KANSAS MENTAL HEALTH COALITION

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

Minutes

September 24, 2014 Monthly Meeting **Valeo Behavioral Health Center, 330 SW Oakley, Topeka, KS**

9:00 a.m.
Introductions and sign-in sheet Rick Cagan, Vice President

Rick Cagan	NAMI,KS	Ira Stam	
Amy Campbell	KMHC	Alexandra Simmons	MHAH
Glen Yancey		Susan Crain Lewis	MHAH
Ken Kerle	CIT-Topeka	Kyle Kessler	ACMHCK
Susanna Honaker	ACMHCK/KAAP	Stuart Little	KAAP
Sally Anne Schneider	Stormont Vail	Marcia Epstein	
Bill Cochran	Topeka Police Dept	Phone:	
Susan Zalenski	Johnson & Johnson	Steve Feinstein	Elizabeth Layton Center
Christy McMurphy	Kim Wilson Housing Inc.		
Sandra Dixon	DCCCA/KAAP	Guests	
Fred Watts	KVC Hospitals Inc	Dave Ranney	KHI
Jason Hooper	KVC Hospitals	Angela DeRocha	KDADS
Ron McNish	Amerigroup	Kari Bruffett	KDADS
Glea Ashley	Valeo	Gina Meier-Hummel	KDADS
Dana Schoffelman	Florence Crittenton		
Steve Christenberry	FSGC		

Financial Report See Report. JoLana Pinon, Treasurer

Minutes of the previous meeting adopted. Motion by Glea Ashley, second Glen Yancey.

Board of Directors: Meet today following the monthly meeting.

9:15 a.m. Reports

Advocacy Committee –Grassroots Advocacy Network - Rick Cagan / Sue Lewis

The KMHC Candidate Survey is a simple survey about general mental health perceptions of state election candidates. It is electronic, so that candidates can fill it out online.

Grassroots Advocacy Network – Lynn Kohr is working to enhance outreach to our current grassroots advocates by contacting them by telephone.

Grassroots Advocacy Training – Rick Cagan is leading effort to establish and maintain training opportunities. At this point, the only Training event on the calendar will be the day before Mental Health Advocacy Day in Topeka. Interested individuals can apply online at the website. Additionally, KMHC will bring the one day training event to any town where there is a core group of participants ready to train. We will set the time and place as it works with the people there.

Advocacy Day – will be March 12 or March 18. Planning to enhance our ability to offer the Advocacy Briefing online for those who are unable to be at the Briefing that morning. Volunteers are encouraged to contact Sue at slewis@mhah.org.

Children's Issues – Hospital report - KVC. Jason Hooper, President of KVC Hospitals. Fred Watts, VP. There are two private hospitals for children in Kansas.

Prairie Ridge – KC – 49 beds. Wheatland – Hays – 24 beds.

Both offer acute psychiatric care, as well as the alternative to State Children's Hospital units formerly housed at Rainbow and Larned.

Distributed a data sheet to show 10,000 ft view. 2093 last year. Average daily census was 47. Average age 13 ½. We serve children ages 6 to 18.

Gender is split 60/40 male/female. Ave length of stay is 6 to 8 days. There are outliers who require more or less.

The population we serve at Prairie Ridge are ½ children in custody, 1/3 are privately referred, and 1/3 are out of state (mostly Missouri).

Wheatland Hospital are 75% private referrals and 25% state custody.

Trends: Increasing number of children needing detox and having drug and alcohol issues.

Significant levels of hopelessness.

20 years ago, I worked with kids in hospitalization, but today nearly the full population is presenting with complicated diagnoses and serious suicidal issues. Significant traumatic events in their lives.

Rick Cagan – state hospitals have specific liaison relationships with CMHCs

Limited opportunities for engaging with treatment after discharge?

Numbers of children who are admitting and their parents are literally checking out and don't want to deal with them, and that creates serious problems with treatment after discharge.

If people have questions for Jason – can field those after the Secretary's report.

9:35 a.m. Special Guest: Kari Bruffett, New Secretary of Kansas Department on Aging and Disability Services

Nice to be back, at many of the groups where I have met, have needed to introduce myself, but I've been here several times in my previous role at KanCare and KDHE.

Will focus on the good news of Rainbow Services Inc. (RSI)
Reviewed the history of the fire marshall's issues and the move of 30 beds to OSH.
KDADS initiated meetings with area leaders and statewide stakeholders to discuss the future of Rainbow. There was a history of concerns about the possibility of Rainbow being shut down.
August 2013 – after KDADS sent out an RFI, began to work with Wyandot Inc and Heartland RADAC.
January 2014 – Governor announced creation of Rainbow Services Inc.
Key goals – to divert people from unnecessary use of jails and hospitals
Increase use of community based resources
Connecting people with existing resources for those who could be stabilized within ten days in the community
Connecting people with substance abuse resources

Recently held a public meeting to review the four month data from the Impact of Rainbow Services Inc.

