D: LOCUS
Attachment E: CALOCUS
Attachment F: Resumes
Attachment G: Letters of Support
Attachment A: Face to Face Crisis Assessment Tool
Session Information

Client: Glover, Hulk (1125162) 12/19/1978
Staff: McClinton, Krista (176)

Service Date/Time: 10/20/2015 8:30 AM - 9:00 AM

Client Program: Crisis (CRISIS)
Activity: Crisis - Assessment (CRS AST*)
Organization: Vail Clinic
Service Location: 53 - Community Mental Health Center

Pre Test Suicide Likert Scale:

01. Occasional thoughts of suicide, not frequent. Thoughts do not cause stress.
02. Thoughts become more frequent, feel more personal.
03. Thoughts of suicide are frequent, accompanied by feeling you may want to commit suicide.
04. Thoughts of suicide are frequent. Consistently feel like you want to die.
05. Thoughts of suicide occur everyday. Almost everything reminds you of suicide and death.
06. Thoughts of suicide, death, dying everyday. Causes you great stress.
07. Obsessed with thoughts of suicide. Start to make a plan. Strong desire to die/end suffering.
08. Begin to put plan in place. Convinced you will commit suicide. Nothing to live for.
10. In the midst of implementing your plan for suicide. Determined to commit suicide.

ES - Emergency Event

Activity:

☐ 1. Suicidal
☐ 2. Homicidal
☐ 3. Gravely Disabled
☐ 4. Other Support

Precipitating Event:
That led to Emergency Situation test

Pertinent History:

test

Strengths and Resources:

☐ 01. Able to Articulate Needs
☐ 02. Motivated to change and learn
☐ 03. Acknowledgement of Psychiatric Problem
☐ 04. Verbal Skills
☐ 05. Compliant with Medication
☐ 06. History of Fair/Good Med Compliance
☐ 07. Currently Employed/Attending School
☐ 08. Enjoys Outdoor Interests
☐ 09. Expresses Desire to Change
☐ 10. Financially Independent
☐ 11. History of Fair/Good Response to Medication
☐ 12. Hobbies and/or Special Interests
☐ 13. Independent in ADL Skills
☐ 14. Insight into Illness/Problem
☐ 15. Intellectual Ability
☐ 16. Knows/Uses Community Resources
☐ 17. Open to Learning New Behaviors
☐ 18. Physical Health
☐ 19. Potential for Insight
☐ 20. Prior Response to Treatment
☐ 21. Recognition of Substance Use Problem
☐ 22. Social Skills
☐ 23. Spirituality
☐ 24. Stable Housing Situation
☐ 25. Supportive Family/Friends
☐ 26. Acculturation/Assimilation
☐ 27. Linguistic/Communication
☐ 28. Socioeconomic Status
## ES Dangerousness Assessment

### SUICIDE

<table>
<thead>
<tr>
<th>Applicable to Client?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### HOMICIDE

<table>
<thead>
<tr>
<th>Applicable to Client?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### OTHER

#### Physical Abuse History:
- 0. No Risk - None Reported
- 1. Low Risk - Minimal Abuse
- 2. Moderate Risk - Moderate Abuse
- 3. High Risk - Severe Abuse

#### Sexual Abuse History:
- 0. No Risk - None Reported
- 1. Low Risk - No Abuse Reported
- 2. Moderate Risk - Abuse Reported
- 3. High Risk - Severe Abuse

#### Substance Abuse:
- 0. No Risk - None Reported
- 1. Low Risk - Social Use
- 2. Moderate Risk - AoD Abuse Hx Not Under Influence
- 3. High Risk - AoD Dependent and/or Under the Influence

#### MH Symptoms:
- 0. No Risk - None Reported
- 1. Low Risk - Mild Symptoms
- 2. Moderate Risk - Moderate Symptoms
- 3. High Risk - Severe/Acute

#### Impulsivity:
- 0. No Risk - Normal
- 1. Low Risk - Occasional
- 2. Moderate Risk - Frequent
- 3. High Risk - Persistent

#### Comments:


### Child/Adolescent Dangerousness Assessment (0-18):

- Concentration or memory problems
- Death of a family member
- Fantasy of being killed
- Fantasy of suicide
- Fluctuating moods and energy levels
- Frequent crying episodes
- History of involvement with juvenile authorities
- History of pervasive patterns of impulsivity
- Irritability
- Isolating self
- Low energy or fatigue
- Media stories about suicide
- Monotonous voice
- Mood congruent delusions
- N/A
- Not enrolled in school or regularly truant
- Not living with natural parents or parent absent
- Parent or close relative who attempted suicide
- Recent abortion
- Recent divorce, other family disruption or intense family conflict
- Recent rejection by significant other
- Recent suicide or gesture among peer(s)
- Recently discovered pregnancy
- Sad postures and facial expression
- Serious disturbance of appetite
- Significant school problems
- Slow Speech
- Somatic complaints
- Talk of hopelessness
- Talk of suicide
- Unresponsive to environment
- Withdrawal from significant peers

---

Glover, Hulk (1125162) 2 of 9 Date Printed: 12/15/2015 12:17 PM
ES Grave Disability Assessment

N/A: ◯ n/a

ASSESSMENT FOR MEETING CRITERIA FOR GRAVELY DISABLED

Is client in danger of serious physical harm due to his/her inability or failure to provide himself/herself the essential human needs of:

- Clothing
- Medical Care
- Food
- Shelter

Does client lack judgment in the management of his resources and in the conduct of his/her social relations to the extent that his/her health or safety is significantly endangered and lacks the capacity to understand that this is so?

- ◯ Yes
- ◯ No

Has there been notice given that the support given by the family member or other individual who has a similar relationship to the person (may not include an employee or agent of a boarding home or treatment facility) is to be terminated?

- ◯ Yes
- ◯ No

If yes, Check appropriate additional criteria:

Is diagnosed by a professional person as suffering from any one of the following:

- ◯ Chronic schizophrenia
- ◯ a chronic major affective disorder
- ◯ a chronic delusional disorder
- ◯ other chronic mental disorder with psychotic features

If other chronic mental disorder with psychotic features

Has been certified for treatment of such disorder

- ◯ Yes
- ◯ No

Has been admitted as an inpatient to a treatment facility for treatment of such disorder at least twice during the last 36 months with a period of at least 30 days between certifications or admissions

- ◯ Yes
- ◯ No

If admitted:

Is exhibiting a deteriorating course leading toward danger to self or others or toward the conditions described with symptoms and behavior which are substantially similar to those which preceded and were associated with his/her hospital admissions or certifications for treatment.

- ◯ Yes
- ◯ No

Is not receiving treatment which is essential for his health or safety.

- ◯ Yes
- ◯ No

Is mental retardation/organic disorder a part of the clinical picture for this client?

- ◯ Yes
Is mental retardation/organic disorder the sole reason for their gravely disabled designation?

- Yes
- No

Additional comments:

ES Current Substance Use

Current Substance Use:
- Yes
- No

Comments:

Current Tobacco Use:
- Yes
- No

Comments:

Toxicology:
- Yes
- No

BAC done:
- Yes
- No

Comments: If Yes, explain

Use of IV Drugs:
- Yes
- No

Comments: If Yes, explain

ES Medical History

Current Medication(s) and Prescriber/PCP:

Pregnant:
- 1. Yes
- 2. No
- 3. Unknown

Current Medical Conditions:
- 1. None Reported
- Asthma
- COPD
- Chronic Pain
- Coronary Artery Disease
- Dementia
<table>
<thead>
<tr>
<th>Developmental Disability</th>
<th>Obesity</th>
<th>Terminal Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Other</td>
<td>Thyroid Condition</td>
</tr>
<tr>
<td>Hypertension</td>
<td>TBI</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

### Previous Treatment Information

<table>
<thead>
<tr>
<th>Treatment Location:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Duration:</td>
<td></td>
</tr>
<tr>
<td>Treatment Type:</td>
<td></td>
</tr>
<tr>
<td>Medications Prescribed:</td>
<td></td>
</tr>
</tbody>
</table>

**Reason/Diagnosis:**

Client compliant with treatment?  
- Yes  
- No

### Additional Provider

<table>
<thead>
<tr>
<th>Treatment Location:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Duration:</td>
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</tr>
<tr>
<td>Treatment Type:</td>
<td></td>
</tr>
<tr>
<td>Medications Prescribed:</td>
<td></td>
</tr>
</tbody>
</table>

**Reason/Diagnosis:**

Client compliant with treatment?  
- Yes
Additional Provider

Treatment Location:

Date/Duration:

Treatment Type:

Medications Prescribed:

Reason/Diagnosis:

Client compliant with treatment? ○ Yes ○ No

Client DSM Diagnosis as of 10/20/2015 09:09 AM

Client: Glover, Hulk (1125162) 12/19/1978
Effective Date/Time: 10/20/2015 09:09 AM
External Diagnosis: No
Diagnosed By: McClinton, Krista (176)
Comments:

Diagnosis

<table>
<thead>
<tr>
<th>DSM-5</th>
<th>ICD-10</th>
<th>SNOMED</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F43.20 - Adjustment disorders, unspecified</td>
<td>F43.20 - Adjustment disorder, unspecified</td>
<td>17226007 - Adjustment disorder</td>
<td></td>
</tr>
</tbody>
</table>

The Diagnoses above display in priority order.
A - Attached Diagnosis

Psychosocial and Contextual Factors

<table>
<thead>
<tr>
<th>ICD-10 Code - Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z56.9 - Other Problem Related to Employment</td>
<td></td>
</tr>
</tbody>
</table>

Diagnostic Formulation

ES Face-to-Face Information

Contact Date: 10/20/2015
Time of Initial Service Request: 07:00 am
### Response Time to Referral:
- 07:15 am
- 07:15 pm

### Type of Service Requested:
- Routine

### Referral Source:
- Other

### Face-to-Face Assessment Details:
- **Date:** 10/20/2015
- **Assessment Start Time:** 08:30 am
- **Assessment End Date:** 10/20/2015
- **Assessment End Time:** 09:00 am
- **Assessment Site:** Center Office

### Payor:
- Self Pay

### Current Therapist/Psychiatrist:
- asdf

### Contact Person:
- asdf

### Contact Relationship:
-

### Crisis Disposition

**Safety Plan:**
- Yes
- No

**Details:**
- Family
- Friends
- Other Professionals
- Follow up with Crisis Team
- Home

### Specific Safety Plan:

### Payer:
- Medicaid
- Medicare
- Private Insurance
- Other
- Self-Pay
- Uninsured

### Referrals Made:
- 01. First Responder
- 02. Admission to CSU
- 03. Respite/Residential Service
- 04. Medical Admission/ER Services
- 05. Referral to Outpatient Behavioral Health Services
- 06. Safety Planning with Discharge Home
- 07. Safety Planning with Discharge Other
- 08. Admission to Psychiatric Hospital
- 09. Admission to ATU
- 10. Admission to Detox
- 11. Other Referral

### List All Referrals/Name of Agencies Referred To:
- AXIS ATU
- Boulder Community Hospital
- Bridge House ATU (Arapahoe/Douglas Mental Health Network)
- Cedar Springs Health System
- Centennial Peaks
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Lighthouse ATU</th>
<th>Parkview Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado Mental Health Institute at Fort Logan</td>
<td>Lutheran Medical Center - West Pines</td>
<td>Peak View Behavioral Health</td>
</tr>
<tr>
<td>Colorado Mental Health Institute at Pueblo</td>
<td>Medical Center of Aurora (Gero-Psychiatric Unit)</td>
<td>Porter Adventist Hospital</td>
</tr>
<tr>
<td>Denver Health Medical Center/Division of Psychiatric Service</td>
<td>Mind Springs Psychiatric Hospital</td>
<td>Poudre Valley Hospital</td>
</tr>
<tr>
<td>Haven Behavioral Senior Care of North Denver</td>
<td>Mountain Crest Regional Behavioral Healthcare Center</td>
<td>Spanish Peaks Mental Health Center ATU</td>
</tr>
<tr>
<td>Haven Behavioral War Heroes Hospital</td>
<td>N/A</td>
<td>The Children's Hospital</td>
</tr>
<tr>
<td>Highlands Behavioral Health System</td>
<td>North Colorado Medical Center</td>
<td>Veterans Affairs Medical Center - Denver</td>
</tr>
<tr>
<td>Hilltop ATU</td>
<td>North Range Behavioral Health ATU</td>
<td>Veterans Affairs Medical Center - Grand Junction</td>
</tr>
<tr>
<td>Capacity/Beds</td>
<td>Payer</td>
<td>TBI/DD</td>
</tr>
<tr>
<td>Medical</td>
<td>Substance Use</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Status of Referrals:**
- Referral Packet, Decisions Made, Etc.

**Location of Client while Looking for Higher Level of Care:**
- Local Hospital/ER
- MHC Office
- N/A
- Other

**Final Disposition:**
- 1. Placed in ATU
- 2. Placed in Respite
- 3. Placed in a Psychiatric Hospital
- 4. Safety Plan
- 5. Other

**Other:**
- Unable to Participate
- Yes
- No
- 1. Very Dissatisfied
- 2. Dissatisfied
- 3. Neutral
- 4. Satisfied
- 5. Very Satisfied
- 6. Unable to Collect

**Did a Critical Incident Occur During this Episode of Care?**
- Yes
- No

**Did Client Participate in the Plan of Care?**
- Yes
- No

**Client's Satisfaction with this Crisis Service:**
- Very Dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very Satisfied
- Unable to Collect

**Post Test Suicide Likert**

**Post Suicide Likert Scale:**
- 0. No thoughts about suicide. This is how an average person feels about suicide.
- 1. Occasional thoughts of suicide, not frequent. Thoughts do not cause stress.
- 2. Thoughts become more frequent, feel more personal.
- 3. Thoughts of suicide are frequent, accompanied by feeling you may want to commit suicide.
- 4. Thoughts of suicide are frequent. Consistently feel like you want to die.
- 5. Thoughts of suicide occur everyday. Almost everything reminds you of suicide and death.
- 7. Obsessed with thoughts of suicide. Start to make a plan. Strong desire to die/end suffering.
- 10. In the midst of implementing your plan for suicide. Determined to commit suicide.

**Signatures**
**Signature #1:** Krista McClinton (LPC) - 10/20/2015 9:25 AM

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Signed</td>
<td>10/20/2015</td>
<td>Krista McClinton (LPC)</td>
</tr>
</tbody>
</table>
Session Information
Client: Glover, Hulk (1125162) 12/19/1978
Staff: McClinton, Krista (176)
Document Date: 12/10/2015
Client Program: (Not Set)

Crisis Aftercare

Contact Made:  ○ Yes  ○ No

Referrals Made
First Responder:  ○ Kept  ○ Made  ○ N/A
Respite/Residential Service:  ○ Kept  ○ Made  ○ N/A
Outpatient Behavioral Health Services:  ○ Kept  ○ Made  ○ N/A
Medical Admission/ER Services:  ○ Kept  ○ Made  ○ N/A
Safety Planning with Discharge Home:  ○ Kept  ○ Made  ○ N/A
Safety Planning with Discharge Other:  ○ Kept  ○ Made  ○ N/A
Admission to Psychiatric Facility:  ○ Kept  ○ Made  ○ N/A
Admission to CSU:  ○ Kept  ○ Made  ○ N/A
Admission to Detox:  ○ Kept  ○ Made  ○ N/A
Other Referral:  ○ Yes  ○ No

List Other:

Signatures
Validation Issues: Error: Requirements not met for Crisis Aftercare.

Electronic Signature: The document can not be signed until the errors above are resolved.

Signature History
Action
Date
Staff
No records found
Follow-Up Crisis Disposition

Safety Plan: Yes
No
Payer: Medicaid
Medicare
Other
Private Insurance
Self-Pay
Uninsured

Referrals Made:
01. First Responder
02. Admission to CSU
03. Respite/Residential Service
04. Medical Admission/ER Services
05. Referral to Outpatient Behavioral Health Services
06. Safety Planning with Discharge Home
07. Safety Planning with Discharge Other
08. Admission to Psychiatric Hospital
09. Admission to ATU
10. Admission to Detox
11. Other Referral

List All Referrals/Name of Agencies Referred To:
AXIS ATU
Boulder Community Hospital
Bridge House ATU (Arapahoe/Douglas Mental Health Network)
Cedar Springs Health System
Centennial Peaks Hospital
Colorado Mental Health Institute at Fort Logan
Colorado Mental Health Institute at Pueblo
Denver Health Medical Center/Division of Psychiatric Service
Haven Behavioral Senior Care of North Denver
Haven Behavioral War Heroes Hospital
Highlands Behavioral Health System
Hilltop ATU
Lighthouse ATU
Lutheran Medical Center - West Pines
Medical Center of Aurora (Gero-Psychiatric Unit)
Mind Springs Psychiatric Hospital
Mountain Crest Regional Behavioral Healthcare Center
N/A
North Colorado Medical Center
North Range Behavioral Health ATU
Parkview Medical Center
Peak View Behavioral Health
Porter Adventist Hospital
Poudre Valley Hospital
Spanish Peaks Mental Health Center ATU
The Children's Hospital
Veterans Affairs Medical Center - Denver
Veterans Affairs Medical Center - Grand Junction

If Admission is Denied by any Facility, Select Reason:
Capacity/Beds
Medical
Substance Use
Transportation

Status of Referrals: Referral Packet, Decisions Made, Etc.

Location of Client while Looking for Higher Level of Care:
Local Hospital/ER
MHC Office
Other

Final Disposition: Mind Springs - Follow Up Crisis Disposition
1. Placed in ATU
2. Placed in Respite
3. Placed in a Psychiatric Hospital
4. Safety Plan
5. Other

Signatures

Validation Issues: Error: Requirements not met for Follow-Up Crisis Disposition.

Electronic Signature: The document can not be signed until the errors above are resolved.

Signature History

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**Session Information**

<table>
<thead>
<tr>
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<th>Glover, Hulk (1125162) 12/19/1978</th>
</tr>
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<tbody>
<tr>
<td>Staff:</td>
<td>McClinton, Krista (176)</td>
</tr>
<tr>
<td>Document Date:</td>
<td>12/10/2015</td>
</tr>
<tr>
<td>Client Program:</td>
<td>(Not Set)</td>
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</tbody>
</table>

**DAP Note**

- **Is this Activity Interactive?**
  - ☐ Yes
  - ☑ No

- **Contact Type:**
  - Description: 

- **Assessment:**

- **Plan:**

**Signatures**

**Electronic Signature:**

**Signature History**

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Glover, Hulk (1125162) 1 of 1 Date Printed: 12/15/2015 12:17 PM
Attachment B: Phone Crisis Contact Tool
Mind Springs - Crisis Phone Contact

**Session Information**

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<tr>
<td>Staff:</td>
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<tr>
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<td>12/15/2015</td>
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<tr>
<td>Client Program:</td>
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</tr>
</tbody>
</table>

**Crisis Phone Contact V1.2**

- **Time of Initial Service Request:** [ ]
- **Type of Service:** [ ]
- **Telephone Number:** [ ]
- **Phone Contact Start Time:** [ ]
- **Referral Source:** [ ]
- **Payor:** [ ]
- **Summary of Phone Contact:**

**Client DSM Diagnosis as of 12/15/2015 01:19 PM**

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<td>Effective Date/Time:</td>
<td>12/15/2015 01:19 PM</td>
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<td>External Diagnosis:</td>
<td>No</td>
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<td>Diagnosed By:</td>
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<td>Comments:</td>
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### Diagnosis

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<th>ICD-10</th>
<th>SNOMED</th>
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The Diagnoses above display in priority order.

A - Attached Diagnosis

### Psychosocial and Contextual Factors

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### Diagnostic Formulation

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</table>

Mind Springs - Crisis Phone Contact
Attachment C: WEBSICAT
Session Information

Client: Glover, Hulk (1125162) 12/19/1978
Staff: McClinton, Krista (176)
Service Date/Time: 1/12/2016 9:00 AM - 9:30 AM

Client Program: Mental Health Outpatient - Adult (MHOP-A)
Activity: Diagnostic Evaluation (DIAG EV*)
Organization: Vail Clinic
Service Location: 53 - Community Mental Health Center

Presenting Problems/Previous Treatment

I have verbally reviewed the following and provided copies where required, regarding confidentiality and mandated exclusions, Disclosure Statement, orientation to the agency and programs/services

Disclosure/Consents: ❑ Yes ❑ No
Is this Activity Interactive? ❑ Yes ❑ No

Presenting Problem: Client's description of presenting problem and current symptoms. Why is the client seeking services now? Current level of functioning, how are current difficulties affecting daily functioning at home and/or work?

History of Presenting Problem: How long have symptoms occurred, changes in severity or frequency, history of previous episode(s), precipitating events

PREVIOUS TREATMENT INFORMATION

Previous Mental Health or Substance Use Disorder treatment? ❑ Yes ❑ No

OP Current Medical Status

Primary Care Physician: ❑ Yes ❑ No
Have you had a physical in the last year? ❑ Yes ❑ No
Current Medications: ❑ Yes ❑ No

Current Medical Status: ❑ 1. No significant problems ❑ 3. Chronic Problems ❑ 4. Debilitating Problems
❑ 2. Acute Problems (30 days)

Previous Medical Hospitalizations: ❑ 1. None ❑ 3. Major Injuries ❑ 5. Surgery

Is client 60 or older? ❑ Yes
<table>
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<th>Question</th>
<th>Answer</th>
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<tr>
<td><strong>Sexually Active:</strong></td>
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<tr>
<td><strong>Pregnant:</strong></td>
<td>No</td>
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<tr>
<td><strong>Comments:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Psychosocial History Module</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Composition of Family of Origin:</strong></td>
<td></td>
</tr>
<tr>
<td>01) Mother</td>
<td></td>
</tr>
<tr>
<td>02) Father</td>
<td></td>
</tr>
<tr>
<td>03) Adoptive Family</td>
<td></td>
</tr>
<tr>
<td>04) Relative</td>
<td></td>
</tr>
<tr>
<td>05) Foster Family</td>
<td></td>
</tr>
<tr>
<td>06) Step Family</td>
<td></td>
</tr>
<tr>
<td>07) Siblings</td>
<td></td>
</tr>
<tr>
<td>08) Group Home</td>
<td></td>
</tr>
<tr>
<td><strong>Do you have relationship issues in family of origin?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>History of Mental Illness in Family:</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>History of Suicide in Family:</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>History of Substance Abuse in Family:</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>History of Abuse/Trauma:</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Comments:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family/Social Relationships</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status:</strong></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with this situation?</td>
<td>No</td>
</tr>
<tr>
<td>Do you have children?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Usual living arrangements past 3 yrs:</strong></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with these arrangements?</td>
<td>No</td>
</tr>
<tr>
<td>With whom do you spend most of your free time?</td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with spending your free time this way?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Comments:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Last Grade Attended:</strong></td>
<td></td>
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</tbody>
</table>
Academic Performance:
- 01. Special Education
- 02. Expulsions
- 03. Suspensions
- 04. Gifted Talented
- 05. On Target

Academic Comments/Other Ed/Training/Vocational Skills:

Employment/Military History-include Branch/Discharge Status:

Employment Pattern:
What is your primary source of income?
- Yes
- No
Do you have automobile/transportation?
- Yes
- No
Do you have a valid driver’s license?
- Yes
- No

Comments:

Number of Times Arrested and Charged
- Yes
- No

Have you ever been arrested and charged with a crime?

OP Cultural/Strengths
- 01. None identified by client
- 02. Age
- 03. Ethnicity
- 04. Religion/Spirituality
- 05. Sexual orientation
- 06. Family Beliefs
- 07. Personal Values/Code of Conduct
- 08. Relational Roles
- 09. Social Groups

Personal Strengths may include assets, resources and natural positives:
- 01. Able to articulate needs
- 02. Motivated to change and learn
- 03. Acknowledgement of Psychiatric Problem
- 04. Verbal Skills
- 05. Compliant with Medication
- 06. History of Fair/Good Med Compliance
- 07. Currently Employed/Attending School
- 08. Enjoys Outdoor Interests
- 09. Expresses Desire to Change
- 10. Financially Independent
- 11. History of Fair/Good Response to Medication
- 12. Hobbies and/or Special Interests
- 13. Independent in ADL Skills
- 14. Insight into Illness/Problem
- 15. Intellectual Ability
- 16. Knows/Uses Community Resources
- 17. Open to Learning New Behaviors
- 18. Physical Health
- 19. Potential for Insight
- 20. Prior Response to Treatment
- 21. Recognition of Substance Abuse Problem
- 22. Social Skills
- 23. Spirituality
- 24. Stable Housing Situation
- 25. Supportive Family/Friends
- 26. Acculturation/Assimilation
- 27. Linguistic/Communication
- 28. Socioeconomic Status
**Abilities or interests**

- 01. Artistic
- 02. Athletic
- 03. Bilingual
- 04. Creative / Crafting
- 05. Endurance
- 06. Intellectual
- 07. Knowledge
- 08. Organizational
- 09. Perception
- 10. Performance
- 11. Social

**Other Strengths / Abilities and Comments:**

---

**OP MSE**

**Mental Status Examination**

**APPEARANCE/ATTITUDE**:
- 1. good hygiene
- 2. cooperative
- 3. poor eye contact
- 4. poor hygiene
- 5. guarded
- 6. hostile
- 7. preoccupied

**MUSCULOSKELETAL**:
- 1. no abnormal movements
- 2. tics
- 3. tremors
- 4. shuffling

**GAIT/STATION**:
- 1. normal
- 2. psychomotor slowing
- 3. psychomotor agitation
- 4. shuffling

**AFFECT/MOOD**:
- 1. appropriate to content
- 2. euthymic
- 3. incongruent
- 4. expanded range
- 5. constricted
- 6. flat
- 7. euthymic
- 8. depressed
- 9. anxious
- 10. irritable
- 11. labile
- 12. anhedonic

**THOUGHT PROCESS/CONTENT**:
- 1. logical and goal directed
- 2. reality based
- 3. circumstantial
- 4. racing
- 5. obsessions
- 6. blocked
- 7. persecutary
- 8. tangential
- 9. delusional
- 10. ideas of reference
- 11. ideas of influence

**PERCEPTUAL DISTURBANCE**:
- 1. none
- 2. auditory hallucinations
- 3. visual hallucinations
- 4. illusions

**Suicidal thoughts**:
- 1. none
- 2. passive
- 3. active
- 4. plan

**Homicidal thoughts**:
- 1. none
- 2. passive
- 3. active
- 4. plan

**ASSOCIATIONS**:
- 1. intact
- 2. loose

**SENSORIUM/ORIENTATION**:
- 1. alert oriented
- 1A. person
- 1B. place
- 1C. time
- 2. disoriented
- 3. somnolent

**MEMORY**:
- 1. normal
- 2. immediate
- 3. recent
- 4. remote

**ATTENTION/CONCENTRATION**:
- 1. normal
- 2. distractible

**FUND OF KNOWLEDGE/ESTIMATE OF INTELLIGENCE**:
- 1. average
- 2. borderline
- 3. low
- 4. above average

**SPEECH**:
- 1. regular rate, rhythm, volume
- 2. no difficulties with articulation
- 3. soft
Risk Assessment

(suicide, homicide, gravely disabled)

Risk Level Based On This Contact:

- 0. No Risk
- 1. Low Risk
- 2. Moderate Risk (factors exist, not imminent)
- 3. Severe Risk (factors exist, risk imminent)

Elaboration of Findings:

Substance Abuse History

<table>
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<tr>
<th>Usage</th>
<th>Substance Type</th>
<th>Age 1st Use</th>
<th>Days Used (Past 30)</th>
<th>Method of Use</th>
<th>Freq of Use</th>
<th>Last Usage</th>
<th>Avg 24 Hr Period Usage</th>
<th>Usage count for last year</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

- Does client use tobacco? Yes
- Days using more than 1 substance (Past 30): No

OP Substance Use History

- Would you like information about how to stop tobacco use? Yes
- History of substance use? Yes

Client DSM Diagnosis as of 1/12/2016 01:36 PM

Client: Glover, Hulk (1125162) 12/19/1978
Effective Date/Time: 1/12/2016 01:36 PM
External Diagnosis: No
Diagnosed By: 
Comments: 

Diagnosis

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<tr>
<th>DSM-5</th>
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The Diagnoses above display in priority order.
A - Attached Diagnosis

Psychosocial and Contextual Factors

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**Diagnostic Formulation**

**Summary/Recommendations**

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<th>05) Family</th>
<th>09) Skill Mastery</th>
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<tbody>
<tr>
<td>02) Academic</td>
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<td>06) Life Stressors</td>
<td>10) Transition from higher level of care</td>
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<tr>
<td>03) Danger to Self/Others/Gravely Disabled</td>
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<td>07) MH/SA issues that impact functioning</td>
<td>11) Scheduling</td>
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<tr>
<td>04) Employment Vocational</td>
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<td>08) Problem Solving/Planning/Judgment</td>
<td>12) Learning Disability</td>
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<tr>
<td>01) None</td>
<td>05) Basic Needs-Food, Clothing, Utilities</td>
<td>09) Meaningful Activities</td>
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<td>02) Access to SSI/SSDI</td>
<td>06) Education/Vocational Training</td>
<td>10) Primary Care Physician</td>
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<td>03) Adequate Employment</td>
<td>07) Financial Resources</td>
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**Summary of Case Management Needs:**

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<th>05) Vocational Services</th>
<th>09) Residential Substance Abuse Treatment</th>
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<td>06) Peer Services</td>
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<td>07) Housing</td>
<td>11) Residential Treatment</td>
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<td>04) Adequate Housing</td>
<td>08) Clubhouse</td>
<td>12) Case Management</td>
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**Client is Referred For:**

<table>
<thead>
<tr>
<th>01) N/A - Evaluation Only</th>
<th>05) Psychiatric Evaluation</th>
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<tbody>
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<td>02) Mental Health Outpatient Treatment</td>
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</tr>
<tr>
<td>03) Substance Abuse Outpatient Treatment</td>
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</tbody>
</table>

**Referral Comments:**

**Records Requested:**

- Yes
- No

**Stage One: Precontemplation:**
- I have no intention of changing behaviors in the foreseeable future.

**Stage Two: Contemplation:**
- I am aware of the problem, thinking about overcoming it but have not yet made a commitment.

