Mental Health/Jails Task Force
Colorado Commission on Criminal and Juvenile Justice
Minutes

July 12, 2018 1:30PM-4:00PM
710 Kipling, 3rd Floor Conference room

ATTENDEES:

TASK FORCE MEMBERS

Joe Pelle, Boulder County Sheriff, chair
Patrick Costigan, 17th JD District Attorney's Office (on the phone)
Benjamin Harris, Department of Healthcare Policy and Financing (on the phone)
Abigail Tucker, Community Reach Centers
Tina Gonzales, Beacon Health Options (on the phone)
Jamison Brown, Colorado Jail Association
Jagruti Shah, Office of Behavioral Health
Charles Smith, Substance Abuse and Mental Health Services Administration (on the phone)

ABSENT

John Cooke, State Senator, District 13
Charles Garcia, CCJJ Member At-Large
Matthew Meyer, Mental Health Partners
Doug Wilson, Office of the Public Defender
Norm Mueller, Defense Bar
Evelyn Leslie, Private Mental Health Treatment Provider
Joe Morales, Adult Parole Board
Frank Cornelia, Colorado Behavioral Healthcare Council

STAFF

Richard Stroker, CCJJ consultant
Laurence Lucero, Division of Criminal Justice

GUESTS

Vincent Atchity, Equitas Foundation
Peggy Heil, Division of Criminal Justice
Moses Gur, Colorado Behavioral Healthcare Council
Danielle Weittenhiller, Office of Behavior Health
Ryan Templeton, Office of Behavior Health
Ali Moaddeli, Arapahoe County Pretrial Release
Lauren Snyder, Mental Health CO (on the phone)
Zena Jahmi, Equitas Foundation
Sarah Wiener, Equitas Foundation

Issue/Topic:	Discussion:
Welcome	Mental Health/Jails Task Force Chair Joe Pelle welcomed the group and asked Task Force members and attendees to introduce themselves.

Issue/Topic:	Discussion:
Recap of June meeting **Action:**	Sheriff Pelle reminded the group that the Task Force is focused on the issue of providing mental health services for individuals who are struggling with significant behavior health issues and are incarcerated in the jails but not eligible for diversion or release due to the seriousness of the charge(s). The primary challenge is the lack of beds at the state level and the inability to access private care due to the inmate status and cost. Richard Stroker provided a recap of last month's meeting. The group had a lengthy discussion to determine how many beds are needed across the state for this population with acute needs that are beyond the jails' ability to provide. There are about 14,000-15,000 jail beds in Colorado and based on the Denver data, it was estimated that between 1 to 1.5% of inmates have significant and acute behavioral health issues, so approximately 150 beds are needed to accommodate this population. It was noted that in 2009, about 150 beds were reduced at Fort Logan. The group reviewed information that showed that there are about sixty *27-65 designated* facilities across the state. Those facilities are hospitals, Acute Treatment Units, Crisis Service Units, and Community Mental Health Centers. It was suggested that contracts should be established between counties and some of those facilities to agree on procedures and protocols which would include security, safety and funding. A working group was formed to start drafting a blue print of such model. The members are Abigail Tucker, Jagruti Shah, Jamie Brown, Frank Cornelia and Moses Gur.

Issue/Topic: Implementation/Designation of regional, secure mental health facilities	**Discussion:** Presentation and review of a written model (in blue below) were included in the meeting materials: Colorado State Forensic Jail Stabilization Unit CCJJ Taskforce History & Agreements: (notes will be inserted when recommendation finalized) Goal: To reduce jail length of stay for individuals struggling with significant behavioral health issues that exceed jail resources to safely manage and that adversely impact an individual's ability to rapidly access services and process through the justice system. Intended Population: Individuals booked into Colorado jails on misdemeanor or felony charges who are ineligible for redirection programs and whose behavioral health needs exceed jail resources and as such require an appropriate setting for stabilization and treatment; often such a facility would need to be 27-65 designated. Taskforce estimates volume for intended population would be between 100-120 individuals per year. Facility: Private hospital or private acute care facility that is 27-65 Designated and credentialed with all Regional Accountable Entities (RAEs) for Medicaid reimbursement. Ideally at least four facilities throughout the State to ensure regional access with locations based on a balance of geography and volume. Services: Services are two-fold and can be iterative depending on individual case o Behavioral health stabilization for acute needs o Competency evaluation & restoration o Services that prepare the individual for return to the jail setting Chain of Custody & Security: To address sheriff department's needs for chain of custody, facilities will work with Sheriff office in design and implementation to ensure that access controls meet demands of detention for individuals in custody. Draft a contract to document chain of custody from detention facility to private facility. This does not impede facilities from hiring their own security staff. Process: • Determine eligibility

- Custody transfer
- Treatment (may be stabilization, restoration, or both)
- Transition back to jail & court system (ensuring rapid process to mitigate decompensation risks upon return to jail)
- Re-entry post court hearings

Remaining Questions:

1. Population estimate calculations to be confirmed
2. Payment for facilities both for treatment and other costs
3. Workforce consideration to effectively staff such a facility
4. Chain of custody agreement
5. Who needs to be included to determine eligibility (i.e. judge, facility, sheriff office, PD?)

DISCUSSION:

Sheriff Pelle expressed that some issues should be fleshed out with regards to the security/safety management and funding. This particular population is the responsibility of the jails regardless of where inmates are transferred. For example, in a case of medical emergency, jails post deputies at hospitals to add security and prevent escape. Often times, the reason why they are not diverted or placed on furlough is because they are facing serious charges.

It was suggested to add to the draft that the safety and security management should be specialized, and the responsibilities of both systems clarified.

