KANSAS MENTAL HEALTH COALITION

Speaking with one voice to meet critical needs of people with mental illness.

Minutes

December 17, 2014 Monthly Meeting **Valeo Behavioral Health Center, 330 SW Oakley, Topeka, KS**
(*teleconference access 1-877-278-8686, enter 982797 use codes: *7 mute / *9 unmute)*
Meeting room wi-fi: Guest@ccess

9:00 a.m.

Introductions and sign-in sheet David Wiebe, President

Attendance List didn't make it around – Need to know who else attended:
Andrew McCarthy
Sue Lewis, MHA of Heartland
Shelley Duncan, Emberhope
Jessie Kaye, Prairie View
Alexandra Simmons, MHA of Heartland
Sheli Sweeney, ACMHCK
Walt Hill, High Plains
Dan Rice, South Central Mental Health
Jason Hooper, KVC
Stephen Feinstein, ELC
Leslie Byork, ELC
Jason Scheck, ComCare
Ric Dalke, Compass
Lynn Kohr
Stuart Little, KAAP
Ken Kerle, CIT
Ira Stamm
Jane Adams, Keys for Networking
David Wiebe, Johnson County MHC
Kyle Kessler, ACMHCK
Sky Westerlund
Glen Yancey
Rick Cagan, NAMI, KS
Susanna Honaker, KAAP
Rob Mealy, KS Psychiatric Society
Marcia Epstein
Susan Zalenski, J & J
Wes Cole, GBHSPC
David Elsbury, CMHC
Steve Christenberry, FSGC
Mark Wiebe, Wyandot
Guests:
Angela DeRocha, KDADS
Gina Meier-Hummel, KDADS
Bill Rein, KDADS

Financial Report see report JoLana Pinon, Treasurer

Minutes of the previous meeting. see draft Add Shelley Duncan to the November attendance on the phone. Minutes adopted – Rick Cagan, Steve Feinstein second.

9:15 a.m. Reports

Advocacy Committee –Grassroots Advocacy Network - Sue Lewis

Met December 3. Committees reported. Legislative Survey had low response so, it was re-sent with a January 1 deadline.

Grassroots Advocacy Network is doing outreach for the 175 or so trained advocates through phone calls and a short survey to collect information about how to best support their work. Want to identify what would be most useful to them in serving as advocates and what might be holding them back from participating actively. For some, the training alone has not been enough preparation for them to feel confident in their advocacy.

A new Training advertisement has been developed and will be put out inviting groups to have local training events or to attend the training event that is scheduled for March 11 in Topeka. KMHC will bring training to your community if you are willing to put together a small group in your area.

Advocacy Learning Initiative – weren't able to attend their last meeting, so will get a report from Scott Wituk about that.

Working on Kansas Mental Health Advocacy Day – will be March 12. The briefing will be held at the Ramada Inn on 6th Street. The committee is also fundraising for the event.

Rick reported that NAMI has released a State Mental Health legislation report comparing recent actions in other states. MHA has also released a similar report. These reports include information about legislation in other states that may be useful to us.

Medicaid Access Coalition – Amy Campbell – The Coalition is looking forward to learning about options that will be promoted by the Kansas Hospital Association and others this session.

Marcia – when KS gets up to speed on initiatives relating to suicide, that also relates to pressure on hospitals and could reduce the need for hospitalization.

Sean Gatewood is looking to schedule a briefing in late January or early February to learn more about the details of the KHA proposal.

Amy emphasized that, as we talk about the changes or investments that can help to keep people in the community and reduce hospital admissions, the issue of the uninsured comes up over and over. KMHC has supported Medicaid expansion and will continue to do so. It will be interesting to see what form it may take.

Governor's Behavioral Health Services Planning Council –Wes Cole

Next meeting will be in Emporia. The Council wants to look more closely at how subcommittees can share or partner

Taking a hard look at the role of NFMHs – probably through a Council task force. They are just not typically at the table in our traditional meetings. As KDADS fills Carla's old position, there will be more emphasis on NFMHs. There are a lot of people in the NFMHs (600 to 700 at any given time) and at one time, there was a collaborative relationship with the NFMHs where we sent clinicians to the NFMHs to provide services and then that stopped. It is troubling to note that the average age is around 40. At a recent meeting with NFMH representatives, there was some troubling information about people who are being sent to the NFMHs.

