Douglas County Care Compact Expansion: Care Coordination Enhancements

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RFQ Questions

1) Description of Developmental Pathways

Started in 1964, Developmental Pathways (DP) is a nonprofit agency serving more than 15,000 individuals with disabilities and their families across Arapahoe, Douglas, and Elbert counties. We support individuals across their lifespans and have experience supporting individuals with co-occurring needs from birth to aging.

We are a designated Case Management Agency (CMA) for long-term care services and are one of Colorado's Community Centered Boards (CCB), connecting people to federal, state, county, and private funding. We are also Colorado's largest Early Intervention (EI) provider and help connect young children to essential resources.

We are a central resource for individuals and families seeking support with disability services. We believe in a 'No Wrong Door' approach to care, and if DP cannot assist an individual or family, we help connect them with others in the community who can.

Our work focuses on care coordination for individuals and families who need help navigating the complex world of disability services. We also actively build, support, and partner with community resources to meet the needs of our community.

Our vision is to partner with individuals in their pursuit of a meaningful life through advocacy, education, connection, and support, all through person-centered approaches.

In relation to The Care Compact (TCC) work, DP has been identified as a key player in TCC partner network since its inception in the Spring of 2020. We participated in the initial brainstorming, planning, and pilot rollout via our engagement in both the executive steering committee and Care Compact operations team meetings as well as continued evolution from the pilot to program implementation phases.

We have been and remain fully committed to the main objectives of the program, with a strong emphasis on improving access to the right services & levels of care for individuals with complex needs.

We have been thankful to be a part of such meaningful work & look forward to supporting the expansion of this program to also provide solid care coordination for youth.

Developmental Pathways is committed to assisting Douglas County in building a program that will best support the needs of the youth and families with mental health, substance use disorders, intellectual and developmental disabilities or delays (IDD), and basic needs.

As the Youth Care Compact program partner, we commit to:

- Continued collaboration providing cross-system supports & resources to youth & families.
- Sharing of expertise as it pertains to our scope of work.
- Engagement in planning and preparing for Care Compact expansion.
- Continued partnership in program operations via dedicated case management/care coordinator & leadership engagement.

2) Evidence of Care Coordination Abilities

Our work focuses on care coordination for individuals and families who need help navigating the complex world of disability services. We also actively build, support, and partner with community resources to meet the needs of the community. Our vision is to partner with individuals in their pursuit of a meaningful life through advocacy, education, connection, and support. We are a central resource for individuals and families seeking additional support and believe in a 'No Wrong Door' approach to care, if DP cannot assist an individual or family, we help connect them with others in the community who can.

In support of TCC, we can provide case management or care coordination for the following areas:

- Disability services
- Benefits navigation and application support
- Community-based case management
- Housing navigation, self-sufficiency, and connection to basic needs
- Crisis response, follow-up care, and coordination of emergency interventions
- Children, Youth, and Family-specific services

Our teams are dedicated to fostering individual and family choice, community participation and inclusion, and collaborative care coordination focused on meeting the whole person's needs.

Individuals and families seeking long-term services are welcomed by teams dedicated to the specific components of the Intake, Screening, and Functional Assessment processes. When receiving initial requests for services, we triage support and determine the best ways to support the individuals' needs.

This includes support with applying for Health First Colorado/ Colorado Medicaid, completing long-term care assessments, providing community referrals to relevant community resources such as behavioral health supports and local programming, and completing person-centered support planning processes.

The result is individuals gaining access to providers and services of all types that can support them in their homes and community. The following key components support these processes:

- **Person-Centered Focus** – As a pioneer in person-centered support, DP trains all employees on allowing the individual (and family, if applicable) to guide and decide their needs and goals

for support. DP Case Managers work with members to identify and implement creative solutions and provide referrals that best meet their needs. Additionally, DP prioritizes operational improvements to create sustainable, scalable models for intake, screening, and referral activities, with a commitment to internal and external innovation to improve our processes and provide simplicity in navigating the system. These operations also enable us to continue expanding in the future.

- **Dedicated Systems Navigation Department** – Our Systems Navigation teams exist to help individuals and families navigate the complex LTSS system, including screening, referrals, and functional eligibility assessments, in addition to assisting individuals in obtaining and maintaining Long Term Care and Health First Colorado benefits. DP emphasizes specialized teams and departments to simplify this process for individuals and families in services.
- **Data Analysis and Performance Review** – We regularly analyze data for intake processes, especially the time it takes to complete each function. This in-depth and systematic analysis allows our organization to utilize real-time data to make decisions and adapt operations, thereby eliminating delays. Our goal is to exceed HCPF stated timelines while providing excellent customer service.

3) TCC Care Teams Dedicated Support

Developmental Pathways strongly believes referral networks require constant care and cultivation. We invest heavily in seeking out and maintaining these connections in service of high-quality, meaningful, and timely referrals across multiple entities in support of individuals and their families/support networks.

DP was a partner agency in the No Wrong Door Metro Collaborative as a part of HCPF's No Wrong Door (NWD) Grant (https://hcpf.colorado.gov/no-wrong-door-implementation-grant). This project formally concluded in 2019. This work cemented the effectiveness of utilizing collective community knowledge to improve the experience of individuals in accessing long-term care support.

