

# KANSAS MENTAL HEALTH COALITION

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

## Minutes

**August 27, 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

**Financial Report adopted.** [See Report](#) Please review the list of received dues on the "detail" tab of the report. Please let me know if there is a discrepancy regarding your dues. Motion by Glen Yancey, second by Jim Brann. JoLana Pinon, Treasurer

**Minutes of the previous meeting adopted as amended.** [See Minutes](#). Page 7 – add – Proposed that the Midwest Bioethics Center be involved in discussions due to the complicated nature of the discussion of pain medications. Motion by Yancey, second by Pinon.

**9:15 a.m. Reports**

**Advocacy Committee –Grassroots Advocacy Network -** Meeting after Coalition. Today is the first quarterly meeting of the Advocacy Committee under its new structure. Will be reviewing the work of the Task Groups – which include

Question – will we be talking about the growing issue of mental health / public shootings and violence?

Advocacy Committee is the workhorse of moving projects forward, but discussions on policy take place here in the Coalition meeting.

Governor issued a proclamation for Suicide Prevention Week on August 22, 2014. The proclamation is posted on the website.

KMHC has also posted the NASMHPD Report – "The Vital Role of State Hospitals" on the KMHC website.

**Hospital and Home** – David Wiebe and Amy Campbell – No meetings have occurred.

**Medicaid Access Coalition** –Amy Campbell – released a listing of election candidates and their stance on whether or not they would consider expanding Medicaid access. States are wanting to see how projects for covering the uninsured in lieu of actual Medicaid expansion are working. KS Hospital Association is moving forward with conversations. Amy believes this will be a more visible subject after the elections, because maintaining the number of uninsured is unsustainable once the general funding provisions of the ACA move forward – reducing funding for serving the uninsured at hospitals and clinics.

**Governor's Behavioral Health Services Planning Council** –Wes Cole - The Hays meeting went well. Moving forward with work with the five Native American Tribes in the state. Will have a SAMHSA site review for the block grant, its expenditures, accountability and the role of the Council. Still have open seats on the Council that need applications. The last of the sub-committee reports will be delivered tomorrow. The sub-committee report format has improved, spending an hour on each sub-committee with back and forth interaction regarding the reports and their recommendations with the Department. Once all of the reports have been given, they will be given to KMHC to post for the public. The Mental Health and Aging Coalition has been folded into the Sub-Committee due to the duplication of efforts. Working on division of efforts – preventing individual sub-committees from taking on topics that are truly the purview of other sub-committees.

GBHSPC Sub-Committee on Aging, KDADS Advisory Group (statutory), and MH and Aging Coalition have the same people serving on them and cover the same topics. The GBHSPC is dissolving the sub-committee and encouraging participation in the other entities.

There has been some skepticism about the process for the sub-committees reports – and recommendations that don't go anywhere. The Executive Committee has established a procedure to allow for agency response to the reports and recommendations. The other thing is raising the awareness at KDADS of the army of volunteers in the field that are working and available to help with implementing recommendations.

Sally Fronsman-Cecil – I'd be interested in knowing what is happening at the state level regarding prevention of violence. I am attending the Topeka Gun Violence Prevention group and am an informal representative of the mental health perspective on that group.

Eric – could Wes speak further regarding the MH and Aging Subcommittee? Who is the contact? Sue Schuster.

Sally – very interested in the mental health and aging issues. I know some of the mental health centers have in-home counseling, but is it fully funded?

KMHC could schedule an update / report from these individuals.

### **GBHSPC Subcommittees**

**Suicide Prevention Sub-committee** – Continues to be in transition with changes from the agency – new chair. Last meeting was more announcements than action. No September meeting. Will meet in October. Encouraging people to be involved in community activities during Suicide Prevention week. Chris Bush is the new liaison from KDADS.

Nationally, there is an increasing degree of bringing people into the suicide prevention discussion who have experienced suicidal thoughts, whether or not they are folks who have

Rick – who are the major players who can influence suicide? CMHCs and emergency rooms – there need to be ER protocols for response to suicide attempts, including followup calls. This may seem a little unfair, but I took a call over the weekend from a veteran's family. The MHC screened him and sent him home and the family was very stressed and called us. This is not about pointing fingers – but we have some opportunities that could be addressed.

National model is changing models of health care (primary care and others) – training for those who work with people who are at risk.

Eric - There is a need for broader community involvement beyond the health care provider.

Wes – we've come a long way with suicide prevention. We have multiple (10) suicide prevention coalitions. That's the beginning. Once we get them established in their communities, they are going to be able to get information out within their communities and spread across the state.

