Reimagining Home: Residential Solutions for Coloradans with I/DD and High Support Needs

SEPTEMBER 2026

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Inclusive Housing Coalition
Autism Housing Network, a project of Madison House Autism Foundation

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Colorado Developmental Disabilities Council

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Contributors

Thank you to the many individuals who participated in this process, especially those who shared their experiences through surveys and/or interviews. May this report offer hope and become a catalyst for action.

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ACCESSIBILITY STATEMENT

This report was designed with accessibility as a leading principle and meets PDF/UA accessibility standards. The Atkinson Hyperlegible font family was used throughout the report. Efforts have been made to provide a consistent heading structure, tagged elements, a structured reading order, sufficient color contrast, and compatibility with screen readers and other assistive technologies. If you experience difficulty accessing any part of this document or need information in an another format, please reach out at gray@aphexdesign.com.

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Executive Summary

Stakes are climbing higher than ever for Coloradans with intellectual and developmental disabilities (I/DD) who require access to at least 24/7, high-intensity support. And while the stakes are high, the systems that care for them are currently ill-prepared, under-resourced and disincentivize innovation.

Families—often with aging parents in their sixties, seventies and eighties—are providing round-the-clock care to loved ones without needed respite, a safety net for crisis and few housing or Long-Term Support Service (LTSS) options designed for their adult children's complex needs. Colorado does not have a plan nor a path forward for when thousands of these caregivers pass or can no longer provide a home and care.

Without housing or LTSS options, Coloradans are at risk to be re-institutionalized, boarded in Emergency Departments, undergo unnecessary psychiatric hospitalization, or placed in skilled nursing facilities that are neither equipped nor appropriate for adults with I/DD. This outcome is traumatic for adults with I/DD and may lead to worsening mental health or physical harm that could reverberate for years. The number of families facing this situation reflects the fact that these are not isolated tragedies—they are predictable system failures that can be prevented through deliberate investment in neuro-inclusive housing and specialized LTSS infrastructure.

Understanding the population-specific needs and preferences for future housing and LTSS is critical for Colorado to respond deliberately and quickly to develop solutions for those being left out of current innovation. This report offers detailed information about the diverse population of those with I/DD who have high support needs. The following is a snapshot of data collected reflecting 73 individuals with at least 24/7 support needs in Colorado:

Demographics

- Urgent planning is needed: 52% of caregiver respondents are over the age of 60; 18% were over the age of 70
- 61% report current residential options are not sufficient to meet their needs
- 43% report needing at least one-to-one support ratios, with 19% report needing at least two dedicated staff persons during awake hours
- 47% have self-injurious behaviors, 37% indicate harmful physical behavior towards others, 41% report disrobing in non-private spaces, 34% have life-threatening elopement episodes, and 60% experience incontinence
- 14% of survey respondents have already had to use the Emergency Department for a crisis due to lack of other I/DD-specific options

Long-Term Support Services

- 95% are on a Home and Community Based Services (HCBS) waiver, yet 53% have been denied support from a service provider due to their high support needs
- Current Medicaid reimbursement rates and inflexible regulatory barriers make it impossible for service providers to meet the need
- The majority of respondents reported a need for specialized behavioral support services while service providers indicated those with high behavioral support needs were more difficult to serve than those with complex medical needs
- Shared living, or living with a caregiver in their own home, was preferred by 62% of respondents
- Unlike demand data from market studies that include the range of support needs, self-direction, paid neighbors, and enabling technology are not highly preferred
- The top concern reported (83%) was lack of adequately trained staff

Housing Preferences

- Two of the top three challenges service providers face in meeting the demand for residential options is finding housing that is both affordable and accessible.
- 82% of survey respondents prefer to own the home versus renting, with nearly half desiring to live with their family member and then bequeath their home to their loved one—potentially creating naturally occurring affordable housing to others.
- The majority prefer a form of neuro-inclusive planned community versus the existing housing stock.
- Unlike demand data from general market studies that include the range of support needs, those with high support needs indicate less demand for apartments/condos and greater demand for accessory dwelling units, small patio homes, and single-family homes.

Although Colorado has largely eliminated the use of I/DD-specific institutional settings, this population, and often their family caregivers, are isolated in their homes, separated from and invisible to their community. Medicaid-funded HCBS is prohibited from paying for room or board, thus this population must have access to both deeply affordable and uniquely accessible housing to keep from entering other institutional settings not designed for those with I/DD. Housing vouchers are largely unavailable and current minimum requirements for ADA-compliant housing units will not meet the need—nor is there enough stock of these units on the market.

Service providers also face multiple steep barriers: low reimbursement rates, significant administrative costs to ensure regulatory compliance, workforce shortages, few housing options accessible for their clients and lack of capital to purchase homes or for housing development. The lowest paid workforce is taking on some of the most difficult caregiving work. Service agencies need skilled individuals to be responsible for the wellbeing of their clients with high support needs, yet they are competing against fast food, gig work and retail industry wages where the workforce has significantly less personal liability. Although many Direct Support Providers (DSP)

experience a deep sense of intrinsic reward from their profession, they also take on mentally and physically draining workloads at poverty wages. Individuals with high support needs require specialized training which places an immense amount of responsibility sitting on each DSP's shoulders. Burnout is high.

Due to workforce shortages, 54% of Colorado service providers reported having turned away or stopped accepting new service referrals.[1] To prepare—and retain—a robust pool of DSP staff to safely serve adults with high support needs will require a greater financial investment and new tools for Colorado service providers. An infusion of support is needed for service providers to develop the organizational infrastructure to handle the training, supervision, risk management, clinical and medical expertise, and other unique aspects of supporting those with high and/or complex needs sustainably.

Without policy and funding changes in both the LTSS delivery and housing industries, families will continue to shoulder impossible burdens, and hospitals will continue to serve as de facto residential providers at staggering public cost.

Colorado has the creative leaders, deep expertise and now the evidence to act. Service providers can be equipped to meet demand if the funding infrastructure and critical workforce is supported. The housing industry has been primed and is willing to meet the needs of this demographic. **There is no time to waste—this population is already in crisis. With targeted investment of attention and finances, Colorado can create solutions that would not only save taxpayers millions, but offer relief to aging family caregivers and give adults with I/DD the dignity of a place to call home.**



Using data collected and feedback from focus groups, three residential concepts were created based on the profile of composite individuals. See the Data-Driven Concept Plan section of the report for full detailed renderings, descriptions and needed changes for implementation.

Study Background

Over the past five years, the Colorado Developmental Disabilities Council (CDDC) and others have invested in market research in order to guide advocacy toward solutions informed by Coloradans with I/DD and their families. Through this work, a theme emerged: individuals with high support needs are facing a severe lack of options for housing and support services.

Stakeholders reported being unable to find providers or residential models that meet their needs. To identify the bottlenecks that are preventing families from receiving care, this study examines the system that supports this population. Colorado has one HCBS waiver specifically designed to serve those with I/DD and 24/7 support needs, the comprehensive Developmental Disabilities (DD) waiver.[2] Enrollment into this waiver is limited and based on funding appropriated by the Colorado legislature. The Colorado Department of Health Care Policy & Financing (HCPF) estimates total enrollment for the DD waiver for 2027-2028 to be 9,790 individuals.[3] According to the HCPF Strategic Plan, the waitlist for the DD waiver is currently at 8,133 persons.[4] The waiting list has multiple tiers, and the As Soon As Available (ASAA) waiting list tier has 2,749 individuals waiting.[5] HCPF reports the average time individuals spend on the ASAA waiting list is 7 years.[6]

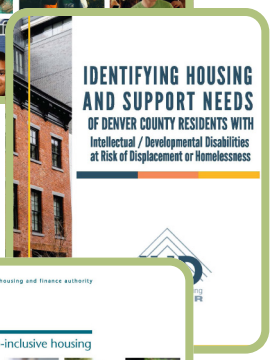
Furthermore, DD waiver funding is prohibited from being used for room and board, and this population largely does not earn an income. Even if a housing voucher is obtained to subsidize rent, access to accessible housing or neuro-inclusive design modifications are limited in the existing housing stock.[7]

As a last resort, families or first responders end up using Emergency Departments for boarding at an estimated $1,856 a day with

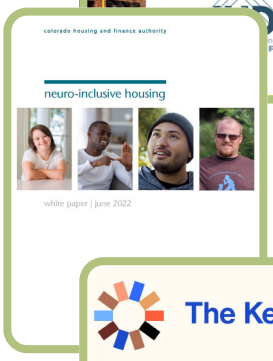
Past Research in Colorado



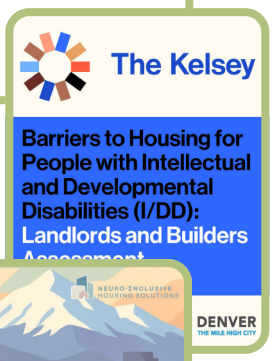
Developmental Pathways Housing & Community Development for Residents with I/DD (2020)



Identifying Housing and Support Needs of Denver Residents with I/DD at Risk of Displacement or Homelessness (2021)



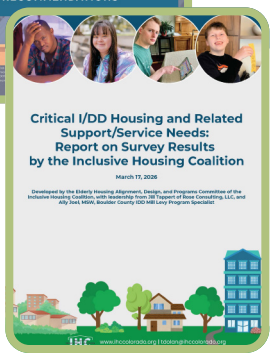
CHFA Neuro-Inclusive Housing Whitepaper (2022)



Barriers to Housing for People with Intellectual and Developmental Disabilities: Landlords and Builders Assessment (2024)



Critical I/DD Housing and Related Support/Service Needs: Report on Survey Results by the Inclusive Housing Coalition (2026)

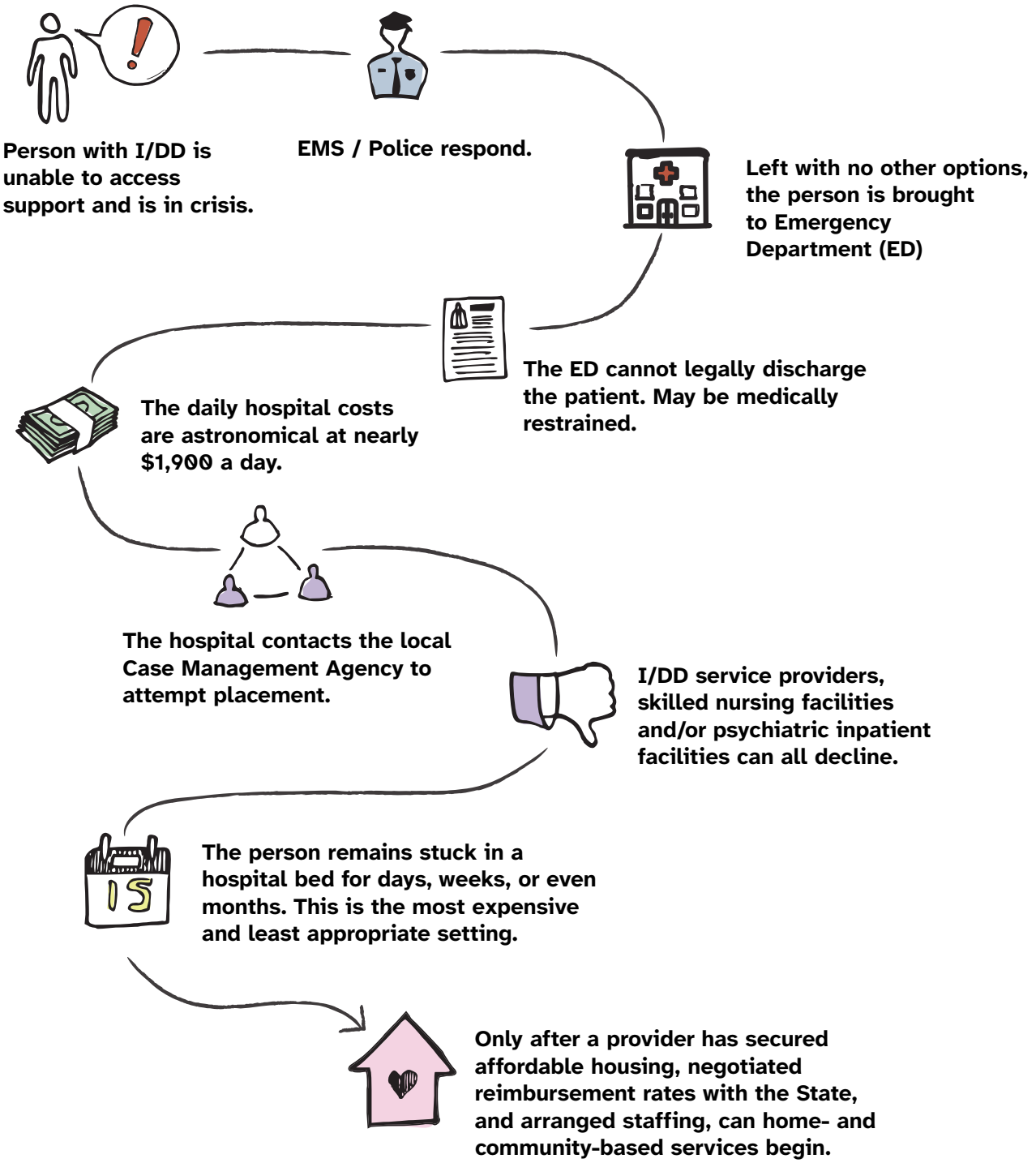


Neuro-inclusive Intentional Communities in Colorado: Investigating Demand & Policy Recommendations (2026)

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few alternative placements available, even in institutional settings like skilled nursing facilities or psychiatric inpatient facilities.[8] The cost of doing nothing is exorbitant and is causing undue trauma to Colorado families. Clearly, urgent planning and legislative action is necessary to meet the needs of those with I/DD who are living in an aging caregiver's home or in need of emergency services.

The following flowchart outlines the typical course of action when the family caregiver of someone with high support needs dies, becomes incapacitated, or can no longer carry the weight of caregiving alone and falls into crisis.



Study Background

The process depicted in the figure above often results in a person with I/DD returning to the family home after the acute crisis is resolved.[9] Yet, caregivers are aging and Colorado will not have them as a safety net for decades to come. Nearly half of the respondents to this study have at least one-to-one support needs, over half are living with a senior caregiver, and emergency room boardings are already occurring due to lack of options.

Setting	Daily Rate	90-day total
Emergency Department boarding	$1,856/day	$167,040
Example Individualized HCBS High-Needs Rate*	$525/day	$47,250
Cost Savings per person	$1,331/day	$119,790
Cost Savings for 50 people	$66,550/day	$5,989,500

** Example rate based on Colorado service provider focus group feedback.*

Funded by the CDDC, Neuro-Inclusive Housing Solutions and the Inclusive Housing Coalition sought to investigate the lived experiences of adults with at least 24/7 support needs, parse out the challenges they and their families faced, understand what solutions are preferred, and create several concept plans based on the data to highlight the required policy or regulatory changes required to bring these re-imagined solutions to life.

Throughout the report, quotes from study participants are offered to help illustrate the diversity of experiences this population faces on a daily basis. Quotes from respondents have been lightly edited for grammar, but tone and content have not been altered.

"Needed psych placement and there was no room anywhere in the state. The only options at the time were to live in the local Emergency Department ad infinitum or go back home."

— SURVEY RESPONDENT

"We are under-resourced for those with high behavioral support needs versus those who need skilled medical support."

— SERVICE PROVIDER FOCUS GROUP PARTICIPANT

"At this time, I have not identified a provider in Colorado that is able to consistently and immediately meet high support needs in a home-based setting without delays. Many providers have staffing shortages, onboarding delays, or limitations in supporting complex needs. There is a need for providers who can offer rapid-start, well-trained in-home support with consistent staffing and flexible scheduling."

— SURVEY RESPONDENT

"I feel like Colorado is completely unprepared for the influx of disabled adults whose parents have aged and can no longer take care of their adult children. We are honestly wondering if we may have to move to a different state to get the help we need."

— SURVEY RESPONDENT

Study Methodology

This study uses a mixed methods process that Neuro-Inclusive Housing Solutions has employed in multiple housing studies across the country, combining quantitative data from a survey with qualitative analysis of long-form responses and focus groups.

METHOD

1. Conducted literature review (see Appendix) of existing research related to residential outcomes and best practices of those with high support needs
2. Reviewed operating residential options from the Autism Housing Network's Housing Directory listings that serve those with high support needs
3. Based on background research, developed a virtual presentation & survey materials (including explanations of housing and support choices as well as several innovative models from across the country) to collect data and guide focus groups
4. Collected and analyzed data from survey instrument and focus groups
    - Two separate surveys were conducted with different audiences; the first one recruited participants who are individuals with I/DD and high support needs, or who are parents/guardians of the same population
    - The second survey went to leaders of disability advocacy organizations or LTSS provider agencies
    - Unless specifically noted, the charts and data referenced below are from the first survey
5. Created concept plans for specific residential solutions based on data collected
6. Shared data and concept plans with advocacy leaders, service providers, and housing professionals to identify policy, regulatory, and funding changes needed to meet the need
7. Drafted report for critical review from Colorado leaders
8. Published report with specific recommendations for future advocacy efforts

DEFINING HIGH SUPPORT NEEDS

There is not a universally accepted definition for a person with I/DD who has high support needs. The Supports Intensity Scale (SIS) and Interim Support Level Assessment (ISLA), are the standardized assessments used by HCPF to determine an individual's level of support when enrolled in the Medicaid-funded HCBS program.[10,11] Support levels range from one to six, with a review process for a SIS level seven for those with exceptionally high needs, and correspond to the funding authorization a person can access to meet their support needs and person-centered plan. SIS Level 6 offers rates associated with shared 24/7 supervision.

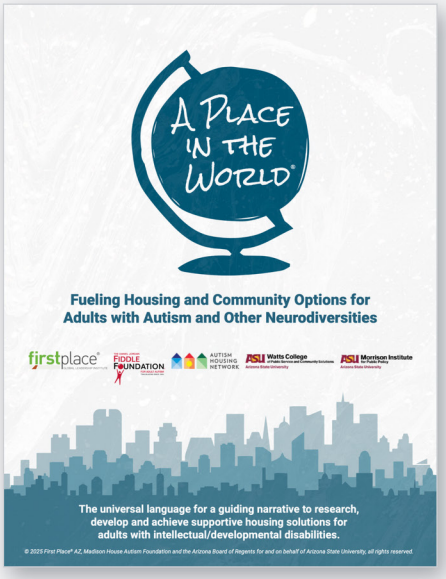
Study Methodology

Although Colorado uses the SIS and ISLA to identify support levels, this data does not always reflect the actual level of support someone may need when no longer living with a family caregiver as underscored by the 2025 Inclusive Housing Coalition (IHC) needs assessment. In the IHC needs assessment survey, participants were asked to share their given SIS level as well as their perceived level of support needed to live outside the family home.[12] Of the 190 respondents of the IHC needs assessment survey, 45% (n=87) respondents indicated they had high support needs defined as "needs 24-hour assistance."[13] The dataset to the right reflects the SIS or ISLA Support Levels reported, showing significant variation despite respondents indicating the need for 24-hour assistance.

SIS Level	Survey respondents needing 24/7 support
1	1
2	0
3	6
4	8
5	16
6	33
7	12
N/A or unknown	11

The *A Place in the World: Fueling Housing & Community Options for Adults with Autism and Other Neurodiversities* report offers foundational shared language needed for researching, realizing, and replicating housing solutions to support adults with autism and/or I/DD.[14] It outlines ten different levels of support as well as defines service delivery models, amenities, development types and includes a Housing Market Guide of 20 different properties from across the country. Nomenclature from *A Place in the World* was used in preparation of presentations and survey tools for this study.

A functional definition of high support needs—for the purposes of this study—is when the person with I/DD must have at least access to in-person, direct support 24/7 to reside outside of the family home or participate in the greater community.



A Place in the World
Fueling Housing & Community Options for Adults with Autism and Other Neurodiversities® (3rd ed.)

Scan here to access the report.

This allows for expanded models of service delivery where a person with I/DD and high support needs does not always have to share the physical space of their home with a Direct Support Professional (DSP), but can access in-person support without waiting for someone to drive to their location. Within this parameter, additional data was collected to understand the diversity and intensity of support for those who have I/DD and high support needs.

The survey captured data from 73 self-advocate or family respondents and 22 representatives from advocacy and/or service-providing organizations. (Respondents to the survey who indicated they needed less than access to 24/7 support were deleted from the data analyzed and are not included in the 73 final respondents). Focus group participants provided feedback to the survey data and sample concept plans.

STUDY LIMITATIONS

- Survey answers are self-reported, meaning that actual support needs were not independently evaluated.
- Four responses were removed from the dataset due to indicating they needed less than 24/7 access to support, or left the question blank.
- Only three self-advocates are represented in the data. Significant effort was made to connect to self-advocates with I/DD who had reliable communication and at least 24/7 support needs including: one-on-one or customized accessibility request on the project website, asking service providers for self-advocate contacts, outreach to self-advocate organizations in Colorado, and directly contacting self-advocates who appear to have high support needs based on public discourse. This lack of self-advocate representation may reflect that the majority of those who need 24/7 support have extensive communication challenges and congitive impairment due to their disability that prevent them from being able to articulate or type their housing and support preferences.

"I can't find a day program for her, it's virtually impossible to find a residential option."

— FOCUS GROUP PARTICIPANT

"She would be ok with in home support staff overnight that are not awake, but would not be able to get by with 'access to off site staff overnight' - she freezes & melts down when the unexpected happens and could not reliably seek off site help when needed (e.g. if a fire broke out)."

— SURVEY RESPONDENT

"Too many stories of abuse- my personal fears prevent me from trying [residential options]."

— FOCUS GROUP PARTICIPANT AND ALSO A CASE MANAGER

"People with high needs prefer stability. Change can cause them to go into a tailspin. Having their own place in the world is incredibly important."

— FOCUS GROUP PARTICIPANT

"There's nowhere to 'give him.' I have to create something. It's coming from my retirement fund."

