KANSAS MENTAL HEALTH COALITION

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

Minutes

Click on underlined items for web links.

August 26, 2015 Monthly Meeting **Valeo Behavioral Health Center, 330 SW Oakley, Topeka, KS**

9:00 a.m.

Introductions and sign-in sheet Susan Crain Lewis, Vice President

Amy Campbell
Rick Cagan, NAMI
Lynn Kohr
Carol Manning, MHA of SC KS
Dana Schoeffelbein, Florence Crittenton
Sky Westerlund, KNASW
Eric Harkness
Corinna West, Wellness Wordworks
Ira Stamm
Steve Christenberry, FSGC
David Elsbury, Kanza
Susan Zalenski, J&J
Sandra Dixon, DCCCA
Jane Adams, Keys for Networking
Marci Epstein
Mike Burgess, DRC
Rob Mealy, KS Psych Society
Ken Kerle, CIT
Christine Wills, Valeo
Andy Brown, Headquarters Inc
Stuart Little, ACMHCK/KAAP
Sheli Sweeney, ACMHCK
Jane Rhys
Guest:
Rep. Kathy Wolfe-Moore
On the phone:
Jessie Kaye, Prairie View
Mark Wiebe, Wyandot
Steve Feinstein, Elizabeth Layton Ctr

Rep. Kathy Wolfe-Moore
Doug Wallace, KDADS

KMHC next steps after the death of our president, David Wiebe. His service was greatly appreciated and he will be missed. Board will be discussing leadership plan at their September meeting to replace David and will have an open officer position.

Financial Report adopted. Andy Brown, Treasurer Records have been transferred to Quickbooks. Cagan motion, Wills second. Please renew your membership at KMHC website - the site will generate an invoice to pay by check. Contact Amy if you have questions.

Minutes of the previous meeting. (Note: Amy's primary laptop failed last week, the availability of minutes will depend on what can be recovered.)

9:15 a.m. Reports

Board of Directors - July meeting Discussion of policy recommendations will begin at the October meeting.

Advocacy Committee –Grassroots Advocacy Network - Sue Lewis - Advocacy Committee will meet today for a four hour strategic planning session to prioritize their work. Will report next month.

Mental Health and Aging Coalition - Nancy Trout – The Coalition has existed since mid-1990's in some form. Currently a 501(c)3. Do not have the kind of support from agencies and organizations they used to have. No paid staff – working to host meetings remotely rather than in person. Meets 4th Friday of the month 12:30 pm – 2 pm. Group has dwindled – CMHCs don't seem to have "Aging Specialists" any more. As those roles are re-assigned, that employee has to take personal time to participate instead of it being a part of their job. It is a private coalition – formerly a subcommittee of the Governor's Behavioral Health Services Planning Council.

Hosting a conference on October 2nd - $65 early reg or $75. Olathe Sunset Building = Area Agencies on Aging. System as it relates to today's aging population. Speakers include Dennis Domer, KU – new cities initiative on aging and architecture. Past heavy narcotics use and its effects on health, impact on needs for long term care. Aging population and sexuality. Also – upcoming conference on hoarding to be sponsored by Wichita/Sedgwick County Hoarding Coalition October 29 at Airport Doubletree.

CMS moving from fee for service to accountable care model for Medicare. Hope to have all payment models to an ACO system by 2018. Would it be possible to get HHS speakers to cover this issue?

Changes of Medicare would be a good topic – maybe could pull it together for next year's annual conference. Kathy Greenlee might be a good person to approach.

Governor's Behavioral Health Services Planning Council – The Council is creating a new committee. Next meeting September 29 in Wichita. Met last week at the Emporia Mental Health Center. Saw some amazing programs

including an 8 bed residential program that they have set up. Also looked at children's programming. Work closely with the school and they go get the kids who need services. Very young children on up to high school. Very successful program.