Rick added that there was some frustration about the inconsistent role / relationship with the CMHCs. There were several facilities who said they had a great relationship with their CMHC.

David would like to see NFMHs at our table.

GBHSPC Subcommittees –

Justice Involved Youth and Adult Subcommittee – will be meeting in January. There is a lot to pay attention to since

Mental Health and Aging Coalition – no report

Children's Issues- Opportunity to comment on proposed changes to the HCBS waivers due December 20. Jane will look at that to see if there is a need to comment.

The State Special Ed Directors group intends to meet to review current trends relating to seclusion and restraint, and suspensions. Suspension rates are very high right now. Jane reports that several schools are refusing to accept a mental health diagnosis as a Disability identifier.

10:00 a.m. Hot Topic: State Hospitals - Bill Rein and Gina Meier-Hummel
-Changes at the State Hospitals since the consultants' reports.
-Agency actions to seek out community resources to improve discharge plans.

Bill Rein, General Counsel, KDADS – said Shawn Sullivan will no longer be able to serve in a dual capacity

Discussed history of how he first became involved in working with people committed to state hospitals as a young attorney living near Larned. Later, as an agency attorney, he was tasked with drafting mental health reform language. He read the Coalition history on the website and has great empathy with our mission.

1 – establishing ongoing cooperative relationship between CMHCs and state hospitals

2 – use of independent and multi-disciplinary evaluations

3 – efforts being made to divert admissions through crisis stabilization and CIT

4 – direct communication between patients and families, similar to the Family and Friends group established regarding SPTP.

At OSH, licensed capacity is 206. Recently, reach 264 patients – a 10 year high. Over the course of the summer, as census began to rise, notified centers that we would begin a census management initiative. Unfortunately, it wasn't enough. There was a complaint to KDHE which stimulated an inspection and the subsequent review. Agency had to take action. Voluntary admissions were suspended until we can get census to 186. I understand that it was very difficult to ask CMHCs to dig and to find alternative resources in the community for voluntary admissions. But as far as I can tell, most of them have done it. Certainly, we don't want to shut off voluntary admissions, but our statutes state that voluntary admissions can be restricted when there are alternatives in the

communities. Developed admission teams to run 24 hours to aggressively triage involuntary admissions. Instead of the old way of just faxing in the admissions forms by the screener, we are

There's nothing secret here, we have sent these plans out to law enforcement, CMHCs, judges, etc. Must consult with admissions officers and hospitals doctors prior to admission. We understand this slows things down. Trying to facilitate physician to physician contact – hospital physician can speak to state hospital physician and this contact can

Closer attention is being paid to the original language defining civil commitment and diagnoses that meet statutory definition for hospital admission. While that has always been there for 35 years, it hasn't always been looked at as closely as it is now.

This isn't all being put on the CMHCs. I support the CMHCs and know there isn't always a lot of resources available. So, we are also beefing up the discharge process – took some of our best people out of central office. They have strong knowledge of the resources that are out there. They met with hospitals

After just a couple of sessions, we were able to discharge over 50 patients. That won't work all the time, but if we have resources that can help – then we are going to bring that to bear. They are going to train and work with the hospital discharge workers. It isn't just knowing what is available, but also knowing who to contact.

This policy has allowed OSH to get close to its licensed bed capacity, but it is an ongoing thing. One weekend of admissions can upset these numbers. We do understand the disruption that can occur in the community, but this is the system that we will use when it is necessary.

The agency has brought in multi-disciplinary professionals to review and evaluate our programs. You are familiar with the Buckley Report. We have also had people from Larned look at what goes on at Osawatomie and vice versa. We used to do it that way all the time. So, we have had some external review and some internal review.

We have also had some special task forces, such as the SPTP Task Force. We are trying to use some independent groups, internal groups and others.

WE found – at Larned that we needed additional staff to provide direct care services. Needed to reduce overtime. Now, I love it out there – to hunt and fish and other activities. But not everyone has my appreciation of that area and it has been very difficult to recruit psychiatrists and other professionals and even direct care workers. Difficult to hire and then difficult to retain. Trying to recruit more psychiatrists and physicians will help. We are working with college to train and develop LMHT (Licensed Mental Health Technicians) to develop a career path here. That used to be a professional track that was useful to people. If we could get some LMHTs, it would free up our nurses to do more evaluation and assessment rather than just administering medications.