— FOCUS GROUP PARTICIPANT

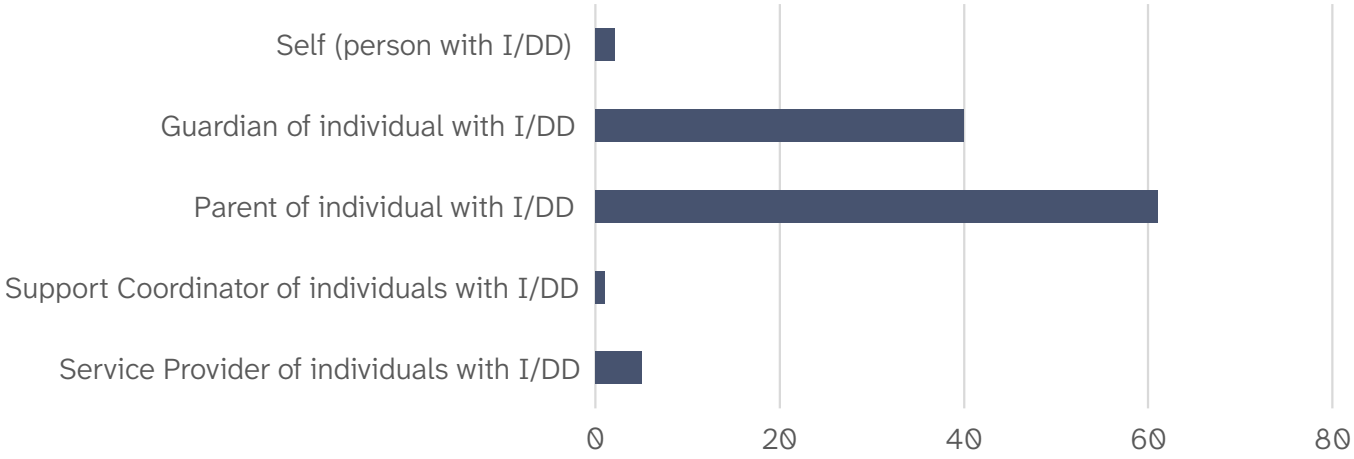
Data Analysis

This section represents data collected from the survey distributed from April–June 2026 unless otherwise specified. Additional data not included in the content below is located in the Appendix.

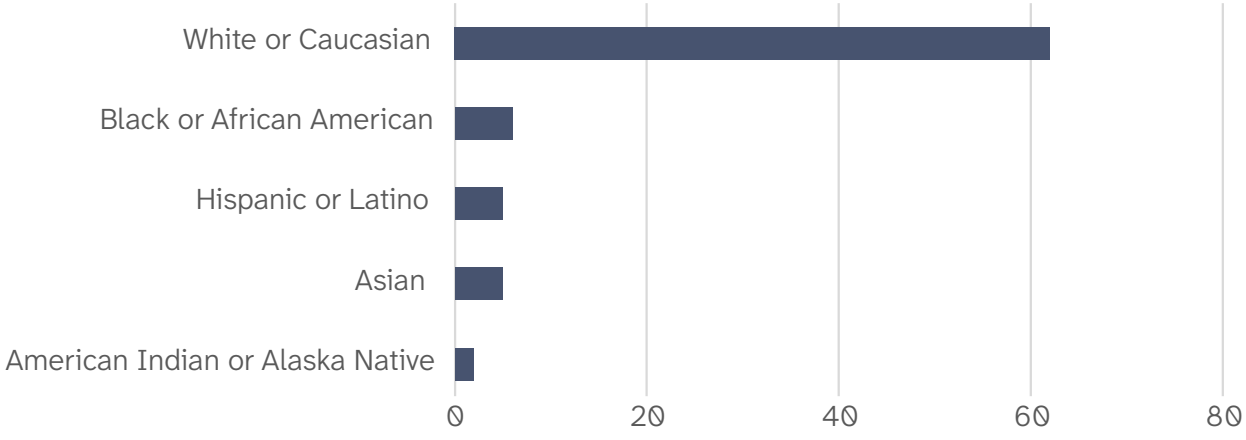
DEMOGRAPHICS

This section includes demographic characteristics not only for the parents and guardians, but also for their adult children/relatives with I/DD. Nearly 85% of respondents were parent caregivers of adults with I/DD. 94% of respondents selected at least two disabilities with which they (or the person they support) identify. Of those respondents, 54 answered with a combination of identified disabilities that were completely unique to them. This underscores the need for person-centered planning and individualized LTSS as diagnosis alone does not dictate needs or preferences.

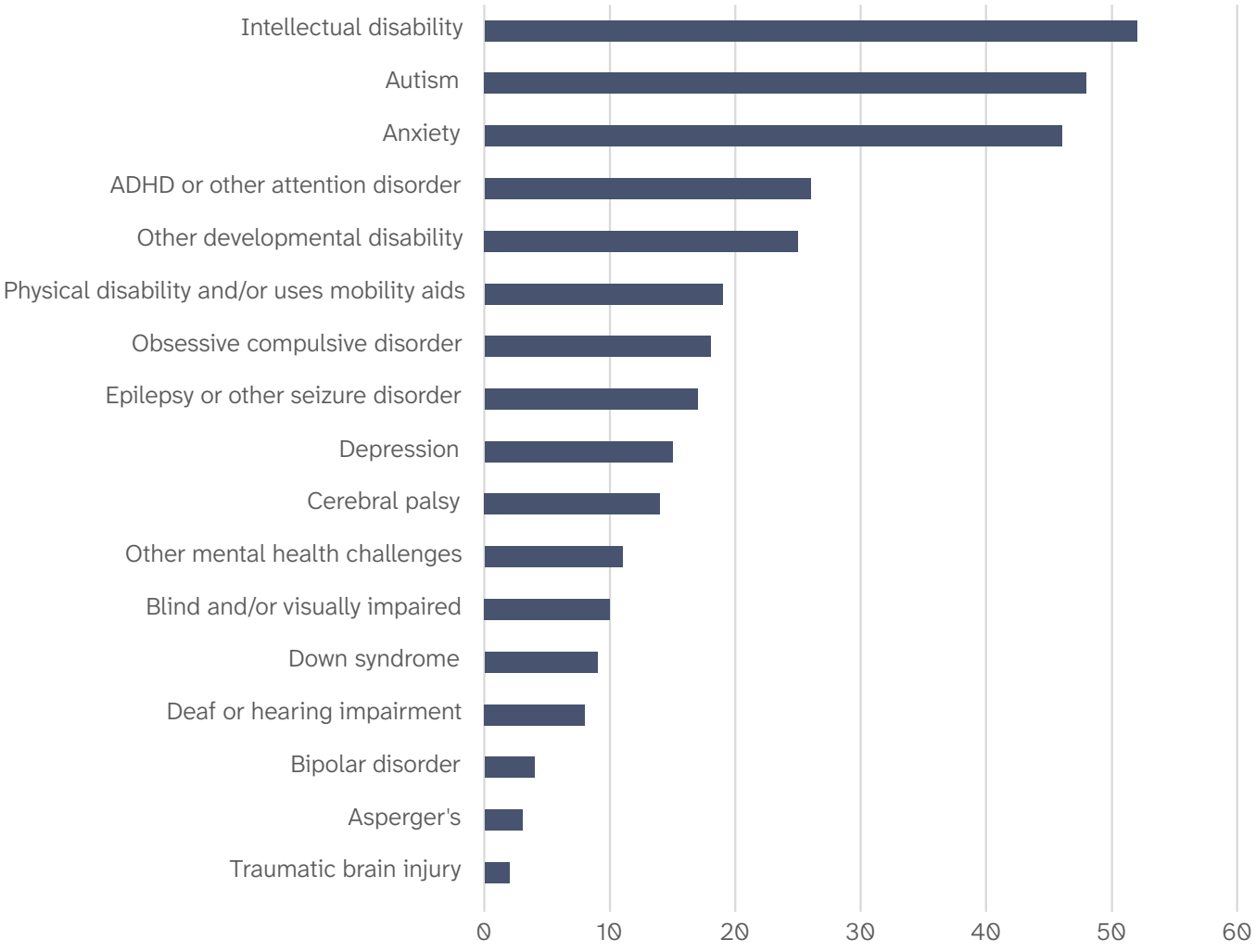
Identity of Survey Respondents: Relation to I/DD



Identity of Survey Respondents: Race, Ethnicity, and Language



The disabilities that I have, or those I support, include:

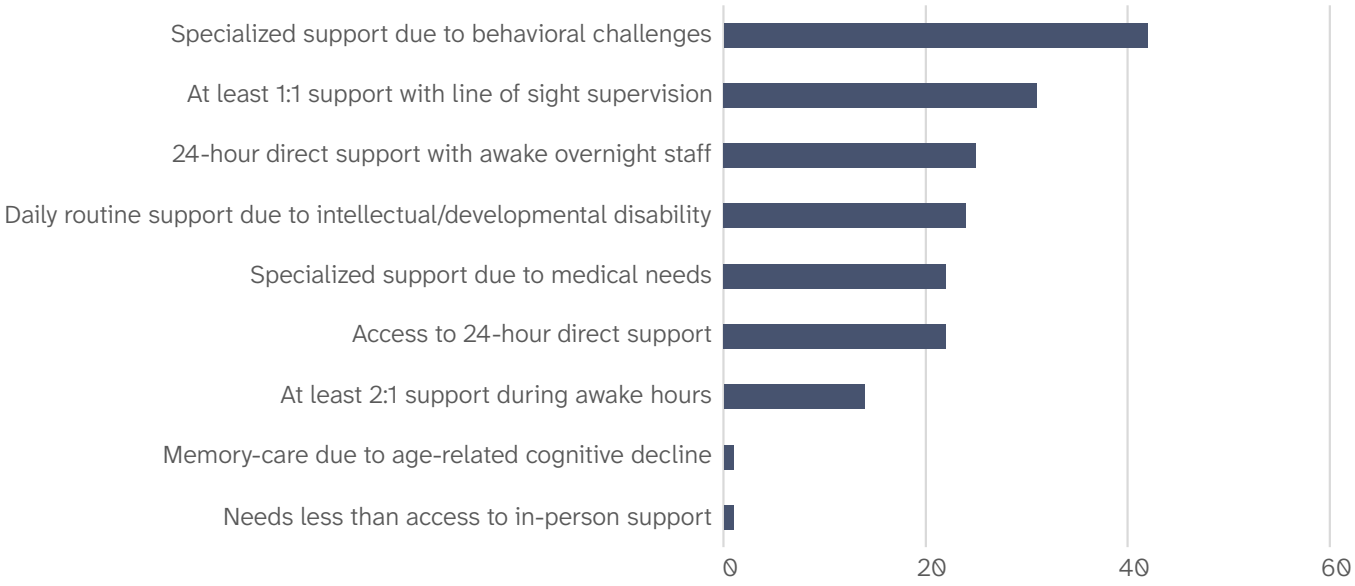


Current Support Needs and Daily Activities

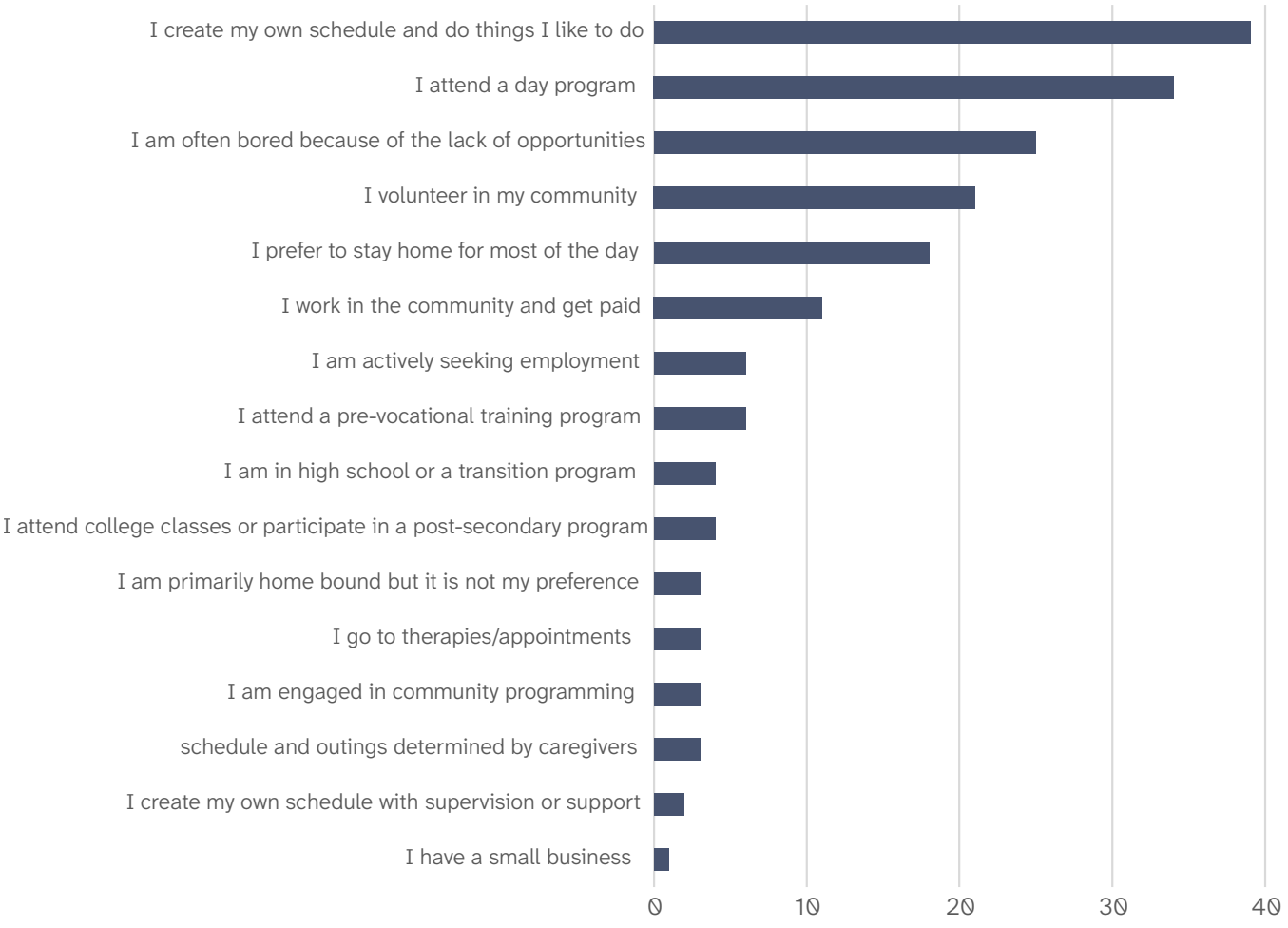
This section contains responses related to the shape of daily life for survey respondents and their loved ones with I/DD, including different types of daily support needs, daily activities, conditions requiring specially trained support staff, and current waivers and supports being utilized.

Respondents most frequently reported needing specialized support for behavioral challenges, followed by 1:1 supervision and 24-hour direct support with awake overnight staff. Needs related to daily routines, medical care, and continuous support were also common, while memory care and minimal in-person support were reported least frequently.

How would you describe your general daily support needs?
Check all that apply.



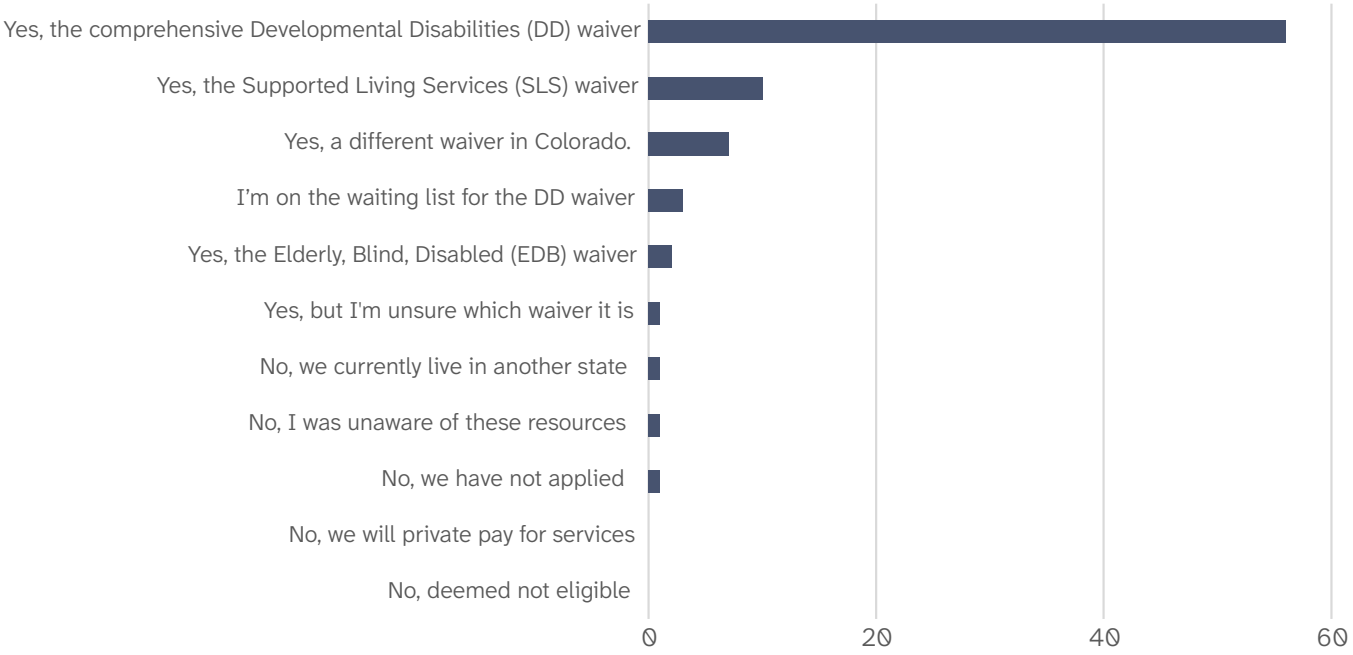
What do your days look like?
Check all that apply.



Data Analysis

This population reports high access to Medicaid funding for services. 95% of respondents are on an HCBS waiver in Colorado (most on the DD waiver) and the majority are utilizing paid family caregiving (77%). 45% attend a day program, yet respondents also indicated they have been turned away or would have to privately pay for the one-on-one support needed to participate due to "double-dipping" (billing for two direct support services at the same time). 29% volunteer in their community and only 12% have found community-based employment. 25% of respondents prefer to stay home most of the day.

Are you currently being served/receiving waiver-funded support services from a Case Management Agency (Community Centered Board)?

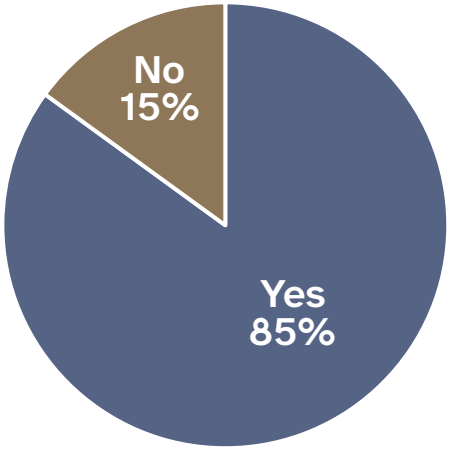


Where High Support Needs Individuals Live

The large majority of those who filled out the survey (85%) live in the family home. A few other respondents indicate they live in a host home, group home, their own home, or the Wheat Ridge Regional Center.

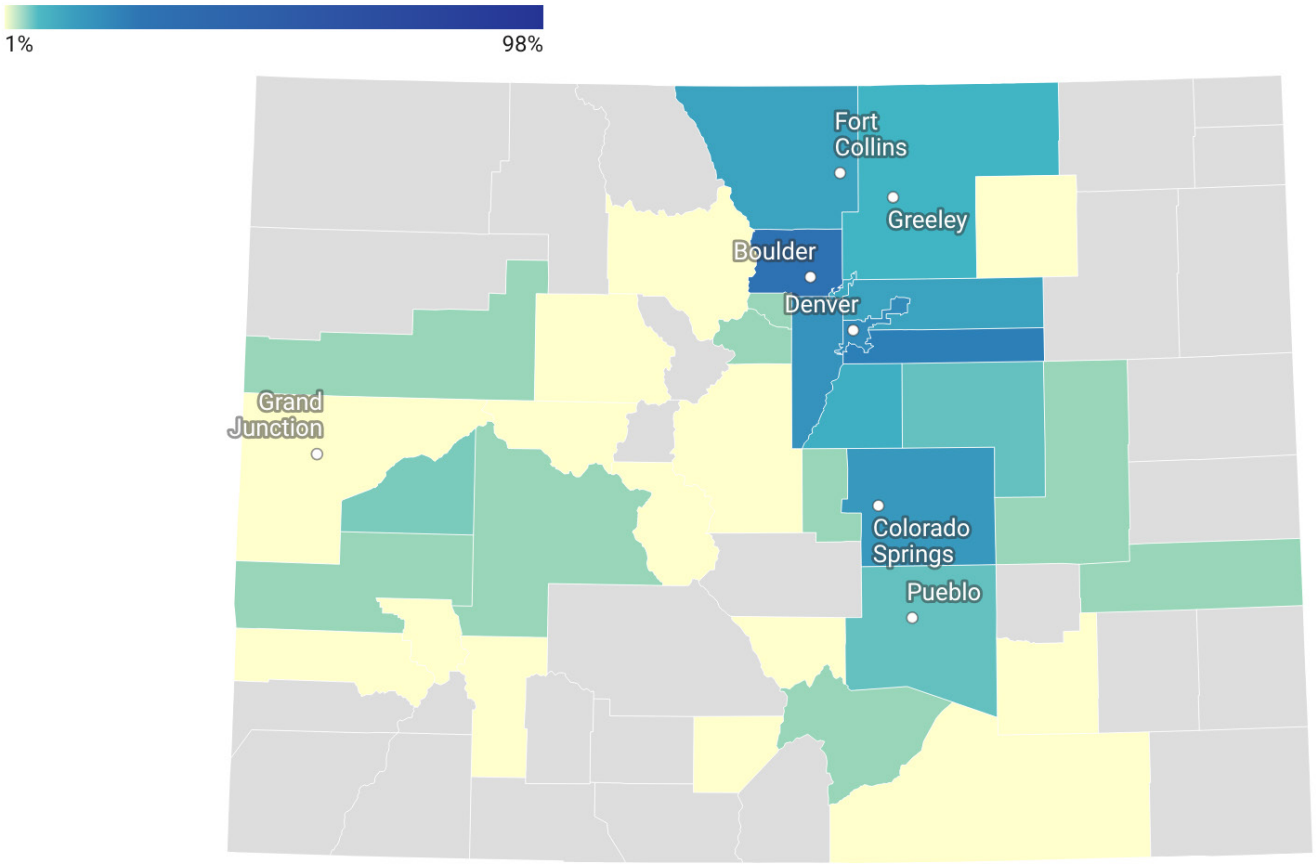
Using combined data from a survey of LTSS providers along with the individuals with I/DD and parents/guardians of adults with I/DD, 36 of the 64 counties in Colorado are represented in the data. Of the individuals and family member

Do you currently live in a family caregivers' home?



respondents, 77% are located in five counties around Colorado's metropolitan centers of Denver, Fort Collins, and Colorado Springs, reflecting the population density of the state around the urban and suburban corridors. Providers surveyed serve a much broader swath of the state, reporting active clients in 35 counties.