Local outcomes of the Metro Collaborative included stronger relationships with agencies like Colorado Access, the Denver Regional Council of Governments, Centers for Independent Living, and other CCBs and CMAs. While DP has always valued collaboration with public and private supports in the community to strengthen outcomes for individuals with disabilities, this pilot reinforced our long-standing commitment to the "No Wrong Door" approach. Successful referral processes support individuals and families by matching them with services that best meet their needs, and DP excels at this work.

DP has long-established relationships with Arapahoe and Douglas counties. This includes county liaison positions that help coordinate support services and therapeutic intervention as necessary with Departments of Human Services, school districts, and other community partners. Our liaisons help to bridge together all agencies working with an individual to ensure collective needs are addressed and thorough communication is occurring between support agencies to avoid duplicative efforts. DP collaborates with the counties we serve and knows strong relationships mean more stability for individuals and families.

Our County Liaisons focus on building strong community partnerships and educating community partners on DP services and supports to build a strong referral network and collaborative relationships. They provide specialized support to children, youth, and adults with complex needs, collaborating with

internal teams and outside entities with the goal of meeting the holistic needs of the individual and family.

These specialized roles facilitate effective communication and problem-solving across systems within our designated service area in the community. Our Crisis team participates in regular meetings and workgroups with HCPF staff, Alliance staff, and other community partners to address system gaps for individuals with a co-occurring disability and behavioral health needs, helping to prevent hospitalization and institutionalization intervention. The Crisis team partners with hospital social workers to collaborate on discharge planning for individuals enrolled in our HCBS waivers or who need to go through the intake process. We also work closely with probation officers and the court system to ensure that individuals who are incarcerated and being released have the appropriate support and supervision to transition back into the community safely and successfully.

Dedicated County Liaisons work closely with the county Department of Human Services offices in the DP-designated service area to ensure smooth and efficient transitions into services for individuals in need. These roles interface with the Child Welfare programs of the respective counties to support some of the most complicated cases in the long-term care system. Housing, legal custody, and adoption processes are all navigated in these cases, and the combination of specialized skill sets, knowledge bases, and established relationships facilitates meeting the needs of these challenging and often traumatic circumstances.

4) **Estimated Fee Schedule**

Request: Two (2) .5 FTEs; a total of 1.0 FTE

For this continued collaboration, we request funding for two (2) half-time employees (.5 FTE) working approximately 18-20 hours/week in service Care Compact Goals. Our current plan is to have one position focus on youth supported through TCC and to have another position focus on adult supports through the TCC. By utilizing the value of a single FTE across two roles, we believe we can more seamlessly integrate care coordination outcomes with other programming across our agency.

Through this funding, we will be able to fully serve Douglas County residents of all ages and with any disability through this work.

Approximate Three Year Fee Schedule

	.5 FTE Youth	.5 FTE Adult	Year 1 Total*	Year 2 Total**	Year 3 Total**
Salary (.5 FTE each)	$29,000	$28,000	$38,000	$58,995	$61,060
Benefits & Fringe	$5,069	$4,898	$6,645	$10,316	$10,677
Cost of Supervision	$6,954	$6,954	$9,272	$14,395	$14,899
Overhead and Operating	$2,009	$2,009	$2,679	$4,018	$4,018
M & G	$10,924	$10,924	$14,565	$21,848	$21,848
	$53,956	**$52,785**	**$71,161**	**$109,572**	**$112,501**

*Year 1 runs from May – December 2024 (8 months)
** Estimated cost growth calculated at 3.5%

5) Potential Conflicts of Interest

We do not believe we will have any conflicts of interest as we work collaboratively to ensure Douglas County residents have the care coordination they need to access services that meet their behavioral and health needs. We provide case management supports only and not the therapy.

6) Sustainability Plan

We are deeply committed to the work of TCC, as we have partnered with it since its inception, and intend to prioritize the collaboration with this group ongoing. This collaboration allows us to connect directly with individuals and families to get them enrolled or engaged in services so that we can provide the care, often long-term, that they need to live meaningful lives.

TCC is one of many arenas where we collaborate to provide wrap-around care for people with disabilities in Douglas County. When this funding no longer remains, we will look to local funds, which includes utilizing existing county Mill Levy funding where appropriate and/or leveraging grant funding through additional funding sources. Throughout this grant period, fifty percent (50%) of both positions will be funded through existing DP revenues. We believe this shared allocation demonstrates our long-term commitment to these roles and this work.

RFQ responses (our references) continue on the next page.

References:

1) **The Arc of Arapahoe, Douglas, & Elbert Counties**

The Arc Arapahoe, Douglas & Elbert Counties is a private 501(c)(3) nonprofit organization dedicated to providing advocacy, information, and support to people with intellectual and developmental disabilities (I/DD) and their families. They have been in business since 1955.

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2) **Colorado Access**

Colorado Access is a local, nonprofit health care company currently contracted as one of seven (7) Colorado's Regional Accountable Entities (RAEs); as a RAE, they serve Adams, Arapahoe, Douglas, and Elbert Counties. Colorado Access has been serving Colorado for 25 years.

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3) **Signal Behavioral Health**

Signal Behavioral Health is one of three Managed Service Organization (MSO) in Colorado, designated by the Colorado Behavioral Health Administration (BHA) to manage and monitor substance abuse treatment services for adults and adolescents who are uninsured or under-insured in our state. They also work as one of the state's Administrative Services Organizations (ASO), managing and expanding community-based crisis services for the Denver/Boulder metropolitan area and serving as a liaison for families and children who need access to behavioral services through the Children and Youth Mental Health Treatment Act. They have been serving Colorado for over 20 years.

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