**Stage Three: Preparation:**
- I am ready to make a change. I would like information about getting help.

**Stage Four: Action:**
- I am in the process of modifying my behavior, experiences and environment to overcome my problems.

**Stage Five: Maintenance:**
- I am working to consolidate and maintain the gains attained during treatment.
Relapse: □ I was making lifestyle changes, then returned to old behaviors.

ENGAGEMENT SERVICE PLAN

Goal: I will establish an effective, working relationship with my assigned provider (s) as evidenced by creation and completion of my initial service plan and regular participation in recommended services.

Objective: I will accept referrals for treatment, follow through with scheduling and attending initial appointments within 30 days of this assessment.

Interventions: I agree to:
- Attend Psychiatric Evaluation appointment if referred
- Attend all appointments
- Cooperate with staff efforts to coordinate care and link to other services
- Utilize Crisis Services if needed
- Respond to outreach by staff

Client Name: 
Client Signature: 
Date: 

Additional Services

Does interactive complexity apply:  ○ Yes
□ No

Signatures

Validation Issues:
- Error: Requirements not met for Presenting Problems/Previous Treatment.
- Error: Requirements not met for OP Current Medical Status.
- Error: Please fill out the Substance Abuse History before attempting to sign this document.
- Error: You must complete a Diagnosis or Psychosocial and Contextual Factor before this document can be signed.
- Error: Requirements not met for Additional Services.

Electronic Signature: The document can not be signed until the errors above are resolved.

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Attachment D: LOCUS
CONTENTS

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Instructions ........................................................................................................................................ 5
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Appendix 2: Placement Grid ............................................................................................................. 28
INTRODUCTION TO ADULT VERSION 2010

With the arrival of managed care programs and principles, the use of quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes is increasingly important. In the past there have been no widely accepted standards to meet these needs. The development of LOCUS has provided a single instrument that can be used for these functions in a wide variety of settings, including both mental health and addictions. It provides a common language and set of standards with which to make such judgements and recommendations. Clinicians now have an instrument, which is simple, easy to understand and use, but also meaningful and sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

LOCUS has three main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service arrays which vary according to the amount and scope of resources available at each “level” of care in each of four categories of service. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.

This system is a dynamic one, and it has evolved over the years of its development. Since its inception, LOCUS has included content related to recovery status, stage of change, and choice. Its simple style and structure has invited use not only by a variety of clinicians with various levels of training, but by consumers themselves, allowing assessment to become a collaborative process. Engagement in this collaboration is central to person centered treatment planning. With this new revision of LOCUS, the first since 2000, language within the rating scales has been further simplified and stages of change (as conceived by Prochaska and DiClemente) have been assigned to ratings in Dimension VI, now called Engagement and Recovery Status. We strongly encourage collaboration between the clinician and the person being assessed whenever this is possible. As systems develop services and processes that facilitate recovery, these changes will allow LOCUS to be an even more powerful tool to assist these transformations.

Version 2010 makes these changes to address semantic concerns, but once again, there are no significant changes in content from Version 2000. Reliability and validity testing results will not be affected by these changes, but additional testing is planned in the future.

The instrument has multiple potential uses:
- To assess immediate service needs (e.g., for clients in crisis)
- To plan resource needs over time, as in assessing service requirements for defined populations
- To monitor changes in status or placement at different points in time.

As with previous versions, the current document is divided into three sections. The first section defines six evaluation parameters or dimensions: 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery Status. A five-point scale is constructed for
each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

The second section of the document defines six “levels of care” in the service continuum in terms of four variables: 1) Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services. The term “level” is used for simplicity, but it is not our intention to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe levels of resource intensity. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service intensities, combining crisis, supportive, clinical, and environmental interventions, which may vary independently. Patient placement criteria are then elaborated for each level of care. Separate admission, continuing stay, and discharge criteria are not needed in this system, as changes in level of care will follow from changes in ratings in any of the six parameters over the course of time.

The final section describes a proposed scoring methodology that facilitates the translation of assessment results into placement or level of care determinations. Both a grid chart and a decision flow chart are provided for this purpose.

We hope that this version of LOCUS will continue to stimulate considerable comment, discussion, and testing as reliability and validity studies continue. It is recognized that a document of this type must be dynamic and that adjustments or addendums may be required either to accommodate local needs or to address unanticipated or unrecognized circumstances or deficiencies. The specific needs of special populations, such as children, adolescents, and the elderly will not be adequately addressed in this adult version. It does not claim to replace clinical judgment, and is meant to serve only as an operationalized guide to resource utilization that must be applied in conjunction with sound clinical thinking. It is offered as an instrument that should have considerable utility in its present form, but growth and improvement should be realized with time and further testing. The AACP welcomes any comments or suggestions. Please send your comments to:

Wesley Sowers, M.D.
Medical Director, Allegheny County Department of Human Services
Office of Behavioral Health
One Smithfield Street, Third Floor
Pittsburgh PA 15222-2225
Phone: (412) 350-3716; Fax: (412) 350-3880; e-mail: sowers6253@consolidated.net
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AACP Task Force on Level of Care Determinations

Wesley Sowers, MD, Chairperson

Cheryl S. Al-Mateen, MD    Richard C. Lippincott, MD
Donald B. Brown, MD        Kenneth Minkoff, MD
Gordon H. Clark, Jr., MD   David Moltz, MD
Benjamin Crocker, MD       Fred C. Osher, MD
Robert M. Goisman, MD      David A. Pollack, MD
Steven Goldfinger, MD      Andres Pumariega, MD
Linda Goldwater Gochfeld, MD Michael A. Silver, MD
Charles Huffine, MD        Clifton R. Tennison, Jr., MD
Margaret Kitchell, MD      Kenneth Thompson, MD
Level of Care Utilization System for Psychiatric and Addiction Services

Instructions for Use

Each evaluation parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met.

There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that at least one criterion has been met should generally be assigned. The result will be that any errors will be made on the side of caution.

Since LOCUS is designed as a dynamic instrument, scores should be expected to change over time. Scores are generally assigned on a here and now basis, representing the clinical picture at the time of evaluation. In some of the parameters, historical information is taken into account, but it should not be considered unless it is a clear part of the defined criteria. In certain crisis situations, the score may change rapidly as interventions are implemented. In other situations, where a subject may be living under very stable circumstances, scores may not change for extended periods of time. Clinical judgment should prevail in the determination of how frequently scores should be reassessed. As a general rule, they will be reassessed more frequently at higher levels of acuity and at the higher levels of care or resource intensity.

Once scores have been assigned in all six evaluation parameters, they should be recorded on a worksheet and summed to obtain the composite score. Referring to the LOCUS Placement Grid, a rough estimate of the placement recommendation can be obtained. For greatest accuracy, the LOCUS Level of Care Decision Tree should be employed and it is recommended that it be used in most cases.

In assigning levels of care, there will be some systems that do not have comprehensive services for all populations at every level of the continuum. When this is the case, the level of care recommended by LOCUS may not be available and a choice will need to be made as to whether more intensive services or less intensive services should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This will again, lead us to err on the side of caution and safety rather than risk and instability.
LOCUS Instrument Version 2010

Evaluation Parameters for Assessment of Service Needs

Definitions

I. Risk of Harm

This dimension of the assessment considers a person’s potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as: past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

1 - Minimal Risk of Harm
   a- No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
   b- Clear ability to care for self now and in the past.

2 - Low Risk of Harm
   a- No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
   b- Occasional substance use without significant episodes of potentially harmful behaviors.
   c- Periods in the past of self-neglect without current evidence of such behavior.

3 - Moderate Risk of Harm
   a- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
   b- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
   c- History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
   d- Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
   e- Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.
4 - Serious Risk of Harm
a- Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
b- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
c- Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
d- Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5 - Extreme Risk of Harm
a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior…
   - without expressed ambivalence or significant barriers to doing so, or
   - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
   - in presence of command hallucinations or delusions which threaten to override usual impulse control.
b- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
c- Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

II. Functional Status
This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person’s capacity for self-care. This ability should be compared against an ideal level of functioning given an individual’s limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.
1 - **Minimal Impairment**
   a- No more than transient impairment in functioning following exposure to an identifiable stressor.

2 - **Mild Impairment**
   a- Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
   b- Recent experience of some minor disruptions in aspects of self-care or usual activities.
   c- Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
   d- Demonstrating significant improvement in function following a period of difficulty.

3 - **Moderate Impairment**
   a- Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
   b- Appearance and hygiene falls below usual standards on a frequent basis.
   c- Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.
   d- Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
   e- Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
   f- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

4 - **Serious Impairment**
   a- Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
   b- Significant withdrawal and avoidance of almost all social interaction.
   c- Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
   d- Serious disturbances in physical functioning such as weight change, disrupted sleep, or fatigue that threaten physical well being.
   e- Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.
5 - Severe Impairment
   a- Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
   b- Development of complete withdrawal from all social interactions.
   c- Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
   d- Extreme disruptions in physical functioning causing serious harm to health and well being.
   e- Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

III. Medical, Addictive, and Psychiatric Co-Morbidity

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases. Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

1 - No Co-morbidity
   a- No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
   b- Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

2 - Minor Co-morbidity
   a- Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
   b- Occasional episodes of substance misuse, but any recent episodes are self-limited, show no pattern of escalation, and there is no indication that they adversely affect the course of a co-existing psychiatric disorder.
   c- May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-existing substance use disorder.
3 - Significant Co-morbidity
   a- Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
   b- Medical conditions exist which may be created or adversely affected by the existence of the presenting disorder.
   c- Medical conditions exist which may adversely affect the course of the presenting disorder.
   d- Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.
   e- Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.
   f- Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

4 - Major Co-morbidity
   a- Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.
   b- Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
   c- Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
   d- Uncontrolled substance use occurs at a level, which poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.
   e- Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

5 - Severe Co-morbidity
   a- Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
   b- Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.
c- Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.

d- Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-existing psychiatric disorder and other aspects of well being.

e- Acute or severe psychiatric symptoms are present which seriously impair client’s ability to function and prevent recovery from any co-existing substance use disorder, or seriously worsen it.

IV. Recovery Environment

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person’s efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

A) Level of Stress

1 - Low Stress Environment

a- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.

b- No recent transitions of consequence.

c- No major losses of interpersonal relationships or material status have been experienced recently.

d- Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.

e- Living environment poses no significant threats or risk.

f- No pressure to perform beyond capacity in social role.
2 - Mildly Stressful Environment
   a- Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
   b- A transition that requires adjustment such as change in household members or a new job or school.
   c- Circumstances causing some distress such as a close friend leaving town, conflict in or near current residence, or concern about maintaining material well being.
   d- A recent onset of a transient but temporarily disabling illness or injury.
   e- Potential for exposure to alcohol and/or drug use exists. *
   f- Performance pressure (perceived or actual) in school or employment situations creating discomfort.

3 - Moderately Stressful Environment
   a- Significant discord or difficulties in family or other important relationships or alienation from social interaction.
   b- Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
   c- Recent important loss or deterioration of interpersonal or material circumstances.
   d- Concern related to sustained decline in health status.
   e- Danger in or near habitat.
   f- Easy exposure and access to alcohol and drug use. *
   g- Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

4 - Highly Stressful Environment
   a- Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
   b- Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
   c- Inability to meet needs for physical and/or material well being.
   d- Recent onset of severely disabling or life threatening illness.
   e- Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. *
   f- Episodes of victimization or direct threats of violence near current home.
   g- Overwhelming demands to meet immediate obligations are perceived.
5 - Extremely Stressful Environment
   a- An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
      - ongoing injurious and abusive behaviors from family member(s) or significant other.
      - witnessing or being victim of extremely violent incidents brought about by human malice or natural disaster.
      - persecution by a dominant social group.
      - sudden or unexpected death of loved one.
   b- Unavoidable exposure to drug use and active encouragement to participate in use. *
   c- Incarceration or lack of adequate shelter.
   d- Severe pain and/or imminent threat of loss of life due to illness or injury.
   e- Sustained inability to meet basic needs for physical and material well being.
   f- Chaotic and constantly threatening environment.

* These criteria apply to persons with past or present difficulties with substance use.

B) Level of Support

1 - Highly Supportive Environment
   a- Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
   b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.
      (Selection of this criterion pre-empts higher ratings)

2 - Supportive Environment
   a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
   b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
   c- Professional supports are available and effectively engaged (i.e. ICM).
      (Selection of this criterion pre-empts higher ratings)

3 - Limited Support in Environment
   a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
   b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
   c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
   d- Resources may be only partially utilized even when available.
   e- Limited constructive involvement with any professional sources of support that are available.
4 - Minimal Support in Environment
   a- Very few actual or potential sources of support are available.
   b- Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
   c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
   d- Client may be on bad terms with and unwilling to use supports available in a constructive manner.

5 - No Support in Environment
   a- No sources for assistance are available in environment either emotionally or materially.

V. Treatment and Recovery History
This dimension of the assessment recognizes that a person’s past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control of symptoms. While it is important to recognize that some clients will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

1 - Fully Responsive to Treatment and Recovery Management
   a- There has been no prior experience with treatment or recovery.
   b- Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
   c- There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

2 - Significant Response to Treatment and Recovery Management
   a- Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
   b- Recovery has been managed for moderate periods of time with limited support or structure.
3 - Moderate or Equivocal Response to Treatment and Recovery Management
   a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
   b- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.
   c- Unclear response to treatment and ability to maintain a significant recovery.
   d- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

4 - Poor Response to Treatment and Recovery Management
   a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
   b- Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

5 - Negligible Response to Treatment
   a- Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
   b- Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

VI. Engagement and Recovery Status

This dimension of the assessment considers a person’s understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person’s ability to be successful at a given level of care.

1 - Optimal Engagement and Recovery
   a- Has complete understanding and acceptance of illness and its effect on function.
   b- Actively maintains changes made in the past (Maintenance Stage).
   c- Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
   d- Understands recovery process and takes on a personal role and responsibility in a recovery plan.
2 - Positive Engagement and Recovery
   a- Has significant understanding and acceptance of illness and its effect on function.
   b- Willing to change and is actively working toward it (Action Stage).
   c- Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
   d- Shows recognition of personal role in recovery and accepts significant responsibility for it.

3 - Limited Engagement and Recovery
   a- Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
   b- Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
   c- Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
   d- Does not use available resources independently or only in cases of extreme need.
   e- Has limited ability to accept responsibility for recovery.

4 - Minimal Engagement and Recovery
   a- Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
   b- Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
   c- Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
   d- Avoids contact with and use of treatment resources if left to own devices.
   e- Does not accept any responsibility for recovery or feels powerless to do so.

5 – Unengaged and Stuck
   a- Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
   b- Inability to understand recovery concept or contributions of personal behavior to disease process.
   c- Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
   d- Extremely avoidant, frightened, or guarded.
LEVELS OF CARE

Definitions

BASIC SERVICES - Prevention and Health Maintenance

Definition:

Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community with special focus on children.

1. **Care Environment** - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.

2. **Clinical Services** - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.

3. **Support Services** - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.

4. **Crisis Stabilization and Prevention Services** - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families and criminal offenders; 2) Debriefing for victims of trauma or disaster; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; and 9) Support of day care and child enrichment programs.

Placement Criteria:

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.
I. LEVEL ONE - Recovery Maintenance and Health Management

Definition:

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Recovery Maintenance programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. In some cases, services may be provided in community locations or in the place of residence.

2. **Clinical Services** - Treatment programming will be available up to two hours per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to four months. Medication use can be monitored and managed in this setting. Capabilities to provide individual or group supportive therapy should be available in at this level.

3. **Supportive Services** - Assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Facilitation in linkage with mutual support networks, individual advocacy groups, and with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all Basic Services (see page 17) will be accessible.

Placement Criteria:

1. **Risk of Harm** - clients with a rating of two or less may step down to this level of care.
2. **Functional Status** - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.
3. **Co-morbidity** - a rating of two or less is generally required for this level of care.
4. **Recovery Environment** - a combined rating of no more than four on Scale “A” and “B” should be required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less should be required for treatment at this level.
6. **Engagement and Recovery Status** - a rating of two or less should be obtained in this dimension for placement at this level of care.
7. **Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.
II. LEVEL TWO - Low Intensity Community Based Services

Definition:

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.

2. **Clinical Services** - Treatment programming will be available up to three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting. Capabilities to provide individual, group, and family therapies should be available in these settings.

3. **Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services (see page 17) will be accessible.

Placement Criteria:

1. **Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.

2. **Functional Status** - ratings of three or less could be managed at this level.

3. **Co-Morbidity** - a rating of two or less is required for placement at this level.

4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales is required for treatment at this level.

5. **Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale “B” of dimension four.
6. **Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.

7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

III. **LEVEL THREE - High Intensity Community Based Services**

**Definition:**

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. These services may be provided in community locations in some cases, including the place of residence.

2. **Clinical Services** - Treatment programming (including group, individual and family therapy) will be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.

3. **Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services (see page 17) will also be available.
Placement Criteria:

1. **Risk of Harm** - a rating of three or less can be managed at this level.
2. **Functional Status** - a rating of three or less is required for this level of care.
3. **Co-Morbidity** - a rating of three or less can be managed at this level of care.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.
6. **Engagement and Recovery Status** - a rating of three or less is required for this level of care.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

IV. **LEVEL FOUR - Medically Monitored Non-Residential Services**

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs.

1. **Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).
2. **Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available than about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.
3. **Supportive Services** - Case management services will be integrated with on site treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

**Placement Criteria:**

1. **Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.

2. **Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).

3. **Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in that circumstance).

4. **Recovery Environment** - an “A” scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “B”. (Availability of Assertive Community Treatment would merit a rating of one on scale “B”). A “B” scale rating of three or less could otherwise generally be managed at this level.

5. **Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).

6. **Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would equivalent to a rating of one on scale “B”). An “A” scale rating of two could generally be managed in conjunction with ACT).

7. **Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on dimension four enabling these criteria to be met even when scores of four are obtained in other dimensions.)
V. LEVEL FIVE - Medically Monitored Residential Services

Definition:

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must be capable of providing the following:

1. **Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.

2. **Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. On site treatment should be available seven days a week including individual, group and family therapy. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.

3. **Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.

4. **Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

Placement Criteria:

1. **Risk of Harm** - a rating of four requires care at this level independently of other parameters.

2. **Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale “A” and “B” (see level three criteria).

3. **Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale “A” and “B” (see level three criteria).

4. **Recovery Environment** - a rating of four or higher on the “A” and “B” scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.
5. **Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

6. **Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

7. **Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

VI. **LEVEL SIX - Medically Managed Residential Services**

**Definition:**

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

1. **Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should be contained within a locked environment (this may not be necessary for services such as detoxification, however) with capabilities for providing seclusion and/or restraint if necessary. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.

2. **Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client’s needs.

3. **Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.

4. **Crisis Resolution and Prevention Services** – These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.
Placement Criteria:

1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.
2. **Functional Status** - a rating of five qualifies placement independently of other variables.
3. **Medical and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently of other parameters.
4. **Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.
5. **Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.
6. **Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.
7. **Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.
# AACP Level of Care Determination Grid

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Recovery Maintenance Health Management</th>
<th>Low Intensity Community Based Services</th>
<th>High Intensity Community Based Services</th>
<th>Medically Monitored Non-Residential Services</th>
<th>Medically Monitored Residential Services</th>
<th>Medically Managed Residential Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Risk of Harm</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>II. Functional Status</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>III. Co-Morbidity</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>IV A. Recovery Environment “Level of Stress”</td>
<td>Sum of IV A + IV B</td>
<td>Sum of IV A + IV B</td>
<td>Sum of IV A + IV B</td>
<td>3 or 4</td>
<td>4 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>IV B. Recovery Environment “Level of Support”</td>
<td>IV A + IV B is 4 or less</td>
<td>IV A + IV B is 5 or less</td>
<td>IV A + IV B is 5 or less</td>
<td>3 or less</td>
<td>4 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>V. Treatment &amp; Recovery History</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>VI. Engagement &amp; Recovery Status</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td><strong>Composite Rating</strong></td>
<td>10 to 13</td>
<td>14 to 16</td>
<td>17 to 19</td>
<td>20 to 22</td>
<td>23 to 27</td>
<td>28 or more</td>
</tr>
</tbody>
</table>

- Indicates independent criteria - requires admission to this level regardless of composite score
- * Unless sum of IV A and IV B equals 2
Attachment E: CALOCUS
ACKNOWLEDGMENTS

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AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS CHILD AND ADOLESCENT COMMITTEE

Charles Huffine, M.D., President; Wes Sowers, M.D.; Kieran O’Malley, M.D.

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY WORK GROUP ON COMMUNITY SYSTEMS OF CARE FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCES

Andres Pumariega, M.D., Chair; Mark Chenven, M.D.; Emilio Dominguez, M.D.; Ted Fallen, Jr., M.D.; Katherine Grimes, M.D.; Graeme Hanson, M.D.; William Heffron, M.D.; Robert Klaehn, M.D.; Lany Marx, M.D.; Tom Vaughan, Jr., M.D.; Nancy Winters, M.D.; and Al Zachik, M.D.

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY STAFF

Kristin Kroeger, Director of Clinical Affairs
Nicole Killion, Clinical Affairs Assistant
PART I

HISTORICAL PERSPECTIVE

The need for the Child and Adolescent Level Of Care Utilization System (CALOCUS) stems from the progressive development since the mid-1980’s of Systems of Care for children and adolescents with serious emotional disturbances. These systems have been further impacted by the development of managed care principles during the 1990’s. These two threads in children’s mental health have resulted in the majority of children and adolescents being treated in community settings with limited access to inpatient and residential services. CALOCUS provides a framework for defining the appropriate character and intensity of both services and resources to meet the needs of these children and adolescents.

Jane Knitter’s 1982 book, Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents In Need of Mental Health Services, was the first to identify significant services gaps for those children most in need of care. She also found that many children were inappropriately receiving services at a higher level of care due to a lack of alternative resources. Ms. Knitter was perhaps the first to recommend “a coordinated range of services for troubled children and adolescents” and the development of “placement standards...that ensure children are placed in hospitals only when necessary.”

The federal Child and Adolescent Services System Program (CASSP) was founded in 1984 as a response to these identified problems. The 1986 monograph, A System of Care for Children and Youth With Serious Emotional Disturbances, by Beth Stroul, M.Ed. and Robert M. Friedman, Ph.D. clearly articulates the need for a coordinated continuum of care that includes a broad array of community-based services. The monograph also provided a set of “Guiding Principles” for the development of local systems of care. These principles are included in Appendix A.

Also essential in the development of multiple levels of care are the principles of “Wraparound” or “Individualized Services.” The development of a Wraparound plan for a child does not rely solely on pre-existing programs or agency services. Rather, it is a comprehensive plan, using both formal and informal supports, to remediate weaknesses and build on existing strengths of the child and his/her family. Augmented by the inclusion of Wraparound services, the System of Care approach has been implemented in some areas so that many children and adolescents can now be safely and effectively treated in community settings.

As managed care has progressed in the 1990’s; there has been a greater emphasis on using cost-effective treatments. Though managed care has often been associated with the denial of services; it can be a useful tool for effective utilization of limited mental health and associated resources. Too often, there has been disagreement between payers, providers and consumers as to the most appropriate Level of Care. VanDenBerg and Grealish pointed out in a 1996 article that, “If the adults disagree, the child fails.” It is hoped that the CALOCUS will help to provide a consensus on level of care determination that is urgently needed.
PART II

FOUNDATIONS AND PRINCIPLES

There have been a number of previous attempts to use clinical assessments as a method of determining level of care needs in children and adolescents. However there has been no clearly defined method for linking the clinical assessment to the need for treatment, or the level of care best suited to deliver this treatment. The previous instruments gave us some idea of the child or adolescent’s clinical status with regard to mood, anxiety, or thought process and other clinical areas of relevance, but they did not always have a direct connection with his/her holistic treatment needs.

Another approach to children and adolescent treatment placement focused on the development of criteria, which were specific to a given child or adolescent’s mental health program. For example, a day hospital might have a set of criteria, which would describe the type of patient that was deemed most appropriate for that program. This idea evolved into the concept of “level of care” which attempted to group services of similar intensity together. Standardized and specific criteria were also developed along with “level of care” definitions.

Finally, the combination of these two concepts resulted in the development of “dimensional”, assessments for “level of care” determinations. This process now combines the assessment related to a child or adolescent’s clinical needs, or functional status, with a set of clearly defined levels of care, and subsequently develops a methodology for matching clinical needs to treatment resources. This structure for assigning appropriate level of care was first developed for LOCUS, by the American Association of Community Psychiatrists.

The CALOCUS instrument is a method of quantifying the clinical severity and service needs of three quite different populations of children and adolescents. It may be used in children with psychiatric disorders, substance use disorders, or developmental disorders, and has the ability to integrate these as overlapping clinical issues. This differs from the adult instrument LOCUS, which did not incorporate patients with developmental disorders.

CALOCUS begins by defining a set of dimensions for assessment that, although limited in number, are all relevant to the type of services that a child or adolescent would need. Our intent was that the ratings used would be simple, yet specific in their content, so there would not be a great deal of complexity, or confusion, in making decisions. The ratings would be quantifiable in order to convey information easily, but also provide a spectrum along which a child or adolescent may lie on any given dimension. Thus, these quantifiable ratings would allow a composite rating score to be obtained that would be the result of the interaction of each of the individual dimension scores. This integration of multiple dimensions is the essence of the CALOCUS instrument. It is this that guides the user to an appropriate CALOCUS level of care assignment.