Sally – question of how we address the signs that are presented by people in various settings – where they should have been identified. But even if they are identified, need the information about appropriate response.

Marcia- we need to impact systems, not just piece-meal. Need to move toward systems of

Sally – and we have to continue to point out that resources and funding have to be spent on this stuff. It's like what happens with Brownback where he says we want to do something, but show me the money.

Marcia – and we know that money is saved when we implement these models.

Sally- to say nothing of saving lives.

Marcia – yes, and we know that implementing models such as San Antonio save millions in law enforcement costs and to save lives.

### **Mental Health and Aging Coalition** – Eric Harkness

**Children's Issues** – no report. NAMI is expanding program called Family Basics – six week curriculum for families with children under the age of 10 who are dealing with issues.

Sally- can we get statistics regarding availability of wraparound and services?

We know that there are children who have difficulty receiving the services that are recommended for them, even when they have Medicaid or other payment sources. The availability of therapeutic foster homes, attendant care professionals and others can depend where you live. Can be an issue of reimbursement, but also – the further west you go – it is an issue of basic availability of employees.

David – we have had a comprehensive discussion about wide ranging services – general .

**9:45 a.m. Lobbyist Report - Amy Campbell**

Candidates Report – outreach.

Issue of Anti-psychotics and inappropriate use within nursing homes. Complex issue as we consider its overlap with the Preferred Drug List issue. Discussed details. Will be an October topic with guests close to the issue.

**10:15 a.m. Guest Topic: KanCare Health Homes - Rick Hoffmeister, KS Dept. of Health and Environment**

**KanCare Health Homes website:** [http://www.kancare.ks.gov/health\\_home.htm](http://www.kancare.ks.gov/health_home.htm)

**Kansas Health Homes: Quick Facts** [http://www.kancare.ks.gov/health\\_home/download/Health\\_Homes\\_Quick\\_Facts.pdf](http://www.kancare.ks.gov/health_home/download/Health_Homes_Quick_Facts.pdf)

Health homes for Medicaid were created within the Affordable Care Act. The project for adults with Serious Mental Illness began in July. All CMHCs, some FQHCs and safety net clinics have signed up to provide the service. They will be paid a per member per month (PMPM) rate per month to provide additional health home services for participants. There are separate billing codes. They will begin the PMPM rate on the first visit by the participant. Every service provided will be billed to the program at a zero reimbursement rate – since services are to be covered by the PMPM.

The program began with a passive enrollment – every Medicaid participant who is eligible received a mailing informing them of the program. The member may choose to opt out. The member may choose which provider will be their health home. Expected about 25% to opt out, but are only seeing around 11% so far.

Eric – surprised, I have been encouraging people to participate, but every one of them has said they will opt out because they believe the goal is to reduce their services.

Sally – does the program add services? Does it add attendant care?

No attendant care.

David Elsbury – What I am seeing in my area is a lower opt out rate than expected. That is positive. I don't think Eric's experience is the experience statewide. As we are presenting the information to folks we are coming into contact with, we are seeing a positive experience. People have been responding positively. Example of phone contact, where an individual said no thank you. Staff member continued to explain politely and said "keep us in mind". He actually called back the next day. It depends on the individual, but on the whole, we are seeing a more positive experience than was predicted.

Rick Cagan – what might be the mindset of the individual who sees the health home as an opportunity for the state to reduce their services.

There may be misinformation out there.

Eric – the folks I speak with have due or undue paranoia. They think the whole system is designed to get them out of services they have grown accustomed to and rely on.

Some of the TCMs and IDD providers seem to think the state has a hidden agenda to get rid of TCMs and we don't. That might or might not be part of it.

Carol Manning – when articles talk about more effective or more efficient services, they then talk about eliminating unnecessary services, and that might be misinterpreted.

David Elsbury – like to see the discussion move further into addressing the whole person and that has been positive. Also, seems in my area that the information has been disseminated into the child welfare system more slowly. As we see time go on and the information gets passed along further into those arenas, we may see different responses.

Rick H – sometimes we are hearing that "this is what we are already doing", but if this is what they are already doing, the results don't show that. We encounter a number of Medicaid participants who don't even know their primary care provider and avoid seeing them. The goal is to address the whole person and attempt to get their needs met. This is supposed to be up close and personal and not just a phone call. We think the MCOs are supposed to be doing care coordination, but a lot of it is phone calls, letters, slick brochures – which are very nice, but this program is supposed to be real personal interaction. A Health Home participant will be able to

have a face to face meeting where they can include others on the team (like a family member) to create a health action plan. That health action plan would be shared with the mh provider, their doctor and whoever else they would like to share with.