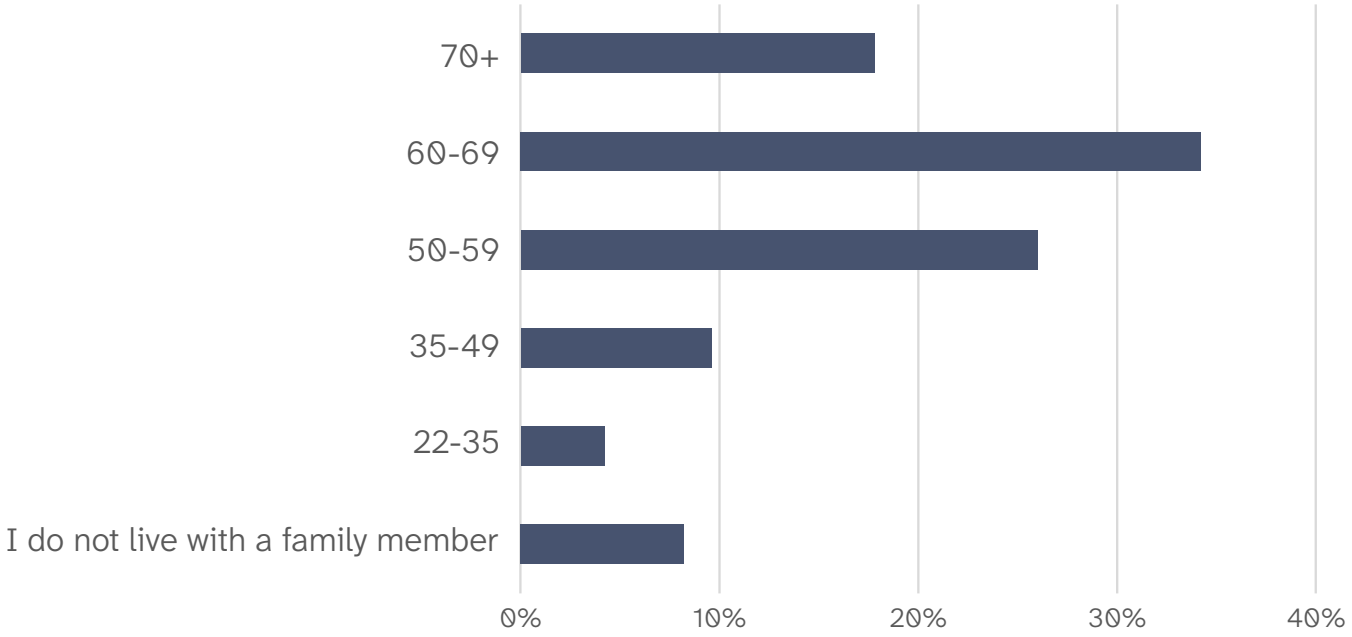
What county do you, your family member with I/DD, or your client(s) live in?



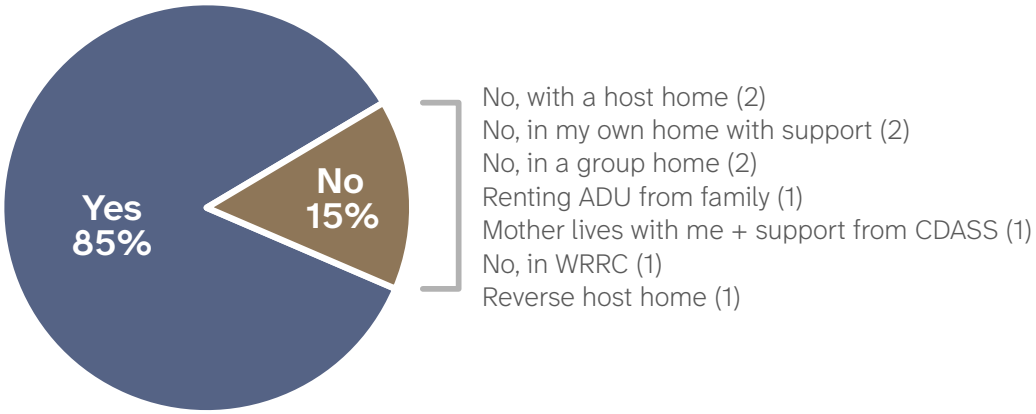
Age Profile of Survey Respondents

A total of 52% of respondents are over the age of 60 and of that group, 18% are over the age of 70. In comparison to studies that included a broad range of support needs, survey respondents who have loved ones with high support needs have an older median age. In contrast, the 2025 IHC needs assessment for the general I/DD population reported 40% of respondents over the age of 60, and the University of Kansas' nationwide study *State of the States in Developmental Disabilities* estimates 22% of family caregivers are over 60.[15,16] Of respondents who live with a family caregiver, over 25% live with a single family caregiver.

If you live with family, what is the age of the family/caregiver that you live with?



If you are a family caregiver, are you single? (Thus, not sharing family caregiving with a partner)



"If providers were able to deliver 1:1 ratios via adequate reimbursement rates more people with high support needs would be able to access services (both in the home and in community)."

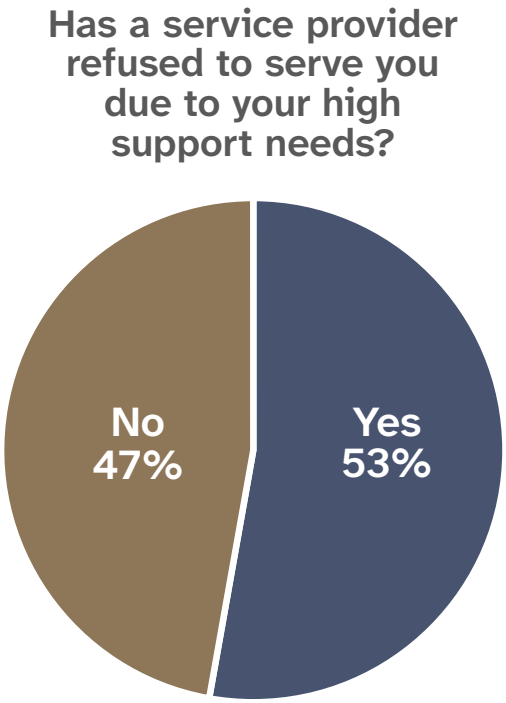
— SERVICE PROVIDER RESPONDENT

Barriers to Accessing Support

Even though respondents may be on an HCBS waiver in Colorado, 53% have been denied support from a service provider due to high support needs. An analysis of open ended responses reflects several reasons respondents listed for being denied services.

- Providers were unable to serve clients with general, unspecified "difficult" behaviors (15 responses)
- Providers were unable to support clients who required one-to-one support (6 responses)
- Providers were unable to serve clients with aggressive outbursts (5 responses) or complex medical needs (5 responses)

Several of these responses intersected with staffing issues in some capacity—lack of adequately trained staff, staff quitting shortly after beginning, and general staffing shortages that service providers are dealing with. Several responses also mentioned that care providers quit once difficult behaviors arose after a "honeymoon" period. Data suggest these are not isolated challenges, but comprise a significant portion of the high support needs population.

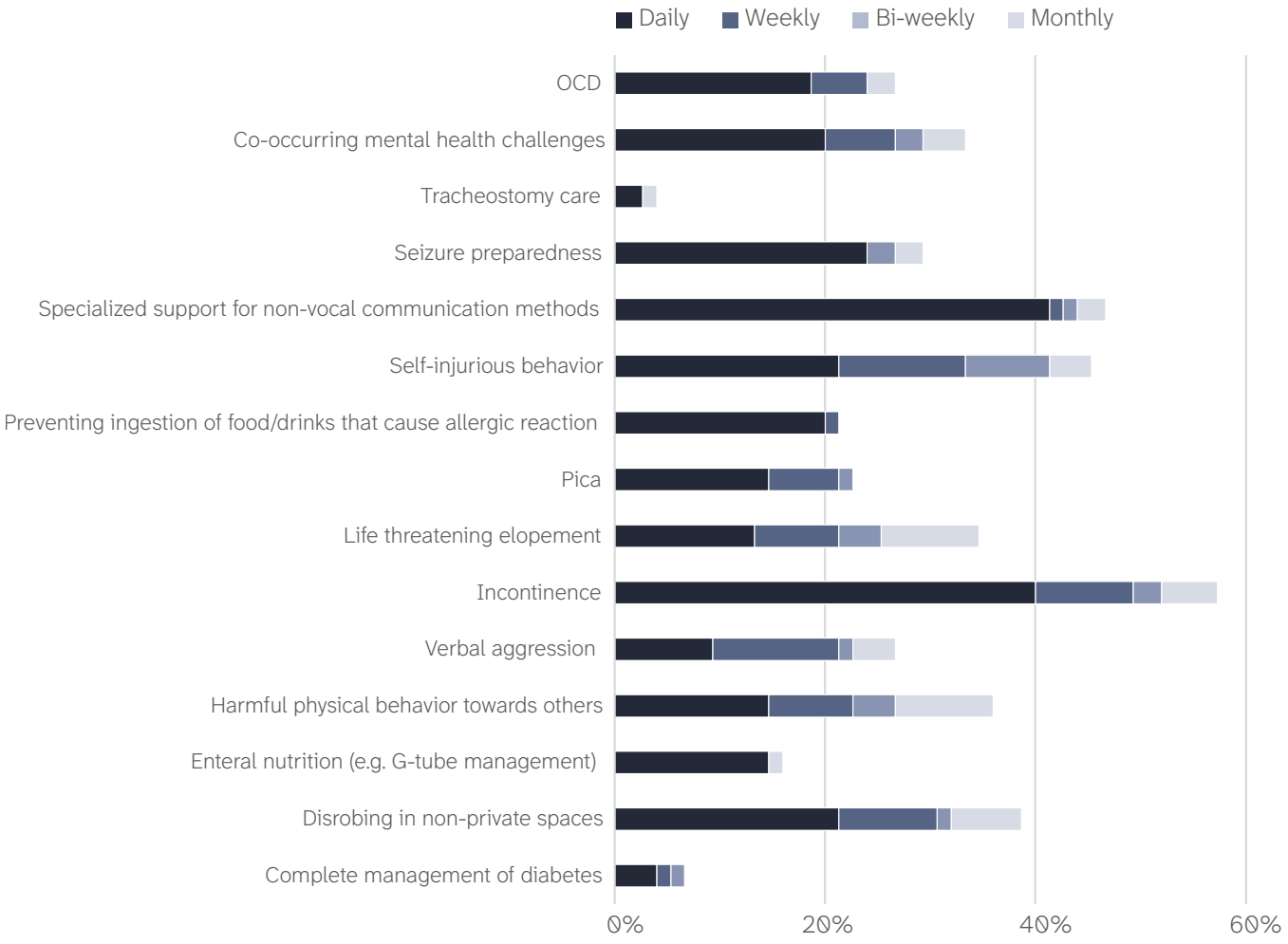


Survey responses indicate a wide range of "difficult" behaviors are relatively common, including:

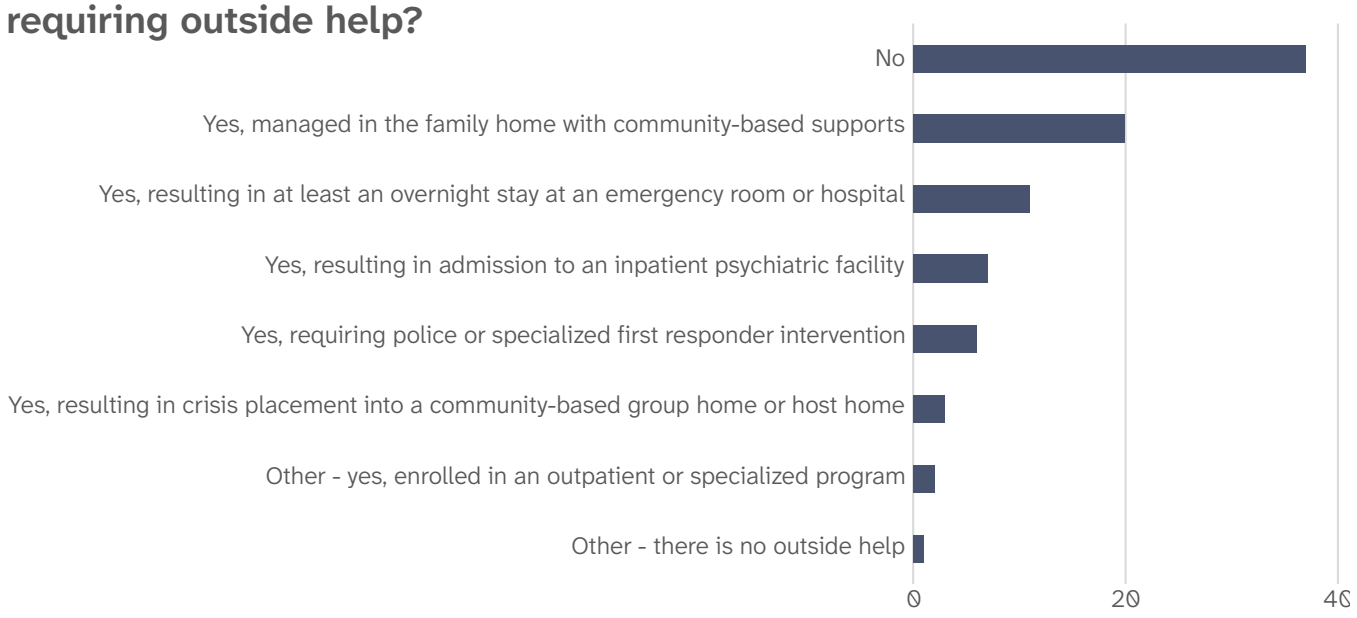
- 47% exhibiting self-injurous behaviors at least monthly with 22% on a daily basis
- 37% indicate harmful physical behavior towards others at least monthly with 15% on a daily basis
- 41% report disrobing in non-private spaces at least monthly with 23% on a daily basis
- 34% have life-threatening elopement episodes at least monthly
- 23% have pica or will compulsively ingest non-food substances

Additionally, 60% experience incontinence, 42% on a daily basis. Complex medical needs also appeared in open-ended responses from individuals who have been denied services, including G-tube feeding (16% of total respondents), issues with administering medication, and tracheotomy/ventilator use.

Conditions Requiring Specially Trained Support Staff



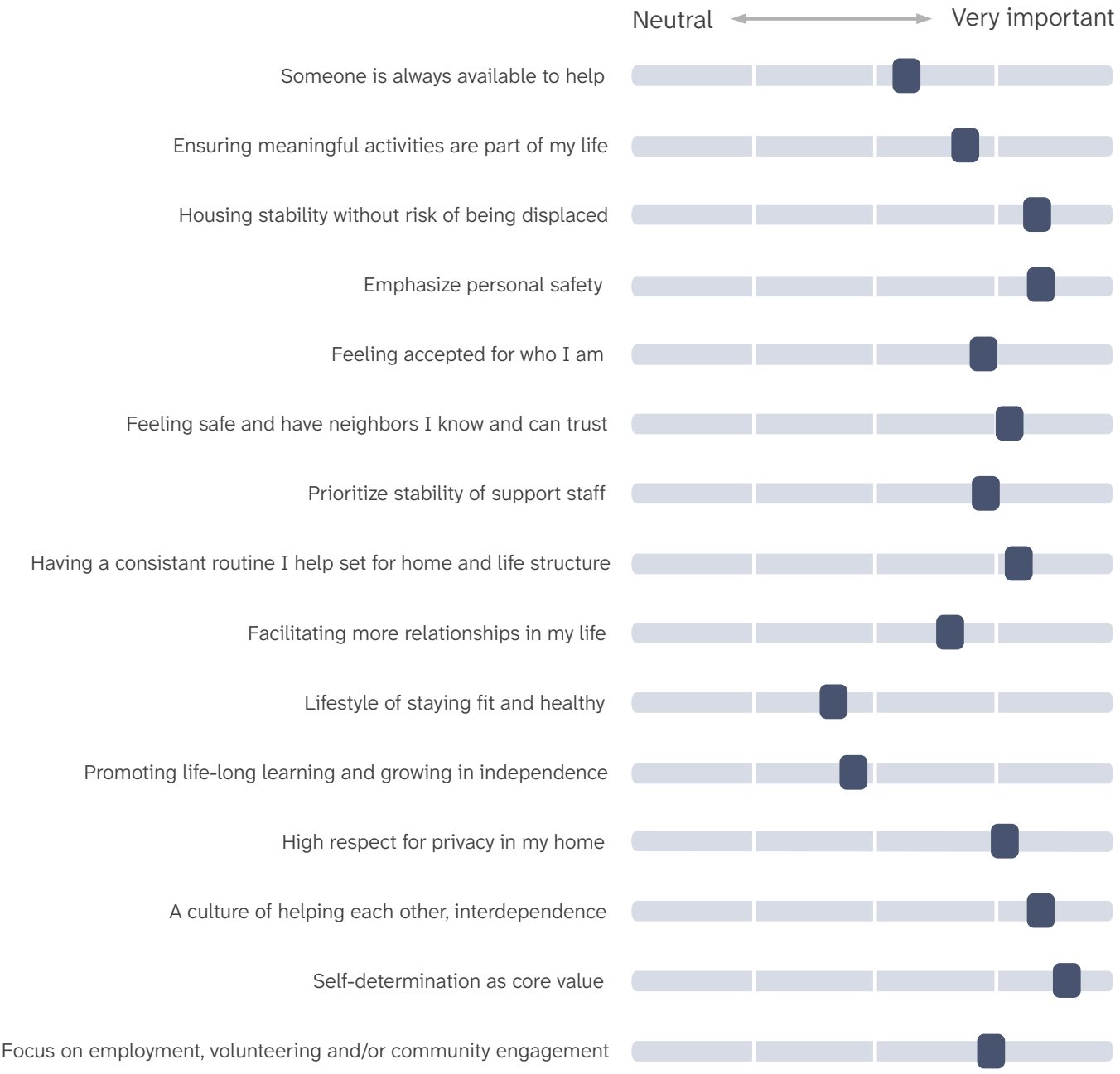
Have you experienced a behavioral or psychiatric crisis requiring outside help?



If so, how helpful was the intervention?



Average Importance Ratings of Values in Residential Settings

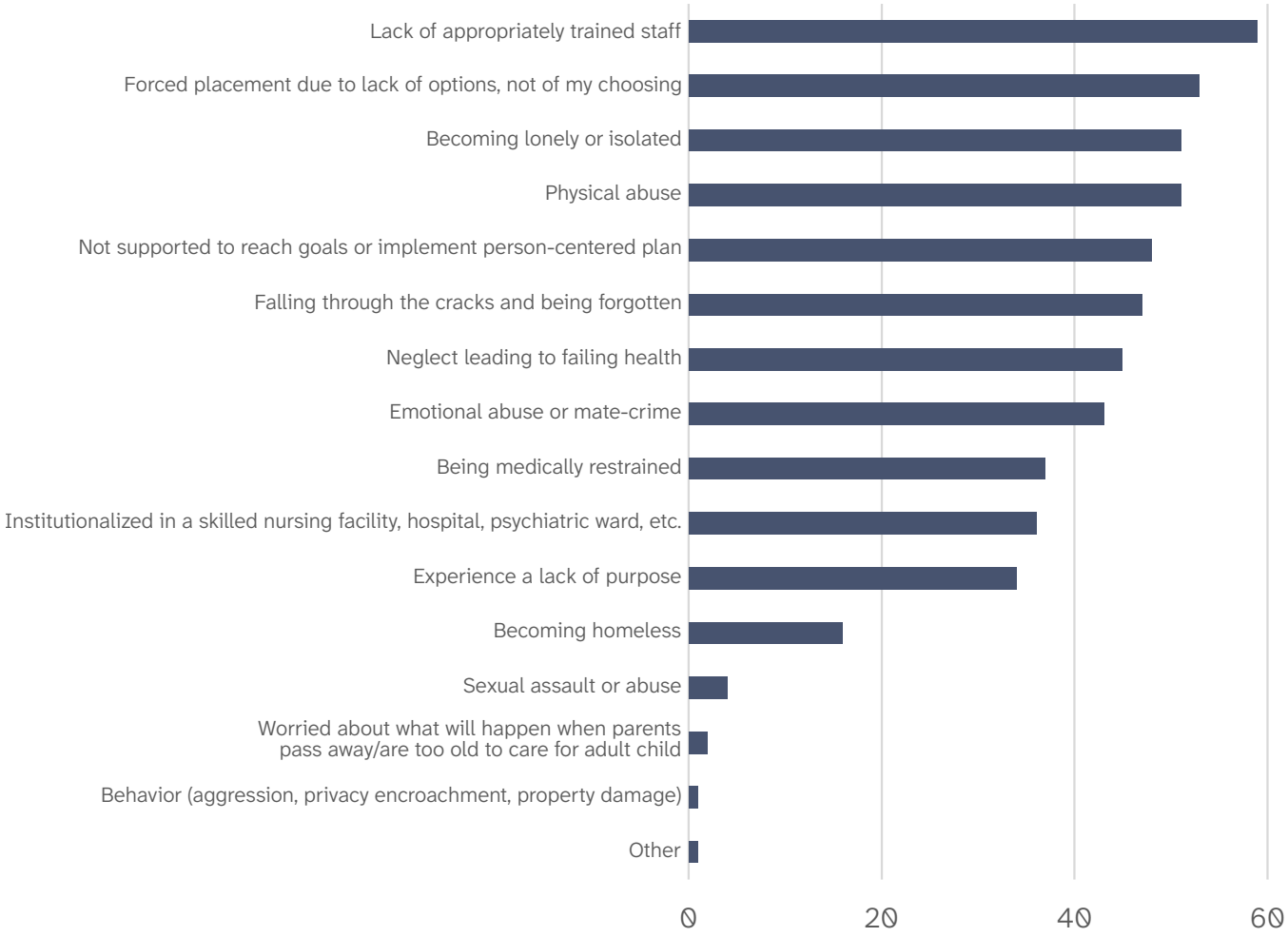


Sliding scale graphics throughout the report are based on Likert Scale survey questions where respondents marked Neutral (1) to Extremely Valuable (5); data points represent the numerical average of all responses.