Cultural competency is essential to accurate use of CALOCUS. A clear understanding of the cultural factors influencing each dimension is important; the dimension of Treatment, Acceptance and Engagement is particularly sensitive to these factors. The use of a cultural consultant may be very helpful in situations where there is a lack of clarity.
In order to develop an instrument applicable to a wide variety of treatment environments and child or adolescent needs it was important to develop a set of definitions for levels of care that described the resource intensities needed at each specific level of care. These definitions needed to be flexible and adaptable, in order to be broadly applicable to the wide variety of treatment environments in which care would be given. This approach was chosen to allow service providers to give adequate clinical services and quality care in the most economic and realistic fashion.

Administration or ease of use, of the instrument was also important. It was anticipated that ease of use, time and universal adaptability would be critical factors in establishing the broad acceptability of CALOCUS. This could lead to the establishment of a single standard agreed upon for use with children and adolescents by insurance agencies, service providers and consumers.

CALOCUS employs multi-disciplinary/multi-informant perspectives on children and adolescents and is designed to be used by a variety of mental health professionals. Although if is primarily used for initial level of care placement decisions, it can be used at all stages of treatment to assess the level of intensity of services needed. An important aspect of CALOCUS is its potential use for fee for service utilization management. Many instruments in the past have developed separate criteria for hospital admissions, continuing care and discharge planning. The CALOCUS instrument makes it unnecessary to use different criteria because of the “dynamic” nature of the quantifiable dimensional ratings. CALOCUS could also be applied to activities such as treatment planning, outcome monitoring and program development.

There are a number of things that CALOCUS will not do. It will not prescribe program design, but rather the type and intensity of resources that need to be available in that program. It does not specify treatment intervention, and it does not invalidate the importance of clinical judgement. CALOCUS also does not limit our creativity in developing specific treatment programs that meet the needs of special populations or localities. This will continue to be the role of the professional clinician.

The following sections of this manual will provide you with more detail regarding the CALOCUS instrument and its appropriate use with children and adolescents.
PART III

CALOCUS DIMENSIONAL RATING SYSTEM

The CALOCUS dimensional rating system is used to determine the intensity of a child or adolescent’s service needs. It operationalizes many of the factors clinicians would consider in determining the most appropriate services and level of care needed. Each dimension has a five point rating scale, from least to most severe. For each of the five possible ratings within each dimension, a set of criteria is clearly defined. Only one criterion needs to be met for that rating to be selected. Therefore, for each dimension, the highest rating in which at least one of the criteria is met is the rating that should be assigned.

CALOCUS has six dimensions:

**RISK OF HARM:** This dimension is an expansion of the LOCUS dangerousness dimension, necessitated by a child’s developmental vulnerability to victimization. Thus, this dimension is the measurement of a child or adolescent’s risk of self-harm by various means and an assessment of his/her potential for being a victim of physical or sexual abuse, neglect or violence.

**FUNCTIONAL STATUS:** This dimension measures the impact of a child or adolescent’s primary condition on his/her daily life. It is an assessment of the child’s ability to function in all age-appropriate roles: family member, friend and student. It is also a measure of the effect of the primary problem on such basic daily activities as eating, sleeping and personal hygiene.

**CO-MORBIDITY:** This dimension measures the co-existence of disorders across four domains: Developmental Disability, Medical, Substance Abuse, and Psychiatric. Remember, if the primary condition is a substance abuse problem or a developmental disability, then any psychiatric condition also present would be considered a co-morbid condition.

**RECOVERY ENVIRONMENT:** This dimension is divided into 2 sub-scales: Environmental Stress and Environmental Support. An understanding of the strengths and weaknesses of the child or adolescent’s family is essential to choosing an accurate rating in this dimension. It is also a measure of the neighborhood and community’s role in either worsening or improving the child or adolescent’s condition. Thus, high ratings on both these sub-scales (Extremely Stressful Environment and No Support in Environment) will have a major impact on both the composite score and the actual level of care chosen.

**RESILIENCY AND TREATMENT HISTORY:** Resiliency refers to a child or adolescent’s innate or constitutional emotional strength, as well as the capacity for successful adaptation (Rutter, 1990). The concept of resiliency is familiar to clinicians who treat children or adolescents who have the most severe disorders and/or survive the most traumatic life circumstances, yet who either maintain high functioning and developmental progress, or use treatment for a rapid return to that state. This dimension also measures the extent to which the child or adolescent and his/her family have responded favorably to past treatment.

**ACCEPTANCE AND ENGAGEMENT (Scale A-Child/Adolescent, Scale-B Parents/Primary Caretaker):** This dimension is divided into two sub-scales to allow for
measurement of both the child or adolescent’s and his/her family’s acceptance and engagement. Clearly, the child or adolescent’s treatment benefits when the family is proactively and positively engaged, and conversely, treatment suffers when the family is disinterested, disruptive or openly hostile toward the process. Only the highest sub-scale score (the sub-scale indicating the most significant challenge to treatment) is used in calculating the composite score.

**Use of Dimensions**

In order to understand what each parameter is measuring, it is important to review the introductory paragraphs for each dimension carefully, beginning on page 12. *Remember, you want to select the highest rating in each dimension, where at least one of the criteria is met.* In some cases, the actual clinical picture may not fit any of the criteria on the rating scales exactly. In that situation, users should pick the closest fit or choose the criterion that most closely approximates the actual condition of the child or adolescent they are considering.

When there is some confusion about which rating should be assigned, and you are not certain which is the closest fit, you should choose the higher rating. No instrument can anticipate every circumstance, or be so general that it can be applied to every situation, so a great deal of clinical judgement will be needed. Although the instrument does supply some guidelines, the clinician is required to make a determination as to which rating within each dimension is most appropriate. The clinician should base their decision on the interview with the child or adolescent, and all other available clinical information. The sources of information may include, but not be limited to other clinical reports, school records, other agency reports, mental health status examinations and/or family interviews.

In the evaluation of children and adolescents, a multi-informant approach that integrates information about the child and family from multiple sources and observers should be used. Scores in CALOCUS are based on the child or adolescent’s status at the time of administration of the instrument. Scores for a particular child or adolescent can be expected to change, especially in crisis situations and as interventions are implemented. When an individual’s life circumstances are stable or functioning has not deviated much from baseline, scores likewise may not change dramatically. Clinicians should use judgment to determine how frequently to re-administer the instrument during treatment. As a general rule, CALOCUS should be administered at the beginning of treatment, at points of significant change (such as on consideration of a change in level of care), and at the termination of services. Under most circumstances, CALOCUS should be administered more frequently at the higher levels of care.
PART IV

LEVEL OF CARE SERVICES

The Levels of Care in CALOCUS are organized in a unique way. In CALOCUS, the focus is on the level of resource intensity, which is more flexibly defined in order to meet the child or adolescent’s needs. Each level of care is defined by a combination of service variables: physical facilities (care environment), clinical services, support services, crisis stabilization and prevention services. Some levels of care may contain the same resources found at other levels of care. With higher levels of care, a greater number and variety of services are utilized. In addition, the need for active case management of services will increase at the higher levels.

The levels of care are defined so that they can be effectively used regardless of the extent of collaboration in a local system of care. In a community with a more traditional array of services, the higher levels of care will necessarily be provided in residential or inpatient settings. In areas where there is an active use of the Wraparound process in a community-based system of care, the higher levels of intensity of service can be provided in the least restrictive environment possible.

One way to think about the levels of care is to compare them with the difference between the services available in a single pediatrician’s office (the lower levels of care) and a major medical center (higher levels of care). For well-baby checks and most common medical conditions, a child or adolescent can be treated in the pediatrician’s office. For more complex problems, especially those that are potentially disabling or life threatening, treatment at a major medical center would be appropriate due to the wider array of services and the availability of specialists.

In CALOCUS, there are seven levels of care:

Level 0: **Basic Services.** This is a basic package of prevention and health maintenance services that are available to everyone in the population being served, whether or not they need mental health care.

Level 1: **Recovery Maintenance and Health Management.** This level of service is usually reserved for those stepping down from higher levels of care who need minimal system involvement to maintain their current level of function or need brief intervention to return to their previous level of functioning. Examples of this level of service are children or adolescents who only need ongoing medication services for a chronic condition or brief crisis counseling.

Level 2: **Outpatient Services.** This level of care most closely resembles traditional office based practice and requires limited use of community-based services.
Level 3: **Intensive Outpatient Services.** It is at this level that services begin to become more complex and more coordinated. The use of case management begins at this level. The use of child and family teams to develop Individualized Service (Wraparound) Plans also begins, using mostly informal community supports such as church or self-help groups and “Big Brothers/Big Sisters.” This level requires more frequent contact between providers of care and the youth and his family as the severity of disturbance increases.

Level 4: **Intensive Integrated Service Without 24-Hour Psychiatric Monitoring.** This level of care best describes the increased intensity of services necessary for the “multisystem, multi-problem” child or adolescent requiring more extensive collaboration between the increased number of providers and agencies. A more elaborate Wraparound plan is also required, using an increased number of formal supports. Additional supports may include respite, homemaking services or paid mentors. In more traditional systems, this level of service is often provided in a day treatment or a partial hospitalization setting. Active case management is essential at this level of care.

Level 5: **Non-Secure, 24-Hour, Services with Psychiatric Monitoring.** Traditionally, this level of care is provided in group homes or other unlocked residential facilities, but may be provided in foster care and even family homes if the level of Wraparound services in the community is extraordinarily high. In either case, a complex array of services should be in place around the child and a higher level of care coordination is needed in order to manage the child’s multiple needs.

Level 6: **Secure, 24-Hour, Services With Psychiatric Management.** Most commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs could be met through the Wrap Around process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for optimal care and that the transition to lower levels of care are smooth.

All of these levels will be discussed in greater detail, beginning on page 24 of this document.
PART V

PLACEMENT METHODOLOGY

As noted earlier, each dimension is defined along a scale of one to five. Each score in the scale is defined by one or more criteria. Only one of these criteria needs to be met for a score to be assigned to the subject. The clinician should select the highest rating level in each dimension that most accurately identifies the child or adolescent’s condition.

Having provided you an overview of the dimensions, the rating system should be discussed. Once you have chosen a rating in each dimension, you use the composite score to arrive at a placement recommendation. The recommendation describes a level of resource intensity which best suits a given patient according to their needs. It does not mean that the child, adolescent or family needs to comply with the recommendation, nor that these are the only services that can be offered. The child, adolescent or family may have an option to choose a lower level of care than that being recommended, unless they are being involuntarily committed for their own safety or the safety of others.

Once scores have been assigned in all six-dimension parameters, they should be recorded on the worksheet and summed to obtain the composite score. Using the CALOCUS determination grid will now give you a rough estimate of the level of care recommendation. It is important to remember that in some cases, independent criteria are defined that will automatically place the child or adolescent in a specific level of care. This may be indicated regardless of their scores in other dimensions. For example, if an adolescent scores very high in suicidal or dangerous behavior, and has no ability to protect their safety outside of the protected setting, then that particular score would indicate placing the child or adolescent in at a level six intensity of service (usually provided in a locked psychiatric setting) no matter what other circumstances existed. These independent criteria are marked in the AACP/AACAP Level of Care Determination Decision Tree (see page 38) and the AACP/AACAP Level of Care Determination Grid (see page 40). The CALOCUS decision tree should be used for the most accurate recommendation. Though the independent criteria may predetermine the level of care, please complete the CALOCUS to obtain ratings in each dimension and a composite score.

When you come to assigning levels of care, there will be some treatment systems that do not have comprehensive services for all populations at every level of the continuum. If this is the case, then the level of care recommended by the CALOCUS may not be available, and a choice will need to be made as to whether more intensive services, or less intensive services, should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This again will lead us to err on the side of caution and safety, rather than risk and instability. The CALOCUS Decision Tree is the most accurate way of determining what level of care a child/adolescent child or adolescent should be offered. Although it may at first sight look complicated, it is fairly simple to use once you become familiar with it. When using the CALOCUS Decision Tree, always begin at the appropriate “Entry Point” found at the top of the page. Then questions pertaining to the score in each dimension will help you arrive at a recommended level of care. It is important, when first using the Decision Tree, to read the questions carefully and pay close attention to the “ands” and “ors” before selecting a Yes or No response.
As a busy clinician you neither have to memorize the definition of each level of care, nor do you have to know the criteria for placement at that level. However, as you become more familiar with the criteria you will then be able to complete your assessments quicker and easier. Eventually you will want to develop an array of services that are available within your treatment system, for each level of care outlined in CALOCUS. So, when a level of care placement recommendation is given, you will know what services are needed to approach the requirements of that level, and also what pieces may need to be appended in order to complete the treatment plan. Services can always be customized according to local and cultural needs.

CALOCUS is a system that is not overly prescriptive. It is flexible and adaptable, and describes an array of services, and level of service or resource intensity, rather than a level of care per se. This quality should allow your treatment system to incorporate CALOCUS with ease.
CALOCUS INSTRUMENT

Evaluation Parameters for Assessment of Service Needs

Definitions

DIMENSION I. RISK OF HARM
This dimension considers a child or adolescent’s potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent’s risk of harming him/herself and of harming others. While Risk of Harm most frequently is manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretations of reality; inability to adequately care for oneself or temper impulses with judgment; or intoxication. Furthermore, Risk of Harm may be manifested by a child or adolescent’s inability to perceive threats to safety and to take appropriate action to be safe. In this regard, younger children and children with developmental or other disabilities, unless protected, are more vulnerable. It also is true that children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

In addition to direct evidence of potentially dangerous behavior or vulnerability from interview and observation, other factors should be considered in determining the likelihood of such behavior, such as past history of dangerous behavior and/or abuse and/or neglect, ability to contract for safety, and ability to use available supports. It also is important to be alert to racial or ethnic biases that may lead clinicians to misinterpret behaviors as threatening or dangerous.

1. LOW RISK OF HARM
   a. No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation.
   b. No indication or report of physically or sexually aggressive impulses.
   c. Developmentally appropriate ability to maintain physical safety and/or use environment for safety.
   d. Low risk for victimization, abuse, or neglect.

2. SOME RISK OF HARM
   a. Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention and no significant distress.
   b. Mild suicidal ideation with no intent or conscious plan and with no past history.
   c. Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others.
   d. Substance use without significant endangerment of self or others.
   e. Infrequent, brief lapses in the ability to care for self and/or use environment for safety.
   f. Some risk for victimization, abuse, or neglect.
3. SIGNIFICANT RISK OF HARM
   a. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.
   b. No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior.
   c. Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g. status offenses, impulsive acts while intoxicated; self-mutilation; running away from home or facility with voluntary return; fire-setting; violence toward animals; affiliation with dangerous peer group.)
   d. Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors.
   e. Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways.
   f. Serious or extreme risk for victimization, abuse or neglect.

4. SERIOUS RISK OF HARM
   a. Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child or adolescent has expressed ambivalence about carrying out the safety plan and/or his/her family’s ability to carry out the safety plan is compromised.
   b. Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction; repetitive fire setting or violence toward animals.)
   c. Indication of consistent deficits in ability to care for self and/or use environment for safety.
   d. Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
   e. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety.

   Note: A rating of serious risk of harm requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

5. EXTREME RISK OF HARM
   a. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior;
      i. Without expressed ambivalence or significant barriers to doing so, or
      ii. With a history of serious past attempts that are not of a chronic, impulsive, or consistent nature, or
      iii. In presence of command hallucinations or delusions that threaten to override usual impulse control.
b. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (e.g., fire setting with intent of serious property destruction or harm to others or self, planned violence and/or group violence with other perpetrators) with history, plan, or intent, and no insight and judgment (forcible and violent, repetitive sexual acts against others).

c. Relentlessly engaging in acutely self-endangering behaviors.

d. A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.

*Note: A rating of extreme risk of harm requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.*

**DIMENSION II. FUNCTIONAL STATUS**

This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities and to interact with others, changes in vegetative status, (such as sleeping, eating habits, activity level, or sexual interest), and capacity for self-care. Functioning may be compared against what would be expected for a given child or adolescent at a given developmental level, or may be compared to a baseline functional level for that individual. For the purposes of this dimension, only sources of impairment directly related to developmental, psychiatric, and/or substance use problems should be considered. While other types of disabilities may play a role in determining the support services required, they generally will not be considered in determining level of care placement in the behavioral treatment continuum. Functional deficits that are ongoing and may place a child or adolescent at risk of harm are rated on Dimension I. An example would be the failure of an autistic child to understand the risk of safety when crossing a busy intersection. Clinicians also need to be aware that psychosocial functioning may be underestimated in the context of low socioeconomic status or different expectations about functioning for children and adolescents of culturally distinct backgrounds.

1. **MINIMAL FUNCTIONAL IMPAIRMENT**
   a. Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care/hygiene/control of bodily functions.

   b. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative vegetative status.

2. **MILD FUNCTIONAL IMPAIRMENT**
   a. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationships with peers, adults, and/or family (e.g., defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems), or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention.

   b. Sporadic episodes during which some aspects of self-care/hygiene/control of bodily functions are compromised.

   c. Demonstrates significant improvement in function following a period of deterioration.
3. MODERATE FUNCTIONAL IMPAIRMENT
   a. Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression.
   b. Self-care/hygiene deteriorates below usual or expected standards on a frequent basis.
   c. Significant disturbances in vegetative activities, (such as sleeping, eating habits, activity level, or sexual interest), that do not pose a serious threat to health.
   d. School behavior has deteriorated to the point that in-school suspension has occurred and the child is at risk for placement in an alternative school or expulsion due to their disruptive behavior. Absenteeism may be frequent. The child is at risk for repeating their grade.
   e. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
   f. Recent gains and/or stabilization in functioning have been achieved while participating in treatment in a structured, protected, and/or enriched setting.

4. SERIOUS FUNCTIONAL IMPAIRMENT
   a. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
   b. Significant withdrawal and avoidance of almost all social interaction.
   c. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
   d. Serious disturbances in vegetative status, such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning.
   e. Inability to perform adequately even in a specialized school setting due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.

Note: A rating of serious functional impairment requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

5. SEVERE FUNCTIONAL IMPAIRMENT
   a. Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors.
   b. Complete withdrawal from all social interactions.
   c. Complete neglect of and inability to attend to self-care/hygiene/control of biological functions with associated impairment in physical status.
   d. Extreme disruption in vegetative function causing serious comprise of health and well being.
e. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.

*Note:* A rating of severe functional impairment requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions. The only exception to this is if the sum of IVA & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

**DIMENSION III. CO-MORBIDITY: DEVELOPMENTAL, MEDICAL, SUBSTANCE USE, AND PSYCHIATRIC**

This dimension measures the coexistence of disorders across four domains (developmental medical, substance use, and psychiatric); but does not consider co-occurring disturbances within each domain. Coexisting disorders across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive, or additional, services. Physiologic withdrawal states related to substance use should be considered medical co-morbidity for scoring purposes. Clinicians must be alert to the under-recognition of co-morbidity in children from lower socioeconomic backgrounds and culturally distinct backgrounds that are underserved.

*NOTE:* If a child or adolescent has more than one disorder in the same domain (e.g., two medical, developmental, substance use, or psychiatric disorders), the second does not count as “co-morbidity” for purposes of scoring on CALOCUS. For example, two medical disorders, such as diabetes and asthma or two psychiatric disorders, such as attention deficit hyperactivity disorder and major depressive disorder, are not counted as additional co-morbidity for the purposes of scoring CALOCUS.

**1. NO CO-MORBIDITY**

a. No evidence of medical illness, substance abuse, developmental disability, or psychiatric disturbances apart from the presenting problem.

b. Past medical, substance use, developmental, or psychiatric conditions are stable and pose no threat to the child or adolescent’s current functioning or presenting problem.

**2. MINOR CO-MORBIDITY**

a. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and/or compensation.

b. Self-limited medical problems are present that are not immediately threatening or debilitating and that have no impact on the presenting problem and are not affected by it.

c. Occasional, self-limited episodes of substance use are present that show no pattern of escalation, with no indication of adverse effect on functioning or the presenting problem.

d. Transient, occasional, stress-related psychiatric symptoms are present that have no discernable impact on the presenting problem.
3. SIGNIFICANT CO-MORBIDITY
   a. Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of treatment for the presenting problem or co-morbid condition, or adversely affects the presenting problem.
   b. Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma).
   c. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem.
   d. Substance abuse is present, with significant adverse effect on functioning and the presenting problem.
   e. Recent substance use that has significant impact on the presenting problem and that has been arrested due to use of a highly structured or protected setting or through other external means.
   f. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.

4. MAJOR CO-MORBIDITY
   a. Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia).
   b. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder.
   c. Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting problem.
   d. Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder.
   e. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.

   Note: A rating of major co-morbidity requires care at a level of 5 (non-secure, 24-hours services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

5. SEVERE CO-MORBIDITY
   a. Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
   b. Medical condition acutely or chronically worsens or is worsened by the presenting
problem.

c. Substance dependence is present, with inability to control use, intense withdrawal
   symptoms and extreme negative impact on the presenting disorder.

d. Developmental disorder is present that seriously complicates, or is seriously
   compromised by, the presenting disorder.

e. Acute or severe psychiatric symptoms are present that seriously impair functioning,
   and/or prevent voluntary participation in treatment for the presenting problem, or
   otherwise prevent recovery from the presenting problem.

*Note: A rating of severe co-morbidity requires care at level 6 (secure, 24-hour services with
psychiatric management), independent of other dimensions.*

**DIMENSION IV. RECOVERY ENVIRONMENT**

This dimension considers factors in the environment that may contribute to the onset or
maintenance of the primary disorder, and factors that may support a child or adolescent’s efforts
to achieve or maintain recovery. Supportive elements in the environment include, first and
foremost, the presence of stable, supportive, and ongoing relationships with family (biological or
adoptive) members. Other important supportive factors include the availability of adequate
housing and material resources, stable and supportive relationships with friends, employers or
teachers, clergy, professionals, and other community members. Clinicians must be alert to
underestimation of family, cultural, and community strengths, where such strengths/resources
may not be evident or may not be readily mobilized. Stressful circumstances may include
interpersonal conflict or trauma, life transitions, losses, worries relating to health and safety, and
difficulty in maintaining role responsibilities.

Because children and adolescents are more dependent on, and exert less control over, their
environment than adults, in the CALOCUS, the recovery environment encompasses the family
milieu, as well as the school, medical, social services, juvenile justice, and other components in
which the child or adolescent may receive services or be involved on an ongoing basis. Two
sub-scales are used to measure this dimension: Environmental Stress and Environmental
Support. These two sub-scales are designed to balance the relative contributions of these factors.

*Environmental Stress*

**1. MINIMALLY STRESSFUL ENVIRONMENT**

a. Absence of significant or enduring difficulties in environment and life circumstances are
   stable.

b. Absence of recent transitions or losses of consequence (e.g., no change in school,
   residence, or marital status of parents, or no birth/death of family member).

c. Material needs are met without significant cause for concern that they may diminish in
   the near future, with no significant threats to safety or health.
d. Living environment is conducive to normative growth, development, and recovery.

e. Role expectations are normative and congruent with child or adolescent’s age, capacities and/or developmental level.

2. MILDLY STRESSFUL ENVIRONMENT

a. Significant normative transition requiring adjustment, such as change in household members, or new school or teacher.

b. Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, or illness or death of distant extended family member that has moderate effect on child and family.

c. Transient but significant illness or injury (e.g., pneumonia, broken bone).

d. Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, or other factor.

f. Potential for exposure to substance use exists.

3. MODERATELY STRESSFUL ENVIRONMENT

a. Disruption of family/social milieu (e.g., move to significantly different living situation, absence or addition of parent or other primary care taker, serious legal or school difficulties, serious drop in capacity of parent or usual primary care taker due to physical, psychiatric, substance abuse, or other problem with expectation of return to previous functioning).

b. Interpersonal or material loss that has significant impact on child and family.

c. Serious illness or injury for prolonged period, unremitting pain, or other disabling condition.

d. Danger or threat in neighborhood or community, or sustained harassment by peers or others.

f. Role expectations that exceed child or adolescent’s capacity, given his/her age, status, and developmental level.

4. HIGHLY STRESSFUL ENVIRONMENT

a. Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment.

b. Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence, or immersion in alien and hostile culture.

c. Inability to meet needs for physical and/or material well-being.

d. Exposure to endangering, criminal activities in family and/or neighborhood.

e. Difficulty avoiding substance use and its effects.
5. EXTREMELY STRESSFUL ENVIRONMENT
   a. Traumatic or enduring and highly disturbing circumstances, such as 1) violence, sexual abuse or illegal activity in the home or community, 2) the child or adolescent is witness to or a victim of a natural disaster, 3) the sudden or unexpected death of a loved one, 4) unexpected or unwanted pregnancy.
   b. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.
   c. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.
   d. Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.

Environmental Support

1. HIGHLY SUPPORTIVE ENVIRONMENT
   a. Family and ordinary community resources are adequate to address child’s developmental and material needs.
   b. Continuity of active, engaged primary care takers, with a warm, caring relationship with at least one primary care taker.

2. SUPPORTIVE ENVIRONMENT
   a. Continuity of family or primary care takers is only occasionally disrupted, and/or relationships with family or primary care takers are only occasionally inconsistent.
   b. Family/primary care-takers are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
   c. Special needs are addressed through successful involvement in systems of care (e.g., low level special education, tutoring, speech therapy.)
   d. Community resources are sufficient to address child’s developmental and material needs.

3. LIMITED SUPPORT IN ENVIRONMENT
   a. Family has limited ability to respond appropriately to child’s developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.
   b. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
   c. Family or primary care-takers demonstrate only partial ability to make necessary changes during treatment.
4. MINIMALLY SUPPORTIVE ENVIRONMENT
   a. Family or primary care taker is seriously limited in ability to provide for the child’s developmental, material, and emotional needs.
   b. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet.
   c. Family and other primary care takers display limited ability to participate in treatment and/or service plan (e.g., unwilling, inaccessible, cultural dissonance).

5. NO SUPPORT IN THE ENVIRONMENT
   a. Family and/or other primary care takers are completely unable to meet the child’s developmental, material, and/or emotional needs.
   b. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults.
   c. Lack of liaison and cooperation between child-servicing agencies.
   d. Inability of family or other primary care takers to make changes or participate in treatment.
   e. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent, and/or threatening others.

DIMENSION V. RESILIENCY AND TREATMENT HISTORY

This dimension records that a child or adolescent’s ability to self-correct when there are disruptions in the environment. This includes the ability to use the environment as well as the child/adolescent’s own internal resources. This judgment can be made by considering how well the child or adolescent has responded to the treatment in the past, but consideration should also be given to responses to stressor and life changes.

For children/adolescents who have faced major life changes and respond adaptively, the score will be low. For children/adolescents who are sensitive to minor changes such as schedule disruptions, the score will be higher. Most children in the autistic spectrum struggle with particular sensitivities that leave them much less flexible to manage the minor bumps of life.

With regard to treatment, children may respond well to some treatment situations and poorly to others. The treatment response in some cases may not be related to level of intensity, but rather to the characteristics, attractiveness, and/or cultural competency of the treatment provided. However, children and adolescents rarely have long histories of prior treatment upon which to evaluate resiliency, thus responses to stressors and life changes with no professional involvement should be considered as well.
Most recent experiences in treatment or care take precedence over more remote experiences in determining the score. For younger children who may not have extensive involvement in any treatment, responses to developmental challenges without professional involvement may be as indicative of resiliency as treatment history.

Recovery for children and adolescents is defined not only as a period of stability and control of problems, but also as a continuation or resumption of progress toward an expected developmental level for a given child or adolescent.