Health Promotion is one of the six core services to be provided by the Health Home. One is establishing a community garden, which would include sowing and growing healthy food, and teaching how to cook it.

Sally – I fail to see how, with some imagination, they wouldn't be able to stick in some attendant care or other services. It depends on how far outside the box you are willing to think.

Right.

Rick Cagan – we have been engaged with KDADS as to how the agency has been working to track reductions in service for participants in HCBS waivers. Couldn't that be tracked for individuals in the Health Home project? There is no assumption that health homes will result in reduced services, but there are a lot of anecdotes out there about how KanCare has resulted in reductions in service for individuals. The problem is that we haven't been tracking the data. Please take back a request regarding data tracking and how we would know if services are being reduced or increased.

David – I would assume that the expectation of reduced costs was intended to come from reduced ER visits and hospitalization.

Rick Cagan – I am not suggesting the agency had a goal of overall reduction of services, but I think the effect of some of the changes that have been made has been a reduction of services.

David Elsbury – the contract process for establishing CMHCs as health homes has been a challenge. The state allowed the MCOs to establish their approach and there was one MCO that was an outlier. The contract approach was so different that it seemed to depart from the State Plan Amendment and the role of the health home provider in providing the services and the lead entities role for oversight. There has also been a variance in the rate for reimbursement and the rate to be withheld by the MCO for management. The state has indicated they have reviewed all of the contracting that has gone on to see if it is viable and the program will be sustainable. As the data has come out regarding enrollment and assignment to providers, there have been questions about whether or not those assignments have been made appropriately. It had been understood that if a person was in a CMHC's CSS program, they would be assigned to that CMHC, but that hasn't always played out. As these concerns have been shared with the state and with the MCOs, they haven't always been addressed. As time passes, we will see how this will play out. There are health programs who have laid out an investment with no money for planning and if the implementation and assignments are not sufficient, then they may not be able to continue. CMHCs are concerned that there may not be sufficient numbers to sustain the necessary investments and staffing.

Rick Hoffmeister – Certainly, the three MCOs have taken a very different approach and we do have some concern about the differences in the program.

David Elsbury – One of the MCOs participated in a recent program and is retaining four of the six services. At six months, the program is to review the program and will audit the results. We hope it will look good, but one of my concerns has been that we are moving farther and farther away from PMPM payment and looking at fee for service as we have more expectations of services.

Rick Hoffmeister – the rollout has been bumpy. There were people who were mis-assigned. They didn't notify some of the CDDOs that some of their assignments had SPMI as a primary diagnosis. There have been delays in getting the information about what is the primary diagnosis that makes the individual eligible for the health home selection.

David Elsbury – that is a concern. The primary diagnosis is required for billing services. For people we currently serve, we know the diagnosis. The expectation that we would do the clinical assessment that would establish that primary diagnosis is not a reimbursable part of the health homes program and health homes staff are not qualified to do that assessment. The MCO should be providing that diagnosis to us.

The MCOs came to Kansas advertised as experts, but it seems that some of the areas of expertise might not have been what we expected. We have been told that it is difficult to pull that information together, but they were supposed to have been assigned based on that diagnosis.

Rick Hoffmeister – we have been told that participants can look at their own portals to see their information, but there have been problems getting the technical assistance to access those portals.

The Chronic Conditions State Plan Amendment has been further delayed. The rollout date has not been established. Still developing the network maps.

Carol Manning – Just an observation, it was very difficult to understand who was supposed to be on the team for the health homes.

Jim Brann – why would your program assign the primary care provider?

The MCOs auto-assign the primary care provider and the member can go back and choose who they want. Then the task of the health home includes asking if they have seen that provider, if they are happy with the provider, etc.

Jim Brann – in 2012, Kansas Legislature defined mental illness by using the DSM. Does your definition include that? Are they part of the state defined mental illness?

Not aware of that.

Discussed other states – some have health homes for Opiate addictions or other chronic conditions. Kansas selected to start with SMI and asthma / diabetes diagnoses.

### **11:00 a.m. KDADS Update - Gina Meier-Hummel, Commissioner, Community Services and Programs**

KDADS hired Carla Drescher to be the new Behavioral Health Director. She has been serving as the assistant Director for a number of years. The agency is now hiring for the Behavioral Health Assistant Director position and the KanCare liaison for Behavioral Health. Also need to hire SUD Program Manager.

KDADS – looking at implementing the DSM V January 1, 2015 – with the ICD-9 coming later.

Some insurance companies in Kansas are moving to the DSM V sooner than later, but they do know how to crosswalk back for billing crossover.

The Governor's Budget Amendment included \$500,000 for SUD services – have signed the contract with ValueOptions to serve approximately 290 people who have been on a waiting list for treatment.