Future Concerns and Plans

This section reflects survey respondents' concerns for the future, current future planning to date, and families' budgets for housing and utilities for adults with I/DD. Top concerns varied widely, but common elements involve fears about reliance on others for support, forced placements, and vulnerabilities such as potential increased risk of suffering abuse. Per federal Medicaid regulations, HCBS waivers cannot be used for room and board. This means that housing assistance and/or financial assistance from family is often necessary for adults with I/DD to afford housing.

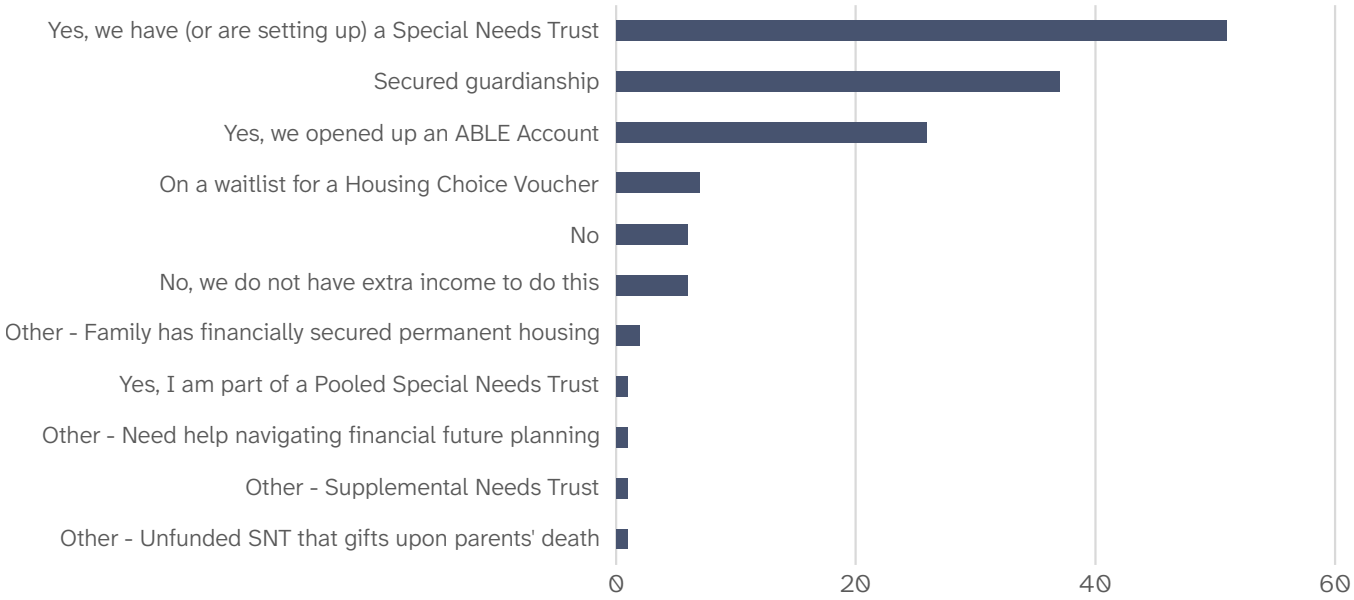
What are your concerns about a future living situation?



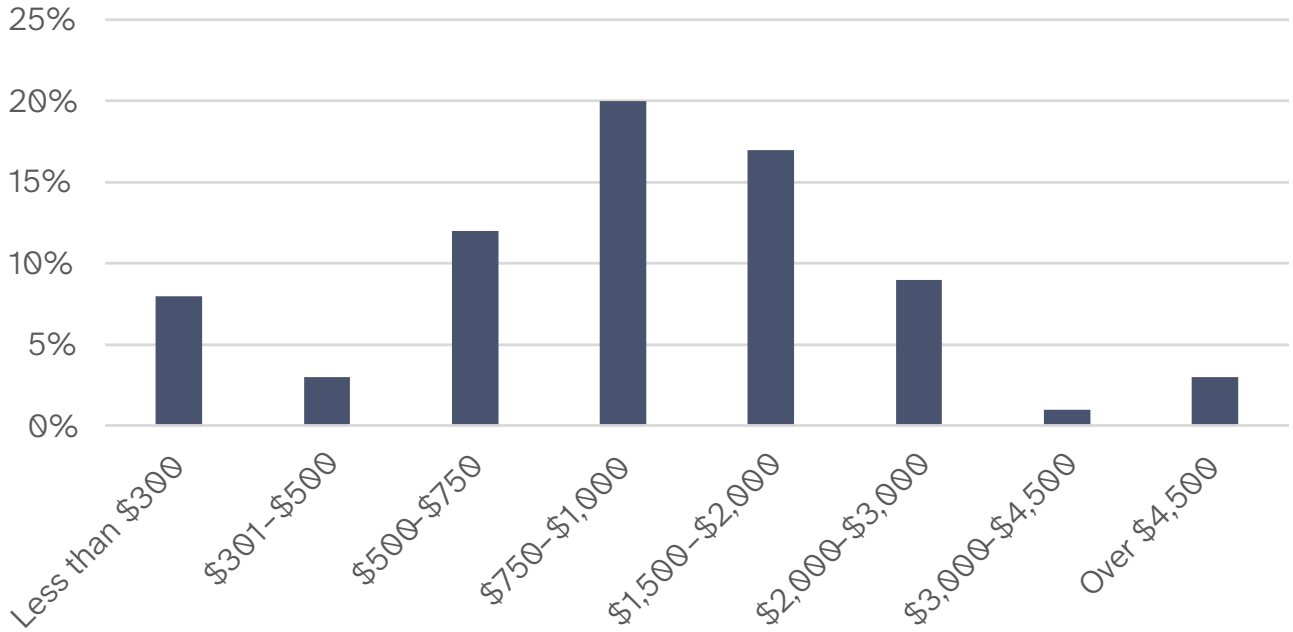
> *Too often, families are forced into crisis before appropriate options are available. Planning needs to start earlier, with real pathways that don't rely on aging caregivers holding everything together. There also needs to be greater acknowledgment that "one size fits all" models—particularly traditional group homes—do not meet the needs or preferences of many individuals with complex disabilities.*
>
> — **SURVEY RESPONDENT**

The majority of respondents (86%) indicated that they have done at least some future planning, with only 10 individuals indicating that their family has done no planning at all. An additional two respondents indicated slightly conflicting answers, stating that while they did not have the funds to carry out future planning, they had already put other plans into motion such as securing a legal guardianship, opening an ABLE account, and creating a Special Needs Trust.

Has your family done any future planning?



How much can you and/or your guardian/family afford monthly to spend on housing and additional non-waiver funded supports?*

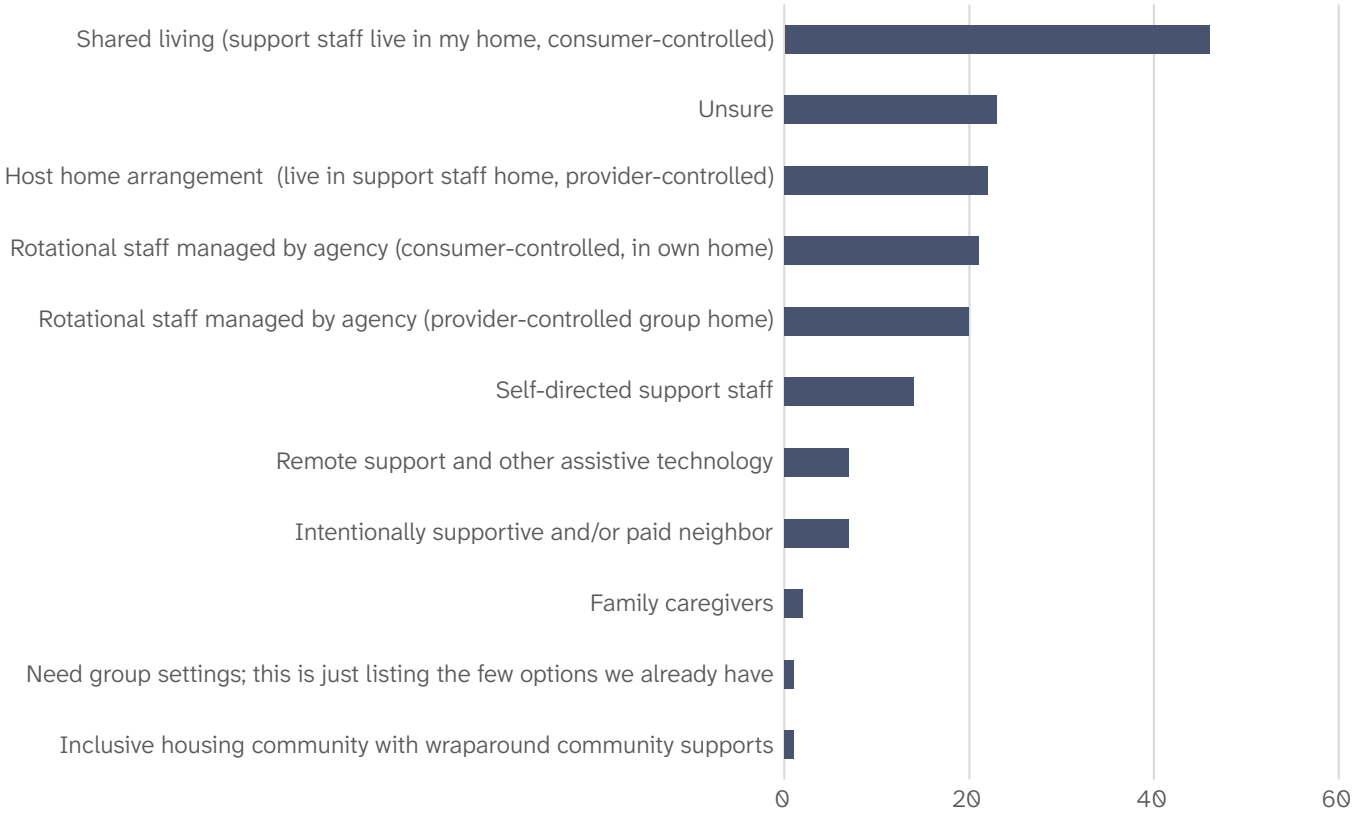


**Other responses:*
I have a Housing Choice Voucher to help pay rent (9%)
Unsure/Other (18%)

SUPPORT SERVICES DEMAND & PREFERENCES

In comparison to other I/DD-specific housing market studies conducted in Colorado (see list in Background section of report), respondents to this survey reported significant differences in service delivery preferences. When including the broad range of support needs, self-direction is identified as highly preferred in market studies; in contrast, respondents in this study that focused on those with high support needs, only 14% of respondents were interested in self-direction. Additionally, fewer than 10% of respondents were interested in paid neighbors, remote support or enabling technology as service delivery models, all of which were more highly rated in market studies that included participants with a broader range of support needs.

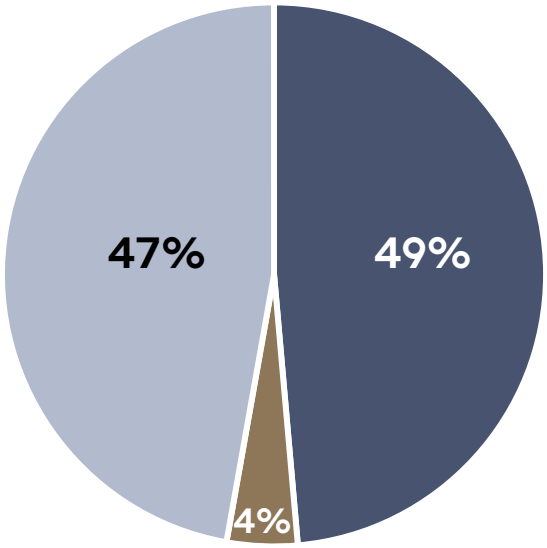
What service delivery model(s) are you most interested in?
Check all that apply.



The majority of respondents to this study (62%) prefer to live with a caregiver in their own home in a shared living arrangement (a consumer-controlled setting). Similar to shared living, 30% of respondents were interested in a host home arrangement, where a person with I/DD would move into a provider's home as a provider-controlled setting. 29% were interested in rotating staff to be managed by a provider in one's own home, and 26% were interested in rotating staff in a provider-controlled setting such as a group home.

Although consumer-controlled service delivery options were preferred when asked about specific service delivery models, 47% of respondents felt they would be open to a provider-controlled setting if it were the right fit.

What type of relationship would you like your service provider to have with your housing?



- Consumer-controlled: I choose my home and preferred service provider(s), thus I can change providers and stay in my home
- Provider-controlled; I pay rent to a service provider (PASA) who maintains the home. I must move to change providers
- Open to either option if it's the right fit

Other Areas of Critical Support

An open-ended question asked respondents to "describe any other areas of critical support needed that are unlisted." The most common areas listed were: help with complex medical needs and medical case management (eight responses) and assistance with healthy eating and cooking (four responses). Two other topics both generated three responses: the presence of awake staff/around-the-clock support, and financial coaching.

Complex medical needs/case management responses ranged from individuals who were completely physically dependent on others for care (quadriplegic) to those who needed close supervision for medication. Several respondents identified case management as essential, as most people in this group experience multiple medical conditions that need to be co-managed carefully. Some also referenced the need for a carefully controlled/calibrated environment as much as possible to prevent triggering certain medical issues.

"Highly variable daily presentation and physical/cognitive capacity was not able to be accommodated by an agency that was trying to group participants with shared supports in order to make fiscal sense."

— SURVEY RESPONDENT

"When all options have been exhausted, it can be a very difficult decision to make, having to give notice of termination. Many family caregivers come on board as paid providers in hopes that we can find respite that may lead to possible permanent placement, however due to some of the extreme needs, this is also a challenge."

— SERVICE PROVIDER RESPONDENT

"More specialized training in autism behaviors to look at it under an I/DD lens instead of mental health."

— SURVEY RESPONDENT

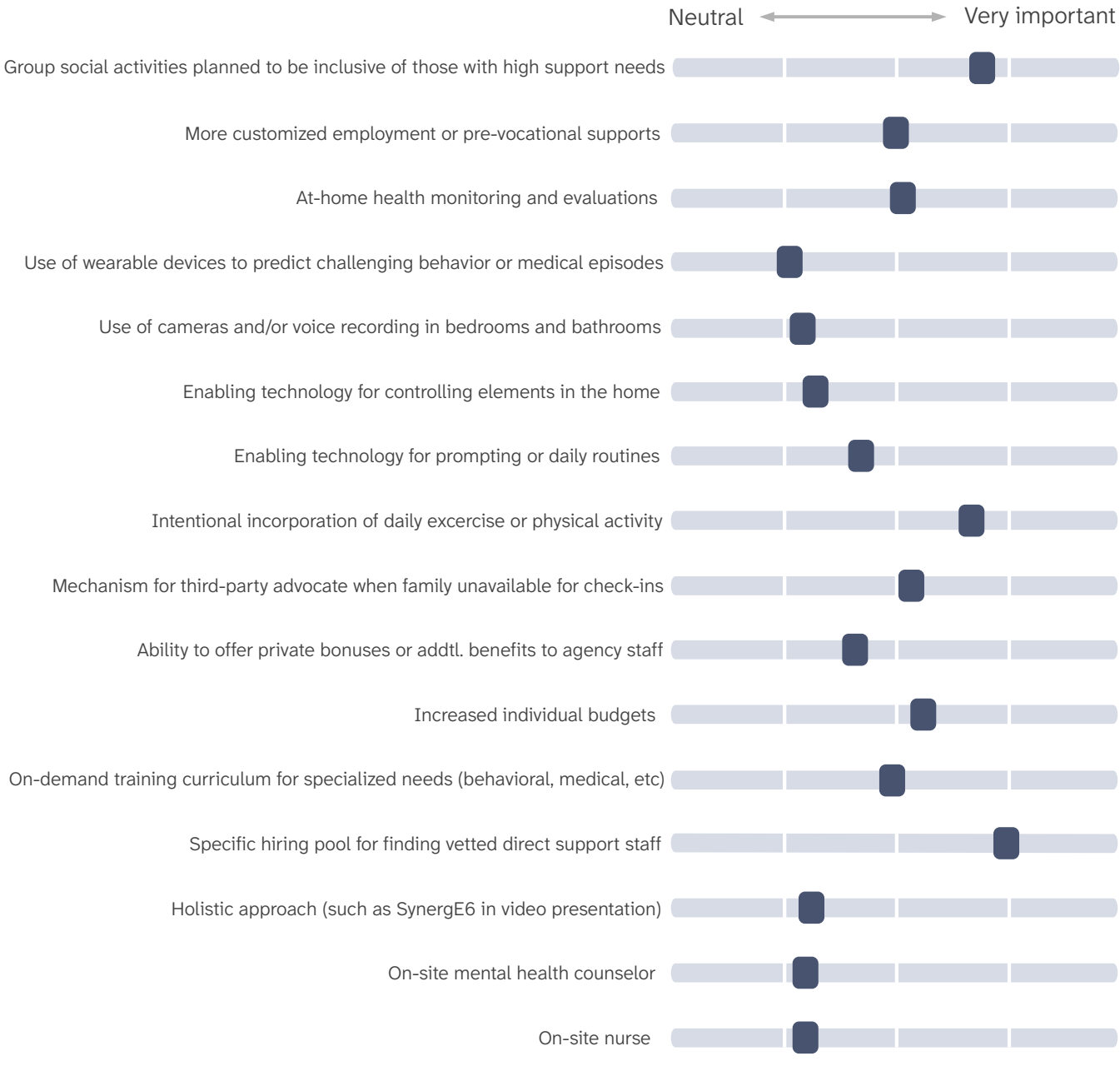
"Regulatory requirements focus on compliance and consequences for non-compliance vs. person centered care, dignity of risk, and advocacy for individuals. It is imperative that the DSP is highly trained and competent in their duties as the weight of an error while working can be life threatening and have serious consequences."

— SERVICE PROVIDER RESPONDENT

Several people indicate the need for assistance with healthy eating and cooking, with varying degrees of necessary assistance required. A couple of respondents indicate a need for supervision and planning, while others require more comprehensive services such as actually feeding meals.

The following additional support needs were identified by only one respondent each: encouragement for social engagement, assistance with essential chores/executive function management, mitigation of property destruction, pet-free home, consistent staffing, someone to monitor internet usage for scam risks, someone to assess/monitor that only safe people were invited into the home, low vision assistance, and general "behavioral" monitoring. Survey respondents also offered additional ideas for enhanced supports or services for lifespan needs, falling largely into two categories: staffing concerns and social supports.

Average Usefulness of Additional Supports or Strategies in Residential Solutions



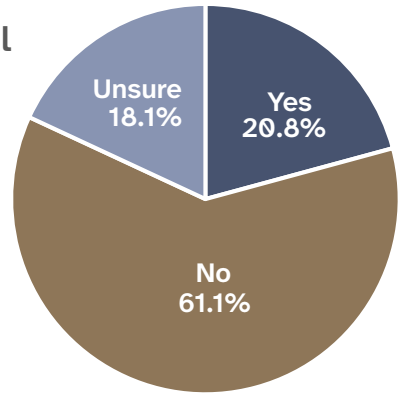
Six respondents noted a need for adequately scheduled or specially trained staff. Three of the six respondents mentioned struggles they've had to get staff scheduled through service providers. Three mentioned specific types of staff training they envision being available as an enhanced support - an ABA therapist, an RPM facilitator, and someone trained to work with individuals with Fetal Alcohol Spectrum Disorders. Three respondents mentioned social support of some kind, and two respondents mentioned exercise/physical health. Respondents mentioning a need for social supports ranged from a desire for scheduled outings to a person to help facilitate friendship-building.

Several other responses to this open-ended question included: transportation assistance, financial/budget support, someone to help residents care for their pets, someone to help with internet navigation/social media, a barber onsite, and a board of directors to oversee the housing development.

HOUSING & DESIGN DEMAND & PREFERENCES

Only 21% of respondents believe current residential options are sufficient to meet their needs and preferences. 61% of respondents indicated that current residential options are insufficient to meet their needs and preferences with an additional 18% who are unsure. The majority of respondents reported a need for specialized behavioral support services; at the same time, service providers who participated in the focus group indicated those with high behavioral support needs were more difficult to find solutions than individuals with complex medical needs.

Are current residential options sufficient to meet your needs and preferences?



"The rates are designed for contracted support or multiple individuals being served together to be able to pay a caregiver hourly. This limits optionality. Many creative solutions that family want do not meet Independent Contractor criteria, and are employment situations."

— **SERVICE PROVIDER RESPONDENT**

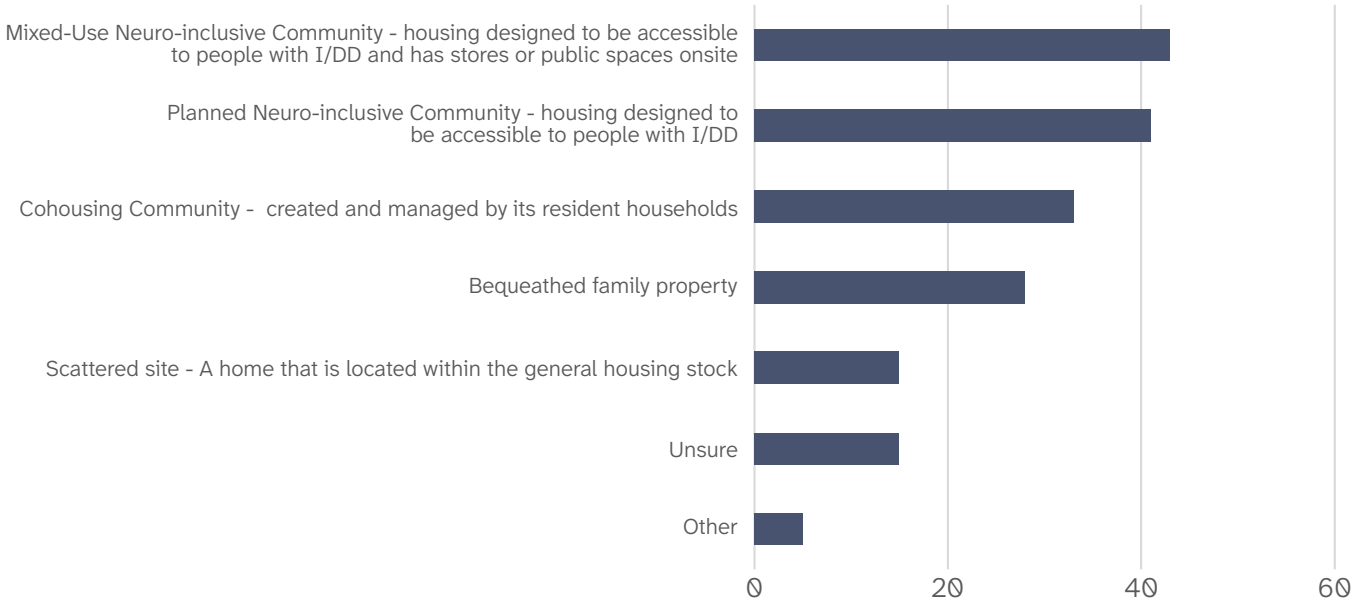
"Right now, if we couldn't take care of our child, the option is for a host home. We are not comfortable with this option as there seems to be a lack of accountability. I have met medical professionals who are almost disgusted with how this population is cared for by host homes. We just feel like these places could be abusive and no one would be the wiser. And that's assuming a home could even be found."