1. FULL RESILIENCY AND/OR RESPONSE TO TREATMENT
   a. Child has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
   b. Prior experience indicates that efforts in most types of treatment have been helpful in controlling the presenting problem in a relatively short period of time.
   c. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.
   d. Able to transition successfully and accept changes in routine without support; optimal flexibility.

2. SIGNIFICANT RESILIENCY AND/OR RESPONSE TO TREATMENT
   a. Child demonstrated average ability to deal with stressors and maintain developmental progress.
   b. Previous experience in treatment has been successful in controlling symptoms but more lengthy treatment is required.
   c. Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings or ongoing care and/or peer support.
   d. Recovery has been managed for short periods of time with limited support or structure.
   e. Able to transition successfully and accept changes in routine with minimal support.

3. MODERATE OR EQUIVOCAL RESILIENCY AND/OR RESPONSE TO TREATMENT
   a. Child has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.
   b. Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
   c. Recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.
   d. Has demonstrated limited ability to follow through with treatment recommendations.
e. Developmental pressures and life changes have created temporary stress.
f. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.

4. POOR RESILIENCY AND/OR RESPONSE TO TREATMENT
a. Child has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.
b. Previous treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure to treatment.
c. Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.
d. Developmental pressures and life changes have created episodes of turmoil or sustained distress.
e. Transitions with changes in routine are difficult even with a high degree of support.

5. NEGLIGIBLE RESILIENCY AND/OR RESPONSE TO TREATMENT
a. Child has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level.
b. Past response to treatment has been quite minimal, even when treated at high levels of care for extended periods of time.
c. Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.
d. Developmental pressures and life changes have created sustained turmoil and/or developmental regression.
e. Unable to transition or accept changes in routine successfully despite intensive support.

DIMENSION VI. TREATMENT ACCEPTANCE AND ENGAGEMENT

The Acceptance and Engagement dimension measures both the child or adolescent’s, as well as the parent and/or primary care taker’s, acceptance of and engagement in treatment. For the purpose of this document, treatment includes an array of therapeutic interventions to address the child’s, adolescent’s, and parent and/or primary care taker’s needs. The sub-scales reflect the importance of the parent and/or primary care taker’s willingness and ability to participate pro-actively in the intake, planning, implementation, and maintenance phases of treatment. It also is critical to note that a parent or primary care taker’s cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Care should be taken to note barriers to proper assessment and treatment based on cultural differences between the youth and parent and/or primary care taker and the clinician. If needed, consultation with or
addition of culturally congruent staff may eliminate cultural barriers to effective assessment and treatment.

Only the highest of the two sub-scale scores (child or adolescent vs. parent and/or primary care taker) is added into the composite score. In addition, if a child or adolescent is emancipated, the parent and/or primary care taker sub-scale is not scored.

**Child or adolescent acceptance and engagement**

The child or adolescent sub-scale measures the ability of the child or adolescent, within developmental constraints, to form a positive therapeutic relationship with people in components of the system providing treatment, to define the presenting problems, to accept his or her role in the development and perpetuation of the primary problem, and to accept his or her role in the treatment planning and treatment process, and to actively cooperate in treatment.

1. **OPTIMAL**
   a. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
   b. Able to define problem(s) and accepts others’ definition of the problem(s), and consequences.
   c. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
   d. Actively participates in treatment planning and cooperates with treatment.

2. **CONSTRUCTIVE**
   a. Able to develop a trusting, positive relationship with clinicians and other care providers.
   b. Unable to define the problem, but accepts others’ definition of the problem and its consequences.
   c. Accepts limited age-appropriate responsibility for behavior.

3. **OBSTRUCTIVE**
   a. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
   b. Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.
   c. Minimizes or rationalizes problem behaviors and consequences.
   d. Unable to accept others’ definition of the problem and its consequences.
   e. Frequently misses or is late for treatment appointments and/or is noncompliant with treatment, including medication and homework assignments.
4. ADVERSARIAL
   a. Actively hostile relationship with clinicians and other care providers.
   b. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.

5. INACCESSIBLE
   a. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness.
   b. Unaware of problem or its consequences.
   c. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.

Parent and/or primary care taker acceptance and engagement

The parent and/or primary care taker sub-scale measures the ability of the parents or other primary care taker to form a positive therapeutic relationship, to engage with the clinician in defining the presenting problem, to explore their role as it impacts on the primary problem, and to take an active role in the treatment planning process.

1. OPTIMAL
   a. Quickly and actively engages in a trusting and positive relationship with clinician and other service providers.
   b. Sensitive and aware of the child or adolescent’s needs and strengths as they pertain to the presenting problem.
   c. Sensitive and aware of the child or adolescent’s problems and how they can contribute to their child’s recovery.
   d. Active and enthusiastic in participating in assessment and treatment.

2. CONSTRUCTIVE
   a. Develops positive therapeutic relationship with clinicians and other primary care takers.
   b. Explores the problem and accept others’ definition of the problem.
   c. Works collaboratively with clinicians and other primary care takers in development of treatment plan.
   d. Cooperates with treatment plan, with behavior change and good follow-through on interventions, including medications and homework assignments.

3. OBSTRUCTIVE
a. Inconsistent and/or avoidant relationship with clinicians and other care providers.
b. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.
c. Unable to collaborate in development of treatment plan.
d. Unable to participate consistently in treatment, with inconsistent follow-through.

4. ADVERSARIAL
   a. Contentious and/or hostile relationship with clinician and other care providers.
b. Unable to reach shared definition of the development, perpetuation, or consequences of problem.
c. Able to accept child or adolescent’s need to change, but unable or unwilling to consider the need for any change in other family members.
d. Engages in behaviors that are inconsistent with the treatment plan.

5. INACCESSIBLE
   a. No awareness of problem.
b. Not physically available.
c. Refuses to accept child or adolescent, or other family members’ need to change.
d. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.
PART VII

CALOCUS LEVELS OF CARE UTILIZATION CRITERIA

The levels of care described in CALOCUS represent a graded continuum of treatment responses designed for use with the CALOCUS dimensional assessments and composite score. At each level of service, a broad range of programming options, allowing for variations in practice patterns and resources among communities, is described. The continuum encompasses traditional services, as well as newer forms of care, such as those in programs inspired by CASSP Principles. Each level of care subsumes the services at every level of care below it. (See Appendix A)

The system of care described in this document includes, but is not limited to, services provided by mental health, social services, juvenile justice, health, education, substance abuse, vocational, developmental disability, and recreational agencies, as well as other programs with unique funding streams and overlapping functions.

Children and adolescents with multiple complex problems usually require the services of multiple components within the system of care. In these cases, integrating care is essential. This document advocates for the use of “child and family” teams, composed of family members, supportive members of the family’s community, and service providers from a spectrum of components in the system of care. These teams give families a role in directing care by bringing together with the family all those with the potential to assist the child or adolescent. These teams may be given various names in different localities, but should include representatives from as many components as necessary from the local system of care. Optimally, Wraparound service principles form the basis for sharing resources and blending services in an individualized service plan for a child or adolescent and family. (VanDenBerg & Grealish, 1996)

The CALOCUS levels of care also provide rough estimates of the staff time involved in providing services at different levels. The actual service time required by each child or adolescent and family is highly variable. However, in the aggregate, service time estimates may be of value to program planners.

**Level of Care Transitions**

The service needs of a child or adolescent and family in treatment are likely to change as treatment progresses. For example, the needed level of care may drop below the provided level of care, and/or the youth’s status may indicate that care may be better provided in either traditional or wraparound configurations. Level of care transitions need not occur sequentially. It may be desirable for a child or adolescent to remain at a higher level of care to preclude relapse and unnecessary disruption of care, and to promote lasting stability.

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A child or adolescent may make the transition to another level of care when, after an adequate period of stabilization and based on the family’s and treatment team’s clinical judgment, the child or adolescent meets the criteria for the other level of care. Re-administration of CALOCUS can help clinicians determine a child or adolescent’s readiness for another level of care, and can help identify the foci of subsequent treatment. A flexible Individualized Service (Wraparound) Plan can facilitate seamless transitions, with the same clinicians and staff providing care at multiple service levels whenever possible.

**Multidisciplinary Treatment Teams**

This document supports the view that many types of agencies and professionals, when providing services within their scope of practice, are integral to the successful treatment of children and adolescents. Programs should be licensed to offer the requisite services for the levels of care provided and should have the staff and program capabilities necessary to provide those services. In addition, while this document does not specify requirements for the levels of clinician training, clinicians should be highly trained, with applicable licensure and/or certification (e.g., child and adolescent psychiatrists, pediatricians, family doctors, child and adolescent psychologists, marriage and family therapists, clinical social workers, professional counselors, psychosocial nurses, independent nurse practitioners, substance abuse clinicians, and/or pastoral counselors), and with training specifically in child, adolescent, and family treatment. Clinicians should provide only care that is within their scope of practice. Non-credentialed staff or paraprofessionals providing therapeutic services as part of the treatment plan should receive supervision by licensed practitioners with training and expertise in child, adolescent, and family treatment. In addition, family members and/or members of the child or adolescent’s community may provide an array of basic (non-clinical) services.

Nothing in this document precludes a child and adolescent psychiatrist from being the primary clinician for both psychotherapeutic and medication services. In addition, at all levels of care including crisis intervention, back-up coverage by child and adolescent psychiatrists is an essential element of the service system.

The levels of care are described along a continuum of restrictiveness and intensity. No recommendations in this document supersede Federal, State, or local licensing or operating requirements for agencies, programs, or facilities.

Even with conscientious assessment and scoring of CALOCUS, critical differences among children and adolescents and their families may demand an Individualized Service Plan encompassing services at more than one level of care. Measured and informed clinical judgment and service planning with the family take precedence. Reasons for deviation from the level of care recommended by the instrument should be documented by the clinician in the case record.
LEVEL 0. BASIC SERVICES FOR PREVENTION AND MAINTENANCE

Basic Services are designed to prevent the onset of illness and/or to limit the magnitude of morbidity associated with individual family or social risk factors, developmental delays, and existing emotional disorders in various stages of improvement or remission. Services may be developed for individual or community application and are generally offered in a variety of community settings. Prevention and community support may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings).

1. CLINICAL SERVICES. It is imperative that Basic Services in all settings provide screening for mental health and developmental disorders. Comprehensive, multidisciplinary assessments for children and adolescents who, after initial screening, emerge with multi-faceted problems should be readily available. Expert evaluations should be readily available. Linkage with mental health and substance abuse services (e.g., scheduling intakes) should be provided to families identified in screening assessment. Consultative services by mental health clinicians should be effectively integrated into all prevention and support functions. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Basic Services should be available to children, adolescents, and families through active collaboration with religious and culturally distinct community groups, and in a variety of community settings, including schools and adult education centers, day care and recreational/social facilities, vocational and social services agencies, and medical facilities. Community volunteers and agency staff should be trained to provide prevention services.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. 24-hour crisis services should be publicized, accessible, and fully integrated into Basic Services in all community settings. Crisis services should include emergency evaluation, brief intervention, and disposition. Child and adolescent psychiatrists and/or psychosocial nurses should be available for direct contact and consultation on a 24-hour basis. Additional crisis intervention and stabilization efforts should include outreach to vulnerable populations, such as homeless families, as well as intervention with victims of trauma and disaster.

4. CARE ENVIRONMENT. Prevention and community support activities may occur in many settings, from a child or adolescent’s home, to schools, churches, medical and recreational facilities, or traditional mental health settings. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); cultural competence (e.g., ambiance that is welcoming
to families of multiple ethnic and socio-economic groups) and specific service needs (e.g., supervised day care so that parents can participate, staff or consultants for non-English speaking and/or hearing-impaired attendees).

Placement Criteria

All children, adolescents, and families should receive Basic Services.

LEVEL ONE. RECOVERY MAINTENANCE AND HEALTH MANAGEMENT

Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those appropriate for Level One services either may be substantially recovered from an emotional disorder or other problem, or, their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development.

1. CLINICAL SERVICES. While clinical services at Level One may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of care. Clinical consultation and assessment should be culturally competent and should consider the extent to which families can mobilize natural supports in the community. Time-limited professional interventions, as well as ongoing case management and follow-up medication services may be provided as part of Level One clinical services. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Level One support services consist mainly of natural supports in the community, including extended family, family friends, and neighbors; church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of care have the capacity to access these community resources as needed without professional intervention.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. 24-hour crisis services should be available to children, adolescents, and families at this level of care. Crisis intervention staff should consult with primary clinicians. Crises services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or psychosocial nurses should be available in each community on a 24-hour basis.
4. **CARE ENVIRONMENT.** Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), or in facilities of other components in the system of care. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

**Placement Criteria**

Children and adolescents with composite scores in the range of 10-13 generally may be stepped down to or receive Level One services. Placement at Level One usually indicates that the child or adolescent has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past, or does not need services that are more intensive or restrictive than those offered at Level One. Placement determinations should be made by culturally competent staff or with consultation by culturally competent clinical specialists.

**COMPOSITE SCORE (Level 1)**

| 10 - 13 |

**LEVEL TWO, OUTPATIENT SERVICES**

This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health clinics or clinicians’ offices. Services also may be provided within a juvenile justice facility, school, social service agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of care, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of care, but continuity of at least one treatment relationship often is essential to maintenance at optimal levels of functioning. Clinicians offering follow-up at Level Two must provide continuing individual and family assessment with the capacity to add needed services as necessary.
1. **CLINICAL SERVICES.** Clinical services for outpatient care consist primarily of individual, group, and family therapies with active family participation in treatment planning and implementation. Treatment intensity ranges from one hour every other week, to two hours per week, unless the primary service consists of monthly medication management. Psychiatric and cultural competency consultation to the treatment team should occur regularly. Medication, evaluation and management may be an essential element. Child and adolescent psychiatrists and psycho-social nurses should be part of the primary treatment team for medication services and 24-hour back-up. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) should be made available as indicated. Medical care from either a pediatrician or family physician should be available in the community.

2. **SUPPORT SERVICES.** Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12-step and other self-help groups; school-sponsored programs; and employment. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal case management. Families also may need support for financial, housing, or child-care problems, or for accessing vocational and education services. These should be included as part of the child or adolescent’s individualized service plan.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** 24-hour crisis services should be accessible to children, adolescents, and families at this level of care. Furthermore, crisis services should be provided in collaboration with the family’s other service providers. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and psychosocial nurses should be available on a 24-hour basis.

4. **CARE ENVIRONMENT.** Outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings. Facilities used for treatment should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.
Placement Criteria

Children and adolescents with a composite score in the range of 14-16 generally may begin treatment at, or be stepped down to, Level Two services. Placement at Level Two indicates that the child or adolescent does not need services that are more intensive/restrictive than those offered at Level Two, or has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

**COMPOSITE SCORE (Level 2) 14 - 16**

**LEVEL THREE, INTENSIVE OUTPATIENT SERVICES**

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either in their families with support, or in alternative families or group facilities in the community. The family’s strengths allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision provided by the family or facility staff. Services may be provided in a mental health clinic or clinician’s office, but often are provided in other components of the system of care with mental health consultation. Service coordination is essential for maintaining the child or adolescent in the community at Level Three. Medical care from either a pediatrician or family physician should be available in the community.

1. **CLINICAL SERVICES.** Level Three services incorporate individual, group, and family therapy. Level Three services increasingly depend on the use of “child and family” teams as service coordination becomes more complex. Service intensity averages approximately three days per week. Psychiatric consultation to the treatment or “child and family” team should occur regularly. Medication management may be an essential part of treatment. Child and adolescent psychiatrists and psychosocial nurses are part of the treatment team providing medication services and 24-hour back-up. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) may be used as indicated. In addition, referrals for clinical services for other family members may be needed. Transition planning for discharge to a lower level of care should be part of the services plan. Medical care from either a pediatrician or family physician should be available in the community.

2. **SUPPORT SERVICES.** Level Three support services include case management by a culturally competent primary clinician or case manager, or with cultural competency consultation as needed. Support services for these children, adolescents, and families should emphasize natural and culturally congruent supports within the community, such
as extended family, neighborhood, church groups, self-help groups and community employers. Families may have difficulty accessing elements of the system of care without professional help due to the complexity of their child or adolescent’s problems. In addition, families may need support for financial, housing, child-care, vocational, or education services. These should be included as part of the child or adolescent’s individualized service plan.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** 24-hour crisis services, including child and adolescent psychiatric and nursing consultation and/or direct contact, should be available at this level of care. Crisis services should be accessible and, when provided, crisis team personnel should contact the family’s primary service providers. Crisis services should include emergency evaluation, brief intervention, and outreach.

4. **CARE ENVIRONMENT.** Intensive outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings. The site should have the capacity for short-term management of aggressive or other endangering behavior. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

**Placement Criteria**

Children and adolescents with scores in the range of 17-19 generally may begin treatment at, or be stepped down to, Level Three services. Placement at Level Three generally is excluded by a score of 4 or higher on any dimension. Placement at Level Three indicates that the child or adolescent either does not need more intensive or restrictive services, or has successfully completed treatment at a higher level of care and needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with cultural competency specialists.

**COMPOSITE SCORE (Level 3)**

17 - 19
LEVEL FOUR. INTENSIVE INTEGRATED SERVICES WITHOUT 24-HOUR PSYCHIATRIC MONITORING

This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs must require the involvement of multiple components within the system of care. For example, an adolescent may require the services of a probation officer, a mental health clinician, a child and adolescent psychiatrist, and a special education teacher to be maintained in the community. These children and adolescents, therefore, need intensive, clinically informed case management to coordinate multi-system and multidisciplinary interventions. Optimally, an individualized service plan is developed by a “child and family” team. Services are delivered more frequently and for more extended periods than at lower levels of care. Services in this level of care include partial hospitalization, intensive day treatment, and home-based wraparound care. Level Four services also may be provided in schools, substance abuse programs, juvenile justice facilities, social services group care facilities, mental health facilities, or in the child or adolescent's home.

1. CLINICAL SERVICES. Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and psychosocial nurses should be determined in consultation with the primary clinician and the child and family team. Primary medical care should be accessible as an integrated part of the comprehensive array of services. Interventions may include individual, group, and family therapy, and may be organized into protocols such as occur in day treatment, or offered as part of a comprehensive wraparound plan. Services may be offered within any of the components of the system of care. Services should be designed for flexibility, as part of an Individualized Service Plan, and with emphasis on building on the strengths of the child or adolescent and family. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Level Four case management services are provided to coordinate the multi-faceted service needs of the children and adolescents and their families at this level of care. Recreational activities, after-school employment, church programs, and other community activities may be integrated into the Individualized Service Plan to form a graded continuum of natural, clinical, and culturally congruent supports, with emphasis on natural supports when available. Families are likely to need support for financial, housing, child-care, vocational, and/or education services. These should be included as part of the child or adolescent’s Individualized Service Plan.
Services should be family-centered, with the goals of either maintaining or reintegrating the child or adolescent into the home and community.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** At Level Four, children, adolescents, and families must have access to 24-hour emergency evaluation and brief intervention services that include direct contact and/or consultation by a child and adolescent psychiatrist or psychosocial nurse. Crisis services must be mobile and integrated into the care plan. Crisis services may be offered by a number of components in the system of care, although care should be taken to avoid service duplication. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of care.

At Level Four, respite care may be offered to families to provide relief from the demands of caring for the child or adolescent and as a “cooling off” mechanism during crises and while treatment plans are implemented.

A Wraparound team’s capacity for managing a child or adolescent at Level Four is partially determined by their age, size, and developmental level, as well as the strengths and size of the team. An inability to manage risk of harm may be reflected in a higher composite score on CALOCUS, and justifies transfer to a more restrictive setting or intensification of the wraparound program to offer active medical monitoring or management.

4. **CARE ENVIRONMENT.** Level Four services may be provided in an outpatient clinic or hospital (e.g., partial or intensive day treatment), any component in the service system (e.g. public or private day school, juvenile detention center, group home), or in the home (e.g., home-based services). The facility must have the capacity for short-term management of aggressive or other endangering behavior. Transportation needs should be accommodated, both for staff to serve children and adolescents in community settings and to help children, adolescents, and families access services. When home-based treatment is provided, staff transportation needs should be addressed. To optimize family participation, Level Four facilities should be located as near as possible to the child or adolescent’s home. Facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people). For adolescents, facilities should allow for a mix of adult supervision and privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.
Placement Criteria

Children and adolescents with scores in the range of 20-22 generally may begin treatment at, or be stepped down to, Level Four services. Placement at Level Four indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

COMPOSITE SCORE (Level 4)  20 - 22

LEVEL FIVE. NON-SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MONITORING

This level of care refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized residential schools, and could be provided in homeless and/or domestic violence shelters or other community settings. It also is possible to provide Level Five services in a child or adolescent’s home, if wraparound planning and resources can provide the needed service intensity in the less restrictive environment. Level Five services include development of a Wraparound program, initiated by the “child and family team” preparing them for the child or adolescent’s re-integration into their family and community and/or treatment in lower levels of care. Ideally, the step-down plan represents a modification of the comprehensive Level Five service plan, providing continuity of care and integrating the child or adolescent’s treatment experiences into the return to the community setting.

1. CLINICAL SERVICES. Programs for children or adolescents in residential settings, or with wraparound plans offering Level Five services in the community, comprise the core treatment at this level of care. The primary clinician should review the child or adolescent’s progress daily and debrief back-up staff as needed. Child and adolescent psychiatrists are integral members of the treatment team and, if not the primary mental health clinician, serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation. Medication management should be available. Treatment modalities may include individual, group, and family therapy, with substance abuse services, either as the primary treatment or as an element of a comprehensive program, available as indicated. Primary medical care should be an accessible integrated part of the comprehensive array of services. Non-credentialed child care staff who work in residential programs and who participate as part
of intensive Wraparound programs should be considered part of the clinical team, participate in treatment planning, be actively supervised and trained, and follow the treatment plan. Staff and programs should be culturally competent, with access to cultural competency consultation as needed. Treatment should be family-centered. The goal of treatment for children or adolescents in out-of-home placements should be a timely return to the family and community. Thus, transition planning should be considered in daily clinical review. Medical care from either a pediatrician or family physician should be available in the community.

2. **SUPPORT SERVICES.** Active case management is integral to care at Level Five regardless of which component of the system of care is the lead service provider. Children and adolescents in Level Five programs should receive adequate supervision for activities of daily living. Supervised off-campus passes or excursions into the community from a home-based wraparound program should be provided. Facility or program staff, supportive family members, and/or family friends identified by the “child and family” team may provide basic support services, including recreational, social, or educational activities, and, as needed, escort to substance abuse or self-help groups. Families may need help for problems with housing, child care, finances, and job or school problems. These services should be integrated into the child or adolescent’s individual service plan.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** Children and adolescents at Level Five may require higher levels of care for brief periods to manage crises. Services may include seclusion and/or restraint interventions, as well as crisis medication, with supervision by a child and adolescent psychiatrist or other senior clinician within their scope of practice. The treatment team should address with the family the conditions under which seclusion and restraint or other behavioral interventions are initiated and terminated. These interventions should be used in accordance with the legal requirements of the jurisdiction and ethical professional practices.

More restrictive care may be needed temporarily because the team cannot safely manage acute exacerbations in the child or adolescent’s risk of harm status or sudden deteriorations in functioning. Reevaluation using the dimension scales of CALOCUS may yield a composite score supporting admission level six. When more restrictive or intensive services are provided outside of the residential unit or wraparound plan, the staff of all involved service components should collaborate with the family to plan a timely return to lower levels of care. In addition, the treatment plan should be reviewed for adequacy in meeting the child or adolescent’s fluctuating needs.

4. **CARE ENVIRONMENT.** When care at level five is provided institutionally, living space must be provided that offers reasonable protection and safety given the developmental status of the child or adolescent. Physical barriers preventing easy egress from or entry to the facility may be used, but doors at Level Five facilities are not
regularly locked. Staffing and engagement are the primary methods of providing security both in facilities and in Wraparound plans. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room for unlocked seclusion and maintain supervision of the other children or adolescents). Capacity for transporting residents off-campus for educational or recreational activities is a critical element of Level Five services.

Level Five facilities should be located as near as possible to the child or adolescent’s home. In addition, facilities for Level Five activities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). Facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

Placement Criteria

Children and adolescents with scores in the range of 23-27 generally may begin treatment at, or may be transitioned into, Level Five services. Placement at Level Five indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for Level Five services should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

COMPOSITE SCORE (Level 5)  

23 - 27
LEVEL SIX. SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MANAGEMENT

Level Six services are the most restrictive and often, but not necessarily, the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of care also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these facilities are able to adhere to medical and psychiatric care standards needed at Level Six. Level Six services also may be provided in community settings, including a child or adolescent’s home, if mental health and medical services are organized at the required intensity and security measures are adequate. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects.

1. CLINICAL SERVICES. Every child or adolescent requiring Level Six services can be presumed to be in a crisis or near crisis state, and therefore, clinical services should reflect the highest level of service intensity and restrictiveness for the protection of the child or adolescent, the family, and the community. Clinical services must be comprehensive and relevant to the emergent and safety issues at hand. Children and adolescents at Level Six require monitoring and observation on a 24-hour basis. Treatment modalities may include individual, group and, intensive family therapy as well as medication management, and are aimed at managing the crisis, restoring previous levels of functioning, and decreasing risk of harm. Substance abuse treatment at Level Six may include social or medical detoxification. Occupational and recreational therapy may be helpful as indicated. The treatment plan must be family-centered and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family physician should be available in the community.

Treatment at Level Six may be organized by a child and adolescent psychiatrist supervising the care provided by the multi-disciplinary treatment team. Child and adolescent psychiatric and nursing services should be available on a 24-hour basis. A member of the treatment team leadership (e.g., a child and adolescent psychiatrist, psychosocial nurse, or other senior clinician) should have daily contact with the child or adolescent. The child and adolescent psychiatrist should consult regularly with the family and the “child and family” team to assure integration of Level Six services with the care provided at previous levels of care. Review of the child or adolescent’s status by the treatment team should occur daily, with the goal of transition planning for a rapid return to lower levels of care. Uncomplicated or specialized transition plans may be necessary, depending on the child or adolescent’s or family’s needs during step-down. All children and adolescents leaving Level Six services must have a well-defined crisis plan that anticipates and accommodates complications during transition to lower levels of care. Medical care from either a pediatrician or family physician should be available in the community.
2. **SUPPORT SERVICES.** All necessities of living and well-being must be provided for children and adolescents treated at Level Six. The children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. A “child and family” team should be created, if not already in place, mobilizing the strengths of the child or adolescent and family to provide support during the crisis and in aftercare. When capable, children and adolescents should be encouraged to participate in treatment planning, and should maintain activities of daily living, such as hygiene, grooming, and maintenance of their immediate environment. Families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Case management for coordination of services provided after transition to lower care levels should begin while the child or adolescent receives Level Six services. Discharge planning should include integration of the child or adolescent into the home and community, and linkage with social services, education, juvenile justice, and recreational resources as needed. All support services should be described in the Individualized Service Plan.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. Crisis stabilization may include seclusion and/or restraint interventions as well as crisis medication, under the supervision of a child and adolescent psychiatrist or other professional within their scope of practice. The treatment team should address with the family the conditions under which seclusion and restraint interventions are initiated and terminated, and these interventions should be in accordance with legal requirements and ethical professional practices. Emergency medical services should be available on-site or in close proximity and all staff should have training in emergency protocols.

4. **CARE ENVIRONMENT.** In most cases, Level Six care is provided in a closed and locked facility. Alternative settings must have an equivalent capacity for providing a secure environment. Facilities should have space that is quiet and free of potentially harmful items, with adequate staffing to monitor child or adolescent using such a space (e.g., seclusion, restraint, and/or holding). Facilities and staff also should provide protection from potential abuse from others. Level Six facilities should be capable of providing involuntary care.