One of the challenges at Osawatomie was a higher number of difficult to place individuals at that facility. One positive out of our recent actions was

Hope this will allow Osawatomie to be what it is intended to be, which is an acute care psychiatric hospital.

Our IT is out there equipping some of the staff with tablets to record notes to go directly to professionals who can then consider PRN medications and such. The hospital is tracking its readmission rates and seclusion and restraint data and comparing that with benchmarks – at this point, we seem to be meeting those benchmarks.

To talk about the SPTP program, there is no question this is one of the most challenging programs in the state. The Task Force developed some positive recommendations and we are working on implementing some of those. We have an internal working group that is working on those and we haven't really been out to advertise that. Families shared with us that they do not have enough information about what goes on with their family members. We have established

This group has been calling other states who have inpatient and outpatient programs and looking at how they manage those programs, what is working and what isn't, and how they move those participants.

Much of my career has been devoted to trying to divert as many admissions as possible. It has been a universal objective to try to provide as many services in the community as possible. We moved forward with the Rainbow Services model to provide crisis beds, short term stabilization and other services at the community level. That is

designed to give professionals the opportunity to have a longer period of time to evaluate the genuine needs of the individuals and to direct them to more appropriate services, including for addictions treatment or other needs.

That is a major objective of our recent initiatives and a primary mission.

I know what families are going through, I know that mental health is a difficult thing. When people are in crisis, it is

Referred back to the SPTP Family and Friends group – thinks there was a good beginning there and good listening and conversation.

Elizabeth Layton Center – have run into very lengthy process, very difficult, had to press the issue for an involuntary. We are glad that the admission was ultimately allowed
Frankly, the individual was discharged to a jail setting and we have been unable to make any contact with him, so we are very concerned about a truly critical situation.

Rein – we want to avoid difficulty.

Leslie – we are dealing with another difficult admission today. Our pool of money to deal with diversions has been reduced and to have difficulty with involuntary admissions is very concerning to us.

Rein – please send a letter to follow up with problems that occur. I know that doesn't help you within the moment, but it will help us to look back and see if directions need to change. We welcome fact-based discussions.

Gina – my cell phone number is on the letter, please use it.

David – what option does the state hospital have if the court signs an admission order?

No option.

Rick – one concern that has been raised is that admissions are being denied and the hospital doc may not give a reason. Our population has increased and our state hospitals have reduced, so some assert that the number of hospital beds

Gina – Gov Mental Health Task Force study is examining the cost of providing mental health. The global amount of money for treating mental health has increased – so, the question is, are we investing in the wrong places? We are continuing to look at crisis beds and housing options.

David – is the majority of that funding Medicaid?

Yes.

David – and what we are dealing with is that the majority of people served are not Medicaid eligible.

David Elsbury – appreciate your comments and appreciate understanding more of the history. In terms of the new policy, some of the language directing the CMHC duty for serving this population – my CMHC is in an area without many resources and we heavily rely on Kansas City area resources. We do not typically recommend any voluntary admissions. To date, we haven't had any admissions rejected, but if we should have an admission rejected, I have great concern about what we would do. We cannot handle that. Our small community resources are not licensed to deal with that. The private facilities that we do work with, will not always accept an admission.

Gina – part of what we are talking about is looking at those communities who need additional resources. We have now enacted a "bed board" to show where there are open beds.

Rein – my heart is in the rural areas and I would be very interested in talking to you about that. When we were writing MH reform, we didn't know if every MHC would come into this because they ran a big risk in providing the slack to care for those who would no longer be hospitalized. That is where the term "participating mental health center" came from. We knew there might be some areas where they wouldn't. But we love the fact that all of them did participate. I've been out of the field for 20 years and I don't know

Elsbury – as a participating mental health center, we signed that agreement with the understanding that the state hospital beds would be there. Additionally, the level of funding available to serve the uninsured was higher. Also, at that time, there were many more private psychiatric beds than there are today. The lay of the land is entirely different now.