— **SURVEY RESPONDENT**

"DSPs need to actually have a higher skill set to be truly successful, and the level of skill is not commensurate to the pay. They need to be a cook, an advocate, a community connector, a behavioral/ motivation expert, a teacher, a motivator, medically knowledgeable, someone with great judgment, willing to allow individuals dignity of risk. This is a high level of skill to get quality DSP."

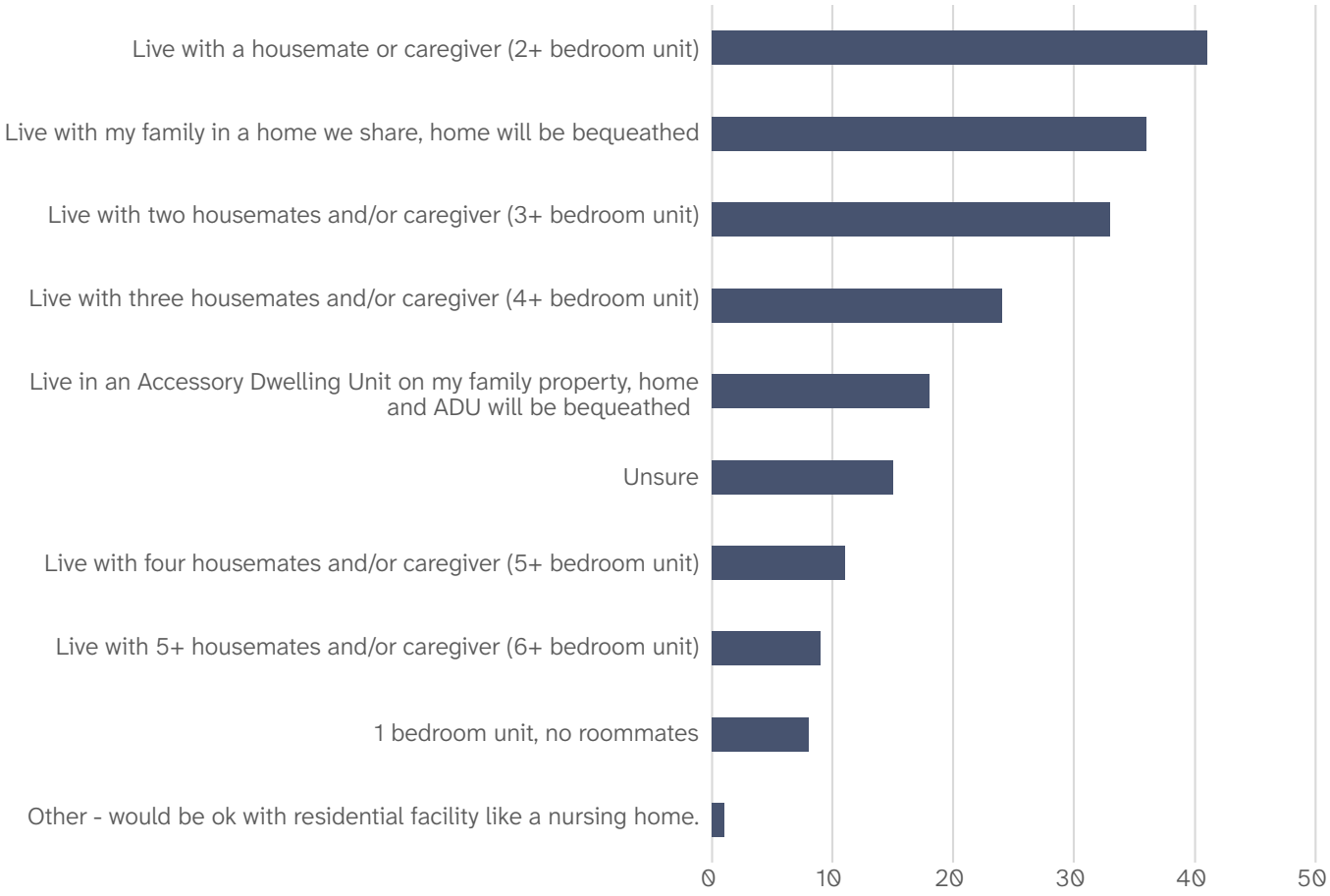
— **SERVICE PROVIDER**

What type of setting are you interested in?

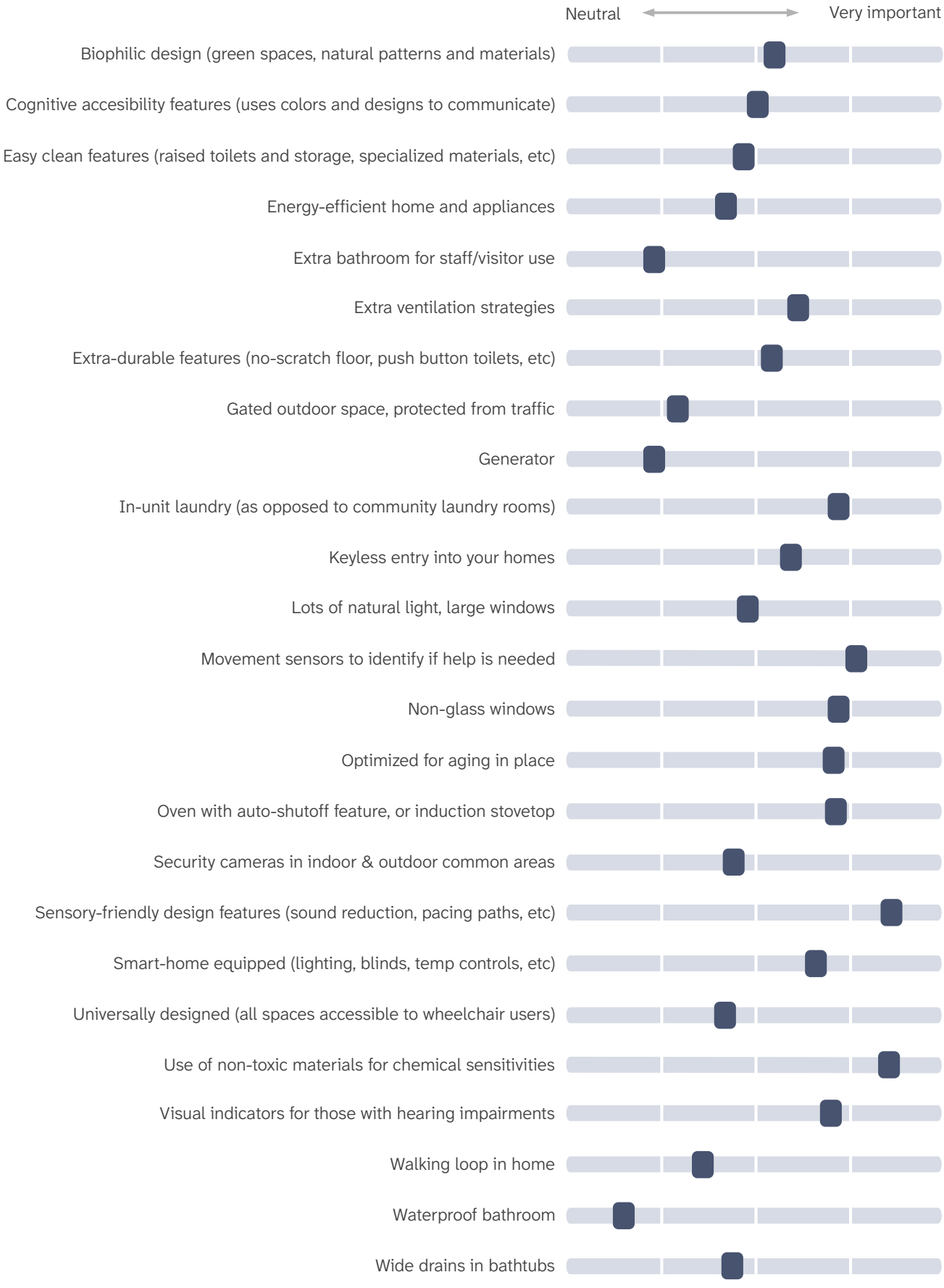


Preferred living arrangement?

Check all that apply.



Average Preferences for Neuro-inclusive Design Features



In comparison to more general market studies conducted in Colorado, respondents to this study reported significant differences in housing preferences. Nearly 48% of respondents prefer to live with their loved one and bequeath the family home; this is much higher rate of co-habitation than seen in market studies that include the broad range of support needs. The majority prefer 2-4 bedroom homes to comfortably accommodate live-in caregivers or roommates with or without I/DD. Additionally, unlike other studies, single-family homes and Accessory Dwelling Units (ADUs) are preferred over other types of housing. Similar to other market studies, intentionally planned communities are more highly preferred than scattered site options.

In addition to the design features ranking above, the survey asked for open-ended responses to the question "Are there any additional design features that would be important for your future home?" The top three were sensory-friendly design (7 responses), specific accessibility design features for individuals with complex medical needs and/or mobility devices (8 responses), and outdoor space (4 responses).

> *"Please, please develop housemate settings—without such onerous licensing and other requirements as we have for "group homes." I'm working on making my own for my daughter and two roommates, but I have to fit a square peg into a round hole to make it work. It shouldn't be this hard. Allow campuses too. Don't throw the baby out with the bathwater—we know "institutions" have a lot of downsides, but there's a huge middle ground that we desperately need—group settings, sometimes on campuses or in intentional communities."*
>
> — SURVEY RESPONDENT

Sensory issues are a common request. Three respondents requested soundproofing, one mentioned a fragrance-free environment (including cleaning products and chemical emissions from furniture, etc.), one mentioned light sensitivities, one mentioned extreme sensitivity to general electromagnetic frequencies (meaning smart devices would be disruptive), and one mentioned the desire for a general de-escalation or sensory room on the premises.

Respondents who mentioned the importance of accessibility design features beyond minimum ADA requirements specifically noted the need for spacious interiors for individuals with mobility devices, extra outlets & power backups for specialized medical equipment, bathrooms that allow independence for wheelchair users, and single-level designs or elevators to access upper levels.

The integration of nature and biophilic design was also a recurring theme. Four respondents touched on outdoor spaces/green spaces in some way, including year-round outdoor access, shared green spaces, and a place to garden and grow things.

The following topics received only a single response, but are worth mentioning as outliers: pet-friendly properties, precautions to prevent elopement, rounded edges and corners to prevent injury, and high integration into the community.

> *"We are very aware of sex abuse so the more eyes and hearts she has on her, the more she will be protected."*
>
> — FOCUS GROUP RESPONDENT

At the end of the survey, an open-ended question was included for respondents to offer "any additional comments or suggestions you would like to share with researchers on the topic of re-imagining solutions."

The 27 responses to this question were highly varied in tone and content. Several participants expressed gratitude that this work was being undertaken; others expressed strong and conflicting opinions about the suitability and/or dignity of different types of housing configurations. Several respondents gave lengthy descriptions of what they envision as an ideal environment for their adult child when they are no longer able to provide care or have passed away. Two respondents mentioned that they felt their situations were more complex than the survey/study was able to capture, but offered no additional clarifying details. Other respondents noted support services and enhanced services that were already noted in other sections, such as transportation and social support. The following garnered multiple mentions:

- Gratitude that this work is being undertaken at all (4 respondents)
- The need for more robust case management/coordination services, particularly for medically complex individuals once parent caretakers have passed away (3 respondents)
- Respondents who were generally confused by the options for housing, unsure, or expressed desperation regarding the reality of the circumstances (3 respondents)
- Request for nonverbal/limited verbal abilities to be included in future surveys (2 respondents)
- The need for multi-disability accessible properties, for individuals with I/DD who also use wheelchairs or mobility devices (2 respondents)





Partners4Housing is a nonprofit that helps families of adults with I/DD create affordable, sustainable, person-centered housing solutions. They do this by conducting a Benefits and Housing Review to identify all eligible income sources, subsidies, and supports (e.g., SSI/SSDI, Section 8, state benefits, SNAP), connecting people using a Roommate Matching Pool to share housing costs, and providing guidance and tailored housing plans to create individualized solutions.

Through a Colorado Department of Family and Consumer Services (CDFC) grant from the Colorado Disability Opportunity Office, Partners4Housing offered a free Benefits and Housing Review to 80 Colorado families with positive feedback: "The free benefits and housing review and subsequent email correspondence to get my questions answered has been priceless! The review was one of the most helpful services I have received for my daughter in a long time." "I don't know how anyone would be able to navigate the system without this type of help.", "It gave us hope, support and many resources to provide a living arrangement for our daughter that can be established now and continue even after we are gone or no longer able to provide her with housing and care. It has always been a worry and now it is not."

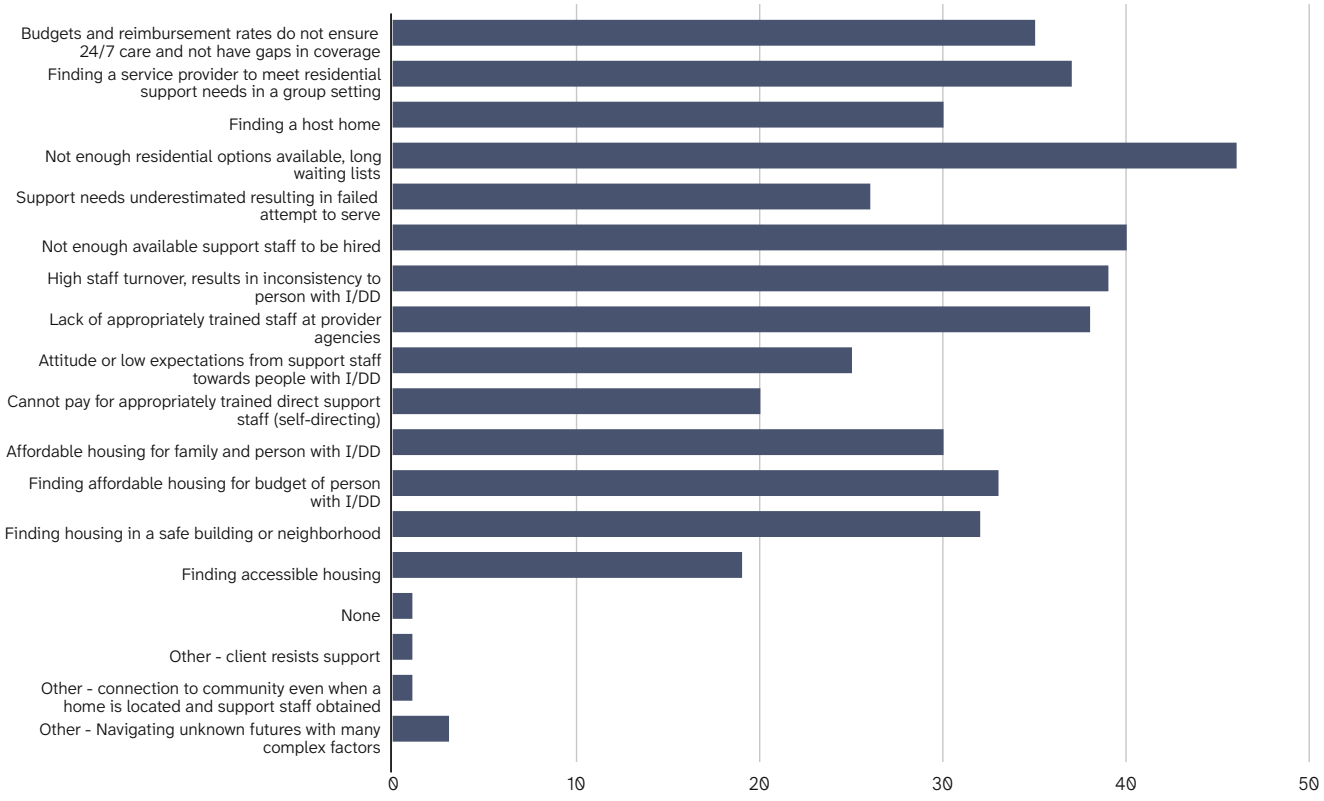
Unique Challenges in Colorado

This section summarizes key challenges that impact current and future residential options for adults with I/DD and high support needs that must be addressed to meet the needs of this highly vulnerable population.

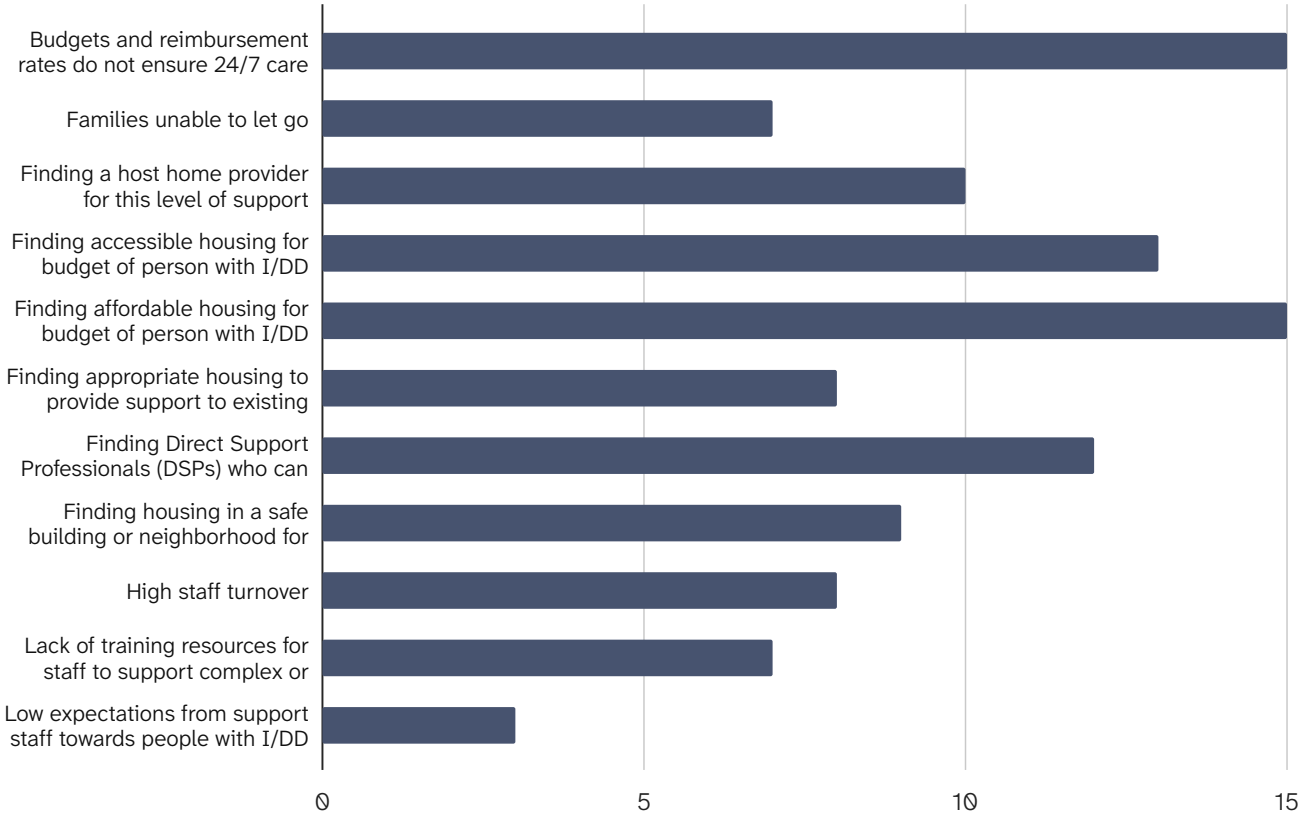
Family members often serve as a voice for the voiceless, manage medical management and advocacy, and act as a human resource safety net. When family is no longer present, there is no role in the current system that replaces the work they did.

- Family members act as unpaid staffing agencies for waiver recipients with high support needs, whether vetting a provider or managing DSPs for those who self-direct their care. When family members are no longer able to fill that role, it is unclear who can will take on this role and how they will be paid. Without a third-party human resource manager, it is uncertain if truly self-directed options will be an option for adults with I/DD and high support needs.
- Family members act as unpaid medical case managers. With high turnover of staff in the field, it is unclear who will find the typical health providers (cardiologists, gynecologists, endocrinologists, etc.) to serve an individual with high support needs. Who will know and be able to share family and individual health history while providing continuity of care for health and behavioral symptoms? Will they be able to adequately prepare the non-I/DD specific

Unique Challenges in Colorado to be Overcome



What are the challenges you face meeting the demand for residential options?
Check all that apply.



provider for how the person with high needs may react to procedures or even just waiting in the waiting room? There is no funding source nor specialized role for a third-party I/DD-specific medical advocate nor funding for interdisciplinary consultation. Although a person with I/DD may not have complex medical needs currently, as they age, age-related health challenges will need to be considered.

- After a contracted study to understand best practices from other states, Colorado case managers have a maximum caseload of 65 individuals per case manager, better than national norms.[17] Yet, a few states who have conducted needs assessments of their highest utilizers have added specialized I/DD case management with smaller ratios for high-support populations, i.e. Oregon (≈ 45–55 individuals), Washington (≈ 50–60 individuals), and Minnesota (≈ 40–50 individuals).

Rigid service definitions and low reimbursement rates not only disincentivize, but limit provider capacity to offer safe support in community-based settings.