Level Six facilities, or their alternatives, should be located as near as possible to the child or adolescent’s home. In addition, these facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.
**Placement Criteria**

Children and adolescents with scores of 28 or higher are appropriate for treatment at Level Six. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff and/or with consultation by cultural competency specialists.

**COMPOSITE SCORE (Level 6)**  

28 or higher
## LEVEL OF CARE COMPOSITE SCORE TABLE

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>Basic Services for Prevention and Maintenance</td>
<td>7-9</td>
</tr>
<tr>
<td>One</td>
<td>Recovery Maintenance and Health Management</td>
<td>10-13</td>
</tr>
<tr>
<td>Two</td>
<td>Outpatient Services</td>
<td>14-16</td>
</tr>
<tr>
<td>Three</td>
<td>Intensive Outpatient Services</td>
<td>17-19</td>
</tr>
<tr>
<td>Four</td>
<td>Intensive Integrated Services Without 24-Hour Psychiatric Monitoring</td>
<td>20-22</td>
</tr>
<tr>
<td>Five</td>
<td>Non Secure, 24-Hour psychiatric Monitoring</td>
<td>23-27</td>
</tr>
<tr>
<td>Six</td>
<td>Secure, 24-Hour Psychiatric Monitoring</td>
<td>28+</td>
</tr>
</tbody>
</table>
ENTRY POINT
Use Entry Point on this page if composite score is 16 or less and score of more than 4 is not present on Dimension I, II, or III. Otherwise, use entry Point on Page 2

Perform Six Dimension Assessment

Is score 2 or less on all dimensions?

no

Is sum of Dim. IV-A + IV-B 4 or less?

no

Is Dim IV-B score 2 or less?

yes

Is score 3 or more present on Dim. IV-A, IV-B, or V?

no

Is score of 3 present on Dimension I, II, or III?

yes

Is composite at least 14?

no

Has patient completed treatment at a higher level of care?

no

Is composite score 10 or more?

yes

Enroll in Level One Recovery Maintenance Health Management

Is Dim V 2 or less and sum of Dim IV-A + IV-B 5 or less?

no

Is score of 3 present on Dimension I, II, or III?

yes

Admit to Level Three Intensive Outpatient

Is composite at least 17 and not more than 19?

no

Is score 3 or more present on Dim. IV-A, IV-B, or V?

yes

Go to page 2 Line “B”

Is score 3 present on Dimension I, II, or III?

no

Is composite at least 14?

yes

Enroll in Level Two Outpatient

Is composite score 10 or more?

no

BASIC SERVICES

-1-
LEVEL OF CARE DECISION TREE Part B
CALOCUS LEVEL OF CARE DETERMINATION DECISION TREE

ENTRY POINT
Use entry point on this page for composite scores greater than 16. Otherwise, use entry point on page 1.

Perform Six Dimension Assessment

Is score of 2 present on two or more dimensions?
Yes
Go to Page 1 Line "A"

No

Is Score 4 or more on any dimensions?
Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is composite score 28 or greater?
Yes

Enroll in Level Six Secure 24-hr Services with Psychiatric Management

No

Is score less than 4 on dimension V & VI?

Yes

Are dimensions IV-A & IV-B both equal to one?

Yes

Is composite score 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?
Yes

No

Is score less than 4 on Dim I?

Yes

Enroll in Level Four Intensively Integrated Services without 24-hour Psychiatric Monitoring

No

Is score of 5 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is score less than 4 on dimension V & VI?

Yes

Are dimensions IV-A & IV-B both equal to one?

Yes

Is composite score 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?

Yes

No

Go to Page 1 Line "C"

Yes

No

C

Go to Page 1 Line "C"

B

No

Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is composite at least 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Yes

No

Is score less than 4 on Dim I?

Yes

Enroll in Level Four Intensively Integrated Services without 24-hour Psychiatric Monitoring

No

Is score of 5 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is score less than 4 on dimension V & VI?

Yes

Are dimensions IV-A & IV-B both equal to one?

Yes

Is composite score 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?

Yes

No

Go to Page 1 Line "C"

Yes

No

C

Go to Page 1 Line "C"

B

No

Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is composite at least 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?

Yes

No

Go to Page 1 Line "C"

Yes

No

C

Go to Page 1 Line "C"

B

No

Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is composite at least 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?

Yes

No

Go to Page 1 Line "C"

Yes

No

C

Go to Page 1 Line "C"

B

No

Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is composite at least 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?

Yes

No

Go to Page 1 Line "C"

Yes

No

C

Go to Page 1 Line "C"

B

No

Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is composite at least 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?

Yes

No

Go to Page 1 Line "C"

Yes

No

C

Go to Page 1 Line "C"

B

No

Yes

Is score of 4 present on dimension I, II, or III?

Yes

Is Score 4 on Dim. II or III and does score on both Dim. IV-A & IV-B equal one?

No

Is composite score 28 or greater?

Yes

No

Is composite at least 20 and not more than 22?

Yes

Admit to Level Five Non-Secure 24-hr Services with Psychiatric Monitoring

No

Is composite 23 or more?

Is ACT present and dimension IV-A 2 or less?
### AACP / AACAP LEVEL OF CARE DETERMINATION GRID

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Recovery Maintenance Health Management</th>
<th>Outpatient</th>
<th>Intensive Outpatient</th>
<th>Intensively Integrated w/o 24-hr Psych Mon.</th>
<th>Non-Secure 24-hr Services with Psych Monitoring</th>
<th>Secure 24-hr Services with Psych Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 5</td>
<td>Level 6</td>
</tr>
<tr>
<td>I.  Risk of Harm</td>
<td>2 or less</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>II. Functional Status</td>
<td>2 or less</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>III. Co-Morbidity</td>
<td>2 or less</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or less</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>IV A. Recovery Environment</td>
<td>Sum of IV A + IV B</td>
<td>Sum of IV A + IV B</td>
<td>Sum of IV A + IV B</td>
<td>3 or 4*</td>
<td>4 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>“Stress”</td>
<td>is 4</td>
<td>is 5</td>
<td>is 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV B. Recovery Environment</td>
<td>Sum of IV A + IV B</td>
<td>Sum of IV A + IV B</td>
<td>Sum of IV A + IV B</td>
<td>3 or less</td>
<td>4 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>“Support”</td>
<td>is 4</td>
<td>is 5</td>
<td>is 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V.  Resiliency &amp; Treatment History</td>
<td>2 or less</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or 4*</td>
<td>3 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>VI. Acceptance &amp; Engagement</td>
<td>2 or less</td>
<td>2 or less</td>
<td>3 or less</td>
<td>3 or 4*</td>
<td>3 or more</td>
<td>4 or more</td>
</tr>
<tr>
<td>Composite Rating</td>
<td>10 to 13</td>
<td>14 to 16</td>
<td>17 to 19</td>
<td>20 to 22</td>
<td>23 to 27</td>
<td>28 or more</td>
</tr>
</tbody>
</table>

*indicates independent criteria - requires admission to this level regardless of composite score

* Unless sum of IV A and IV B equals 2

+ See text for special circumstances
Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

<table>
<thead>
<tr>
<th>I. Risk of Harm</th>
<th>IV-B. Recovery Environment - Level of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Low Potential for Risk of Harm</td>
<td>□ 1. Highly Supportive Environment</td>
</tr>
<tr>
<td>□ 2. Some Potential for Risk of Harm</td>
<td>□ 2. Supportive Environment</td>
</tr>
<tr>
<td>Score _______</td>
<td>Score _______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Functional Status</th>
<th>V. Resiliency and Treatment History</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Minimal Impairment</td>
<td>□ 1. Full Response to Treatment</td>
</tr>
<tr>
<td>□ 2. Mild Impairment</td>
<td>□ 2. Significantly Resilient and/or Response to Treatment</td>
</tr>
<tr>
<td>□ 3. Moderate Impairment</td>
<td>□ 3. Moderate or Equivocal Response to Treatment and Recovery Management</td>
</tr>
<tr>
<td>□ 4. Serious Impairment</td>
<td>□ 4. Poor Response to Treatment and Recovery Management</td>
</tr>
<tr>
<td>□ 5. Severe Impairment</td>
<td>□ 5. Negligible Response to Treatment</td>
</tr>
<tr>
<td>Score _______</td>
<td>Score _______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Co-Morbidity</th>
<th>VI-A. Acceptance and Engagement - Child/Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. No Co-Morbidity</td>
<td>□ 1. Optimal</td>
</tr>
<tr>
<td>□ 2. Minor Co-Morbidity</td>
<td>□ 2. Constructive</td>
</tr>
<tr>
<td>□ 5. Severe Co-Morbidity</td>
<td>□ 5. Inaccessible</td>
</tr>
<tr>
<td>Score _______</td>
<td>Score _______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV-A. Recovery Environment - Level of Stress</th>
<th>VI-B. Acceptance and Engagement - Parent/Primary Caretaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Minimally Stressful Environment</td>
<td>□ 1. Optimal</td>
</tr>
<tr>
<td>□ 2. Mildly Stressful Environment</td>
<td>□ 2. Constructive</td>
</tr>
<tr>
<td>□ 3. Moderately Stressful Environment</td>
<td>□ 3. Obstructive</td>
</tr>
<tr>
<td>□ 5. Extremely Stressful Environment</td>
<td>□ 5. Inaccessible</td>
</tr>
<tr>
<td>Score _______</td>
<td>Score _______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Composite Score</th>
<th>Level of Care Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A. Clinical Level of Care Recommendation  
(Assign before using CALOCUS)  

B. Calculation of Composite CALOCUS Score  

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Dimension Rating (circle score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Risk of Harm</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2. Functional Status</td>
<td>1 2 3 4* 5</td>
</tr>
<tr>
<td>3. Co-Morbidity</td>
<td>1 2 3 4* 5</td>
</tr>
<tr>
<td>4. Recovery Environment</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Environmental Stressors</td>
<td></td>
</tr>
<tr>
<td>Environmental Support</td>
<td></td>
</tr>
<tr>
<td>5. Resiliency and Treatment History</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6. Acceptance and Engagement</td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Parent and/or primary care taker</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

(Note: please record the higher of the two scores)

Note: **Bold** indicates independent criteria-requires automatic admission to a higher level of care regardless of combined score. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six.  
* = independent criteria may be waived if sum of IV-A and IV-B scores equal 2.

COMPOSITE CALOCUS SCORES (add right column)  

C. CALOCUS Derived Level of Care Recommendation (Consult Grid and Decision Tree)  

D. Actual (Disposition) Level of Care  

Reason for Variance from CALOCUS Level of Care Recommendation  

Patient/Family Name:  

Date of Scoring:  

Name of Scorer:  

---
Cassandra Dawn Williams  
2938 Trinity Peaks Way  
Grand Junction, Colorado 81504  
Phone: (970) 589-0004

SCHOLARSHIPS AND AWARDS
- Employee of the Month; May 2002: Mesa Developmental Services
- Mesa State Presidential Scholar; fall of 1996 thru spring of 1998
- Colorado Press Association $2,500 Scholarship/Internship 02/98
- School Colorado Academic Scholarship $1,000: Language & Literature Department 04/97
- El Dorado High School “Most Outstanding Leadership Award” 05/89
- El Dorado High School “Outstanding English Award” 05/88

EMPLOYMENT HISTORY:
02/2015 – Present
**Case Management Director:** Mesa Developmental Services, Grand Junction, Colorado

Responsible for the oversight and supervision of the case management department for Mesa Developmental Services. Job duties include developing and implementing training of case management practices and procedures for all new and on-going staff. Monitoring and evaluating case management practices to ensure service delivery is within the guidelines set forth by state rules/regulations as well as agency policy. Regular evaluation of case management staff job performances and providing feedback and training as needed. Assisting and advising case management staff on the development and maintenance of necessary documentation, monitoring requirements, client advocacy, conflict resolution and referral for additional or alternative support services as needed. Communicating with state representatives as necessary for resolution with billing issues, requests for information, survey and resulting outcomes, as well as notification of individual enrollments, transfers and discharges from services.

10/2011 – 02/2015
**Senior Case Manager:** Mesa Developmental Services, Grand Junction, Colorado

Responsible for implementing, coordinating and monitoring the case management process for assigned individuals. Serving as an advocate for assigned individuals and assisting in attaining goals and objectives in conjunction with program providers. Establishing and convening Interdisciplinary Teams for assigned individuals, completing required assessments and developing annual Service Plans reflecting individual’s needs and desired goals. Developing Service Authorizations for the payment of support services as outlined in the SP and pre-authorized through CCMS.
Monitoring services and supports regularly for effectiveness include observing individuals in their residential and program sites, documenting issues or conditions affecting individual’s progress, responding to client service needs and monitoring for signs of abuse/neglect/exploitation. Regularly communicating with individuals, family members, advocates/guardians, program providers and others as necessary for coordination of services/supports. Modifying documentation to reflect programmatic changes as needed. Assuring individual records are maintained. Coordinating the movement of individuals within the developmental disabilities system as well as exit from the system. Also responsible for providing training/support to new case managers as well as ongoing support for all other employees within the case management department.

06/2008 – 09/2011
Senior Case Manager: Mesa County DHS, Grand Junction, Colorado
Responsible for implementing, coordinating and monitoring the case management process for assigned client’s including evaluating client’s functional eligibility for Medicaid services and setting up/monitoring services as outlined in the client’s Service Plan.

Case Manager: Mesa Developmental Services, Grand Junction, Colorado
Responsible for implementing, coordinating and monitoring the case management process for assigned clients. Serving as a client advocate and assisting them in attaining goals and objectives through MDS and outside agency programs. Coordinating and monitoring resources and service delivery within MDS and outside service providers. Establishing and convening Interdisciplinary Teams for assigned clients, completing required assessments (100.2 and Supports Intensity Scale) and developing annual Service Plans. Monitoring services and regularly evaluating client progress and service effectiveness. Working with clients, their family members and program staff and observing clients at program sites on a regular basis. Documenting issues or conditions affecting client progress, investigating and responding to client service needs and monitoring for signs of abuse/neglect and notifying adult protection as needed. Routinely modifying the Service Plan to reflect programmatic changes, submitting Prior Authorization Requests and maintaining CCMS database. Coordinating the movement of clients within the developmental disabilities system or exit from the system.

Residential Supervisor: Mesa Developmental Services, Grand Junction, Colorado
Responsible for the overall management and supervision of two group homes, one for dually diagnosed adults and the other for developmentally disabled adults with behavioral difficulties. Job duties included assuring clients
receive all habilitation services identified in their I.P.’s including development/implementation of ISSP’s and SESP’s and provision of other identified services and supports. Developing and maintaining work schedules for each facility and assuring staff work within the scheduled hours. Routinely observing staff performance on all shifts and providing feedback, coaching and support. Conducting regular meetings to address staff and program issues. Participating in screening and interviewing for open positions. Assuring facilities are maintained in a clean and safe manner and meet the standards set by the health department. Monitoring and maintaining program budgets.

**Residential Aide: Mesa Developmental Services, Grand Junction, Colorado**  
Responsible for the care of eight developmentally disabled adults. Job duties included accessing community services, implementing support plans, encouraging independence, providing personal care and daily documentation.

**Reporter: Palisade Tribune, Palisade, Colorado**  
Responsible for news gathering, interviewing, reporting and writing news and feature stories.

**EDUCATION**  
Mesa State College, Grand Junction, Colorado  
**BACHELOR’S IN MASS COMMUNICATIONS (EMPASIS: PUBLIC RELATIONS & WRITING)**  
Degree: July 1998 (Summa Cum Laude)

Fullerton College, Fullerton, California  
**ASSOCIATE’S IN LIBERAL ARTS**  
Degree: June 1995
Current Work Experience

I started working as an RN for Mesa Developmental Services in 1988. I was responsible for staff education, direct care and case management for all individuals in services, and employee health for staff members. In 1998 I worked with the Director of Behavioral Health Services and Colorado West Mental Health Agency developing a Psychiatric Clinic to better serve the needs of our population. I've coordinated that clinic for the past 17 years, as well as presenting to the Human Rights Committee for Strive. We currently work with a Psychiatrist and Psychiatric Nurse Practitioner from Mind Springs in Grand Junction, CO.

In 1996 I became the Director of Nursing, managing a staff of 4 RNs. The Nursing Department grew to accommodate the needs of the agency, as our census increased and we continued to serve more medically challenged individuals in the community.

In 2009 I assisted in the development of three 8 bed houses that served individuals needing highly skilled medical care as they transitioned out of the Grand Junction Regional Center. These individuals required 24/7 Nursing Care on-site. These are the only houses in the state of Colorado currently offering that level of care for the population we serve.

Currently, as VP of Medical Supports, I oversee the Nursing Department at Strive, as well as coordinating the Psychiatric Clinic, and functioning as QA manager for medical staff.

Work experience

Rocky Mountain HMO Grand Junction, CO 1985 — 1988
Home Health Nurse/Discharge Planning Nurse
Participated in the Health Fair annually, certified all HMO staff in CPR/First Aid, presented classes to Nursing staff on assessment skills, worked with Mesa College Nursing students as part of their Home Health education.

St. Mary's Hospital Grand Junction, CO 1981 — 1985
Charge Nurse of Cardiac Care Unit
Worked as Charge Nurse of an Intensive Cardiac Care Unit. Instructor of Basic Arrhythmia class for all new employees, Instructor of Coronary Class for local Police and Fire Department, Instructor of Advanced Cardiac Life Support.

Kootenai Memorial Hospital Coeur d'Alene, ID 1977 — 1981
RN
Started as staff nurse in the ICU-CCU from 1977-1978, promoted to Day Charge Nurse of CCU in February of 1978 and worked in that capacity until November of 1981. While in that position I assisted in the development of a Cardiac Rehab Program at the hospital. Instructed an arrhythmia class for RNs, LPN, and EMTs. Gave a presentation on how to develop a Cardiac Rehab Program to the Idaho Nurses Association at their State Convention in 1980.

RN
I worked as a staff nurse in the CCU initially, from 1973-1975. I was then promoted to Day Charge Nurse in the Intermediate CCU and Cardiac Rehab floor from 1975-1976. In 1976 I was given the opportunity to work in the Cardiac Catheterization Lab, assisting the Cardiologist performing the procedures.
Qualifications

In 1992 I assisted with the development of the Colorado Association of Nurses for the Developmentally Disabled (CANDD), and continue to be a Charter Member of that organization. I have been a member of the National organization (DDNA) as well, attending their annual conferences to receive ongoing education in the DD/ID field of Nursing, as well as completing the DDRN certification through that agency.

Education

North Dakota State University

Graduated from North Dakota State University with a degree in Nursing in 1973.

References

References available upon request.
Christina Cruz
3051 N. 14th St., Grand Junction, Co. 81506
H: 970-256-9377, C: 970-250-0727
E-mail: Pristine57@aol.com

Education:
Colorado Mesa University
Bachelor of Arts, Psychology: May 2006
Bachelor of Arts, Criminal Justice: December 2009
Adams State University
Master’s Counseling Psych/Mental Health: May 2014

Coursework:

Experience/Internship:
Mesa County Sheriff’s Department, Fall 2007/Spring 2008
Performed research under the direction of Professor Gizzi, Under-Sherriff Speiss, and Lieutenant Hendricks on the efficiency and effectiveness of the MCSO.
Intervention Inc. under the direction and supervision of Professor Michael Bozeman, MDS (Strive) working with Karen Reinertsen in Behavioral Health.

Therapist/Clinical Behavioral Specialist: 05/14 to Present
As a therapist/behavior specialist, I am responsible for individual and group counseling, behavioral consultations, assessments, and functional analysis severing individual who are dually diagnosed with an intellectual disability and mental illness. I work on an inter-disciplinary team (OT, Nursing, Case Management, and Behavioral Team) on a daily basis in serving individuals. I conduct several groups including; Relaxation, Circles (boundaries), and a Skills Group with and emphasis in DBT.

Direct Staff Provider: Strive a.k.a as Mesa Developmental Services: 03/13 – 05/14
Providing direct care and support services for individuals who are receiving services. Ensuring that individuals are living to the fullest potential possible. This entails working with individuals who have been diagnosis with developmental in addition to mental health diagnosis.

Customer Service and Home Health: SCS an Activstyle Co., 05/06 – 03/13
Performed marketing and customer service calls to home health agencies, and customers in over 17 states
Professionally engaged with customers and handled conflict resolution. Developed excellent time-management skills.
Residential Youth Services/Youth Coach: Hilltop, 12/04 – 05/06
Supervised and worked with high risk youth, and their families in a high structured environment. Worked extensively with youth offenders to help reintegrate them back into the community.

Customer Service, SCS an Activstyle Co.: 03/03 – 12/04
Provided efficient and effective customer service. Developed excellent organizational skills to handle customers needs. Controlled customer transactions within 17 different states

References: Available upon request
Elaine A. Wood

29113 North Road
Hotchkiss, CO 81419
970-640-9712

Education:
- Bachelor of Science: Special Education, Rehabilitation, Counseling and Related Services
  University of Northern Colorado – Greeley, CO
  Graduated 1980
  (1979-1980 Internship with Division for Vocational Rehabilitation through the Department of
  Corrections in Canon City and Colorado Springs)

Work Experience:
- Community Options: May 14, 1985 to present
  Case Manager:
  - Manage a caseload of 40+ individuals with Developmental Disabilities
  - Demonstrate a respect and enjoyment working with those with Developmental Disabilities
  - Coordinate the development and implementation of the SP
  - Facilitate team planning process (SP’s, special staffings, etc.)
  - Completion of the functional assessment, SP, DDD section, IPCS
  - Monitor those services identified and received
  - Provide conflict resolution, negotiation, crisis intervention and mediation as needed
  - Participate in various committees (HRC, Placement, Steering, etc.)
  - Serve as liaison between and consultant to other agencies (DHHS, Law Enforcement, attorneys, local schools, etc.)
  - Maintain a caseload that has individuals with children. Requires working closely with the Children’s case manager and Children’s services – have an understanding of some of those processes (Child Find, EI, FSSP)
  - Complete all necessary paperwork, including, but not limited to forms related to: HCBS-DD funding; HCBS-SLS funding; HCBS-CES; TCM; CORE; requests for emergency resources; level of need checklists; etc.
  - Plan and organize work effectively; perform complex writing skills; maintain files
  - Manage stress, stressful situations and adapt readily and effectively to change
  - Exercise discretion and independent judgment
  - Work independently and promote a sense of responsibility and professionalism
  - Attend appropriate trainings
  - Participated in the deinstitutionalization of those living at SJLC and the placement of those who moved from Harold’s Group Home
  - Presented 1st client and several thereafter to Behavior Pharmacology Clinic
Promoted to Assistant Case Management Director 10/01/1994 to present:
- Maintain caseload with higher numbers and those with challenging issues (Parents with Developmental Disabilities; CES; Regional Center; Offenders/legal issues, etc.)
- Provide support and back-up to Case Management Director
- Supervised benefits specialist position until move to the Delta/Cedaredge area. Performed duties of that job when specialist was on vacation, extended medical leave, etc. (Completed food stamp applications, Medicaid applications, handled tax documents, benefits reporting, etc.)
- Directly supervise the case manager at Aspen Crest (support, direction, evaluation, etc.)
- Actively participated in or initiated development of internal systems (IP’s, quarterlies, etc.)
- Over the last 18 years, performed many of the duties of the Case Management Director when she was gone on vacations, extended medical leaves, etc.:
  - Supervision of all case management staff
  - Complete and send necessary reports to the state (vacancy, HCA, etc.)
  - Serve as second BUS Administrator
  - SIS (trained and served as interviewer)
  - QIS (trained and serve as evaluator)
  - CCT (trained and will perform duties of Intensive Case Manager as required)
  - PASARR (trained and perform duties as required)
  - Coordinate, organize and facilitate meetings as needed: HRC, Eligibility, Placement, etc.
  - Attend Admin team meetings as requested
  - Member of Delta County Adult Protection Team
  - Provide training to other agencies
  - Attend Case Management Director meetings as requested
  - Have extensive history and knowledge of systems, processes

  Additional employment during that time with International Rehabilitation Associates as a Rehabilitation Specialist

- Unyeway Inc. – Ramona Activity Center – Ramona, California: 1982 – 1984 as a vocational team leader at a day program providing services to persons with Developmental Disabilities

- Cheyenne Village – Colorado Springs, CO: 1980 – 1982 as a vocational team leader at a vocational site providing services to persons with Developmental Disabilities
**Extracurricular Activities/Achievements:**

- Established the 1st ever soccer program in Delta County School District
- 11 years Head Coach of the Boys Soccer Program now located at Delta High School
- 2008- Made history by coaching the boy’s high school soccer team to the first ever soccer State Championship on the Western Slope. Was voted Western Slope League Coach of the Year and Colorado Coach of the Year. Was selected to and coached at the All State Game
- 21+ years coach of multiple recreation and competitive soccer teams (have coached hundreds of children)
- Yearly certification as FIFA referee (governing organization of world soccer)
- President of Hotchkiss Youth Soccer
- Past President/current member (21+ years) of Delta County Youth Soccer
- Active member of Colorado High School Coaches Association
- Active member of Colorado High School Soccer Coaches Association
- Active member of National Soccer Coaches Association
- Active member of National Federation of High Schools
- Former member and newly re-appointed member of the North Fork Pool Park and Recreation District Board of Directors (NFPPRD-Special District serving the North Fork)
- Was part of former Governor Romer’s Smart Growth Plan. Formed and served on first ever Leroux Creek Planning Committee (reporting to Delta County Planning and the County Commissioners). Mediated public meeting between 200 community members and Delta County regarding land use. Was recognized for my mediation skills and the ability to facilitate a potentially volatile group and keep everyone focused and on task.
- Served on the Cottonwood Golf Course Board of Directors. Served on task force with the City of Delta regarding a new golf course.
- For 2 years, coordinated/organized golf tournament fundraiser for Community Options

**References:**

Kelly Roy – Delta County DHHS Supervisor  872-1201  
Esther Koontz – NFPPRD Administrator  872-6122  
Tammy Smith – Delta County School District School Board Member  872-2196
Jacqueline Marie Skramstad  
1215 Riverview Drive  
Glenwood Springs, Co 81601

**Education:**  
Santa Clara University, Santa Clara, CA  
Bachelor of Science in Psychology, Emphasis in Biology  
June 1989  
San Jose State University, San Jose, CA  
Master of Social Work  
May 1994

**Licensure:**  
Licensed Clinical Social Worker in California August 1998- May 2002  
Licensed Clinical Social Worker in Colorado May 2002- Present

**Special Skills:** Moderate written and verbal Spanish language skills

**Experience:**  
Mind Springs Health

<table>
<thead>
<tr>
<th>Date</th>
<th>Position</th>
<th>Responsibilities and Responsibilities</th>
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<tbody>
<tr>
<td>7/1/15-</td>
<td>Regional Director</td>
<td>Senior management level position responsible for 3 counties in the Mind Springs Health service area. Insure that the programs are implementing services consistent with the direction of the agency and that the services Meet the compliance standards set by the agency. Provide supervisory supervision to the 3 program directors.</td>
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<tr>
<td>Present</td>
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<tr>
<td>1/1/06-</td>
<td>Program Director</td>
<td>Clinical and administrative oversight for all of the services and programs provided by Mind Springs Health in Garfield County. This includes managing the budget, program development, community collaboration, grant writing, and hiring and retention of staff. This position includes making sure the clinical programming meets the standards set forth by Mind Springs Health and providing needed clinical training and supervision to insure the quality of the services provided. I also maintain a limited caseload.</td>
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<tr>
<td>7/1/15</td>
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<tr>
<td>8/03-12/31/05</td>
<td>Program Coordinator</td>
<td>Provide individual, family, and group therapy for a limited caseload consisting of adults, children, and families. I also have administrative responsibilities for the outpatient clinics in Garfield and Rifle. These responsibilities include providing clinical supervision for the outpatient therapists and participating on a rotation to provide after-hours supervision to the crisis team and detox program. I am also responsible for the hiring and training of clinical staff.</td>
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<tr>
<td>6/02-8/03</td>
<td>MHP III</td>
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</tbody>
</table>
Outpatient clinician that serves a variety of clients. Provide individual, family, and group therapy for children, adolescents, adults, and older adults. Conduct family assessments and convey treatment recommendations to the clients. Provide some after hours crisis service.