Rein – and I'm not saying the law doesn't need to change or be updated, but at that time, we put in the language

Rick – I understand that ComCare's voluntary admissions go to Via Christi, so, this issue would be even worse without the overflow contracts.

Discharge topic – Amy – Had a great meeting with Gina where we talked about this and the work that is being done in trying to identify and encourage

I have discovered in talking to people who do offer resources within the community and they indicate that this issue of disqualifying people who are dually diagnosed or have issues that are not clearly defined as eligible for state hospital service is a real problem. They have a concern and a hesitance to accept a discharge for someone who will not be allowed to return to the hospital when a crisis occurs and there are not stabilization services for these other concerns. The NFMH meeting asserted that the state hospital will reject a person who has dementia, even when they have a longstanding mental health history prior to the dementia.

Gina – emphasized that the agency is aware of the lack of resources and is especially trying to identify and encourage a broad base of resources at the community level. We did discover that there were many people at OSH who had been there for a very long time and had IDD issues.

Are there any initiatives with any private hospitals? We used to use Two Rivers Hospital, but they have told us that they won't accept Kansas Medicaid and would need a specific arrangement with KDADS.

Gina – we have been looking at those private beds and talking with those who are interested in partnering with us. Use any resources at your disposal and contact us if needed. We rarely enter special agreements, but we can.

David Elsbury – Is KDADS aware that some of the Missouri border hospitals are not willing to take Kansas Medicaid? Is this an issue regarding working with our MCOs? Is this all of the Missouri hospitals?

Don't know – will follow up and look into the Two Rivers situation.

Rick – how would you advise us to move forward into the Legislative Session – what do we need to work together on?

How will the agency be implementing the Governor's Allocations?

Gina – our list has not yet been finalized.

Angela – the current allotment for FY 15 and moving forward into FY 16 – we have not finalized that budget, but none of that will come out of the hospitals.

What about the CMHCs?

We don't know, but the Secretary is very much aware of the efforts that we are making in this area and how important they are.

Amy said that Carla and Gina have been in regular contact with her and with the Coalition. They have been a great resource and have regularly reported to our group.

Carla reported: Adult Inpatient Manager position is supposed to be filled in the next few weeks and that will help to move forward the NFMH discussions.

KDADS issued an announcement for funding that will be available for diversionary programs through the Law Enforcement Advisory Council. A portion of that funding was distributed for CIT funding and these will be different grants for community based prevention / diversion programs.

Carla will try to bring Sarah to report on Prevention Subcommittee and the efforts to integrate Prevention programming beyond just substance abuse treatment.

10:40 a.m. Lobbyist Report- Amy Campbell

- KanCare Oversight Committee - Access to Mental Health Medications Issue: Recommendation to repeal statutory exemption from PDL / management.
- Legislative Budget Committee - Handout: State General Fund forecasts and Governor's Allocations
- NFMH Meeting

Discussion of Consensus Recommendations is for members only.

11:00 a.m. Proposed language for Consensus Recommendations:

Substance Abuse Prevention and Treatment - See handout.

Stuart Little

Rick – Coalition should maintain a position that any treatment for co-occurring disorders should be based on evidence based practices that recommend that mental health treatment

Sky – it is a good thing to add to the consensus recommendations, but there are two things that jump out. The statement that substance abuse disorders are chronic brain disorder and not a lifestyle choice – not professional agreement on that. Even Bill Rein referenced the fact that there are people with

Suggested removing that sentence due to lack of consensus.

Mark – don't want to dump the whole sentence. There is increasing evidence that this is not within the realm of ethical and moral choice. Could work with it to the message across.

Sky – wouldn't oppose a broader statement. (Mark and Sky can finesse it?)

Last bullet point – preserve and strengthen the professional addictions counselor workforce development – Coalition has not taken a workforce position in the past. If you want to keep it, should use broader reference to behavioral healthcare workforce.

Jason Scheck – minor edit – substance abuse treatment v. substance use disorder. SUD is the more current reference. Update that.

Stuart – KAAP would suggest KMHC strike that last bullet until such time the Coalition decides to weigh in on workforce issues in the future.

11:25 a.m. Announcements:

11:30 a.m. Adjourn

For more information, contact: Kansas Mental Health Coalition

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