- Adults with I/DD and high support needs often have limited verbal communication skills and often rely on their staff in the most intimate moments of life: bathing, using the bathroom, menstrual hygiene, assistance in placing food in one's mouth, etc. DSP's are the crux of quality of life and have enormous influence on daily outcomes—especially DSPs skilled enough to work with individuals with the highest needs—yet they are paid nearly poverty wages. Turnover is high as they can find employment as a housekeeper, stocker, cashier or fast food

worker and be paid the same or higher with nearly no liability, specialized training and little responsibility in comparison.[18] Last reported, Colorado has an average 39% DSP turnover rate, with some agencies experiencing up to 81% turnover.[19]

- Providers cannot support individuals with one-to-one or higher support needs in their own home due to insufficient daily Medicaid reimbursement rates.
  - For example, Level 6 Group Residential Services and Supports has a reimbursement rate of $315.23/day, or $13.13/hour for a 24 hour period. This is clearly not sufficient for one-to-one support, 24/7 at typical $19.08/hour DSP wage, let alone a specialized staff rate or other administrative costs.[20]
- In some cases, safety concerns prevent the option of sharing a home with another service recipient, yet rates are set on the assumption that the individual will be living with other service recipients.
  - For example, service providers can only bill a maximum of 7,112 combined units per person of Specialized Habilitation, Supported Community Connections, Prevocational Services, and Supported Employment per service plan year.[21] Therefore, when billing for the time of a DSP to be present with an individual who needs at least one-to-one support, there is a gap of 1,648 hours in the year, equal to nearly 10 weeks of time where a provider cannot provide individualized support. The annual limit drops to 4,800 if the person they are supporting is not employed or does not want to seek employment, thus reflecting a gap of 3,960 hours or nearly half the year.
- Colorado prohibits concurrent billing of two HCBS services that overlap in time or purpose. Waiver recipients with high support needs could participate in existing day programs if they could also bring a DSP to provide the needed individualized support to participate. (Behavioral supports could be billed to offer clinical support or problem solve for minimal periods of time, but the number of units that could be billed under the waiver is far less than what would be needed for daily participation.) Currently, families must private-pay for a DSP in order for their loved

"Case mgmt are over worked, have too large of case load to do more as they could and even though they know so much about our IDD adult, they can't do more to support due to no time. Hire more case managers, limit their caseload based upon need and give attention support and following their needs. When I die, who will?"

— SURVEY RESPONDENT

"Medical management [is critical area of need] (not just taking to appointments —actually managing the medical case and needs)"

— SURVEY RESPONDENT

"For those of us that have RNs on staff [medical management] is an additional cost that is "built into the residential rate" that is CRITICAL to success for medically complex individuals AND THOSE THAT ARE AGING. The individual that has lived with me, as an example, has had 24 doctors appointments in the last year, and this does NOT include the 2 X / week outpatient PT and the 3 surgeries and all the needs around that. This is not someone who would have previously been categorized as "Having high medical needs." To intimately manage this level of health care needs requires a level of dedication and SUPPORT."

— SERVICE PROVIDER

one to participate in most day programs.

- Service providers must balance budgets by serving other individuals with low support needs in programming in order to serve those with higher or complex needs. They could not sustain financial viability if only providing residential support to individuals with high support needs. This discourages the specialization of providers and limits their ability to serve a population that would otherwise have to be served in more expensive, non-specialized settings.
- Service providers can negotiate rates with HCPF in extraordinary circumstances, but service providers report an excessive administrative burden and that the state does not agree on rates based on documented, actual costs of a person's needs. This gap between what HCPF is willing to offer versus what it actually costs in the marketplace to support the individual with complex needs means the provider must be willing to take a financial loss or is forced to not fully meet the needs of the individual.
- Service providers are operating on thin margins, putting people with I/DD at risk of losing the few options currently available. In the 2026 Colorado legislative session, advocates reported that the proposed 4% across the board cut would have forced 44% of service providers to close or suspend programming.[22]

There are existing federally approved HCBS Medicaid billing codes used in other states that may be applicable for use in Colorado.[23] Some states have created state-specific solutions by creating incentives for partnerships and braiding funding sources, including state general fund supplements.[24,25,26] More research is needed to understand how adding these codes or a state-funded solution may impact how Colorado service providers could better support adults with I/DD and high support needs. Although beyond the scope of this study, the following is a list of federally approved HCBS Medicaid billing codes other states use to support the population of those with high support needs that may be applicable for use in Colorado:

"The SIS Level 7 option is flawed, not consistently applied, the admin burden is significant, and the process is kept secretive. Apparently, this process is going to be reviewed and standardized through this current budget crisis, which concerns me that we will see rates drop, although for providers, these are actual costs."

— SERVICE PROVIDER SURVEY RESPONDENT

"The rates (or lack of rates that cover costs) alone are a huge issue. While the state allows for a negotiated rate, they rarely will agree with you and pay you a rate that is sustainable; even when they give you that increased rate, you are at the mercy of the system to maintain it. If case management fails to submit justification in a timely manner, the rate will be automatically dropped, or the state could decide that it is no longer justified. The state is asking agencies to absorb that risk. The lack of willing providers to absorb that risk is a direct reflection of the reality that you will likely not get the rate you need to provide the support."

— SERVICE PROVIDER SURVEY RESPONDENT

"Models other than Host Homes or independent living are lacking."

— SERVICE PROVIDER SURVEY RESPONDENT

Code	Service Description	Used by States	Billing Method	Relevance for Colorado
S9485	Crisis intervention, per diem (24-hour stabilization or therapeutic home stay)	AZ, NC, OH, UT, WA	Billed daily for short-term crisis stabilization; requires clinical documentation and 24-hour staffing	Could fund therapeutic crisis homes operated by Program Approved Service Agencies (PASAs) s for adults with I/DD in behavioral crisis
H2011	Crisis intervention service, per 15 minutes (mobile or in-home response)	AZ, NC, OH, WA	Billed in 15-minute units for mobile crisis or in-home stabilization	Enables PASAs to bill for on-site behavioral crisis response and de-escalation
H0030	Behavioral health hotline service	AZ, NC, LA	Billed per call or per hour; supports 24/7 crisis lines	Could integrate with Colorado Crisis Services for I/DD-specific triage
90839/ 90840	Psychotherapy for crisis, first 60 min + each additional 30 min	CA, MT, OH	Billed by licensed clinicians for acute behavioral episodes	Allows PASAs with clinical partners to bill for therapeutic crisis sessions
T2024	Specialized behavioral support, per 15 mins	CO (existing HCBS), OR, MN	Billed under HCBS for intensive behavioral support	Already available in Colorado; could be expanded for higher staffing ratios (2:1 or 3:1)
T2016	Residential habilitation, per diem (medical-complexity or high-acuity home)	OR, WA, MN	Billed daily for enhanced residential supports with nursing or clinical oversight	Could support PASA-operated medical-complexity homes for adults with I/DD
H2022	Community-based wraparound services, per diem	OH, UT	Billed daily for integrated behavioral and medical coordination	Could fund PASA-led multidisciplinary teams for high-utilizer adults
H2033	Multi-systemic therapy for youth/ adults with complex behavioral needs	NC, OH	Billed per session; requires certified MST clinicians	Adaptable for PASAs serving adults with co-occurring I/DD and MH diagnoses

> *"Workforce development is critical. Enhanced training opportunities for Direct Support Professionals (DSPs), including trauma-informed care, behavioral intervention strategies, and crisis prevention, would improve outcomes and reduce turnover. Creating career pathways and improving compensation structures would also support retention of experienced staff."*
>
> — SERVICE PROVIDER SURVEY RESPONDENT

Despite the immense impact DSPs have on who they serve, training for DSPs is not currently reimbursable for service providers; it is unbillable time with heavy administrative costs.

- For individuals with high support needs (whether due to complex medical, communication or behavioral supports) it is crucial that the DSP is given ample time to learn the individualized nuances needed that could have life or death implications to the specific clients they are serving. Being able to learn and recognize behavioral triggers or transfer a person safely from a bathtub does not occur effectively in a classroom. Based on survey and focus group feedback, when service providers can no longer self-fund the intensive DSP training needed, a DSP may not be prepared to safely support the person with high needs.
- Lack of adequate training puts the individual with I/DD at risk of injury or trauma.
- Lack of adequate training also contributes to injury of staff, abuse, burnout and/or premature termination.
- Turnover among DSPs is higher when serving those with high support needs and costs service providers between $4,200 and $5,200 in direct and indirect costs.[27]

The above all contributes to liability a service provider must consider, creating stronger disincentives for service providers to try supporting a high needs individual.

> *"Rates do not account for 1:1 or enhanced staffing needs (Level 6/7 individuals), Burnout among DSPs supporting high-acuity individuals, Competition with higher-paying industries (retail, warehouse, etc.), Lack of career pathways for DSP retention, Limited crisis response or stabilization resources in the community, Limited options for individuals who cannot succeed in traditional host homes, Lack of appropriate day program or employment options, increasing residential burden, Policies that do not reflect current acuity of individuals being served."*
>
> — SERVICE PROVIDER SURVEY RESPONDENT

Respite and accessible social opportunities are severely lacking.

- Respite is not funded under Colorado's DD waiver, but other Colorado HCBS waivers offer additional respite options. Some service providing agencies use their own overhead to help cover needed respite for their host home providers. Otherwise, host home providers must use their daily rate to pay for their respite, disincentivizing access to help when needed.
- Finding respite providers who can handle complex support needs is difficult, especially as

training is unpaid and would require a significant amount of time for initial training and onboarding at the time respite is needed.

- Natural supports are limited. Other states have utilized AmeriCorps programming to offer non-billable or natural support for adults with I/DD. AmeriCorps programs are collaborative service initiatives that place AmeriCorps members within service providing agencies to assist with community engagement, self-advocacy training, and inclusive programming.[28,29] Those who serve as AmeriCorps volunteers still need to be specially trained and service agencies would need to have capacity to fund administration to manage the volunteers.

Affordable housing investment and opportunities are largely inaccessible to the high support needs population; yet without access to affordable housing, this population will continue to be placed in provider-controlled settings which data shows is not always their preference.

- Affordable housing units are concentrated in more urban and suburban environments due to scale. Smaller scale, affordable multi-family properties in rural and mountain towns options are more limited due to the difficulty of developing and maintaining such housing.
- Accessible units are limited in affordable properties, typically only meet minimum ADA accessibility standards, and are not required to be leased to a person with a disability.
- Affordable housing and scoring rubrics are designed for neurotypical populations and do not account for additional design choices that can enhance accessibility as well as staff and client wellbeing for individuals with high support needs.
- Colorado's utilization rate of disability-specific vouchers is below the HUD standard utilization target of 95%, leaving vouchers unused.[30] Reasons may include that accessible units are unavailable, units can not be found within the payment standards, landlords refusing to accept vouchers, etc.[31] When contacted, Colorado Division of Housing reported that, "we are unable to lease up to our full award

"When I stop working for free, his budget won't make sense."

— **FOCUS GROUP PARTICIPANT**

"How can someone not burnout [host home provider]? I do this as her mother with strong attachment. There is no respite—I can't find or fund them. Sometimes I just need a breath, a few hours of respite."

— **FOCUS GROUP PARTICIPANT**

"Because of her unusual list of diagnoses, many on face value will not serve her without getting to know her."

— **SURVEY RESPONDENT**

"High dollar amount of property damage without option for reimbursement, lack of general safety plan other than the police evacuating the home and allowing the client to continue with property damage until he was done, then police would intervene."

— **SERVICE PROVIDER SURVEY RESPONDENT**

"If our group home closes, I can see residents going to a Long Term Care facility [due to lack of options]."

— **FOCUS GROUP PROVIDER PARTICIPANT**

potential because our agency has been managing a severe budget shortfall for over two years. Under these funding constraints, we cannot issue new or turnover vouchers—including Mainstream and Non-Elderly Disabled (NED)—as our sole focus must remain on maintaining assistance for our existing families within our available Budget Authority."[32]

- Landlord tolerance for property destruction or more involved accommodations (ceiling tracks, waterproof bathrooms, etc.) may be limited.
- Landlord tolerance for behaviors or noise being reported by neighbors, especially those who share walls, is difficult to manage.
- The Colorado Housing & Finance Authority offers the HomeAccess loan program to parents for purchase of a unit for their dependent loved one with a disability.[33] Yet, subsidies to afford the home are limited and may still be restricted to owner-occupiers, disqualifying a person with I/DD and high support needs as they would likely not be listed on the deed/title nor have the income to afford the mortgage.
- Local zoning restrictions could limit addition of ADUs to properties.

> *"Key design features should prioritize safety, visibility, and flexibility. This includes clear sightlines for supervision, controlled access to high-risk areas such as kitchens and exits, durable materials to withstand property destruction, and sensory-friendly environments to reduce overstimulation. Homes should allow for both privacy and active supervision, support staff presence when needed, and include environmental modifications that can be adjusted based on the individual's evolving needs. Outdoor space should be safe and enclosed, and overall design should support both independence and immediate intervention when safety concerns arise."*
>
> — SERVICE PROVIDER SURVEY RESPONDENT

Colorado lacks an I/DD-specific crisis response and infrastructure for those with I/DD and relies on general behavioral health crisis services that lack I/DD expertise.

- 14% of respondents have stayed overnight in the emergency department or hospital due to a behavioral or psychiatric crisis requiring outside help. Relying on the emergency department or a hospital for crisis intervention is not only expensive but unfair to both the provider and the individual with I/DD who should have access to an I/DD-specific crisis solution.
  - The 2014 'Dual Diagnosis Gap Analysis Project' conducted by University of Colorado JFK partners offers detailed challenges that adults with I/DD face to access behavioral supports, even when a mental health co-occurring diagnosis exists, that leads to emergency department admissions and repeated use of first responders.[34] The subsequent Crisis Resource Guide and Template Crisis Plan are valuable tools, but systemic challenges persist.
- Unlike other states, Colorado's current system has no statewide specialized I/DD mobile crisis teams, no therapeutic crisis stabilization homes, and no Medicaid crisis billing codes in the DD waiver.

- START (Systemic, Therapeutic, Assessment, Resources & Treatment) is a nationally recognized, evidence-informed crisis prevention and intervention model for people with I/DD who have complex behavioral or mental health needs.[35] National START evaluations consistently show substantial reductions in emergency department use, psychiatric hospitalization, and crisis episodes for individuals with I/DD and co-occurring mental health needs.[36] Colorado has only one program, Denver START, launched by Rocky Mountain Human Services.[37]

> *"There is also a significant need for flexible residential models, including options for higher-acuity individuals who require enhanced staffing, environmental supports, or transitional placements. This includes access to short-term stabilization resources to prevent placement disruption. For aging caregivers and families, enhanced supports should include transition planning, family support services, and respite options to ensure long-term sustainability of care."*
>
> — SERVICE PROVIDER SURVEY RESPONDENT

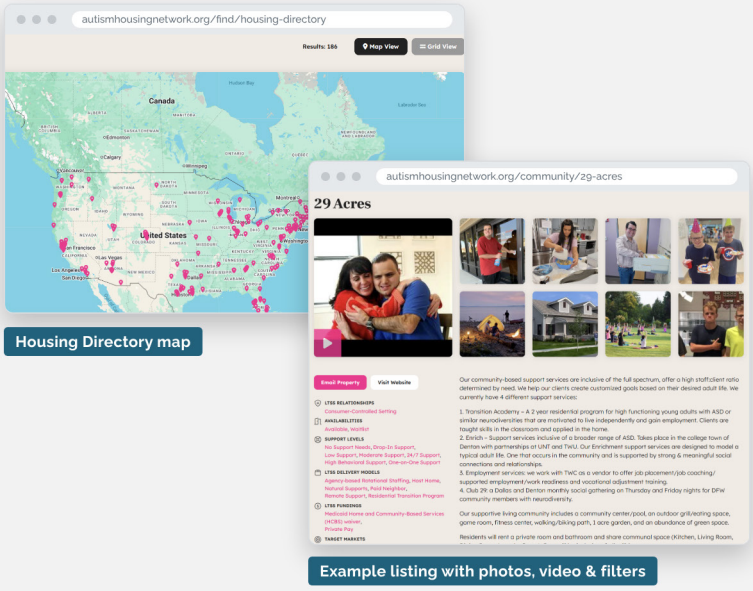
In focus groups, service providers underscored that they have the experience to support adults with high support needs, but the system is failing them—making it logistically and financially impossible to serve this population. Additionally, they shared that high support needs of those they serve have decreased over time when their individualized person-centered plan can be implemented. They need greater flexibility in the use of individual budgets and higher reimbursement rates to maintain the organizational infrastructure to provide ongoing residential support from a stable and specialized workforce.

> *"Consistent, reliable in-home caregiver staffing with the ability to start services immediately is critically needed. There are ongoing gaps due to provider onboarding delays, staffing shortages, and inability to support high needs. Additional needs include crisis-prevention support, behavioral/sensory regulation support in the home, and flexibility in service hours to match real daily care demands. Coordination between providers is also lacking, resulting in delays and unmet needs."*
>
> — SURVEY RESPONDENT

Data-Driven Concept Plans

Overall, Colorado needs a wide range of housing and support options that can be customized according to individuals' needs and preferences. One respondent labeled any sort of group setting a "fake community," while still other respondents expressed the belief that their adult child would thrive in an assisted living-like setting that is quieter and more peaceful than traditional group homes. For the respondents who described their vision of what a happy, thriving future would look like for their children, the sense of longing and anxiety were palpable in their answers.

Using the survey data and focus group feedback, the following concept plans were developed. The narratives in the section that follows are based on composite individuals and the three options are meant to be examples for practical modeling purposes. It is important to note that these concept plans are based on the composite individual described in each narrative, and are not representative of what would be best for all persons with I/DD. This population is incredibly diverse in preferences, support needs, and lifestyle.



Housing Directory map

Example listing with photos, video & filters

Autism Housing Network

Search housing by location, support level, funding and more, with photos and video for each listing.

Scan to explore the website.

autismhousingnetwork.org

CONCEPT A: TECH-ENABLED ACCESSORY DWELLING UNIT (ADU)

Jeremy's Solution:

Jeremy is highly sensitive to his environment and has not had success with housemate arrangements. He thrives on knowing what to expect and does best with person-centered, structured routines. He has a history of self-injurious behavior and has injured others when overwhelmed. Wear and tear with potential for property destruction due to repetitive water stimming (self-soothing actions such as spitting and flicking walls, flushing toilets repeatedly and turning water faucets on to flick the streaming water) would make maintaining a rental property difficult as a landlord would likely request early termination or not renew his lease due to property destruction. Therefore, his family added a detached, sensory-friendly, modular ADU to their backyard for Jeremy. The main home or primary residence and ADU will remain in a Special Needs Trust (SNT) upon the death of his parents. So long as Jeremy is alive and owning the property is primarily for this benefit, the SNT would lease the main home to a service provider with the intent that it can be used as a staff office, programming space, provide affordable housing for DSPs, or be sub-leased to other adults with I/DD.

Jeremy's single-story ADU is designed to be ultra-sound absorbing and provide extra auditory insulation from outside sounds, yet also includes a back deck for him to enjoy watching the hummingbirds and partake in his favorite activity, hot tub soaks! It includes no furniture with sharp edges but instead a floor bed with his favorite Batman bedding, a giant hanging swing and TV built into a moveable wall covered by plexiglass. He has a small kitchenette with smart appliances and an induction hotplate instead of an oven. The bathroom has industrial fixtures and the entire house is waterproof and includes water sensors for overflows. Each area of the home has intentional spaces for visual guides or tablet placement for self-direction or video modeling, and cameras strategically placed for remote support. When Jeremy begins to feel overstimulated or his wearable indicates he is becoming stressed (elevated heartbeat and perspiration detected), his environment can shift into a personalized calming space with a touch of a "Bat Button" on his table or remotely. This activation dims and turns lights a blue hue, turns on his favorite soundtrack and his favorite superhero (Batman) prompts him to sit in his "Batcave" and swing as the on-call staff, located just steps away, can come and check in to provide in-person support.

Housing Arrangement Examples:

A detached tiny home, manufactured or modular ADU can be added to existing property; adding attached structure to existing home (such as above garage apartment); remodel home for ADU with separate entrance (conversion of garage); purchase of property with built-in ADU. This may be part of bequeathing a family home and/or allowing a provider to add an additional ADU to a property. Not only does this offer a low cost, customizable additional accessible housing unit, it also offers families a sustainable housing solution as rent from the provider or housemates can help cover taxes, insurance, property management and maintenance.

Proposed Service Delivery Model:

Rotating staff offered to individuals with I/DD in their ADU while family occupies the main home. When family no longer lives in the main home, a service provider uses space in the 4-bedroom home as needed and in accordance with SNT intent. Remote support is offered to the person living in the ADU with access to in-person, agency-based rotating staff in primary residence as needed 24/7. ADU also incorporates enabling technology.

Existing Barriers for Implementation:

It is unclear if Jeremy could access additional support within his ADU if his family is his Individual Residential Services and Supports (IRSS) provider as it could be considered double billing when two providers would be at the same location and the same time. Additionally, service providers are prohibited from serving more than three waiver recipients in non-licensed settings.[38] Thus, even if bedrooms are available and additional housemates desired, a person with I/DD cannot invite more than two other waiver recipients to share their home and be supported by any provider without the risk of losing HCBS funding. Some communities in Colorado use zoning restrictions to prohibit the addition of ADUs; others require approval and/or permitting and therefore potentially prohibitive upfront costs (such as example drawings or engineering plans) without guarantee that an ADU will be approved. Financing of ADUs can be difficult or cost-prohibitive due to high upfront infrastructure or downpayment requirements. Research and use of wearables for early detection of seizures and/or stress that could lead to a meltdown is still early in development and integration with remote support technology is not readily available.

Required Changes or Clarifications for Implementation:

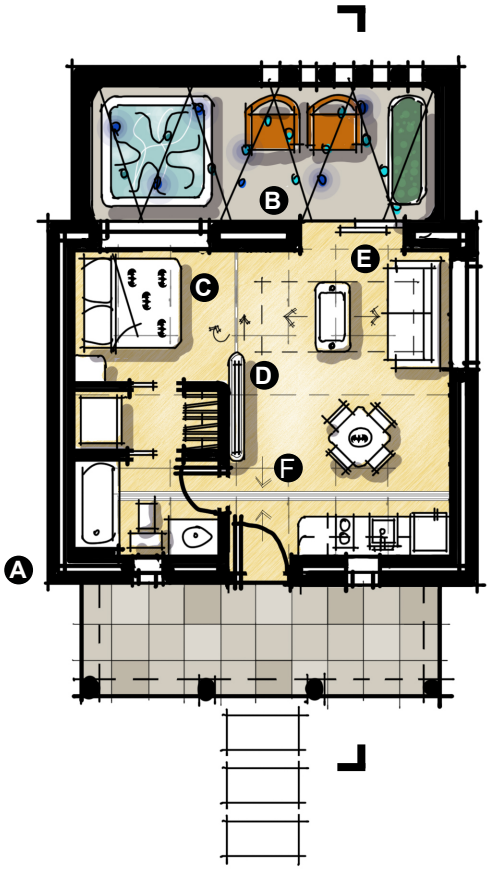
- The Department of Local Affairs (DOLA), Department of Housing (DOH), and/or CHFA should provide template zoning language for local communities to waive prohibitions or restrictions for ADUs where the purpose is to provide affordable, accessible housing for adult dependents of homeowners or specifically for adults with I/DD.
- Colorado should review IRSS occupancy limits under ADA Title II and Section 504 to ensure they do not restrict waiver recipients' right to live together in consumer-controlled homes. Absent a clear health or safety justification, such limits may constitute disability-based discrimination.