**San Benito County Mental Health**

8/99-4/02
Mental Health Clinician
Provided individual and family therapy for a varied caseload consisting of adults and children. Provided crisis services for the county including assessments for voluntary hospitalization. Coordinated the school-based services and provided the mental health assessments to determine if a student qualified for mental health services on his/her IEP.

**EMQ Children and Family Services**

12/94-8/99
Clinician
During the time I was a clinician in several different programs for the agency: a school-based day treatment program on a middle school campus, a residential treatment program, and an intensive day treatment program. Provided individual, family, and group therapy for youth ranging in age from 5 to 18. Also provided clinical leadership for the treatment teams that included paraprofessional staff.

8/93-12/94
Contract Worker for the Child and Adolescent Crisis Team
Provided mobile crisis response for the children and adolescents in Santa Clara County that were thought to be a danger to themselves or others. Conducted assessments to determine if the client met the criteria for an involuntary psychiatric hospitalization. Provided intervention and treatment planning to prevent the need for hospitalization.

6/92-8/93
Versatility Team Supervisor
Created and implemented a crisis response team for the residential treatment programs. The team responded to crisis on the campus as well as worked with residential staff to proactively distribute resources to the most at risk area.

6/92-8/93
Therapeutic Crisis Intervention Trainer (Cornell Model)
Trained staff in the method of crisis intervention used by the agency. This is a three day training for staff that includes methods for avoiding crisis, restraint techniques, and a format for conducting a follow-up interview with the client.

1/91-6/92
Program Supervisor
Provided direct supervision for six paraprofessional staff in a residential treatment program serving six adolescent/preadolescent girls. Maintained an effective staff schedule and maintained the program according to Community Care Licensing regulations.
Milieu Activity Therapist
10/89-1/91
Supervised six adolescent/preadolescent girls in a residential treatment facility. Guided them through their daily routine and planned therapeutic group activities.

Palo Alto VA Medical Center
9/93-5/94
Internship as a therapist
Completed a nine-month internship at the clinic. Provided individual therapy and case management services to a varied caseload. Co-facilitated a support group for clients suffering from PTSD. Followed several clients in a medication clinic to monitor stability on their medication. Provided crisis intervention, assessments, and inpatient admissions as part of a multidisciplinary resource team.

Andrew Hill High School
9/92-5/93
School counselor internship
Provided individual and group therapy at a high school on the East side of San Jose. The issues addressed in therapy varied from school performance, social issues, family issues, gangs, substance abuse, and domestic violence amongst the teenage girls and their boyfriends.
GOAL: To find a position in an academic setting that utilizes my education, experience and abilities.

Strongest Skills And Abilities

- Experience working within a government bureaucracy including knowledge of state statutes and regulations and assistance with formulating plans of correction following surveys
- Over a dozen years developing and teaching behavioral curriculums to a diverse student population
- Positive behavioral program development and design, including needs assessment, implementation, evaluation and monitoring
- Successful employee counseling and mediation
- Effective management of multiple projects and assignments
- Readily grasping and implementing difficult concepts
- Ability to meet tight deadlines
- Excellent communication skills, including public speaking and writing
- Outstanding interpersonal and teamwork skills
- Able to work independently and efficiently
- Dependable and reliable

Professional Experience 1997 to Present - State of Colorado Department of Human Services
Clinical Behavioral Specialist II
Grand Junction Regional Center
Grand Junction, Colorado

- Developed curriculums for and taught courses in Basic Study Skills, Behavior Programming, Human Growth and Development, Death and Dying, Alzheimer's, Our Court System, Therapeutic Communication, Therapeutic Mtieu, Professional Boundaries in Healthcare and Impulse Control Disorders (a college level course)
- Developed positive behavior programs for a caseload of 30 individuals with Developmental Disabilities, many with dual diagnoses that include mental illness and personality disorders
- Developed safety control plans as needed
- Assessed cognitive and adaptive skills using a variety of current assessment instruments
- Conducted functional assessment for residents and outreach clients
- Provided direction and consultation to interdisciplinary team, including residential staff and supervisors
- Provided crisis intervention to adult developmentally disabled population in the residential setting
- Analyzed behavioral data and made recommendations for program revision, as needed
- Provided employee mediation, counseling and support for direct care staff
- Facilitated group sessions including Anger Management Skills, Social Skills, Court Competency Group, Offender Group and Boundaries Group

2004 to 2008 - Self Employed

Consultant

- Provided cognitive and IQ assessment for Licensed Psychologist using current assessment instruments
- Conducted functional assessments for clients served by local Community Center Board
1982 to 1986 - Hiitop Rehabilitation Hospital
Grand Junction, Colorado

Department Supervisor for Administrative Assistants

- Provided secretarial support to Director and hospital Administrators
- Supervised a clerical staff of four
- Provided transcription services to Agency Physician

Training:

Foundations of Behavioral Analysis
Multicultural Services in Developmental Disabilities
Mediation Training (50 hours)
Zenger Miller Supervisory Training
Verbal Judo
Quality Assurance, How to Conduct Internal Investigations
Generations at Work
Verbal Defense and Influence

Education:

M.S., Psychology, California Coast University
B.A., Mesa State College
Aspinal Scholar 1997
President's List 1992-1997
Graduated Magna Cum Laude

References:

Sharon S. Jacksi, Ph.D., Vice President
Division of Behavioral Health and Wellness
Mesa Developmental Services
950 Grand Ave., Grand Junction, Co 81501
Direct: 970-256-8608

Shonna Davis
Service and Support Coordinator
Grand Junction Regional Center
2800 Riverside Parkway, Grand Junction, Co 81501
Direct: 970-5991

Linda Idell
Clinical Therapist, Speech
Grand Junction Regional Center
2800 Riverside Parkway, Grand Junction, Co 81501
Direct: 970-5996
Janice Curtis
2840 North Forest Court, Grand Junction, CO 81501 | 970-216-6441 | jcurtis@frontier.net

Professional Summary

SKILLS
- Program Creation - Create new programs, evaluate on-going needs and respond accordingly.
- Coordination – Coordinate programming for over 10 counties.
- Management of Personnel Resources – Interview, hire and manage peer staff and volunteers. Matrix manage with other supervisory staff.
- Education and Training – Train all peer staff and determine the training used in peer groups.
- Troubleshooting – Use Plan, Do, Study, Act. Work with other agency staff to improve continuity of care.

Experience

PEER SUPPORT SERVICES MANAGER | MIND SPRINGS HEALTH | 04/2000 TO PRESENT

Created the Peer Support Program for Mind Springs Health, which has expanded from one group a week to almost 20 groups a week in Mesa County. Initiated the addition of peer staff to the Crisis Stabilization Unit, the Mobile Crisis Response Team and in-home Crisis Respite. Provide direct supervision and supervision to peer groups.

Awards
- Presented the Mind Springs Health In-Home Crisis Respite at Alternatives, the National Consumer Conference, October 2015.
Joan Esther Levy

432 W. Sunset Drive
Fruita, CO. 81521

Academic Background

Birmingham High School; Van Nuys, CA.
Diploma awarded June, 1971

University of Colorado, Boulder
Bachelor of Arts, Psychology; May, 1976
Bachelor of Science, Therapeutic Recreation; December, 1978

University of Northern Colorado, Greeley
Master of Arts, Parks and Recreation Administration; June, 1983

University of Colorado, Denver
Master of Public Administration; May, 1994

Professional Experience

Mesa Developmental Services/STRIVE  Grand Junction, CO.
September, 1983 to present

Vice President/Quality Assurance (November 2012-Present) Responsibilities include:
• Develops and implements organizational quality assurance monitoring plan, ensures compliance with applicable statues and regulations and the provision of quality person-centered supports.
• Coordinates and oversees accreditation and licensure processes
• Oversees abuse/serious incident investigation process.
• Review contracts as assigned and assures compliance as such. Manages independent contractor process.
• Coordinates annual strategic planning activities and coordinates collection of data for strategic plan metrics.
• Serves as “gatekeeper” for all organization policies. Assures policies are assigned, developed and reviewed as required. Develops policies as assigned.
• Serves as agency safety coordinator. Chairs safety committee and oversees safety activities including safety inspections, safety training and accident investigation

Additional positions held at MDS/STRIVE include:

VP/Human Resources (2014-2015 concurrent with Quality Assurance)
• Oversight of all Human Resource functions including the following:
  o Refined and updated agency recruitment, screening and hiring processes.
- Oversight of disciplinary and termination processes.
- Participated in development of a new salary schedule.
- Managed all unemployment claims.
- Facilitated benefits administration including assisting in development and rollout of new ACA compliant health insurance package.
- Re-established the Strive safety committee and initiated a safety program.
- Developed and maintained Human Resources policies.
- Assured compliance with all applicable labor laws (including ACA, FMLA, FLSA, Colorado Worker’s Compensation Act) and completed applicable required submissions (i.e. EEO-1, OSHA 300)
- Provided requested HR support to Strive employees, supervisors and administrators.

Residential Director (1991-2012)
- Responsible for overall operation of all residential programs operated by MDS/Strive.
- Supervised Residential Supervisors, Occupational Therapists, Service/Support Specialists, Duty Officers and others responsible the day to day operation of the department.
- Had lead role in opening 8 group homes between 1985-2010 and was also responsible for the development of the SLS, PCA and Host Home programs at MDS/Strive.
- Developed policies and operational procedures related to residential services.
- Assured regulatory compliance.

Adult Services Supervisor/Coordinator (1988-1991)
- Supervised group homes, day and vocational programs.
- Responsible for the day-to-day operation of such programs including personnel management, program management, fiscal/budget management, regulatory compliance and contract compliance (vocational settings)

Program Services Coordinator (1986-1988)
- Supervised and trained program specialists who were responsible for assessment and program (ISSP) development for individuals in MDS’ residential and day programs.
- Developed assessment tools, curriculum and program templates.
- Collected, analyzed and maintained data regarding individual performance/progress on programs.

Recreational Therapist (1983-1986)
- Developed and implemented ongoing recreational programming for group home residents.
- Developed habilitation programs for residents, using recreational activities to facilitate personal growth and goal attainment.
- Facilitated an array of Special Olympics programs for individuals served by MDS (Track and Field, Bowling, Softball, Basketball and Swimming).
- Planned and facilitated outdoor recreation activities such as camping, fishing and rafting trips.

Weld County Community Center Foundation  Evans, CO.
February, 1979-August, 1983
• Recreational Therapist (3 1/2 years)
• Transportation Coordinator (1 year concurrent with Rec. Therapist)
• Residential Counselor (1 year)
Kimberly J. Boe
Cell: 970-260-5302 office: 970-683-7075
Kjboe58@yahoo.com

Healthcare Executive Operational Leader
As a Healthcare Operational expert, I have successfully lead a turnaround effort for West Springs Hospital, decreasing length of stay, increasing profitability, and improving Quality outcomes. West Springs Hospital is a 32 bed locked inpatient psychiatric Hospital, expanding from 32 beds to 75 beds, initially opening 11 Crisis stabilization beds and then planning a hospital expansion adding 32 additional inpatient beds. Outstanding ability to implement strategies and assemble quality teams that achieve superior results and performance.

PROFESSIONAL EXPERIENCE:

West Springs Hospital, Grand Junction, Colorado
Vice President of Inpatient Psychiatric Hospital - June 2009 to present:
• Directed successful turnaround of hospital operations, including improved Quality outcomes and financial performance resulting in hospital expansion effort. West Springs Hospital is expanding from 32 to 75 beds, initially adding 11 Crisis Stabilization inpatient beds, and planning for 32 additional inpatient beds in the future.
• Lead turn-around effort for psychiatric hospital, increasing daily census by 50%, decreasing length of stay by 3.3 days, and improving bottom line financials from $4,000,000 annual loss to break-even or positive bottom line.
• Interview and participate in recruitment efforts for all hospital vacancies in conjunction with Human Resources. Developed vacancy refill plan resulting in adequate staffing for patient acuity and conformance to staffing matrix.
• Serve on Corporate Leadership team, Development Committee, Marketing committee, Finance, Safety and Risk, Quality and Infection Control committees.
• Responsible to Hospital Board of Directors and corporate Board of Directors.
• Participate in Strategic planning, setting appropriate and achievable goals, and utilizing best practice to ensure quality services.
• Lead a strong team of 6 direct reports designing programming for 11 bed hospital expansion.
• Leading team of 5 direct reports in an ongoing effort to implement inpatient Electronic Heath Record including significant modification of modules to fit a hospital setting. Refinement and ongoing development at this time.
• Implemented concurrent documentation system for psychiatric providers and healthcare team resulting in improved efficiency, decreased failed activities and decreased use of transcription service. Effort resulting in approximate savings of $2,500/month.

Wyoming Behavioral Institute, Casper, Wyoming
Director of Admissions, Mobile Crisis Assessment team, Case Management/Utilization Review - May 1985-May 2008:
• Provided oversight and direction to team of 12 clinicians with focus on accepting referrals, assessing for level of care, and hospital admissions for 110 bed inpatient psychiatric hospital.
• Developed policies and procedures for Mobile Crisis Assessment services and worked closely with community partners to operationalize.
• Supervised inpatient Case Management team, including assuring concurrent insurance reviews were conducted in a timely manner, collateral information was obtained, and discharge planning occurred.
• Conducted all insurance denial appeals for facility. Denial rate of <6%
Moose Lake State Hospital, Moose Lake, Minnesota
Recreational Therapist – August 1980 to February 1984:

- Provided therapeutic recreational services and activities for adults patients hospitalized in state hospital facility. Conducted daily recreational therapy groups, developed therapeutic treatment plans, provided therapeutic outings for longer term residents including arranging for charitable donations and tickets to events in the northern part of Minnesota.
- Worked with a variety of client populations including those with Chemical Dependency issues, developmentally delayed adults, chronically mentally ill adults, and geriatric psychiatric individuals.

CAREER HIGHLIGHTS: Successful turn-around of West Springs Hospital. Improved bottom line from $ 4 million annual loss to break even and/or positive bottom line.

- Improved Quality outcomes, decreased length of stay, increased daily census, decreased insurance denials, increased provider productivity and efficiency.
- Experience in both not-for-profit and for-profit hospital settings

EDUCATION:

Master’s Degree of Management
Specialty focus: Human Resources Management
University of Phoenix 2007

Bachelor of Arts: Recreational Therapy
University of Northern Iowa, Cedar Falls, Iowa 1980

ADDITIONAL SKILLS AND ACCOMPLISHMENTS:

- Member of ACHE
- Implementation of multi-disciplinary treatment teams
- Introduction of new food vendor improving quality and food delivery
- Incorporation of Pharmacy services on-site
- Development of Partial Hospital Program
- Electronic Medical Record implementation
- Development of medical care program through recruitment of Family Nurse Practitioners
- Involved in contract review and refinement
- Excellent oral and written communication skills
- Knowledge of Lean Six Sigma and PDSA-have attained Yellow Belt status

REFERENCES AVAILABLE UPON REQUEST
Krista C. McClinton  
P O Box 4304  
Edwards, CO 81632  
(970)390.7916  
kristamccclinton@gmail.com

EXPERIENCE

1999 to current  
MIND SPRINGS HEALTH

December 2015 to present  
Vice President of Informatics
  • Integration of Financial Data and Clinical Analytics

July 2015 to present  
Director of Informatics
  • Provide organizational development expertise and industry trend in Electronic Health Records
  • Supervision of Data team and Electronic Health Record team
  • Develop company-wide outcomes protocols
  • Develop measures that demonstrate cross system values
  • Develop Balanced Score Card for Mind Springs, Inc.
  • Responsible for Key Performance Indicators

November 2011 to present  
Regional Director Rural/Resort Region  
Colorado Consortium Project Administrator

  • Performed all duties of the Assistant Regional Director
  • Led data/reporting team for the outpatient mental health center in order to produce reports for quality outcomes
  • Participated in Quality Management, Outcomes, and Data Team
  • Developed Key Performance Indicators (KPIs) for MSH
  • State involvement for CSTAT measures
  • Developed detox in Pitkin County through community collaborative
  • Transitioned detox in Garfield County into a Substance Use Outpatient Continuum
  • Developed budgets of Mind Springs Health and assisted in developing financial proforma
  • Participated in Lean Six Sigma State of Colorado event which resulted in standardized practices and assessments

August 2010 to November 2011  
Assistant Regional Director Rural/Resort Region

  • As a member of Senior Leadership and Executive Corporate Leadership teams, provided subject matter expertise as a part of Strategic Planning
  • Implemented Electronic Health Record throughout ten county offices as well as in West Springs Hospital
  • Supervised Program Directors in Eagle, Garfield and Pitkin counties
  • Obtained new funding from community partners
  • Developed detox in Eagle County through community collaborative
  • Conducted Leadership University courses, such as Strategic Planning, Change Management, Leadership Development
December 2004 to August 2010
Program Director, Eagle County
- Supervised therapists in clinical situations
- Oversaw internship program and provided clinical supervision
- Collaborated with organizations in community to educate adolescents on depression and suicide prevention
- Implemented substance abuse groups for adolescents
- Attained Employee Assistance Program contracts
- Maintained accurate paperwork
- Maintained balanced budget
- Re-established and build meaningful community relationships

December 1999 to December 2004
Mental Health Therapist, Emergency Services Therapist
- Assessed and counseled adults and adolescents in therapy sessions using cognitive-based approach
- Facilitated psychodeucational high school groups at two local high schools
- Conducted problem solving groups at Red Canyon High School
- Maintained accurate paperwork
- Responded to clients in crisis situations
- Evaluated high risk clients to assist in their safety
- Aided local schools, doctors, hospitals, jails in assessing clients
- Initiated hospitalization when necessary

1995 to 1999
EAST ALABAMA MENTAL HEALTH CENTER, Opelika, AL
Child/Adolescent Therapist, 1999
- Counseled children, adolescents, and adults in therapy sessions
- Provided group and individual therapy to local schools
- Responded to emergencies in all offices
- Instructed patient education classes
- Assisted medical team in medication assessment and management

Outreach Services Specialist/Case Manager for Mobile Intervention Team, 1995-1999
- Assisted in medication management for high risk clients
- Managed caseload of up to 50 clients
- Developed and implemented efficient intake process
- Simplified initial contact procedures
- Physically managed difficult clients using Nonviolent Crisis Intervention
- Educated clients about medication, mental illness, and personal needs
- Assessed employee training needs

EDUCATION
BS in Psychology, Auburn University (1992)
MS in Counseling Psychology, Troy State University (1999)

PROFESSIONAL DEVELOPMENT/COMMUNITY SERVICE
Certified Case Manager in Mental Health
Certified Patient Educator
Certified Love and Logic Facilitator
Licensed Professional Counselor (LPC) State of Colorado (3732)
Eagle River Youth Coalition Board Member
Wayfinder Board Member
Total Health Alliance Board Member, Executive Committee
Lean Six Sigma Yellow Belt
Alchemist, Alembic Institute, Kaiser Foundation
Steering Committee, West Regional Mountain Health Alliance
Resume’

Lynda A. Wonders
1445 Main Street
Grand Junction, CO 81501
(970) 712-4857

EDUCATION

Certificate of Administrator Training/Alternative Care Facilities-Colorado Department of Health Care and Policy 2008
Bachelor of Science-Weber University 1997
Associate of Applied Science-Mesa State College 1992
Certificate in Office Management-Mesa State College 1992
Certificate in Medical Assistance-Mesa State College 1992

WORK EXPERIENCE

Mind Springs Health-Director of Psychiatry Practice- March 2014-Present
Managing overall operations of Mind Springs Health psychiatry clinics and ensuring good business and clinical practices.

Independent Contractor- December 2010-December 2013
Bookkeeping for private clients and ghost writing for 3 health magazines.

Sweet Wonders Honey- May 2010-December 2014
Owned and operated small beekeeping business with 54 hives. Mentored children and new beekeepers in beekeeping naturally.

Hilltop-Director of the Commons- November 2007-May 2010
Full management of a Non-Profit Luxury Assisted Living Facility with Direct Oversight Responsibility of over 180 Residents, and supervision of 100+employees.

Western Valley Family Practice-Practice Administrator- March 1999-November 2007
Full Management and Accounting functions for 12 Provider Medical Clinic with 45+ employees, 2 locations, and a After Hours Clinic..

ACS-Medical Manager Software Support- November 1998-March 1999
Provided software technical support for Mesa County Medical Offices.

Several Small Medical Clinics (Specialty and Primary Care)-Office Manager 1992-1998
Full management and bookkeeping functions for medical offices.
SKILLS


Proficient in Insurance Contract Negotiation, Directing Physician and Staff Meetings, Risk Management, Physician and Mid-level Provider Contract Negotiation, EMC and Paper Billing, ICD-9 and CPT coding, Transcription, Medical Terminology and Basic Medical Assistance skills.

Very strong in Organizational Abilities. I love to take on big projects. Even-tempered, friendly, soft-spoken.

Some large projects accomplished:
- Construction Manager for the construction of Western Valley Family Practice Redlands building at 2237 Redlands Parkway.
- Developed, implemented, and managed the Redlands After Hours Clinic, staffing it with local physicians.
- On the Physicians IPA panel to research EMR systems and advise the Western Slope Physician offices on each programs capabilities.
- Implemented EMR at Western Valley Family Practice for both locations.
- Staffed local physicians for FHW Urgent care facility.
- Created a Restructuring plan for The Commons of Hilltop that was successfully implemented after I left my position.
- Was directly responsible for reducing costs while maintaining staff morale and quality of resident care, with outstanding financial results as the Director of the Commons.

PERSONAL INTERESTS

Rock-climbing, Beekeeping, Kayaking, Slot Canyoneering, Backpacking, Hiking, Reading, Deciphering Rock Art, Gardening, and Adventure!

SEARCH AND RESCUE/Mesa County Sheriffs Department

Technical Rope Rescue Team-4 years-Provided search and rescue technical including body recovery. Led non-rock climbers up Independence Tower for annual fundraising event.

Ground Team-2 years-Provided search and rescue for lost individuals, evidence search, grid search, and county assists.

Board Member on Mesa County Search and Rescue-2 years.

Treasurer Technical Rope Rescue Team-3 years.
Academic Background

Rifle High School; Rifle, CO.
   Diploma awarded May, 1972

Mesa State College
   Bachelor of Arts, Counseling Psychology; May, 1992
   Graduated Summa Cum Laude

Professional Experience

Mesa Developmental Services/STRIVE   Grand Junction, CO.
October, 2005 to present
April, 2000-September, 2003
August, 1992-April 1998

Behavior Specialist (April 2015-present). Responsibilities include:
   • Completion of Functional Assessments
   • Completion of Comprehensive Life Reviews
   • Development of Behavior Support Plans for individuals on caseload.
   • Attendance at psychiatric medication clinic

Additional positions held at MDS/STRIVE include:
   • Adult Case Manager
   • Family Support Coordinator/Case Manager
   • Host Home Provider
   • Behavior Assistant
   • Conducted psychological evaluations to determine eligibility for MDS services and for Social Security, under the supervision of Mac Griffith, PhD.

Legal Center for Persons with Disabilities
Grand Junction, CO.
September, 2003- October, 2005

Advocate for children receiving special education services. Responsibilities included:
   • Advocated for children receiving special education services at IEP meetings and in other forums.
   • Represented individuals with disabilities when appealing service denials.
   • Provided advocacy training and training in the IDEA act to families.
   • Conducted investigations into deaths of individuals residing in institutions.
Mesa County Department of Human Service
Grand Junction, CO.
April, 1998-April, 2000

Adult Case Worker. Responsibilities included:

- Established eligibility for services (EBD waiver, Home Care Allowance (HCA) and Children’s Medical Waiver (CMS).
- Managed caseload of individuals on the EBD and CMS waivers and/or receiving HCA.
- Assisted individuals on caseload in acquiring services and accessing available resources.
- Conducted required monitoring and face-to-face contact with individuals on caseload.
CURRICULUM VITAE

1968-1972  Texas Christian University; graduated with BS in Biology

1972-1976  University of Texas Health Science Center in San Antonio; graduated with MD

1976-1977  Began Residency in Psychiatry and University of Texas Health Science Center in San Antonio. Interrupted as below with military obligations.

1977-1980  General Medical Officer and Commander, 731st Gen. Dispensary, Hohenfels FRG.

1980-1983  Resident in Psychiatry, Letterman Army Medical Center, Presidio of San Francisco, California; completed.

1983-1985  Division Psychiatrist, 1st Cavalry Division, Ft. Hood, TX

1985-1986  Attending Psychiatrist, Darnall Army Hospital, Ft. Hood, TX

1987-1990  Attending Psychiatrist, Olin E. Teague VA Hospital, Temple TX, full inpatient responsibilities.

1990-1991  Medical Director for Psychiatry Ward, Montrose Memorial Hospital, Montrose, CO
1991-1994  Attending psychiatrist, Colorado West Mental Health Center and attending psychiatrist, St. Mary's Medical Center, Grand Junction, CO. Mornings, inpatient psychiatry, afternoons outpatient work with Colorado West.

1994-2006  Attending psychiatrist St. Mary's Medical Center. Mornings, inpatient; afternoons outpatient clinic. Worked with patient population for 12yrs to geriatric. Left when department disbanded by hospital.

2006-2014  Attending at North Mississippi Medical Center, Tupelo MS. 2/3 inpatient responsibilities and 1/3 outpatient responsibilities.

2014 to present:  Mind Springs Health and West Springs Hospital. Medical Director: Crisis Stabilization Unit and Crisis Response Team. Attending psychiatrist: providing direct patient care for adult and adolescent patient. On-site response to jails, local acute care hospitals as needed. Providing direct psychiatric care monthly for Regional Center and STRiVE, locally.

Diplomate in Psychiatry through the American Academy of Psychiatry and Neurology.

Currently licensed in Mississippi, Colorado

Past licenses in Texas, lapsed.

**Professional interest and strengths:**

Working with multi-disciplinary team, preferably inpatient

Extensive experience treating mood disorders, PTSD, neuropsychiatric conditions and geriatrics.
Michelle Hoy, LPC, CACIII
0276 Cliff View Circle
Parachute, Co.81635
(970) 618-4426
maxmilomom@msn.com

Education

B.A., 1994, Fort Lewis College, Durango, Colorado. Major in Psychology with an emphasis in Elementary Education.

Professional Certifications

Licensed Professional Counselor (L.P.C.) 3917
Certified Addictions Counselor III (C.A.C.III) 6399
Lean Six Sigma Yellow Belt

Professional Experience

Mind Springs Health, Grand Junction, Colorado, 2004 - present

Executive Vice President- Mind Springs Health, 6/15 - present
Strategic, clinical and administrative oversight of 10 counties, 14+ office operations of the Mental Health Center.

Assistant Vice President- Mind Springs Health, 1/15 - 6/15
Provided oversight for company-wide Peer Specialist workforce, expanding this workforce from 5 to 40 FTE. Created treatment teams and clinical pathways of care to address volume increases and workforce shortages, successfully serving most individuals who made requests.
Owner of $1 million renovation; successfully working with multiple teams with strategic planning, effective communication and leadership to complete this project under budget and ahead of deadline.
Continued to provide all Regional Director duties as well.