9:45 a.m. Prevention and Mental Health - Information shared by Corinna West, Wellness Wordworks
Working for four years to create a sustainable scalable solution to some of the issues our mental health system faces. Have had 12 diagnoses and up to 6 medications at a time. Came through all of those situations and found a way to graduate from mental health treatment. Encourage a goal of true recovery and allowing people to leave treatment. Need a way to create a role for recovery coaches, a guide to move people through treatment to recovery. I define recovery as "All this goes away". How do we bring graduation from services, or moving people to minimal level of services or move people to the amount of services they desire.
Health Care Foundation of Greater Kansas City granted $10,000 for development of a model.

Problems of the US Mental Health Care "System"

1. Chronic Trauma
2. Isolation
3. Economic Stress
4. Discrimination

One Solution: Poetry as Social Justice and Community Development = Threefold

1. Mental illness prevention
2. Lay Person Interventions
3. Recruits for certified peer specialist positions (Peer run recruitment and preparation / support improves training, improves staff morale/job satisfaction, and retention.)

A scalable, replicable business model: scaling by strategic partnership, movement building, and delivery network building.

1. Advocacy partners in coalition to ask funders for public mental health approach
2. Human Experience Language to keep mental health simple
3. Research partnerships to document wellness program effectiveness

Ira Stamm: At one time, our treatment was 80% psycho-social and 20% medical. Today, it seems our model is flipped 80% medical and 20% psycho-social. We need to seek more balance in this concept.

Eric – how can your model address integrated care for addictions issues as well?

The issues are primarily the same and need similar supports. Trouble thinking, emotions are out of whack, trouble dealing with relationships – cuts across all of those fields. Providing safe places to be, safe methods to process and move through trauma.

Sally – feel pretty strongly that we are missing important support for our peer services in the state. Talked about the history of change to state recovery conference – good regional model, but still miss the statewide group.

Amy – Continuum of Care Committee also discussed importance of funding sources. As the system has resulted in more and more restricted funds, less unrestricted funding, the kinds of individual support programs that we know are very important are being more restricted as well. Peer groups meet less often, fees are required, some centers have few, if any peer specialists. Many centers have excellent programs, but others have very little.

10:00 a.m. Guest Topic: KDADS Adult Continuum of Care Report - Doug Wallace, KDADS
At the request of Secretary Bruffett, the committee was created to look at our current system and make recommendations for system improvement particularly as it related to available resources within the community at a time that beds are restricted at the state mh hospitals.

Broad membership
Quick turnaround = five in-person meetings
Small group work – reviewing same topics and making recommendations
From those discussions, developed lists of barriers and opportunities.

It was a short time frame for the committee to take on a large issue. Only touched on the key issues, not time for in-depth. Wanted to continue to meet to continue to look at the recommendations, review progress, and revise recommendations.

Could not recommend number of state mh hospital beds – difficult when the community resources need to be improved. If we enhance that system, the number of people who need the state mh hospital will change.

Group didn't feel that they received data that would inform a determination of number of beds, but that they absolutely felt the beds that are currently off line should be reinstated as soon as possible. Generally, felt that the current number of beds are insufficient.

David Elsbury suggested the group talk to Walt Hill to get a study that he refers to regarding recommended hospital beds per population.

Recommendations:
See Report.

The agency supports creating an ongoing role for the group to move some of these things forward.

Rick – KDADS has received this report – what is the low hanging fruit they might move forward?
When will Children's Continuum of Care Committee move forward? (don't know)

Doug – Commissioner Rein reminded the group that the Secretary was really looking for short-term action items within her authority. Looking at NFMHs, housing and other community resources will be pursued relatively quickly. There are funding opportunities out there now that would help with this. More to be done.

Carol Manning – LMHT discussion – there are almost no LMHTs left in the state. Was there discussion of that?

That was part of the discussion.

Sky – one of the very core things for success in mental health is the relationship the client has with somebody they can trust long term over time. If you look at staff turnover over time through all systems, the clients are still staying in those facilities / programs. If there is staff turnover, there is not stability for those clients.