When an inmate is in need of emergency medical services, the Affordable Care Assistance can be used after 24 hours of hospitalization. Can it apply for behavior health hospitalization?

Dr. Tucker expressed that she was hoping that it would also apply for behavior health hospitalization and advocated for parity between the behavior health system and, as it exists, the medical system providing that the private facility is *27-65 designated* and has all the required credentials.

There are federal limitations with regards to the number of beds allowed and the group will examine those limitations.

With state facilities such as Fort Logan or Pueblo State Hospital, there is a systematic court order for transfer. When transferring to private hospitals for urgent care and because a court order may not be obtained in time, deputies are posted in the medical center to ensure custody. Some of the options for the model discussed are to either develop a court order process that transfers

	responsibility of the custody on a temporary basis or having contractual agreement in place between the facility and the jail. Danielle Weittenhiller shared that the Office of Behavior Health (OBH) is reaching out to *27-65 designated* facilities along the Interstate-25 portal to offer partnership and fund ten beds for competency restoration. The purpose is to offer immediate treatments and assessments outside of the jails settings while inmates are waiting for availability in the State hospital. Those beds will be reimbursed by OBH. Abigail Tucker commented that these are very commendable efforts but would also advocate for parity between medical and behavior health services. If medical services are covered after 24 hours of hospitalization, behavior health services should be part of the same process which would create a more sustainable solution that is not attached to a 10-bed pilot and would decouple from the requirement of competency. Danielle Weittenhiller agreed and offered to join and be part of these efforts. Moses Gur asked Danielle Weittenhiller to kindly keep the Task Force updated on the conversations and feedback from facilities that have been reached out. Ryan Templeton of OBH indicated that while there are about sixty *27-65 designated* facilities in the state, not all facilities (such as Community Health Centers) could potentially accommodate an acute population with jail settings. Ryan estimated that a total of twenty hospitals with psychiatric units might be possible candidates. *Should Colorado Access be included in conversations for the Behavioral Healthcare Inc. and its regions with regards to Medicaid funding?* No since Colorado Health Care Policy and Financing (HCPF), which oversees all the areas, and Beacon Health Options, which covers Region 2 and 4, are represented in this Task Force. Peggy Heil relayed a conversation she had with HCPF and understood that the facility had to be designated an acute general facility care in order to receive Medicaid payments. Denver Health Hospital is classified as an acute care unit and not a psychiatric hospital with the required credentials. Richard Stroker suggested that the model with desired outcomes should be described including issues of implementation, funding, support of existing pilot, use of Medicaid, etc. **Who determine eligibility and who is involved?** It was agreed that either health care providers when available in the jails or jails personnel would initiate a process. **Who decides**? A court order is desirable to support the transfer of custody and reduce jail staff impact.

It was commented that a court order would be desirable for emergency situations. Hospitals still refuse to admit individuals based on their inmate status and a court order would solve this issue.

The idea of establishing bond conditions was suggested to allow transfer of custody to the care facility. One of the challenges is that most of the targeted population are on pretrial for serious offenses and unlikely to be released or diverted.

It was agreed to flesh out a process related to emergency actions and including notification of court, public defenders and district attorneys and payment/reimbursement for care of the receiving facility.

The M1 process on the civil side was discussed and it was suggested that this process be extended to the criminal side. Jail staff initiate the M1 process and have the ability to place somebody in the event of eminent threat even if the person is on inmate status. This process immediately triggers a judicial review and involves the court.

Richard Stroker summarized that a court order would be the most desirable option in order to move someone to a facility and get the services. If this option is not available, an emergency action process should be in place (including notification to the court). The group agreed to look at M1 hold process and extend to the criminal side.

At receiving facility:
Currently, when a jail transfers someone to a hospital, the jail is responsible for the cost of the first 24 hours' care and the cost of the security. It was suggested that, in this model, the providers could recover the Medicaid reimbursement and counties would ensure the security in the facility. If there are multiple counties transferring into the facility, the transferring counties could reimburse the security cost to the hosting county jail where the facility is located. Each county should enter agreements with the health facilities in their region.

This topic will be discussed at more length at the working group level to flesh out which entities would be responsible for the security costs, what will be the security components and how the inmate will be managed.

Payment
Ben Harris joined the group by phone and the group asked whether the reimbursement by Medicaid was contingent to the type of facilities and the level of acuity of the patient. It was understood by previous discussions with HCPF that a full care hospital with psychiatric unit could receive reimbursements when a specialized psychiatric hospital might not be eligible for reimbursement.

Ben Harris clarified that the reimbursement depends upon how the facility is classified but doesn't depend on the services received. To be more specific, full care hospitals have a provider code "17" and claims are accepted regardless of the type of treatment after 24-hours hospitalization. Acute care hospitals usually

	have different codes and claims would be denied. Richard Stroker expressed that progresses have been made today about the elements of the model. There is more clarity about how to determine eligibility, who is involved, how and when courts are involved, when seeking court order, M1 holds and how emergency steps play out and, more to discuss at the working group level about who is responsible for security costs. Then, the group talked about how the health care aspect be covered and welcomed the pilot project developed by OBH and discussed how to expand on these efforts.

Issue/Topic:	**Discussion:**
Next steps and Adjourn	Richard Stroker asked the working group if they are willing to flesh out the model to include today's discussions. Ben Harris and Ryan Templeton were invited to participate to the working group discussions. Joe thanked the group for the continued participation. Meeting adjourned at 3:00 pm

Next Meeting

August 9, 2018 1:30pm – 4:00pm 710 Kipling, 3rd Floor Conference room