Gov MH Task Force recommended formation of the Law Enforcement Behavioral Health Advisory Committee. The group has been meeting and will roll out shortly. Lea will make a report at the CIT Summit on September 14.

Gov MH Task Force recommendation regarding target communities – agency has been working with Greenbush to review data to identify communities with special needs for behavioral health. There will be investments into willing communities who will engage in strategic planning to address those needs.

Gov MH Task Force recommendation for evaluating cost of MH care across Kansas – pursuing an RFP.

Secretary has been meeting with the GBHSPC to hear the sub-committee reports. Excellent information there.

Priorities moving forward:

Concerted effort to work on integrating our prevention program with other programs on behavioral health – more on housing, veteran's issues, etc.

Kansas was awarded grant for planning to develop strategic plan for interventions relating to opiate / prescription meds addictions.

Quality oversight – internally we are working on integration.

SBIRT – Screening Brief Intervention and Referral to Treatment – working on training and outreach to health providers for identifying alcohol and substance use needs and provide education or referrals to treatment. Hope to aid in early identification. (Medicaid billable)

Working on having more data driven decisions.

Supported employment

Strengthen outreach to at risk families – working with DCF. Very focused on coming alongside CMHCs to develop crisis intervention / hospital diversion enhancement.

Pretty soon will have an announcement to show success data regarding Rainbow Services Inc. The folks who are going to state hospitals are not from Johnson / Wyandotte counties in large part. In June, was 114 people. In July, saw 144 people. KC Police changed their protocols to make it easier to go to RSI. Have been visiting law enforcement agencies in the communities to share the services available.

Jim Brann – sheriff in Leavenworth indicated that Rainbow was wonderful, but wasn't available to him.

GBA had \$1 million for one-time money for hospital diversion to strengthen the CMHC system to help with the uninsured populations and crisis services. We have received proposals and will award the contracts late September. Will include startup funding and program. Different proposals look a little different based on their local data and available resources and partnerships. Will target two additional areas of the state with \$500,000 each.

Rick Cagan – would the state consider expanding the service area for RSI to include Leavenworth and Douglas?

The state is hesitant to do that right now because they want to stay true to the intent of the pilot and because the general orders just went into effect. They allow officers in the field to call and talk to someone on staff to get an immediate diversion to RSI. It prevents the officer from having to go to multiple locations to get the approval.

Jim Brann – you are aware that Bill Rein is working on warrantless diversion.

Bill has been sharing information with a constituency who is interested in that objective, he is sharing his expertise about the current statutes and we don't have a position on that idea at this time.

State Mental Health Hospitals – there is an ongoing discussion relating to Hospital to Home. As we have received reports from the GBHSPC, evaluating if the Council is already doing that work.

Rick Cagan – there is no focus in the Council on the work of the hospitals other than annual visits.

Gina – would be interested in looking at documentation of the original mission. Everything we have heard and I have looked at seem to indicate that pieces of this work are being looked at in other ways. So I am happy to look at anything else you might have.

#### **11:25 a.m. Announcements:**

**Kansas Public Health Association has asked us to co-sponsor a health issues forum for the Governor's Election Candidates.** It would not be a debate, but a Q & A with pre-prepared health care questions. Co-sponsors would pay \$100.

Motion to co-sponsor approved. Motion by Jim Brann, second Rick Cagan. Will only occur if the candidates agree to participate.

Voter Registration – Mark Wiebe has information to help agencies to provide voter registration and to incorporate the new I.D. requirements. Feel free to contact him if you would like the information.

#### **11:30 a.m. Adjourn**

**2014 KMHC Meetings: 9 a.m. – 11:30 a.m.** Jan 22, Feb. 26, Mar. 26, April 23, May 28, June 25, July 23, Aug 27, Sept. 24, Oct. 22, Nov 19, Dec. 17 **Board:** 12 noon quarterly the 4<sup>th</sup> Wednesdays (March 26, July 23, Sept 24, Dec 17)

#### **11:35 - 11:50 a.m. SPECIAL MEETING OF THE BOARD OF DIRECTORS**

For more information, contact: Kansas Mental Health Coalition

c/o Amy A. Campbell, Lobbyist

P.O. Box 4103, Topeka, KS 66604  
785-969-1617, fax: 785-234-9718, campbell525@sbcglobal.net

David Wiebe, President  
5608 Cherokee Circle, Fairway, KS 66205  
913-645-6175;

<http://kansasmentalhealthcoalition.onefireplace.com>  
[dwiebe@kc.rr.com](mailto:dwiebe@kc.rr.com)