Jeremy's Bat Cave

Concept A - Tech-Enabled Accessory Dwelling Unit (ADU)

Concept | A newly-built ADU to provide supported housing for a young adult with I/DD and significant behavioral and communication challenges.

Priorities | Safety of the individual, sensory friendly environment, waterproof due to water stim behaviors, controlled environment with no roommates, meet individual preferences (wing, hot tub, batman theme)



A *Double stud wall assembly enhances acoustic performance by significantly reducing exterior noise transmission.*

B *Enclosed rear patio offers a safe outdoor space to reduce elopement risk and features softened curved walls, a hot tub, blue lights, and a flower planter that extends calming and self-regulation opportunities. The walls offer privacy for disrobing outdoors if desired.*

C *Rounded architectural edges promote a safer, more comfortable, and less visually rigid experience.*

D *Fully enclosed and operable TV module pivots between the bedroom, living room, and kitchen to maximize flexibility while also defining each space for its intended use. The module is enclosed behind plexiglass for safety.*

E *The center coffee table doubles as a swing to help engage self-regulation when the 'bat cave' mode is activated. Multiple types of swings are under couch storage and can be swapped as desired.*

F *A Luxury Vinyl Plank (LVP) floor and radiant heating offer a durable, waterproof surface with multiple drains to enable water stimming over a comfortable and safe surface.*

G *Walking loop within home has reinforced rubber to provide cushion and protection from wear and tear.*

H Sound paneling on the ceiling helps mitigate internal noise and reduce echo.



CONCEPT B: DOUBLE LIVE-IN CAREGIVER ARRANGEMENT

Lisa and Javier's Solution:

Lisa uses a power wheelchair, is medically fragile, has quadriplegia and uses assistive technology for limited communication. She uses a respirator and has seizures which she takes a medical marajuana tincture to control. Her caregivers help identify precursors and prevent bed sores, ensure she can breathe by monitoring the health of her trach tube, and ensure her favorite foods are pureed or pulsed well so she does not aspirate. Turnover of rotating staff triggers her anxiety and subsequent challenging responses as she relies on paid staff to manage her medical complexity that could have life-threatening implications.

Lisa met Javier at an adaptive wilderness camp years ago. They fell in love and have been life partners for nearly a decade. He uses a power wheelchair and also needs support for nearly all of his activities of daily living (transfers from wheelchair to car/bed/couch, meal prep and eating, bathing, toileting, etc.). They want to live and be supported together.

Lisa's provider has been serving this population for well over 40 years. The provider agency owns a large, 8-bedroom group home that was built decades ago and is no longer used because rates for the services provided in group homes have been reduced and it was no longer financially feasible for the provider agency to operate the group home. The families of Lisa and Javier have the financial ability to retrofit the home into three separate living areas: one for Lisa and Javier, and two other living areas for separate live-in care providers who will work in 72-hour shifts. Although the home was already ADA-accessible, several key design choices were added into Lisa and Javier's home to protect the health and physical strain of both caregivers and those needing support: a whole-home generator in case of power outage, ceiling lift tracks that connect the bed and bathrooms for push-button transfers, large drains installed in elevated tubs, suction equipment stations with splash-proof surfaces, medical outlets in bedroom and living areas, dishwashers and laundry machines with sanitization cycles, high and medical-grade HVAC filtration with additional small windows for ventilation and airflow in key areas. Each of the three living areas includes separate kitchens, bedrooms, one bathroom, a living room and separate entrances to offer greater privacy and respite for the off-duty provider.

Having two separate live-in home providers allows for continuity of care from fewer individual people overall while also providing needed breaks or "time off" to prevent burnout for the provider. It also offers immediate access to additional support or emergency respite, which can be difficult to access for those who have complex and high support needs.

Housing Arrangement Examples:

Rental or shared equity model using a tri-plex or split-level home with three separate dwelling units. Older, large group homes that have been un- or under-utilized could also be retrofitted to this model. Ideally, the home would allow for each live-in caregiver household to enter, cook meals, and have a space for downtime when they are not supporting the adult(s) with I/DD.

Proposed Service Delivery Model:

Two shared living or host home providers live in the same unit or directly next to one or two people with I/DD they are supporting. This allows for built-in respite and quick access to emergency backup who are familiar with the person(s) with I/DD.

Existing Barriers for Implementation:

There is not currently a waiver-funded financial mechanism for two host home or shared living providers to support a person with I/DD interchangeably. Lisa is medically fragile, her guardian will be an out-of-state sibling, and parents are concerned how her health will be monitored and managed week-to-week. Medical marajuana cannot be administered by Medicaid-funded staff or agencies, creating a gap in who will be able to administer her prescription when her family is no longer able. There is not an adequate funding source for providers or families to acquire or retrofit existing housing to reflect this arrangement.

Required Changes or Clarifications for Implementation:

- Create a fund or rotating loan program that can acquire and/or retrofit existing housing to meet the affordable, accessible housing needs for adults with I/DD.
- Explore options available to provide a living wage for two live-in caregivers.
- Design and fund a program to offer interdisciplinary clinical consultation for those with complex medical or behavioral support needs.

Lisa & Javier's Retreat

Concept B - Double Shared Living Arrangement

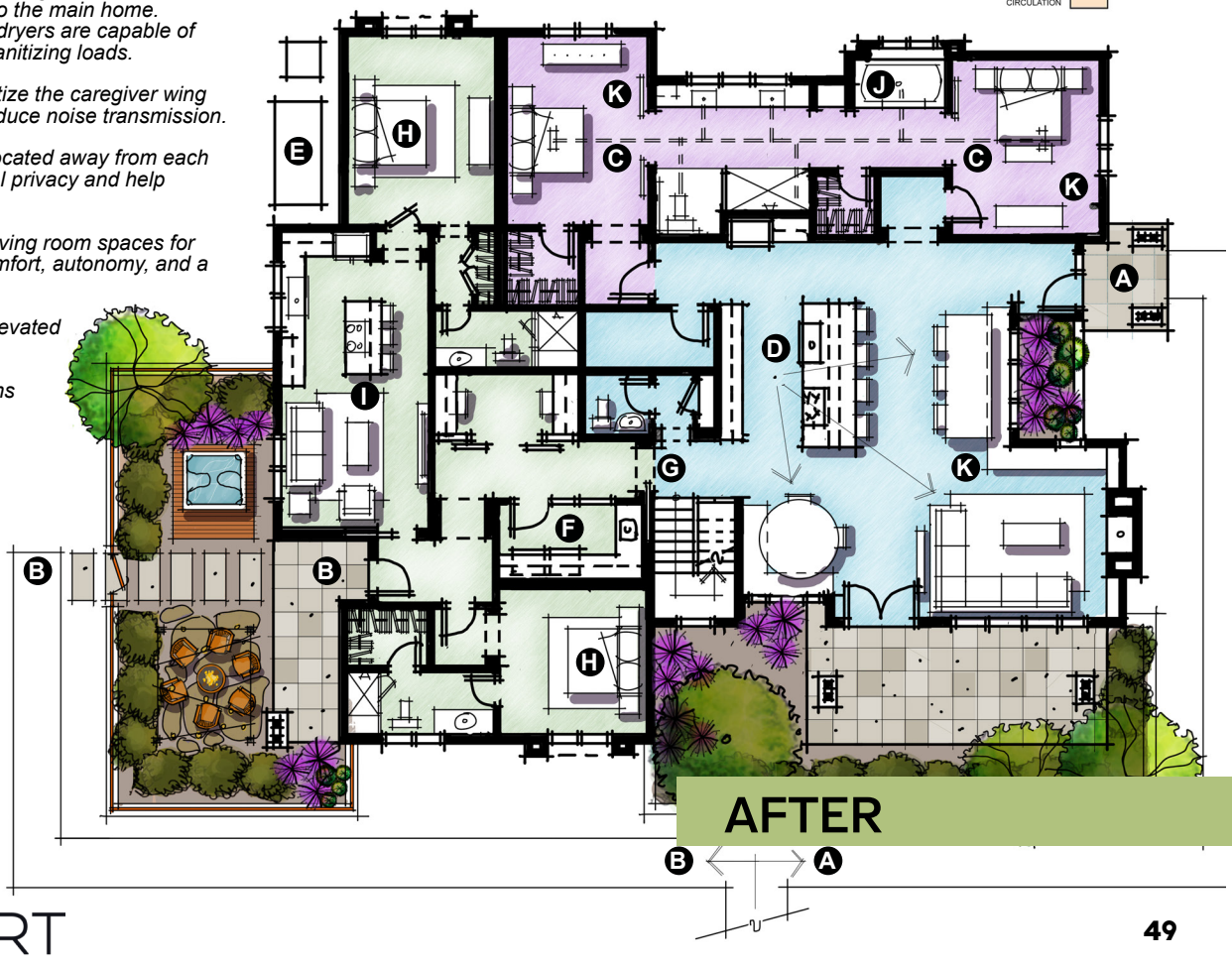
Concept | An existing 8-bedroom group home renovated to meet the needs of a medically fragile couple with I/DD who use wheelchairs and require two separate live-in caregiver households.

Priorities | Private spaces for couple and live-in caregivers, reliable access to electricity for medical devices, universal design beyond ADA Accessibility, physical safety during transfers and bathing.

- **A** *Re-orient main entry to enhance privacy for live-in caregivers.*
- **B** *A separate home entry and courtyard reinforces a strong sense of independent living and gives caregivers an opportunity for social interaction with guests or relaxation during off-hours to avoid burn-out.*
- **C** *Integrated ceiling lift tracks connect Lisa & Javier to their bedrooms, bathrooms, and shared transfer points, enabling safe and efficient push transfer supports.*
- **D** *Kitchen range located on the island to improve social engagement and participation with enhanced line of sight to the living area when cooking.*
- **E** *Whole-home generator is tucked along the rear of the property to provide reliable backup power during outages while minimizing visual impact.*
- **F** *Relocated laundry room facility improves operational efficiency and caregiver access while maintaining high visibility to the main home. Commercial washers and dryers are capable of handling frequent heavy sanitizing loads.*
- **G** *Pocket doors help to privatize the caregiver wing to enhance privacy and reduce noise transmission.*
- **H** *Caregiver bedrooms are located away from each other to maximize personal privacy and help support varied schedules.*
- **I** *Independent kitchen and living room spaces for caregivers helps foster comfort, autonomy, and a stronger sense of home.*
- **J** *Large drains installed in elevated tubs.*
- **K** *Medical outlets in bedrooms and living areas.*



BEFORE



AFTER

CONCEPT C: SMALL-SCALE, MIXED-USE INTENTIONAL COMMUNITY WITH DAY PROGRAM AND/OR SOCIAL ENTERPRISES ON-SITE

Kai's Solution:

Kai loves the outdoors, but has a history of elopement and is unaware of vehicular danger. In the family home, they would deadbolt all the doors leading to outside and had alarms on every window as Kai has been nearly struck several times running into the street from their suburban home. Kai can jump on a trampoline for hours, squealing with delight, much to the dismay of neighbors next door. Some days, Kai can take a trip to a favorite hiking spot and spend all day on the trail. But on more anxious days, Kai has also maneuvered out of a specialized seatbelt and nearly caused a car accident from grabbing the driver on the highway. Access to medical and dental care is also difficult and Kai needs to be sedated for routine care such as teeth cleaning or blood draws.

Kai's parents recently purchased a 3-bedroom home in a new neuro-inclusive pocket neighborhood in a small mountain town. A local service provider was able to secure free land just inside the town limits and partnered with a community land trust to attract a developer and create 24 affordable homeownership opportunities for adults with I/DD, host home providers and/or direct support professionals. The front of the property is public, hosting a neuro-inclusive health clinic and commissary kitchen as well as a maker-space and co-op gift store/farmstand. The residential part of the property is gated, with limited entrances and designed to keep cars on the outskirts of the property. It includes two different outdoor experiences, walking paths, a common house that has organized activities Kai can decide to join or not and the option for Kai to eat with others or simply take prepared meals home.

Due to the site plan and thoughtful design, Kai can freely leave home and walk around the neighborhood safely with limited DSP support—without concern for crossing streets or staying on sidewalks. On good days, Kai trains for Special Olympics at the local gym, goes for a hike, or bikes around the lake. On less predictable days, Kai can stay home and tend to the community garden, act as a greeter at the gift shop, or work on a project to sell in their booth. Kai is able to retreat home if needed and re-join communal activities once they are more regulated. This planned community also has a health and housing focus which is particularly valuable as access to healthcare, let alone neuro-inclusive practitioners, is generally difficult in rural communities. With this local healthspot, designed to be neuro-inclusive in both design and process, getting teeth cleaned, a blood draw, or weekly occupational therapy is done in a familiar place with providers who understand. It is helpful for providers as well as it is a rural regional hub where they can set up and schedule a day's worth of appointments. Kai lives with parents for now, but the plan is for them to move out and then Kai has the flexibility to add housemates if desired and/or have a live-in caregiver move in for a shared living arrangement.

Housing Arrangement Example:

A small-scale planned housing community (~8-35 total units) designed to be accessible, yet not exclusive, to those who have high support needs and may not be able to safely participate in the greater community every day due to medical or behavioral challenges. The property would include recreational amenities and optional programming that would be meaningful to residents and allow them to participate as well as retreat to their home easily, without the need for additional transportation. The purpose of the property would not be to isolate or prevent residents from engaging in the greater community, but to offer alternative options for meaningful activities outside of their home when getting into a vehicle may be unsafe or having quick access to retreat to their home is needed or preferred. Affordable housing for neuro-affirming DSPs, respite providers, or residents who would offer natural supports could be considered. This housing arrangement could be a rental property, shared equity partnership, or homeownership with or without a Homeowners Association.

Proposed Service Delivery Model:

Unlike past campus-based provider-controlled models of care from a single service provider, the proposed concept plan would be a consumer-controlled setting, keeping housing separated from service delivery. Available to anyone who desires to live in a neuro-inclusive planned community, residents would choose their home, preferred service provider, and service delivery model as needed. Residents could voluntarily participate in on-site employment, day programming or supportive amenities as desired. These shared spaces could be leased to different businesses, community-based organizations, or service providers. Resident participation would not be prescriptive by a single service provider, but based on residents' individual schedules and person-centered plans.

Existing Barriers for Implementation:

In order to be affordable to adults with I/DD, housing assistance is needed. Subsidies to develop small scale (less than 30 units), multi-family properties are limited and current multi-family, affordable housing funding streams base evaluation criteria on neurotypically-focused affordable housing standards. Development of rural and mountain communities is often met with pushback and the need for annexation or zoning modification will nearly always result in an uproar from existing residents, putting political pressure on elected officials. Furthermore, stigma of settings with a higher density of individuals with disabilities persists, particularly if they are not scattered within the typical housing stock, alongside fears that such developments may be or become institutional in nature. Thus, all potential residents must be meaningfully informed of other residential options and, in honoring their right to choose their own home, their choice should be clearly documented as their preferred residential setting in their person-centered plan.

Required Changes or Clarifications for Implementation:

- Develop a specialized health and housing funding source designed to provide the capital needed for development of properties where the unit size and layout, amenities and site plan are responsive to the high support needs I/DD population.
- Prioritize housing for adults with I/DD in Proposition 123 Affordable Housing Financing Fund and the Affordable Housing Support Fund to incentivize affordable small-scale housing solutions and land banking that include at least 25% of units for adults with I/DD.



For more in-depth discussion and analysis of the demand for intentional communities, characteristics that distinguish intentional from institutional settings, and the lived experience of people with I/DD living in intentional communities in Colorado, please refer to the 2025 Neuro-Inclusive Intentional Communities in Colorado: Investigating Demand & Policy Recommendations report

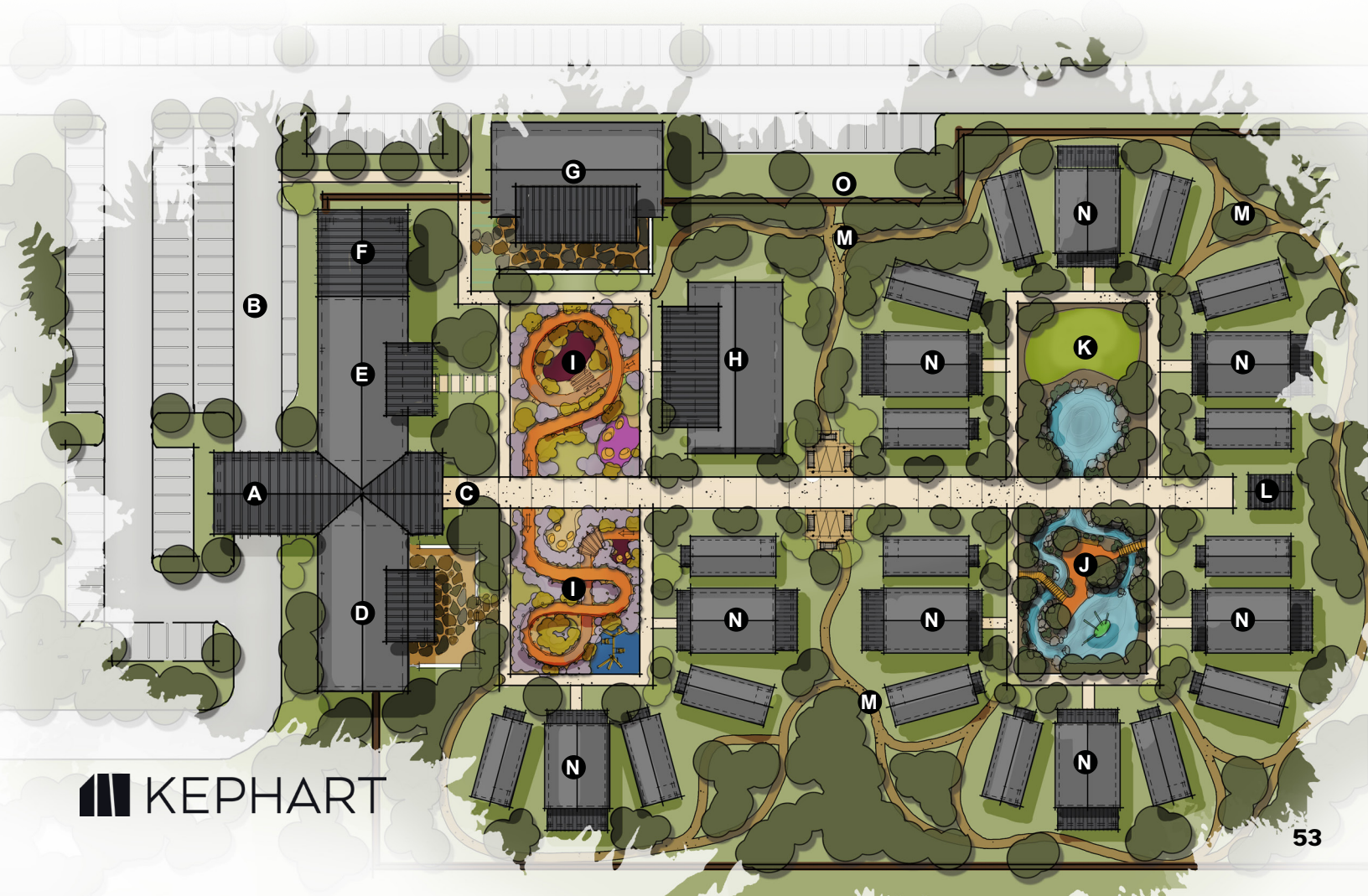
Kai's Place

Concept C - Mixed-Use Intentional Community

Concept | A planned, neuro-inclusive, gated pocket community with eight (8), 2-bedroom units designed to meet the accessibility needs of individuals with I/DD and high support needs.

Priorities | Pedestrian oriented to protect from traffic dangers, gated for outdoor freedom of those who elope, meaningful opportunities for individuals to engage with their community, sensory friendly and universally designed.