Rep. Kathy Wolfe-Moore – It was an honor to be involved in the committee and surrounded by so many accomplished people. Do we have any update on when the beds will be re-opened? *Perhaps October.*
We
There is a meeting of area stakeholders tomorrow at RSI. We are hearing that the State's funding of the program may not be certain. We believe that funding over time will be crucial.

RSI Model – importance of community coalition – involvement of the local stakeholders, law enforcement, judiciary, local govts, hospitals – makes it more difficult for policymakers at the state level to set aside their investment.

10:30 a.m. Legislative Update Amy Campbell

- KanCare Oversight Committee Report - Friday, August 21 – Mike Burgess – if you've been to any of these meetings, you've been to most of them. Long meeting with back to back speakers.

  Concerns about numbers of people opting out of the health homes.

  Discussion of waiver integration project – concept is to integrate all of the 1115 waivers to change from entitlement to health outcomes. Timeline is Sept 30 to post the draft. Public comments end November 20. Then submit to CMS. Four or five states have done something similar. From an advocacy perspective – a lot of unknowns. Hard to comment on something we don't understand. Moving to outcomes might be beneficial, or might be a challenge with the MCOs developing the plans of care. Will people have to fight to get the services under a new model?

  Jane Adams – health homes: I'm dealing with a family who didn't know they were in a health home and then opted out, then CMHC said they refused service.

  Amy – Kansas Legislature postponed health homes for chronic conditions program. Now we are hearing that the murmurs about tossing it out altogether. Would be a terrible shame if we blew this opportunity due to our own failures of implementation.

David Elsbury – some of the challenges can be traced to the MCO assignment of particular participants to certain health home providers. We had cautioned the agency that this could be a problem. Recommended that SED children should be assigned to current mh services provider. Also, some were assigned to provider outside their geographic area. We need to learn lessons from Missouri and other places and not toss it aside.

Carol Manning – we now have our own lessons and can tweak our program to provide good services. Always takes longer to start something than we might anticipate.

Ira – think it is unlikely to be tossed out due to other influence. Think CMS is unlikely to back off at the state level.

Most of the discussion in the meeting was about further investigation.

- Kansas Hospital Association – new Behavioral Health Task Force – meets today
- KDHE Mental Health Medication Advisory Committee - First meeting September 1: 10 am - 12 noon

11:00 a.m. KDADS Update - KDADS Behavioral Health - Ted Jester, KDADS

Screens – CMS has decided Kansas is not in compliance with Parity Act because we require a CMHC screen for voluntary hospitalization.

Third party screens are considered a qualitative assessment.

Policy will take effect October 12. MCOs will have until then to have their policies in place so that screens will no longer be required for hospitalization at a private hospital. Will send the MMIS policy. Private hospital will

PRTFs are different. Policy hasn't changed too much. MCOs will be involved. Current process requires qualified mh professional evaluation – course of action determined. Then they go back to the CMHC – community based service treatment team. If the team agrees that placement is appropriate, then that plan is developed with the PRTF.

Have asked MCO to be involved, but don't start UM until day 61. Now, there won't be a screen and there won't be that team as it has been operationalized. Regardless of how they come to the system, the MCO will facilitate a team meeting with caregiver, provider as appropriate, youth as appropriate – everyone who is knowledgeable

If it is deemed appropriate, the MCO will have the ability to authorize that stay according to medical necessity. The 60 day framework won't be a part of that. There is a federal time frame that will continue to be used, beginning planning at 14 days. Should be based on medical necessity and individualized for the child.

PRTFs are based on chronicity and not acuity. None of us want the PRTFs to start looking like hospitals. I share the fear that they might start doing stay screens every 24 hours like they do with hospitals.

Role of the qualified mental health professional goes by the wayside. Although they might be involved depending on who the family has called

David – what procedure code would that be for us if the T code is gone?

Ted – that is $400 billable one time. Case code is $30 one time.

David – I can understand that the screen might go by the wayside, but why would the team meeting also go by the wayside? You are still going to need that.