Regional Director-Mesa County, 2/12 - 12/14
Active participant and leader of Continuous Quality Improvement teams, creating and maintaining Open Access model of care, improving internal business operations to meet quality metrics, and to implement Trauma Informed Care systems.
Manage budget of over $8 million with consistent revenue contributions to agency. Work with many partnering agencies in the area to create systems of care, collaborations that are mutually beneficial and to create programs to address gaps in the service continuum.
Oversee and administer out patient, crisis response, detoxification, housing, vocational, drop in day center and residential substance abuse programs. Talented in creating trust, transparency and a teamwork philosophy resulting in efficiency, high production and quality.

- Managed growth of clinical team from 20 to 45 clinical staff resulting in appropriately serving increased volume from 2,656 clients to 3,827 clients.
- Developed 5 new programs within 2 years resulting in wider range of continuum of services, and managing cost.
- Increased Peer Specialist participation from 0 to 5 employees in the clinical team resulting in better outcomes and cost control.
- Managed teams to move from a partial EMR to a fully implemented and paperless EMR resulting in lower costs, greater coordination of care and quality.
- Led expansion and renovation of physical plant by successfully moving 100+ employees to 3 locations with 30 days’ notice to accomplish the task.
Program Director- Clinic Based Programs, 12/2009 - 2/2012
Maintain all duties as listed below as well as adding the adult clinical team to supervisory duties. Supervise a team of 14 therapists, a Clinical Supervisor and a Business Services Supervisor. Provide leadership to create and maintain good morale, team work atmosphere resulting in reduced turnover and high accountability within the team. Coached team to consistently achieve and surpass productivity expectations, decreased amount of outstanding paperwork from team, managed budget of $5.5 million with consistent revenue contributions to the agency. Achieved greater alignment between the clinical and business teams, resulting in increased efficiencies as well as overall team and client satisfaction. Clinical Director of Therapeutic Day Program, a joint endeavor with School District 51 and Colorado West Regional Mental Health. Successfully created and maintained two therapeutic classrooms serving 12 students. Served as a team member of many internal committees including the Quality Management Team, CareLogic (EMR) Team, Intake redesign, and Data Committee. Provided trainings and information to many community partners including Mesa County, School District 51, and the Chamber of Commerce.

Clinical Director- Child and Family Programs, 08/2007 - 12/2009
Supervised a team of therapists, case managers and supervisors; clinical and administrative oversight conducted. Administered programming and contracts for the Child and Family Division. Collaborated with community partners to create and maintain successful partnerships and increase client outcomes. Responsible for maintaining and creating budgets for the programs. Participated as a leader in coordinated efforts to create new and improved agency wide systems. These new systems allowed for greater efficiencies for the agency as well as greater access to care and quality of care for clients. Selected as a core team member to create, test, implement and train a new company wide electronic medical record.

Program Coordinator- Juvenile Justice Programs, 08/2005 - 08/2007
Supervised a team of therapists, case managers and trackers, providing clinical and administrative oversight. Responsible for maintaining and creating budgets for the programs. Created programming for juveniles within the implementation and maintenance of the Turnabout State Pilot. Implemented Functional Family Therapy (FFT), the first site on the Western Slope. Successfully marketed FFT and the Turnabout Pilot Program to partnering agencies and the community. Participated in extensive training in Functional Family Therapy. Selected to become the FFT clinical supervisor by the national FFT team, and became a certified FFT site. Completed the Leadership Institute for the Addictions Treatment Field, USDA Graduate School.

Mental Health Professional III, 10/2004 - 08/2005
Provided therapy for children, adolescents and families in group and individual settings. Provided support to kinship, and foster homes in order to maintain placements for children. Maintained or exceeded productivity expectations.

Adams State College, Alamosa, Colorado, 2003, 2005
Adjunct Teacher
Co-taught a master’s level course in the practical experience in community counseling. Provided group and individual instruction to students, as well as individual supervision of counseling skills to students.

San Luis Valley Counseling Clinic, Alamosa, Colorado, 2002 - 2004
Private Practice Therapist
Provided individual counseling to adults, and adolescents. Conducted marriage counseling as well as play therapy for children. Reported to the court and attorney’s regarding custody issues.

Alamosa County Department of Social Services, Alamosa, Colorado, 1998 - 2004
Caseworker III
Investigated and assessed for levels of risk and safety for children. Provided comprehensive treatment planning and monitoring of services to families with abuse and neglect issues. Conducted individual and family meetings as well as therapeutic supervised visitation with families. Preparation of court reports and provided court testimony.

Social Services Therapist, 1996 - 1998
Created and executed a substance abuse therapy program and system for delivery to parents working with the Social Services agency. Furnished individual and family therapy sessions with adults, adolescents and children. Coordinated and collaborated with caseworkers and court personnel to improve outcomes for families and children.

Adolescent Substance Abuse Therapist, 1995 - 1996
Supplied individual and group therapy to adolescents with substance abuse issues and children whose parents were substance involved. Developed original programming to deliver this service within a school based health center.

DUI Therapist, 1995
Conducted individual and group therapy and education sessions for court-ordered clientele with DUI convictions.
WORK EXPERIENCE

April 2009 to Present  
**Strive, Inc.**  
Grand Junction, Colorado

- **Audyssey Clinical Director**  
  Responsible for coordination and administration of the Autism Diagnostic and Referral Clinic. Conduct assessments, develop and supervise the implementation of ABA treatment programs for children with Autism Spectrum Disorder. Therapeutic responsibilities include conducting Social Concepts groups for children and adults with ASD, individual and family therapy for those affected by ASD. Provide educational classes and presentations for families and school personnel, including an 8 week course *ABA for Parents*.

- **Behavioral Health Services, Supervisor, Lead Therapist**  
  As supervisor responsible for hiring and day to day supervision of behavioral specialists and administrative staff. Responsible for budget administration, service quality, interdepartmental coordination and performance outcome measures.

  As a lead therapist responsible for individual and group counseling, behavioral consultations, assessments, and functional analysis of problem behaviors with individuals with intellectual/adaptive disabilities ranging from mild to profound level of functioning. Work with inter-disciplinary teams on a daily basis in serving individuals.

**February 2003 - April 2009**  
**Summit Performance Group, President**  
Grand Junction, Colorado

Assessments, coaching and consultation with business executives. Counseled executives on goal setting, performance outcome measures, systems analysis and leadership skills. Small business and Fortune 100.

**October 1992 - December 2004**  
**Psychological Associates,**  
Grand Junction, Colorado

Provided individual and group counseling for adults, adolescences, and children. Primary populations served were: Emotionally and behaviorally disturbed children, victims of sexual abuse, post traumatic stress disorder, individuals with anger management/physical aggression, developmental disability and co-occurring mental health disorders; Emphasis in cognitive behavioral therapy, anger management, and applied behavior analysis.
October 1988 – October 1992
Hilltop Rehabilitation Hospital-Psychological Services
Grand Junction, Colorado

Inpatient neurological rehabilitation including cogitative assessment, behavioral interventions and counseling. Residential treatment program for individuals with traumatic brain injuries including behavioral programming, counseling and staff training. Outpatient counseling services including domestic violence offenders, family therapy and child therapy.

February 1985 – September 1988
Marriage and Family Counseling
Grand Junction, Colorado

Individual, group and family therapy. Primary populations served: emotionally and behaviorally disturbed children, adult and juvenile sex offenders. Served on community Child Sexual Abuse Task Force with law enforcement, courts and district attorney’s office.

January 1983 – September 1985
Domestic Violence Project-Counseling Coordinator
Grand Junction, Colorado

Supervised counseling staff. Provided individual and group therapy to victims of domestic violence. Served on community Domestic Violence Task Force with law enforcement, courts and district attorney’s office.

June 1979 – November 1982
Kalamazoo Valley Intermediate School District-Behavior Specialist
Kalamazoo, Michigan

Created and supervised the implementation of applied behavioral analysis programs for developmentally disabled and emotionally-behaviorally disturbed children in a public school setting. Trained and supervised paraprofessional staff.

Certifications and Education

January 14, 1994
Licensed Professional Counselor
State of Colorado (#847)

September 30, 2011
Board Certified Behavior Analyst
(# 1-11-9305)

June 1982
Master of Arts Degree in Behavioral Psychology, Magna cum Laude
Western Michigan University
Kalamazoo, Michigan

June 1980
Bachelor of Arts Degree in Psychology, Cum Laude
Education

1999 - Master of Social Work. Colorado State University, Fort Collins, CO
1993 - Bachelor of Science in Journalism, with extensive coursework in Sociology and Spanish. Dean’s List. Northwestern University, Evanston, IL

Professional Experience

Sarah Johnson
515 Cedar Ave.
Grand Junction, CO 81501
970-712-0259, sarahmikej@hotmail.com

Director of Child and Family Programs
2/14 – present. STRiVE, Grand Junction, CO

Parenting Place Coordinator
11/13 – 2/14. STRiVE, Grand Junction, CO
- Manage daily and long-term operations of STRiVE’s parenting education and outreach programming.
- Facilitate collaborative relationships with community organizations and families.
- Supervise contracted and staff facilitators and child care providers.
- Write grant proposals for ongoing and start-up program funding.

Care Transitions Intervention Program Supervisor
- Implemented federally funded, multi-agency grant based at St. Mary’s Hospital to improve care transitions from hospital to home through increased patient engagement and improved self-management skills.
- Coordinated interagency oversight of program and collaboration with stakeholders.
- Supervised Transition Coach staff.
- Write grant proposals to support partner agency projects.

Patient-Family Coordinator
12/06 – 6/11. St. Mary’s Hospital, Grand Junction, CO
- Provided continuing care assessments of patients and families and developed treatment and discharge plans with interdisciplinary health care team.
- Identified psychosocial, emotional, educational and financial strengths and needs.
- Coordinated with outside organizations to facilitate access to services and resources.

Family Therapist
9/02 - 6/03. Mesa County Department of Human Services, Grand Junction, CO
- Conducted family, group and individual therapy sessions at Family Tree School.
- Partnered with students and multidisciplinary staff to manage behavior and create a positive classroom learning environment.

Child Welfare Senior Case Manager (Adolescent Services and Child Protection Intake)
9/99 - 9/02. Mesa County Department of Human Services, Grand Junction, CO
- Investigated reports of child abuse and neglect.
- Provided crisis intervention and case management services to families in which
abuse, neglect and/or family conflict are present.

- Coordinated services with community agencies, law enforcement and District Court.
- Mesa County Employee of the Month, August 2002.

**Program Director**


- Planned and coordinated after-school and summer enrichment activities, including bilingual programming, for school-age children.
- Supervised assistant director staff.

**Prenatal Plus Care Coordinator, MSW Intern**


- Provided comprehensive support and education to low-income pregnant women at high risk for poor pregnancy outcome.
- Assisted clients to access community services and achieve self-sufficiency goals.

**Welcome Baby Program Coordinator, MSW Intern**

1/98 - 5/98. The Family Center/La Familia, Fort Collins, CO

- Developed and implemented home visitation program for new parents.
- Provided individualized parent education, advocacy and referral services.
- Coordinated weekly new parent support group.
- Promoted community and interagency collaboration for early childhood programs.

**Information and Referral Specialist**

9/96 - 1/98. First Call ServiceNet, Fort Collins, CO

- Provided information, referrals and short-term crisis intervention.
- Maintained Larimer County human service database.
- Assisted in development of agency marketing plan.

**Family Self-Sufficiency Program Coordinator, VISTA Volunteer**

8/93 - 8/94. Conejos County Housing Authority, La Jara, CO

- Developed and implemented self-sufficiency program for residents of low-income housing in four San Luis Valley communities.
- Recruited, trained and managed advisory council and volunteer mentors.
- Promoted program to housing authority residents and community.

**Specialized Training and Skills**

**Proficient in oral and written Spanish.** Completed 12-week advanced Spanish course at Escuela Mexicana, Guanajuato, Mexico (April 2010); 6 weeks of advanced Spanish at Colegio de Lenguas Adelita, Guanajuato, Mexico (May 2010); and intensive Medical Interpretation class at St. Mary’s Hospital, Grand Junction (February 2011).

**Bridges out of Poverty training.**

**Current BLS certification,** including Adult, Child and Infant CPR.
Administrative and Management Experience

Chief Executive Officer, STRiVE
January 2015 to Present
Manages budget of $18 million, staff of 350, and service population of 1300.
Oversees STRiVE operations serving the developmentally disabled children and adults in Mesa County under the direction of the Board of Directors and directs plans, develops and implements STRiVE programs in conjunction with the department directors. Assures provision of quality services consistent with the STRiVE mission, policies set forth by the Board of Directors and prevailing statutes and regulations. Maintains Community Centered Board designation for agency.

Vice-President Behavioral Services and Supports, STRiVE
July 2011-January 2015
Managed department of licensed therapists, nursing, and occupational therapy serving adults and children in comprehensive Medicaid waiver program
Developed Audyssey evaluation clinic, serving individuals with autism. Served on STRiVE Leadership Team

Director, Division for Developmental Disabilities (DDD)
December 2007 to May 2011
State of Colorado, Department of Human Services (CDHS)
Directed state agency providing leadership in developmental disabilities
Managed service provision and case management for 8000 adults and 5500 children with developmental disabilities through community centered boards
Networked with individuals in service, providers, advocacy groups and families
Coordinated with Health Care Policy and Financing (HCPF) in the management of the Medicaid waiver programs with budget of $300 million

Director, Wheat Ridge Regional Center (WRRC)
December 2004 to December 2007
State of Colorado, Department of Human Services
Directed and managed $20 million agency providing ICF-MR and Medicaid Waiver services to 161 individuals with developmental disabilities and co-occurring mental health diagnoses
Developed and implemented agency policies to meet the requirements of CDHS, HCPF, and the Colorado Department of Public Health and Environment (CDPHE)
Supervised 7 department directors including medical, psychological, therapeutic and operational departments

Director, Grand Junction Regional Center (GJRC)
July 2003 to December 2004
State of Colorado, Department of Human Services
Directed $15 million agency providing ICF-MR, Medicaid Waiver and Nursing Home services to 154 individuals with developmental disabilities and co-occurring mental health diagnoses
Developed and implemented agency policies to meet the requirements of CDHS, HCPF and CDPHE
Supervised department directors in the areas of health services, psychology, program services and administration
Rocky Mountain Regional Director
November 2000 to July 2003
Good Shepherd Communities, California (changed to Bethesda)
Directed and improved regional operations of a non-profit human service agency serving the developmentally disabled
Expanded mission of agency to include children’s services through Children’s Habilitation Residential Medicaid Waiver program
Participated in corporate cabinet team whose function was to provide strategic direction and oversight to multi-state agency of $38 million?

Larimer County Regional Director
October 1986 to December 1993
Martin Luther Homes, Nebraska
Directed non-profit human service agency specializing in residential, therapeutic, and learning programs for individuals with developmental disabilities
Addressed psycho-social needs of clients through development of systematic clinical review process, including psychiatric, psychological, and medical input

Day Services Director
August 1974 to July 1983
Imagine! Boulder Community Centered Board
Managed early intervention and adult services day programs

Clinical Experience

Consulting Psychologist
December 1998 to November 2000
Sewall Child Development Center, Denver Colorado
Provided psychological evaluation and therapy services to children and their families with multi-problems
Participated in weekly Developmental and Evaluation Clinic, collaborating with pediatrician, speech and occupational therapists, and social worker
Consulted with teaching staff on behavioral and psycho-social issues
Supervised master’s level clinicians

Senior Services Consultant
March 1994 to November 1998
Senior Counseling Services, Denver, Colorado
Psychological evaluation and individual psychotherapy to persons in nursing homes and assisted living facilities
Facilitated clinical and behavioral goal development with nursing home management team representatives
Supervised master’s level clinicians and consulted in 3-4 healthcare facilities on a weekly basis throughout Colorado (Fort Collins, Greeley, Denver, Lamar, Holly)
Participated in psychoactive drug and chemical restraint committees at facilities

Private Practice
August 1983 to November 2000
Boulder and Estes Park, Colorado
Diagnostic assessment, individual therapy and consultation with children and adults specializing in developmental change, life transition, developmental disabilities and chronic illness.
Worked with children and families in crisis, including foster care, illness, residential and hospital treatment and school consultation

Sharon S. Jacksi, Ph.D.
**Education**

William Smith College, Geneva, New York  
Bachelor of Arts, Psychology, 1971

Peabody College, Vanderbilt University, Nashville, Tennessee  
Master of Arts, Psychology, 1973

Peabody College, Vanderbilt University, Nashville, Tennessee  
Doctor of Philosophy, Psychology, 1975  
Fellowship: John F. Kennedy Center 1971-1975  
Dissertation: Mother-infant interaction/infants with handicapping conditions

**Licensure**

Licensed to practice clinical psychology in state of Colorado  
Licensed as nursing home administrator in state of Colorado

**References**

Available upon request
RESUME
Thomas John Turner

Education:
Master of Arts in Educational Administration & Leadership
University of Northern Colorado, Greeley, CO
Graduated December, 1992  4.0 cumulative GPA

Bachelor of Arts in Social Work
Colorado State University, Ft. Collins, CO
Graduated June, 1975  3.7 cumulative GPA

Professional Experience:
Executive Director of Community Options, Inc., 1995-present. Overall administration of Community Centered Board providing and/or coordinating services and supports for approximately 500 persons with intellectual and developmental disabilities in a six county area in southwestern Colorado. Overall responsibility as Single Entry Point and OHCDS for Case Management Services, program operation and regulatory compliance for GRSS, IRSS, SLS, CES, FSSP, EI, CWA, SE and DHHS services through both internal and external service providers. Management of annual budget exceeding $9m per year, with a staff of 205 and over 60 contractors. Board Member and frequent Executive Committee member of Colorado Association of Community Centered Boards (CACCBA/Alliance, 1995-present. President, CACCB, 2000-2001. Appointed to Colorado Conflict of Interest Task Force, 2011 and Conflict Free Case Management Task Group, 2013-2014. Member of Alliance Focus on the Future Steering Committee, 2011.

Direction of Case Management, Family Support Services, and Model 200 Waiver services for approximately 500 persons with developmental disabilities and their families. Monitoring of services and supports provided by service agencies. Supervision and training for 15 professional and support staff, as well as training and support for the agency and service area at large. Direct residential services were also provided through this Department from 1987-1992. Responsibilities included direct supervision of Residential Director and Program Managers, overall responsibility for program provision, budget development and implementation, regulatory compliance, etc. for programs serving 75 residents. Appointed to State Task Force which rewrote Division for Developmental Disabilities Case Management Rules and Regulations 1989-90. Served on committee that wrote the original grant for Community Supported Living Arrangements in 1993. Vice President of Larimer County Options for Long Term Care (Single Entry Point) Advisory Committee, 1994. Vice President of Colorado Chapter of National Association for the Dually Diagnosed, 1992-1995.


Field Instructor:
Resume-Thomas Turner
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Publications:
"Siblings: The Forgotten Factor in Program Provision for Families with a Developmentally Disabled Child" co-authored with Dr. Peter Kopriva of Fresno Pacific College and Dr. Rebecca Kopriva of California State University, Fresno. Published in Council for Exceptional Children-Division on Physically Handicapped Journal, Fall, 1991.

Conference Presentations:
"Sibling Support Services" presented to Colorado Association of Community Centered Boards State Conference (offered for graduate credit through University of Northern Colorado); American Association on Mental Deficiency Five State Regional Conference; Council for Exceptional Children State Conference; The Association for Persons with Severe Handicaps State Conference; Child Health Council State Conference. 1980-1986.

Computer Skills:
Functional in Microsoft Office Word, Outlook, PowerPoint, and Excel.

Other Interests:
Singing, camping, hiking, biking, reading.
Valita Ann Speedie  
1151 18 Road  
Fruita, CO 81521  
(970) 639-8322  
vmspeedie@yahoo.com

EXPERIENCE

Strive  
Grand Junction, Colorado

Vice President – Adult Services 2015 – Present

This position is responsible for the overall supervision of adult residential and vocational services provided by Strive, a licensed Colorado Service Agency for individuals with intellectual and developmental disabilities. The position assures that all services and supports are provided to individuals as required by their service plans and by regulations, standards, policies, best practices, State and Federal law. Additionally, this position exercises discretion and independent judgement in overseeing budgetary compliance, personnel matters, and the design and review of programmatic services.

- Facilitates a therapeutic/teaching/learning environment
- Fosters person-centered atmosphere
- Participates in the development and implementation of new program initiatives
- Assures facilities adhere to regulatory standards in reference to life safety, fire safety and physical plant maintenance
- Oversees and actively participates in departmental and agency-wide strategic planning
- Participates in the development of departmental and program budgets
- Responsible for the oversight of expenses and revenue projections

State of Colorado – Pueblo Regional Center  
Pueblo West, Colorado

Director 2006 - 2015

This position is responsible for all activities of Pueblo Regional center to include meeting all legal requirements. This also includes the design and delivery of quality supports and services that improve the safety, security and independence of adults with developmental disabilities at the Pueblo Regional Center, one of three Regional Centers in the State of Colorado. The Regional Centers provide services to adults with intellectual and developmental disabilities who exhibit co-occurring disorders to include mental health issues, behavioral issues and extreme medical conditions.

- Responsible for the development and implementation of the vision, mission, strategic planning, philosophical direction and quality management of the Agency.
- Designed and implement organizational structure.
- Provided leadership by defining program objectives in the areas of health services, therapeutic supports, residential services and vocational services.
- Ensured systems were in place to assess, implement and modify program plans along with supports and services.
- Oversight and responsibility for the short-term and long-term financial management of the Agency.
- Allocated, monitored and adjusted resources for personnel services, operating and capital outlay budgets.
- Coordinated and collaborated with Developmental Disability Services, Community Centered Boards, The Legal Center, advocates, parents, family members and guardians in order to assure the role of the Regional Center was responsive to the needs of individuals in the context of the entire service systems.
- Ensured compliance with all federal, state and local laws, rules and regulations.
- Developed plans, regional center policies and procedures, and initiatives to ensure coordination, collaboration, prominence and outcome measures that support and align with mission of the Department of Human Services.
- Ensures that internal administrative services; such as quality assurance, staff training, individual records, transportation and staffing, were designed and delivered to support the mission, vision and core values of the Agency.

**Childrens ARK, Inc.**
Green Mountain Falls, Colorado

Chief Executive Officer 1994 -2006

This position is responsible for the overall growth, leadership and supervision of Childrens ARK, Residential Treatment Centers/Residential Child Care Facilities. These not-for-profit facilities provided clinical, educational, residential, day treatment, medical, physical, spiritual and cultural activities to adolescent males and females who suffered from one or more significant mental health and behavioral issues.

- Responsible for consulting on a weekly basis with officers of the Board of Directors to assure a smooth interface between Board expectations and the eight senior Masters and Doctoral level Directors of this Agency.
- Facilitated and assured that plans, policies and procedures, as established by the Board of Directors, were enacted in a consistent manner.
- Provided support and motivation to senior management Directors: 1) in the development of their individual department , 2) in consensus making between department, and 3) as a mediator between departments and external agencies.
- Integrated Federal HIPAA requirements into existing corporate policies.
- Ensured compliance with Residential Child Care Facilities and Residential Treatment Centers Rules and Regulations as well as compliance with all State and Federal laws.
- Conceptually designed, developed and authored the Employee Handbook.
- Communicated with Chief Financial Officer/President regarding: 1) all proposed changes relative to mental health rate setting by Colorado’s Health Care Policy and Financing and 2) oversight of Agencies $5,000,000 annual budget.
- Facilitated the development of residential, clinical and educational programs and services.
- Interfaced, on an ongoing basis, with attorneys regarding any corporate litigation.
- Oversaw marketing and promotion of Childrens ARK with Colorado’s Stake Holders.
- Researched, identified and wrote national and state grants for capital campaigns and general operating proposals.
- Identified, developed, wrote and submitted RFPs.
- Responsible for the development, coordination and management of outreach programs.

**Missouri Technology Center for Special Education**
University of Missouri, School of Education - Kansas City, Missouri

Director/Senior Research Investigator 1986-1994

This position was responsible for the direction of a State funded project designed to provide information, training and technical assistance to Missouri’s K-12 special educators. The focus of program was to integrate and, based upon individual needs, modify computer technology for individual student use and educators presentations.

- Directed and provided the dissemination of information, training and technical assistance to special educators in 530 school districts.
- Responsible for hiring and evaluating professional and support staff members.
- Managed an annual budget of more than $300,000.
- Designed and implemented long-range staff development activities.
- Coordinated training, technical assistance, telephone support, conference exhibits and state-wide trainings.
- Oversight of newsletters focused on utilization and modification of computer technology for special education needs.
EDUCATION

Ed.S. University of Missouri – Kansas City, MO 1991
Area of emphasis: Higher Education Administration

M.A. University of Missouri – Kansas City, MO 1985
Area of emphasis: Learning Disabilities and Behavior Disorders

B.A. University of Illinois, Chicago, IL 1972
Area of emphasis: History

CERTIFICATIONS

State of Colorado Professional Teachers Certificates – Type B
Social Studies Secondary
Special Education Moderate Needs K-12

State of Missouri Teachers Certificates (lifetime certifications)
Emotionally Disturbed K-12
General Science 7-9
Learning Disabilities K-12
Social Studies 7-9

State of Kansas Teachers Certificates
Learning Disabilities K-12
Social Studies 7-12

SYNOPSIS OF PROFESSIONAL ORGANIZATIONS AND SERVICES

Colorado Association of Family and Children's Agencies, Inc.

USAAC/ISAAC United States Society for Augmentative and Alternative Communication and the International Society for Augmentative and Alternative Communication

Missouri Council of Administrators of Special Education

Johns Hopkins University – Region VII Co-Chair and National Search Judge for the competition to identify applications to assist persons with disabilities

Council for Exceptional Children
Vicki L. Grassman MSW, LCSW, ACSW
6430 Edgeware Street
Fort Collins, CO  80525-4100
970-218-7325

Professional Summary
Significant experience in leading a team of clinical and business professionals to excel in providing superior customer service with documented success in clinical outcomes. Direct experience in developing and managing budgets, human resources, clinical social work, grant development, fundraising and team building.

Professional Experience
SummitStone Health Partners, Chief Operating Officer 1991 – Present
Provide leadership for the organization as a key member of the Executive Team. Responsible for setting policy in clinical and business areas. Other significant responsibilities include serving on the Access Behavioral Health North East Executive Committee and Quality Assurance and Utilization Management Committee, recruitment of appropriate clinical staff and providing program specific orientation to all applicable staff. Represent the center in a variety of State activities including ongoing membership on the Colorado Behavioral Healthcare Council (CBHC) the statewide membership organization for Colorado's network of community behavioral health providers. Lead a variety of consumer and advocacy meetings as required. Represent SummitStone and to the community through consultation, education, participation on local task forces and committees.

Northeast Behavioral Health (NBH), LLC, Manager of QA 1998 – 2000
Key founding member of NBH, a corporation established by and between the community mental health centers of northeast Colorado, to respond to the State’s Request for Proposal with regard to Medicaid Capitation and implement the Medicaid Capitation Program in northeast Colorado following award of the contract. The Capitation Program covers twelve counties of Colorado and approximately 60,000 lives.

Responsible as the Manager of Quality Assurance/Improvement and Chairperson of the Quality Improvement Task Force, for the development of all quality improvement and program activities of NBH. These activities included setting annual goals and objectives for the QI plan, monitoring the performance of all QI and Utilization Management activities and meeting all State QI requirements.