- **A** *Covered porte-cochère drop-off zone and gated entry to the community. A breezeway greets residents and visitors alike, and provides a clear circulation path to all cottage clusters and outdoor amenity spaces.*
- **B** *Assigned owner and visitor parking is strategically located around the exterior perimeter to improve safety and allow for a more walkable internal community.*
- **C** *Wide pedestrian paths allow for golf carts to transport groceries, trash, or other cottage unit needs effectively to and from the parking lot.*
- **D** *Neuro-inclusive health clinic is on-site for any medical needs, providing faster care and more tailored sensory and physical environments to offer a calm, low-stimulus experience.*
- **E** *Co-op gift store or farm stand with a community garden that offers residents an opportunity to sell crafts or goods to establish financial independence.*
- **F** *Covered outdoor gathering space for events or other community activities.*
- **G** *Commissary kitchen provides a shared, sensory-friendly commercial workspace that fosters employment, skill-building, and establishes camaraderie and stronger sense of community. Prepared meals are available for residents to take out or eat family-style if desired. This is a voluntary amenity in addition to kitchens provided in the main cottage units.*
- **H** *Multi-purpose community space for supportive amenity programming and group activities.*
- **I** *Neuro-inclusive Discovery Park with elevated, widened paths that create a playful experience to and from different park activity zones. The cushioned path is accessible and provides a way-finding tool that meanders through the colorful landscape (offers a high-energy, highly sensory zone).*
- **J** *An outdoor water stream and splashing feature provide a safe space for tactile exploration, a constant sound blanket, cooling and calming experience, and predictable stimulation to help the community thrive (offers calm, medium sensory zone).*
- **K** *Open green space for outdoor community gathering (offers calm, low sensory zones).*
- **L** *Security office and monitoring station to provide faster response times to each cottage cluster quadrant.*
- **M** *Private outdoor walking paths and trail network for exercise and sense of discovery.*
- **N** *Cottage clusters are distributed around internal courtyards to provide a variety of adjacencies to outdoor amenity areas.*
- **O** *A property fence around the perimeter of the community creates limited access points and separates the pedestrian and vehicular circulation in the community.*



KEPHART

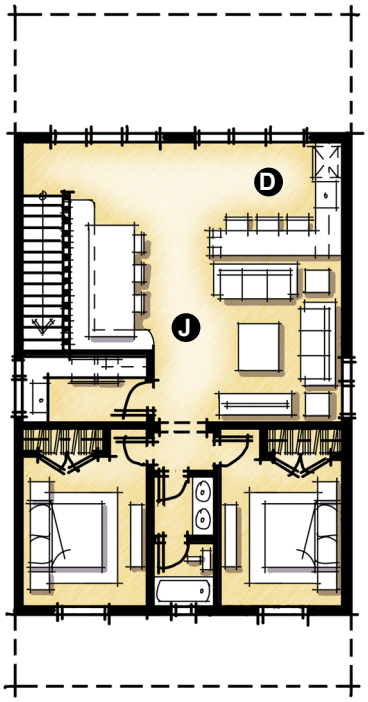
Kai's Place

Concept C - Mixed-Use Intentional Community

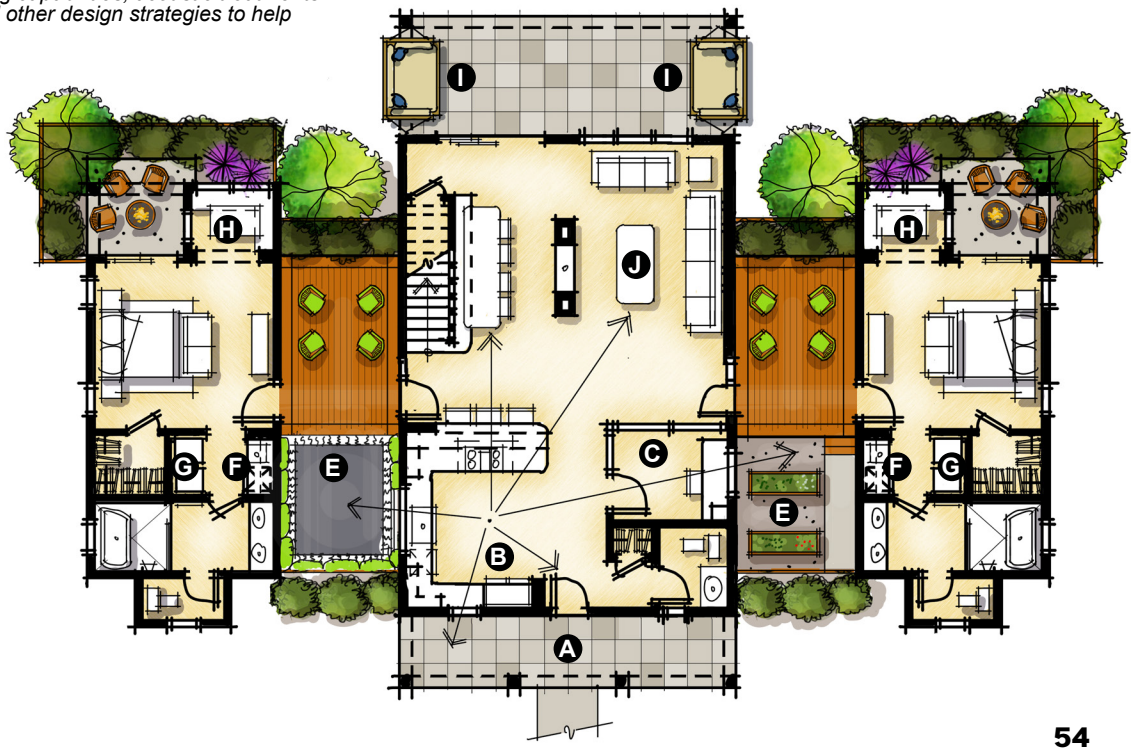
Concept | A 3-unit home with flexibility for a live-in caregiver or rotating staff. Each unit has its own bedroom, bath and kitchenette to offer flexibility in living arrangement as well as balance for shared and private spaces.

Priorities | Line of sight design for rotating staff, intentional private and shared spaces, flexibility of use and/or re-sale.

- **A** *Single access through the main cottage for monitored entry. The front porch faces outdoor parks and open spaces to encourage social interaction opportunities.*
- **B** *Open concept kitchen becomes the heart of the home and maintains high visibility to all areas for constant supervision. Cooking range faces the living and dining areas for constant supervision.*
- **C** *Office and safe room in case of physically aggressive behavior provides a space limited to caregiver use. Tempered glass partitions maintain high visibility and enhance physical safety.*
- **D** *A private upstairs kitchenette, dinette, and living space bring flexibility to the main cottage. These second story spaces can act as a live-in caregiver unit, additional resident with I/DD, or roommate offering natural support.*
- **E** *Semi-private deck and soothing zone can be specialized to each user. For Kai, this is a trampoline zone with padded or netted walls to create a safe bounce space, but these courtyards could be converted to outdoor gardens, water fountains, or other programmatic needs that help bring comfort to each resident.*
- **F** *Private kitchenette in secondary cottages allow for storage of personal food and drink items that help bring independence to each unit.*
- **G** *A laundry space in each unit helps reinforce independent living and creates a more controlled environment (like specific scents, detergents or dyers sheets, or chemical sensitivities).*
- **H** *A private nook can be modified for each individual, creating a calming, quiet space.*
- **I** *A private outdoor patio includes structural modifications to allow for a bed-sized swing.*
- **J** *Each home incorporates additional neuro-inclusive design measures to create a more comfortable, intuitive, and supportive living environment for a diverse range of users; this includes additional steps like color drenching (to reduce color contrast), trim matching the wall color, adjustable lighting and dimming capabilities, acoustic treatments to minimize noise transmission, and other design strategies to help bring comfort and flexibility.*



Second Floor | Main Cottage



KEPHART

Recommendations

The following are recommendations that arose during the process of this study, grounded in data collected and focused on meeting the demand for housing and supports that would be inclusive of adults with I/DD and high support needs.

DATA COLLECTION & PLANNING

1. Quantify and develop plans to meet the needs of aging caregivers or families before impending crisis
    a. Estimate the number of persons with high support needs, including levels of support needed and specialization of medical or behavioral staffing
    b. Outreach, identify and assist senior caregivers who have adult dependents with I/DD with system navigation and transition
    c. Create a comprehensive printed guide, in-person class, and/or video training for caregivers to better understand housing, support and life planning options
2. Expand current programs to include an I/DD-specific ombudsman for complaints and subsequent action of reported neglect or abuse
3. Complete further cost analysis to accurately assess cost savings (healthcare, first responder, staff turnover, etc.) when a person with I/DD and high support needs is adequately funded and service providers have the needed flexibility to serve them in their choice of setting from a continuum of options
4. Several market rate neuro-inclusive cohousing and mixed-use communities are currently being developed and data could be collected on pre- and post- move-in outcomes for residents

LONG-TERM SUPPORT SERVICES

5. Increase HCBS individual budgets and flexibility of use as a mechanism to accelerate unique solutions for those with high support needs
    a. Create systemic channels to expedite approval of SIS Level 7 requests to accurately reflect the needs of the significant population of individuals who require one-to-one and two-to-one support
    b. Allow providers to negotiate rates of complex and high needs waiver recipients based on actual costs, not pre-determined assumptions by policymakers
    c. Allow for additional services to be billed per diem for needed support for an individual to participate when also billing group programs or daily rates

d. Explore solutions to allow two live-in caregivers, as a double host home and/or a double shared living arrangement

e. Conduct a comprehensive analysis of what other states have implemented to meet those with high and complex support needs, and then amend HCBS waivers and/or State Plan to include billing codes recognized and used in other states that could help service providers better support adults with I/DD and high support needs

6. Invest in a career path and the long-term stability of case management & direct support staffing

   a. Fund a complex medical and complex behavioral training and/or certification program in line with credentialing and/or apprenticeship programs in other states that lead to greater pay for specially trained and credentialed DSPs

   b. Offer paid training for DSPs to work alongside a current DSP who supports a specific adult with complex or high support needs for better continuity of care

   c. Identify, train, and compensate specialized case managers that support those with complex or high support needs

   d. Set standards for smaller client ratios for case managers supporting individuals with high or complex support needs

   e. Create a registry of credentialed DSPs and case managers specialized to support high needs populations

7. Expand Colorado's diversion-based Money Follows the Person (MFP) program for those at risk for institutionalization

   a. Estimate the gap of current capacity to meet future demand when family caregivers are no longer available to be the community-placement option

   b. Study the cost-effectiveness of Colorado's At-Risk Diversion efforts for state-funded expansion

   c. Identify and secure experienced case managers

"They need a state system to walk the walk about person-centered services and truly get behind the importance of keeping people safe in their own communities. Most changes that are made create even more challenges to an already complicated I/DD system."

— SERVICE PROVIDER SURVEY RESPONDENT

"The system used to better support high needs individuals with high behavioral and medical needs when rates were negotiated per setting and per support needs. There were agencies that had very specific areas of expertise and usually open placement options to access in an emergency for agencies and families. Completely understand CMS requirements for a consistent assessment, but the assessment has to better address exceptional needs, or the state needs to have a better Level 7 process and actually approve and pay for what is needed to support someone. Approval for lower rates than requested puts people at risk."

— SERVICE PROVIDER SURVEY RESPONDENT

"We need a continuum of solutions rather than traditional residential options that exist in Colorado today. The data demonstrates substantial

who specialize in supporting individuals with high support needs to provide a year of Transition Coordination (TCM-TC) Diversion Services and/or enhanced case management and monitoring

d. As done in other states, use MFP funds to develop several residential demonstration projects targeting those with high support needs that have the potential to be replicated if deemed successful. Examples of use may include new staffing ratios, hybrid HCBS + clinical models, on-site nursing or behavioral supports, etc.

HEALTH & CRISIS MANAGEMENT

8. Develop a third-party mechanism for medical case management by dedicated I/DD-informed health professionals
    a. Significantly enhance training and HCBS coordination expectations with Regional Accountability Entities (RAE)
9. Offer training, designation and incentives for I/DD-informed health providers
    a. Secure funding sources for interdisciplinary clinical consultation
10. Incentivize providers to develop a robust specialized behavioral or medical respite opportunities through paid training and higher reimbursement levels to offer relief to family caregivers or host home providers
11. Develop a temporary residential respite/stabilization mechanism for service providers to quickly respond to crisis placement needs
12. Evaluate Denver START outcomes to understand if implementing a START-aligned statewide model could support a dedicated I/DD crisis continuum—"someone to call, someone to come, and somewhere to go"

variation in support intensity, living preferences, and circumstances, thus making a strong case for varied, thoughtfully designed housing and support options matched to individual needs and preferences, including family homes/ADUs, shared living, individualized homes, intentional/neuro-inclusive communities, and other models that are designed to meet individuals & families uniquely and often-times complex needs."

— SERVICE PROVIDER SURVEY RESPONDENT

"A key need is expanded access to behavioral and mental health services, including providers who are trained and willing to work with individuals with complex behavioral presentations. Services should be available at a frequency and intensity that matches the individual's needs, rather than limited by current provider capacity... There is also a need for integrated service models, where residential, behavioral, medical, and employment supports are coordinated rather than siloed. Individuals benefit significantly when providers are aligned and communication is consistent across teams."

— SERVICE PROVIDER SURVEY RESPONDENT

HOUSING & COMMUNITY DEVELOPMENT

13. Raise awareness and resources for families who want to bequeath their family home, assist in the purchase of a home for their loved one, and/or add an accessory dwelling unit

    a. Create a Colorado-specific guide for families to understand legal, financial, property management supports and services options to secure housing for their loved one

    b. Provide low-cost financing options for purchase of ADUs, tiny homes, or manufactured homes

14. Create a new funding stream for developing or retrofitting neuro-inclusive housing that includes enhanced amenities and accessibility features to accommodate those with the highest support needs

    a. Develop additional guardrails in addition to current regulatory standards and provide a strong incentive for the housing industry and service providers to collaborate for targeted solutions

    b. As further described in the *Neuro-Inclusive Intentional Communities in Colorado: Investigating Demand & Policy Recommendations* report, a funding stream could be created in various ways including:[41]

        - Develop a Colorado Neuro-Inclusive State Tax Credit program
        - Develop a Colorado Neuro-Inclusive Housing Trust Fund
        - Create a Neuro-Inclusive Housing Social Impact Bond
        - Develop a pool of state-funded neuro-inclusive project-based vouchers, increasing as need increases
        - Create a Neuro-Inclusive Revolving Loan fund to help local communities jumpstart solutions with local partners
        - Earmark an annual state budget line item allocation using the General Fund or Cash Funds (statutory "special-purpose" accounts funded by fees, fines, or earmarked taxes) that funds a minimum number of units per year of neuro-inclusive housing
        - Explore how the newly created Colorado Disability Opportunity Office could offer a stronger support towards neuro-inclusive developments

15. Leverage existing government owned properties and affordable housing funding streams, from single-family homes to multi-family properties, designed to be accessible for adults with I/DD who have high behavioral or medical support needs

    a. Echoing recommendations from Colorado's HB23-1296 Task Force on the Rights of Coloradans with Disabilities, direct Colorado Office of Economic Development and International Trade (OEDIT) and the Division of Housing (DOH) to analyze and report to the Governor and legislature on opportunities to leverage available funds to increase the inventory of accessible housing[42]

16. Strategize based on the source of funding, such as:
    a. Adding I/DD as a specific prioritization of need
    b. Providing bonus points in scoring
    c. Matching funds for low-income housing developers who agree to set aside units for people with I/DD
    d. Setting aside a percentage of the funding source targeting adults with I/DD or neuro-inclusive development
    e. Draw from existing funding sources, including programs in DOH, Colorado Housing Development Grant Fund, allocation of Low Income Housing Tax Credits (thus advocating change in the Quality Allocation Plan), Proposition 123 Colorado Affordable Housing Financing Fund and the Affordable Housing Support Fund, Community Land Trusts, etc.
17. Develop a Colorado I/DD Housing Plan in order to prevent the displacement and/or institutionalization of people with I/DD
    a. Outline the need, explicitly including those with higher support needs, and include tools and resources that could be shared in both the housing industry and at the local level through the Colorado Division of Local Affairs and the Division of Local Government in order to reach planning departments and local appointed and/or elected officials in all areas of Colorado
    b. Create a toolkit for local communities to assess and modify zoning codes to allow for increased housing options for adults with I/DD. For example, waiving restrictions on ADUs if they will be used for a dependent loved one, reducing parking requirements, discounts on property taxes, or waiving restrictions on the number of unrelated persons who can reside at a property
    c. Colorado manufacturers of tiny homes, pre-fabricated, modular, and/or ADUs should be informed of this need for accessible options. As modeled in Massachusetts, a competition for model floorplans would offer great advertising opportunities and be useful in the development of a toolkit or guide for families.[43]

> *"Colorado only investing in family caregiving options, host homes and independent apartments is leading to a crisis. If Colorado wants to move to solving this impending issue, they must INVEST in a model that is an alternative to one of the above."*
>
> — SERVICE PROVIDER SURVEY RESPONDENT

Conclusion

Reimagining Home: Residential Solutions for Coloradans with I/DD and High Support Needs calls for a pragmatic, compassionate shift—from crisis containment to proactive investment. **The choice before policymakers is not between spending and saving; it is between spending inefficiently on emergency placements or investing strategically in community capacity.** Every dollar spent on ER boarding or psychiatric hospitalization could fund multiple days of appropriate, person-centered support in a neuro-inclusive home.

Colorado can lead by creating a tiered safety net that will protect vulnerable adults, relieve aging caregivers, and stabilize service-providing agencies. An infusion of support for the direct support workforce could create career paths, offer training, enhanced skill sets, pay living wages and bolster a sense of pride and dignity to continue providing essential care for this vulnerable population. Planning and implementing solutions tailored for individuals with high needs will also yield measurable fiscal returns—reducing avoidable hospitalizations, institutional placements, first responder utilization, and direct support staff turnover costs.

Coloradans cannot ignore the impending disaster or succumb to decision paralysis—a lack of action is not tolerable. Colorado must build the housing, service provider capacity, DSP workforce and funding infrastructure before this crisis occurs. **The path forward is hopeful and achievable.** Service providers and families are ready to innovate and the data offers paths forward that reflect what Coloradans actually want. With coordinated leadership from HCPF, the General Assembly, and local housing partners, **Colorado can build a system where no adult with I/DD is left in an emergency room because there was nowhere else to go.** This report is the start of a blueprint—what remains is the will to act.



Appendix

STORIES AND QUOTES: COLORADAN VOICES

Through the process of this study, dozens of people shared stories from their lives—firsthand experiences, unmet needs, hopes and fears for the future, and more. This appendix contains longer quotes shared by survey respondents and focus group participants as well as stories from Colorado families who are hoping to see positive change for their loved ones with I/DD and high support needs in the coming years.

What Inclusion Would Look Like for My Son

> *"My son prefers rigid predictable routines, familiar staff, short visits, zero outings, low stimulation, lots of privacy and solitude. New places and caregivers are a nightmare for him. He's a danger to ride in a van with and will attack other riders and support staff, but is peaceful and smiling with little to no behaviors when given lots of space and peace. He would love to live in a nursing home setting in a private room more than a group home setting where unpredictable situations, noise and constant staff rollover would result in cyclical vomiting syndrome episodes and violent/destructive behavior that wouldn't occur in a more predictable quiet setting.*
>
> *He would love to wheel down to a lunch hall for a meal at the same time every day. That is what inclusion would need to look like for him. Current models are totally irrelevant to his needs and wants. Group homes do not want him because he has constant nighttime support needs, never leaves the house, has complex medical needs, and is nonverbal. There are no breaks for the caregiver whatsoever, even to sleep, making a nursing home style model of care more sustainable for providers and for him in the absence of me as his mother, willing to do things no one else would. It would be a huge relief to know such a place existed. We are a single parent household with no money for expensive private placements."*
>
> — **SURVEY RESPONDENT**

Cindy & Roberta's Story

> *"My daughter has nowhere to go when I can't take care of her anymore.*
>
> *It's devastating to know that your child's health and safety and very life rely on other people and to see no path forward. Roberta (not her real name) is amazing. She is sharp and fun and has a wealth of knowledge about certain topics. She loves to see friends, revels in holiday celebrations, and really enjoys food.*

Roberta is also hard. She has adult-size meltdowns, self-injures, and requires a lot of accommodations and flexibility. She's medically complex with rare conditions that require intentional and often subtle monitoring and numerous medications and interventions. She prefers to never leave home, and she thinks that we'll both die if I go away overnight.

She has high support needs in every facet of her life, from personal care to medical management and implementation, even opening a heavy door. She needs assistance with communication and making plans with friends. She absolutely requires stability and for her team to know her really well.

So where can she go that has adequate support, is stable with long-term care providers, allows her to live with friends, facilitates community engagement, ensures some lifestyle autonomy, and will endure for her lifespan? An apartment, even with "concierge services," isn't a fit due to her high support needs. A traditional host home isn't a fit because she would have to conform to someone else's culture and lifestyle, would be at risk for isolation, and would be vulnerable living alone with a provider (or a couple). A reverse host home is better, but it still creates too much isolation and vulnerability. Adding housemates to a traditional host home or reverse host home helps in many ways, but it's not a long-term, stable solution because it fails when the primary resident or the provider passes or moves on. A traditional group home might be a good fit, but there are none in our community.

So what then? We need a shared living arrangement that allows for a housemate model similar to typical young adults living together. Group settings—when done well—can help prevent isolation and vulnerability and can be stable for lifespans. The current options in Colorado have gone too far in the name of de-institutionalization and many people are left with no path forward. We need additional options. My daughter needs a home."

— ROBERTA'S MOTHER

Systemic Changes and a Vision for the Future

"Across the lifespan, supports need to be flexible, individualized, and designed to evolve as needs change—not limited by age, funding silos, or rigid service models. For individuals with high support needs, consistency in caregivers is critical, along with a workforce that is well-trained, adequately compensated, and supported to stay long-term.

Enhanced supports should include access to 24/7 services that can scale up or down as needed, crisis prevention and response systems, and coordination across medical, behavioral, and community-based services. Families also need ongoing support—not just in early years—including respite, navigation assistance, and planning for the future as caregivers age.

There is a significant need for meaningful day options beyond traditional programs, including supported employment, community-based activities, and opportunities that reflect the individual's interests and strengths. Social connection should be intentionally built into services to reduce isolation.

Technology can play a larger role as well—remote monitoring, communication tools, and assistive tech that promotes independence while maintaining safety. Transportation remains a major barrier and should be more flexible and responsive.

Finally, planning must include long-term sustainability—what happens when parents are no longer able to provide care. This requires coordinated housing, services, and funding systems that truly center the individual's quality of life, dignity, and belonging in their community."

— **SURVEY RESPONDENT**

Justine's Story

Justine is a 20-year-old woman who loves being around people and enjoying time outdoors, especially walks. She has significant developmental disabilities including being deaf and non-verbal.

"My husband and I currently care for Justine in the family home. Justine requires full assistance with activities of daily living. We assist her with feeding, bathing, dressing and hygiene. Justine cannot be left alone even for short periods of time. She does not understand safety concepts so there is always the potential that she could accidentally harm herself.

We know that we won't be able to care for Justine forever. She has a sister who is a few years older who would help if needed but we don't think it is fair for her sister to have that burden. Ideally, Justine would live in a group home with caregiver support. That type of setting would provide the social interaction that is so important to her."

— **JUSTINE'S MOTHER**

Happy & Peaceful Environment for a Happy & Peaceful Guy

"I think the ideal setting for my son would be a group home that is beautiful and well cared for and a beautiful facility where family members can come and go and check out quality of care. For my son, the place would have to be fully wheelchair accessible and the care area would have to accommodate a ceiling lift or a higher lift and a special bed...

A place that felt like a home not a hospital with a beautiful outdoor space that is wheelchair friendly, has staff to provide access to community activities (ball games, concerts, fun runs, and on site activities) - and a loving staff that works shifts so they don't get overly exhausted. A place to build friendships and have the medical and therapy support that he needs. I envision something similar to a nice up-scale 55+ community with the activities and amenities that would make one want to live there. Perhaps a community room that you could reserve if you wanted to have a family party for your adult child's birthday or something. A movie theater

and on-site gym would be nice for group activities and therapy. Perhaps outdoor fire pits and picnic shelters, where people can congregate and visit- all wheel-chair accessible. Natural light and transportation needed.

Somewhere that I can move my son when I'm too old to provide daily care—a place where I can feel confident that he's safe, getting good care and building community. Perhaps with the option for case management for his insurance and Medicaid benefits. When I am too old or I am gone. I want my daughter to go visit her brother in a beautiful well cared for home, but I don't want her to have to be responsible for his care and care. In a perfect setting, he might have neighbors who are not disabled or only have physical disability needs. I don't want him to end up at the place where many of his neighbors have emotional or mental disabilities that caused them disruptive behaviors. He is a happy and peaceful guy and likes a happy and peaceful environment."

— SURVEY RESPONDENT

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