Ted – a couple of things – changes of care placement. Kid might go to a PRTF, then might need hospitalization, might then go back to the PRTF. Why have 3 screens? Decisions were to do away with screens when you change the level of care.

The CBST in the new world doesn't have to require the full team of the CMHC – just a clinician who is knowledgeable about the youth.

David – still don't understand it. You referred to mental health reform and county of responsibility – the CMHC will still be on the hook for accountability for the child when they come out. Appears to me that the CBST question is not the same as the screen question.

Ted – we were forced to do the change with the screen out of necessity and hoped to do the change for adults and postpone for the children. Hoped to have a children's screening team meeting and discuss all of these things. But the code doesn't differentiate between children and adult. Still going to have a children's continuum of care committee process. There are other things in the children's world that we know are missing.

Amy – whether adults or children, we know that the transitions between inpatient and community are often where the ball is dropped. Perhaps the individual doesn't follow up, perhaps someone isn't able to be there. Either way, the CMHC is responsible and we know the meeting occurs. Aren't you just making that more difficult.

Dana – what if an MCO is not assigned?

Ted – described the process. When medical card is provided, MCO will be involved and will begin utilization management.

Dana – but at day 45, we won't have the CMHC screen to rely on if the MCO wants to deny eligibility retroactively.

Ted – same as now, still have to have a psychiatrist's screen, still have to meet medical necessity.

Jane – so, if we have a child who needs to go to the hospital, they go straight to the hospital?

Ted - They can, or they can go to the CMHC first. It is true that the CMHC won't have any way to influence how many people are going to hospitals even though one of their outcomes for their contracts is associated with the numbers of hospitalizations from their catchment area. They won't have the opportunity for diversion they have today. The MCOs have responsibilities here

Amy – will the private hospital have any incentive to bring the CMHC in? Not really?

Ted – we hope so. We will encourage that continued participation.

David – we will still have people in departments who will have daily contacts with the hospitals. We will still be looking for the people that we can treat on discharge.

11:25 a.m. Announcements

Behavioral Health Prevention Listening Tour: handout

The 90-minute sessions are planned:

- Aug. 31 — 1:30 p.m., City Limits Convention Center, 2225 S. Range, Colby.
- Sept. 1 — 9 a.m., Clarion Inn, 1911 E. Kansas, Garden City.
- Sept. 2 — 8:30 a.m., Wichita State University Metropolitan Complex, 5015 E. 29th, Wichita.
- Sept. 2 — 2:30 p.m., Courtyard Marriott, 3020 Riffel Drive, Salina.
- Sept. 3 — 1:30 p.m., Holiday Inn Express, 3411 Iowa, Lawrence.
- Sept. 4 — 9 a.m., Memorial Building, Alliance Room, 101 S. Lincoln, Chanute.

Each session will include an introductory presentation on the Kansas Department for Aging and Disability Services plan to overhaul the state's approach to promoting behavioral health.

"We have consolidated all of our behavioral health prevention efforts and we want to give Kansans information about how the new approach will work," KDADS Secretary Kari Bruffett said in a prepared statement.

The new approach is being coordinated by the Center for Community Support and Research at Wichita State, which in June was awarded a $684,997 contract by KDADS.

KDADS officials have said the new approach will be more holistic, data-driven and result-oriented than previous efforts. Development of the new approach is expected to take about a year, KDADS officials have said. - See more at: http://www.khi.org/news/article/kdads-schedules-listening-sessions-on-behavioral-health-overhaul#sthash.mKUrmvMu.dpuf

11:30 a.m. Adjourn

2015 KMHC Meetings: 9 a.m.–11:30 a.m. Jan 28, Feb. 25, Mar. 25, April 22, May 27, June 24, July 22, Aug 26, Sept. 23, Oct. 21, Nov 18, Dec. 16 **Board Meetings:** 12 noon quarterly the 4th Wednesdays (March 25, July 22, Sept. 23, Dec. 16)

For more information, contact:
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