Larimer County Mental Health Center, Community Support Program Administrator 1988 – 1991
Led the Day Treatment, Residential Treatment, Intensive Case Management and Vocational Services teams. Responsibilities included all management, planning and program development activities for the team. Proposed the creation of and designed and implemented the Intensive Case Management Team and expanded the number of residential beds available for clients. This position was responsible to and supervised by the Executive Director.
Professional Experience - continued
Larimer County Mental Health Center, Inpatient Program Manager/Psychiatric Social Worker 1978 – 1989
Responsibilities included: Supervision and treatment of consumers on a 11 bed psychiatric ward of a general, community hospital; screening and assessment of admissions to the psychiatric unit; individual, family and group therapy; collateral contacts; discharge planning; arranging medical examinations and follow up care; psychiatric, drug and alcohol treatment and nursing home. Continuity of Care Coordinator, duties included: screening and arranging admission to Colorado State hospitals, coordinating with the hospital consumer disposition, discharges and follow-up treatment.

Weld County Department of Social Services, Social Worker 1977 – 1978
Investigated reports of child neglect and/or abuse, counseled families on a variety of issues, arranged foster care and protective day care placements when appropriate; referred clients to community resources and became involved with the legal system on various levels consistent with specific case demands.

Education
University of Wisconsin, Milwaukee, WI Master of Social Work, 1976
Carroll College, Waukesha, WI Bachelor of Science in Social Work, 1975

Professional License and Affiliations
Licensed Clinical Social Worker Colorado
Academy of Certified Social Workers
ADAD CACIII 1987 – 1995

Community Activities
Centennial Area Health Education Center 1995 – 2005
served on Board of Directors 1997 – 1999
Colorado Rural Legal Services 1996 – 1997
Served on fund raising committee
New Bridges Day Shelter 1990 – 1992
Served on the initial Board of Directors of this Program from start-up until after its first year of Operation
Crisis and Information Helpline 1976 – 1979
Served as a volunteer and provided limited training and back-up support to other volunteers
National Charity League 2008 – 2015
served on Board of Directors 2011-2014
TERESA SEDLAK, LPC, CACII
1545 AMBROSIA COURT • FORT COLLINS, COLORADO 80526 • 970.231.0713
tsedlak28@gmail.com

Leadership & Management ~ Employee Hiring & Development ~ Event Planning & Execution
Employee Training & Education ~ Policy & Program Development ~ Customer Service
Budget & Operation Management ~ Licensed Professional Counselor ~ Chemical Addiction Counselor

- A versatile, high-performance, detailed, and result oriented professional with extensive experience in education, counseling, leadership, and management. Natural ability to quickly develop and maintain key relationships with clients and business partners. Skilled in the ability to create and launch new programs.
- Successful management oversight of multiple programs. Demonstrated expertise in leadership and management. Excellent written and oral communication skills. Excellent problem solving and crisis management skills.

PROFESSIONAL EXPERIENCE

CRISIS SERVICES COORDINATOR, SUMMITSTONE HEALTH PARTNERS
FORT COLLINS, CO • AUGUST 2014 - PRESENT

Responsibilities: Develop, create, and implement 24/7 Crisis Stabilization Services, which include a walk-in clinic, mobile assessment team, and a Crisis Stabilization Unit. Work as a collaborative partner with both SummitStone Health Partners and Colorado Crisis Services. Develop and implement programming and policies. Hire, orient, and train supervisory staff, clinical staff, support staff, case management staff, and medical staff. Operational oversight of Community Crisis Clinic.

Accomplishments:
- Developed, built, and created Fort Collins Community Crisis Clinic, which includes, 24/7 walk-in services, mobile assessment team, and the Crisis Stabilization Unit (CSU).
- Participated in the design and development of the Crisis Stabilization Services (CSS) building.
- Hired and trained sufficient personnel to operate walk-in, mobile, and residential services for 24/7 programming.
- Received high ranking from the state during site visit.
- Management of subordinate program supervisors and team leads. Management of interdisciplinary employees.
- Trained staff to consistently meet requirements and expectations from the state and the regional crisis services. Community Crisis Clinic staff regularly excel in low errors in reporting and documentation.
- Successfully collaborated with regional and local partners in building and promoting crisis services.
- Participated in the regional oversight committee.

RESIDENTIAL TREATMENT PROGRAM SUPERVISOR, TOUCHSTONE HEALTH PARTNERS
FORT COLLINS, CO • JULY 2006 - JULY 2015

Responsibilities: Manage, supervise, and train both employees and undergraduate interns. Provide and monitor staff education. Provide clinical and supervisory oversight of adult residential program. Facilitate clinical assessments and crisis management. Develop and implement programming and policies. Monitor and enforce state, health department, and corporate compliance. Facilitate weekly staff and clinical meetings. Collaborate with interdisciplinary teams, both internally and externally. Responsible for managing program budget, participating in the agency yearly budget process and strategic planning. Participate in Northern Colorado interagency team.

Accomplishments:
- Selected for "Leadership Fort Collins" and "Leadership Northern Colorado" through local Chamber of Commerce.
- Received top rankings in Colorado State Health Department Inspections.
- Managed daily operation of the residential treatment program and staff.
• Hired, developed, evaluated, and managed staff of 10 employees. Task supervisor for undergraduate interns. Planned and organized staff retreats and education for programming improvement and team building.
• Created residential treatment clinical program. Developed policies and protocols.

TERESA SEDLAK, LPC, CACII
PAGE 2 OF 4 • 970.231.0713 • tsedlak28@gmail.com

• Worked in collaboration with various Northern Colorado agencies to help clients receive appropriate mental health services. Agencies include Poudre Valley Hospital, Fort Collins Police Department, Colorado State University, Poudre School District, Larimer County Health District, State of Colorado Probation, Larimer County Community Corrections, Adult Protective Services, District Attorney, Catholic Charities Mission, Sister Mary Alice Murphy Center for Hope, and Larimer County Jail.
• Supervisor of Emergency After Hours On-Call Team 2007-2009

ADULT RECOVERY PROGRAM MANAGEMENT SUPERVISOR, TOUCHSTONE HEALTH PARTNERS
FORT COLLINS, CO JULY 2011- JANUARY 2014

Responsibilities: Develop, coordinate, and implement new adult mental health services program. Manage subordinate supervisor and provide clinical oversight of program. Provide training and education. Develop peer specialist and volunteer program. Develop and implement program budget.

Accomplishments:
• Successful development and implementation of new program. Facilitated increase of adult recovery services.
• Management of subordinate program supervisor, five peer specialist employees, and program volunteers.
• Successful collaboration with Colorado state wide mental health organizations.

ASSOCIATE COORDINATOR, MOUNTAIN CREST HOSPITAL (POUDRE VALLEY HEALTH SYSTEM)
FORT COLLINS, CO DECEMBER 2001- AUGUST 2006

Responsibilities: Manage and coordinate adolescent residential direct care services. Provide oversight of daily operation of the residential treatment program. Hire, orient, and supervise direct care staff. Formulate and implement policies, procedures, and patient care standards. Function as a collaborative member of an interdisciplinary clinical team. Provide and coordinate staff education. Facilitate case management duties, counseling services, utilization reviews, clinical assessments, and intake of residential clients. Train hospital staff in de-escalation and physical management techniques (MANDT). Communicate between departments to ensure quality patient care and customer service. Assist with financial accountability and the yearly budget process. Facilitate weekly staff meetings. Provide individual therapy and group counseling.

Accomplishments:
• Nominated for 2006 PVHS Employee of the Year. Promoted twice during tenure at Mountain Crest Hospital.
• Received top ranking in JCAHO survey.
• Organized 10 staff retreats for education, programming improvement, and team building.
• Hired, developed, evaluated, and managed 20 employees.
• Functioned as collaborative member of an interdisciplinary team which consisted of physicians, nurse practitioner, therapists, educators, and administrators.
• Member of the PVHS senior management “Learn and Lead” team.
• Developed and implemented adolescent residential treatment program.
• Trained and educated hospital staff in the implementation of the electronic health record. Developed computerized staff compliance tracking program.
• Created and produced employee recognition photo board. Created residential staff recognition program.
• Participated in the safety committee and the development of employee standards of behavior.
• Organized, planned, and implemented staff “field day” and community adolescent day camps.
MUSIC TEACHER, OLANDER ELEMENTARY SCHOOL (POUDRE SCHOOL DISTRICT)  
FORT COLLINS, CO  AUGUST 1998- JUNE 2001

Responsibilities: Teach general music to students in grades k-6.

Accomplishments:
- Supervised, managed, and taught 550 students in grades k-6.
- Created and produced numerous audio-visual productions, incorporating music with technology.
- Designed, produced, and directed 9 large-scale musical productions.

MUSIC/CHEMISTRY TEACHER, GEORGE C. MARSHALL SCHOOL (DEPARTMENT OF DEFENSE DEPENDENT SCHOOLS)  
ANKARA, TURKEY  AUG 1996- MAY 1998

Responsibilities: Teach general, vocal, and instrumental music to students in grades k-12. Teach general chemistry to high school students.

Accomplishments:
- Turkey/Spain/Island District Music Festival Coordinator. Developed, produced, and coordinated international music festival for students, families, dignitaries, and educators from Turkey, Portugal, Spain, and Bahrain. Directed and implemented all festival logistics; including performance and rehearsal venues, housing, banquets, schedules, advertisements, and festival programs.
- Supervised, managed, and taught 240 students in grades k-12.
- Designed, produced, and directed 6 musical productions.
- Sponsored freshman class and cheerleading team.

EDUCATION

COLORADO STATE UNIVERSITY  
FORT COLLINS, COLORADO
M.Ed., Education and Human Resources

UNIVERSITY OF DENVER  
DENVER, COLORADO
M.A., Curriculum and Leadership

UNIVERSITY OF SOUTHERN CALIFORNIA  
LOS ANGELES, CALIFORNIA
B.S., Music Recording  
B.A., Music

LICENSES AND CERTIFICATIONS

State of Colorado Administrator Training
Licensed Professional Counselor (LPC) expires 8/2017
Certified Addictions Counselor II (CACII) expires 8/2017
Certified Advanced Mandt Trainer 2003-2006

**TERESA SEDLAK, LPC, CACII**

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CPR, QMAP, and First Aid Certifications
State of Colorado Special Services License, Counseling (K-12) expired
State of Colorado Professional Teacher License, Music (K-12) expired

**AFFILIATIONS**

Leadership Fort Collins Steering Committee 2008- current
Leadership Northern Colorado Steering Committee 2015
Leadership Northern Colorado Class of 2011
Leadership Fort Collins Class of 2008
WomenGive Member
Certified Disaster Responder for Larimer County Disaster Response Team 2006- current
Foundation Music School Board, Vice President 2010- current
Larimer County Juvenile Community Review Board 2008-2014
Centennial Children's Choir Pianist 2011-2012
Sedlak Piano Studio, Owner and Piano Teacher
Deborah Lapp, who received her BSW from Colorado State University is the Director of the Department of Resource Coordination and Development (DRCD) at Foothills Gateway. Deborah is responsible for coordination of all case management services for adults and children with Intellectual/Developmental Disabilities (I/DD) in Larimer County. These case management services are provided for the following programs; Supported Living Services (HCBS-SLS), Comprehensive Services (HCBS-DD), Children’s Extensive Supports (CES), Family Support (FSSP), Children with Autism (CWA), Children’s HCBS waiver and Early Intervention. Intake, eligibility and waiting list case management are also included. Over 2400 individuals are served by case managers at Foothills Gateway for Larimer County. Prior to employment at Foothills Gateway, Deborah was employed with the CCB in northeastern Colorado as a case manager for 10 years. Deborah has been employed by Foothills Gateway for 30 years. Her responsibilities began as Residential Director for 7 years, and has been DRCD/Case Management Director and on the Management Team since that time. Her 40 year career has been spent working with and developing services for individuals with I/DD. Additional responsibilities include budget development and management, strategic planning and over all agency management operations.
Resume for Crisis Grant

Marla J. Maxey is a graduate of the University of Northern Colorado. She has been employed by Foothills Gateway Inc. for twenty three years. Marla is the Case Management Coordinator and supervises the case managers who support adults enrolled in the Developmental Disabilities Medicaid Waiver program. She is certified as both trainer for the Learning Communities Person Centered Practices and to administer Support Intensity Scale Assessments. In conjunction with Larimer County Adult Protection, Marla oversees all mistreatment, abuse, neglect and exploitation investigations completed by the Community Centered Board. Marla is part of a team that meets regularly with Program Approved Service Agencies to review monitoring, quality of services. This team also discusses new services that may be needed in Larimer County to support individuals with intellectual disabilities. Additional responsibilities include Human Rights Committee training, prior authorization of waiver services, researching and resolving billing rejections.
Sarah J Sharp  
970-901-6953  
2565 I Road Grand Junction, CO 81505  
sbonnell@mesadev.org  

Summary  
Worked professionally with individuals who have developmental disabilities for over 13 years. Additional personal lifelong experience brings a strong family and person centered perspective. Maintains a strong understanding of state rule and regulations that impact services and funding. Competent at managing responsibilities in a high-demand atmosphere. Skilled at interacting with families and consumers of all backgrounds and lifestyles. Creative thinker and able to solve crisis or concerns that others would view as a roadblock.

Highlights:

Response to Intervention Specialist
- Monitored progress of over 450 children
- Created intervention plans for all underperforming students
- Trained teachers on meeting needs
- Promoted parent relations with school
- Facilitated a complete overall of the department, reviewing, revising and retraining on regulations/policies.
- Increased billing efficiencies by 200%
- Bridged the gap between 0-3 supports and supports for older children.
- Was elected to be the first woman President of the University of Northern Colorado

Education

Masters in Education-English for Speakers of Other Languages  
Colorado Mesa University, Grand Junction, CO 2007-2009

Bachelor of Arts, Interdisciplinary Studies-Elementary Education  
Emphasis: Communication/Psychology  
Minor: Psychology  
University of Northern Colorado, Greeley, CO 1999-2003

Experience

Mesa Developmental Services- CCB Case Management  
Grand Junction, CO 2012-2013

Mesa School District  
Title I experience  
Grand Junction, CO 2007-2012

Daniels Fund- Program Officer Associate  
Denver, CO 2005-2006

Running Creek Elementary  
Title I School  
Elizabeth, CO 2004-2007

Work/Leadership Positions

Vice President of Resource Coordination and Development, 2015-Present, MDS  
Direct the departments coordinating state resources for children and adults in services. Oversee state allocations and authorizations. Assure regulations are being complied with. Assure training and staff supports are in place. Point person to manage crisis and difficult cases for the agency.

Director of Children’s Services, 2013-2015, Mesa Developmental Services  
Assured implementation of early intervention program for nearly 200 children per year. Developed and implemented policies and procedures. Trained staff and assured compliance within state regulation. Acted as a liaison between staff and the state directors and school district personnel. Advocated for the importance of early intervention at community meetings and with stakeholders to increase support.

Student Body President, 2002-2003, University of Northern Colorado  
Represented 11,000 students to the UNC President, Faculty and Staff. Supervised the actions of nine vice presidents on the Student Representative Council. Budget Director for Student Representative Council, allocating $240,000 and advising the allocation of a $5.5 million budget.

Sarah J. Sharp Resume

Page 1
Honors and Awards and notables
Mesa County Crisis Team, active member 2013-present
Mesa Developmental Services Leadership Team, active member 2013-present
Outstanding Woman of the Year, University of Northern Colorado, 2003
Weld County Young Woman Leader of the Year, Journey Conference, 2003
Colorado Cares Volunteer Service Award (awarded by Bill Owens), 2002
Weld County Star of Excellence Award, 2002

References:
Dr. Sharon Jacksi, Ph.D
CEO of Mesa Developmental Services/ Strive
950 Grand Ave.
Grand Junction, Co 81507
970-256-8608

Dr. Susan Hepburn, Ph.D
Licensed Clinical Psychologist in Colorado
Associate Professor, Psychiatry & Pediatrics
Director of Research for JFK Partners
University of Colorado Anschutz Medical Campus
Education-2 South; 5th Floor, Rm. 5215
13121 E. 17th Ave., Campus Box C-234
Aurora, CO 80045
susan.hepburn@ucdenver.edu

Shawn Foley
School Psychologist and RtI Team Member
Mesa School District 51
Office number (970) 254-6825
shawn.foley@d51schools.org

Karen “Sparky” Turner
Program Officer-Grants Team
The Daniels Fund
Office number (720) 941-4482
kturner@danielsfund.org

Family and Client References:
Available upon request
Attachment G: Letters of Support
January 12, 2016

Sarah Miller  
Department of Health Care Policy and Financing  
Purchasing and Contracting Services Section  
1570 Grant Street  
Denver, CO 80203-1818

Re: Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado | RFP # UHAA 2016000079

Dear Department of Health Care Policy and Financing:

On behalf of West Mountain Regional Health Alliance, I am pleased to write this letter in support of the submission by Rocky Mountain Health Plans and its partners of their proposal for the Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado.

WMRHA is a partnership of 38 health care providers, hospitals, county public health and human services, local governments and community agencies working to build an integrated health care system to achieve optimal health for all people who live in the West Mountain region (Garfield, Eagle and Pitkin Counties). The WMRHA’s vision is that residents of the West Mountain region, especially vulnerable populations, have equal access to the exceptional, comprehensive, integrated and cost-effective health care services they need for optimal health.

The integrated health care system that we are working to build includes behavioral health, integrated with medical and dental care. The Alliance believes that there is a strong need for increased access to behavioral health care, including prevention, crisis and treatment services, particularly for vulnerable populations including the disabled.

Rocky Mountain Health Plans and its partners are well positioned to provide the services described in this RFP and to conduct this Pilot Project in the Front Range and the Western Slope. As providers of community-based behavioral health services and services for individuals with an intellectual or developmental disability for decades, these organizations have the expertise, strong community relationships, and deep commitment to provide excellent services and an innovative model to this population. The existing infrastructure of these organizations, and the services they already provide, serve as a strong basis from which to implement this Pilot Project, to provide crisis services to individuals with I/DD, and to provide data and lessons learned to the state that will allow for expansion and replication of a solid and innovative model.

West Mountain Regional Health Alliance and its members are committed to supporting the development and implementation of this Pilot Project and will offer its support to Rocky Mountain Health Plans, its partners, and the Pilot Project. We have full confidence that this collaboration will deliver on the requirements of the proposal.

Please do not hesitate to contact me at 970.928.1609 or Rbrooks@mountainfamily.org if you are in need of further information.

Sincerely,

Ross Brooks  
Board Chair

P.O. Box 1909 Glenwood Springs, CO 81602 • 970.928.1609 • westmtnreghealth@gmail.com
January 11, 2016

Sarah Miller  
Department of Health Care Policy and Financing  
Purchasing and Contracting Services Section  
1570 Grant Street  
Denver, CO 80203-1818  

Re: Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado | RFP # UHAA 2016000079

Dear Department of Health Care Policy and Financing:

On behalf of the Mesa County Health Leadership Consortium, I am pleased to write this letter in support of the submission by Rocky Mountain Health Plans and its partners, of a proposal responding to the Colorado Department of Health Care Policy and Financing Request for Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado.

The Mesa County Health Leadership Consortium was formed in 2010 to provide a foundation for open dialogue between health care organizations to address population health issues, inadequate access to care, and barriers to utilizing existing health care resources in Mesa County. The Consortium has identified and mobilized system-wide partnerships between health and human service agencies to provide a complete picture of, and develop solutions to gaps in service delivery, health care staffing, and public understanding of health care issues in Mesa County.

Behavioral health services, crisis services, and services for individuals with I/DD are integral parts of a healthy community. Improving the coordination of care in Mesa County is a priority for the Consortium and ensuring these services are available to all patients is vital. The Crisis Center Pilot Project will benefit patients who have fallen through existing safety nets; these patients will benefit greatly from individual plans and coordinated case management to support them through their crisis while helping them develop tools and strategies to successfully handle future issues.

Rocky Mountain Health Plans and its partners are well positioned to provide the services described in this RFP and to conduct this Pilot Project in the Front Range and the Western Slope. As providers of community-based behavioral health services and services for individuals with an intellectual or developmental disability for decades, these organizations have the expertise, strong community relationships, and deep commitment to provide excellent services and an innovative model to this population. The existing infrastructure of these organizations, and the services they already provide, serve as a strong basis from which to implement this Pilot Project, to provide crisis services to individuals with I/DD, and to provide data and lessons learned to the state that will allow for expansion and replication of a solid and innovative model.
The Mesa County Health Leadership Consortium is committed to supporting the development and implementation of this Pilot Project and will offer its support to Rocky Mountain Health Plans, its partners, and the Pilot Project. The Consortium has full confidence that this collaboration will deliver on the requirements of the proposal.

For any questions, please do not hesitate to contact me at 970-248-6974 or jeff.kuhr@mesacounty.us.

Sincerely,

Jeff Kuhr, PhD
Executive Director, Mesa County Health Department
Co-Facilitator, Mesa County Health Leadership Consortium
January 19, 2016

Sarah Miller
Department of Health Care Policy and Financing
Purchasing and Contracting Services Section
1570 Grant Street
Denver, CO 80203-1818

Re: Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado | RFP # UHAA 2016000079

Dear Department of Health Care Policy and Financing:

On behalf of Poudre School District, Integrated Services, I am pleased to write this letter in support of the submission by Rocky Mountain Health Plan and its partners, of a proposal responding to the Colorado Department of Health Care Policy and Financing Request for Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado.

Poudre School District provides special education services for students who are eligible under the Colorado State Approved Eligibility Categories. Our charge is to provide services and specialized instruction to assist students to access the curriculum, achieve growth and ultimately graduate, ready to proceed to post high school education and training or enter the world of work. In an effort to work collaboratively with other community partners as part of the Family Assessment and Planning Team (FAPT), PSD has consistent members of the team. FAPT works to provide supports to families in an effort to keep children in their homes and local schools while avoiding residential placement outside of Fort Collins. While PSD provides social and emotional supports needed for students to benefit from education, it is frequently not all the supports a student needs to manage the challenges in all aspects of their lives, especially children who are in crisis. We also are aware that crisis services for children and adults with I/DD are not readily available when and where families need these services in the state of Colorado.
Rocky Mountain Health Plans and its partners are well positioned to provide the services described in this RFP and to conduct this Pilot Project in the Front Range and the Western Slope. As providers of community-based behavioral health services and services for individuals with an intellectual or developmental disability for decades, these organizations have the expertise, strong community relationships, and deep commitment to provide excellent services and an innovative model to this population. The existing infrastructure of these organizations, and the services they already provide, serve as a strong basis from which to implement this Pilot Project, to provide crisis services to individuals with I/DD, and to provide data and lessons learned to the state that will allow for expansion and replication of a solid and innovative model.

Poudre School District is committed to supporting the development and implementation of this Pilot Project and will offer its support to Rocky Mountain Health Plans, its partners, and the Pilot Project. We have full confidence that this collaboration will deliver on the requirements of the proposal.

For any questions, please do not hesitate to contact me at my office, 970-490-3213 or via email rtober@psdschools.org

Sincerely,

Romie Tobin Ph.D.
Integrated Services - Coordinator
January 19, 2016

Sarah Miller  
Department of Health Care Policy and Financing  
Purchasing and Contracting Services Section  
1570 Grant Street  
Denver, CO 80203-1818

Re: Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado | RFP # UHAA 2016000079

Dear Department of Health Care Policy and Financing:

On behalf of Mountain Crest-UCHealth, I am pleased to write this letter in support of the submission by Rocky Mountain Health Plan and its partners, of a proposal responding to the Colorado Department of Health Care Policy and Financing Request for Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado.

Mountain Crest is a 26 Inpatient bed Psychiatric Hospital and Outpatient Clinic. We provide coverage in the emergency department at Poudre Valley Hospital and Medical Center of the Rockies as well. We service the greater Fort Collins, CO area. The population mentioned in the proposal is in need of services in our area. There is a great need for housing and case management in particular.

Rocky Mountain Health Plans and its partners are well positioned to provide the services described in this RFP and to conduct this Pilot Project in the Front Range and the Western Slope. As providers of community-based behavioral health services and services for individuals with an intellectual or developmental disability for decades, these organizations have the expertise, strong community relationships, and deep commitment to provide excellent services and an innovative model to this population. The existing infrastructure of these organizations, and the services they already provide, serve as a strong basis from which to implement this Pilot Project, to provide crisis services to individuals with I/DD, and to provide data and lessons learned to the state that will allow for expansion and replication of a solid and innovative model.

Mountain Crest-UCHealth is committed to supporting the development and implementation of this Pilot Project and will offer its support to Rocky Mountain Health Plans, its partners, and the Pilot Project. We have full confidence that this collaboration will deliver on the requirements of the proposal.
For any questions, please do not hesitate to contact me at PHONE or EMAIL.

Sincerely,

Dawn Williams, LPC
Manager of Behavioral Health
Mountain Crest Hospital
UCHealth
970 207-4817
Dawn.Williams@UCHealth.org
January 14, 2016

Sarah Miller
Department of Health Care Policy and Financing
Purchasing and Contracting Services Section
1570 Grant Street
Denver, CO 80203-1818

Re: Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado | RFP # UHAA 2016000079

Dear Department of Health Care Policy and Financing:

On behalf of Foothills Gateway, I am pleased to write this letter in support of the submission by Rocky Mountain Health Plan and its partners, of a proposal responding to the Colorado Department of Health Care Policy and Financing Request for Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado.

Foothills Gateway is a non-profit organization that currently provides a wide array of services to the I/DD community, one of our most vulnerable populations. Examples of services include habilitation, family support services, housing, respite and case management to children and adults in their programs. Foothills Gateway strives to improve the lives of people with disabilities and assisting them to achieve their greatest potential.

Rocky Mountain Health Plans and its partners are well positioned to provide the services described in this RFP and to conduct this Pilot Project in the Front Range and the Western Slope. As providers of community-based behavioral health services and services for individuals with an intellectual or developmental disability for decades, these organizations have the expertise, strong community relationships, and deep commitment to provide excellent services and an innovative model to this population. The existing infrastructure of these organizations, and the services they already provide, serve as a strong basis from which to implement this Pilot Project, to provide crisis services to individuals with I/DD, and to provide data and lessons learned to the state that will allow for expansion and replication of a solid and innovative model.

I have no doubt that Foothills Gateway is committed to supporting the development and implementation of this Pilot Project and will offer its support to Rocky Mountain Health Plans, its partners, and the Pilot Project. I have full confidence that this collaboration will deliver on the requirements of the proposal.

For any questions, please do not hesitate to contact me at 970-498-6821 or kmorrison@larimer.org.

Sincerely,

Kelly Morrison
Deputy Division Manager
Larimer County
Department of Human Services
January 7, 2016

Sarah Miller  
Department of Health Care Policy and Financing  
Purchasing and Contracting Services Section  
1570 Grant Street  
Denver, CO 80203-1818

Dear Department of Health Care Policy and Financing:

Re: Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado | RFP # UHAA 2016000079

On behalf of St. Mary’s Hospital Regional Medical Center, I am pleased to write this letter in support of the submission by Rocky Mountain Health Plan and its partners, of a proposal responding to the Colorado Department of Health Care Policy and Financing Request for Proposal to Provide Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot Project for the State of Colorado.

Rocky Mountain Health Plans and its partners are well positioned to provide the services described in this RFP and to conduct this Pilot Project in the Front Range and the Western Slope. As providers of community-based behavioral health services and services for individuals with an intellectual or developmental disability for decades, these organizations have the expertise, strong community relationships, and deep commitment to provide excellent services and an innovative model to this population. The existing infrastructure of these organizations, and the services they already provide, serve as a strong basis from which to implement this Pilot Project, to provide crisis services to individuals with I/DD, and to provide data and lessons learned to the state that will allow for expansion and replication of a solid and innovative model.

St. Mary’s Regional Medical Center is committed to supporting the development and implementation of this Pilot Project and will offer its support to Rocky Mountain Health Plans, its partners, and the Pilot Project. We have full confidence that this collaboration will deliver on the requirements of the proposal.

Sincerely,

Shelley Peterson  
Vice President Patient Services/CNO