See full report at KMHC website to see the actual numbers reported.

Actual data for saved costs is around $400,000 by diverting people from hospitalization.
Surveying people who come to RSI about where they would have gone if they hadn't come to RSI = indicates almost a million dollars of reduced costs.

Have saved money from people diverted from ER visits.
Have saved money from people diverted from jail – don't have the actual costs for that item.

140 admissions / 128 unduplicated in August. This shows only a small number are repeat visitors.

Hospital diversion numbers are increasing for this region. OSH number of bed days are decreasing in comparison to 2013 and admissions are down. We don't expect the bed days to decrease as dramatically as the number of admissions, because the folks who are going on to OSH have more intense needs.

At the briefing, we received requests for more specific demographic data – that information is collected, so we can tabulate it.
Looking at whether or not an RSI model or something like it will work in other communities.
I don't know if you can put RSI in western Kansas and have it work, but might be able to do it in other urban centers. The model that is important is how that came about.

Rick Cagan – Lea presented this information at our CIT summit. KMHC will post data on our website.

Sue Lewis – what is the lease arrangement?

Gina – it is a three year contract with the State and they are currently working on their sustainability plan. We expect to be able to present data showing the savings generated.

Sue Lewis – will there be a plan to re-invest those savings?

Gina – that discussion will be a part of the budget planning with the Governor and the Secretary.

Kari – we are also talking to community partners about their cost savings and how we can incorporate their participation to maintain those benefits.
Dave Ranney – will you be proposing a duplicate model in Salina or Wichita?

Kari – we will be working with the community partners to talk about opportunities and how we can take advantage of the current resources to expand this.

Continuum of Crisis Intervention Grant – awarded a onetime grant for $1 million to ComCare, Sumner County, plus, to include short-term crisis intervention and stabilization, connection to substance use services, mobile crisis services, transportation. Will look different on the ground, but will have similar goals. That funding begins October 1st.

Shelley Duncan – who are the community partners you are working with?

MHCs, counties, municipalities, law enforcement, SUD providers, and the more partners we have, the more likely we will have sustainable models.

Health Homes are underway and KDHE is holding weekly stakeholder conference calls for SMI health homes. The purpose of the calls is to learn about issues with implementation and how the program is working and resolve those issues.
The chronic conditions health homes phone calls are held every other week.

During the transition for folks who are eligible due to a developmental disability and a co-occurring mental illness, there is an issue to make sure that their targeted case managers are able to contract with the health homes to continue to provide those services within the health homes structure. Can't offer the TCM separately, or Feds would consider that duplicative. Want to stop focusing on whose responsibility it is to care for the person, and focus on providing the health homes services focused on the individual.

DSM-V – KDADS has been working with the BSRB to revise regulation language to include the DSM-V. Will have until January 1st to implement. DSM-V does not include implementation of ICD 10 – that is targeted for October 2015. We have a commission wide internal group working on this, discussing the DSM-V implementation. There was an early October date set for a stakeholder meeting to discuss. Working on the cross-walk to see how it will impact. Specific concerns exist for the Autism Waiver and how that will work with DSM-V changes.

Going back to the DSM-V and the crisis grant – Gina and her team have other efforts underway as well. At our public meeting, housing and homelessness is a critical issue and a gap for RSI as well. Need to coordinate better across all of the state and federal programs. Assessing those needs and the need for structured living environments as well. Looking at the need to increase community beds as well. We understand that border community hospitals that used to have beds available, no longer offer those beds. Focusing on communities that have higher admission rates and how to intervene in those regions.

We are both assessing and putting into place immediate interventions.

Rick Cagan – I know Kari had a briefing from the Housing Subcommittee on the Housing Initiative. Is there any movement at KDADS to provide some seed funding to move forward that Initiative?

Kari – we have as an action step to choose a benchmark to improve towards. That was a primary takeaway from that group. I don't think we have that yet. The meeting was only an hour, and we were unable to establish that goal by the end of it. Have heard and believe the need for focus on housing and homelessness.

Glen Yancey – there is a level of security that is obtained by having a nearby resource in the community. Don't know how you measure that, but it is important rather than expecting that people will have to travel away from family.

Gina – the RSI model works very hard to establish community connections for participants, so that people are .

Question of where Hospital to Home work will be resumed. Amy expressed concern that KMHC had approached the agency about proposed purposes and structure of the Hospital to Home group, yet we have heard that the agency has now decided the group is disbanded. Concerned that the members have not been notified.

Cagan – expressed that the subcommittees of the Council hasn't had the same focus to address the immediate pressure that is currently on the State Hospital.

Secretary – want to emphasize that we don't expect to see any decrease in focus on the issues that were taking place in Hospital to Home. Want to continue that work in the Council and subcommittees. Want to be sure we aren't focused on the structure of the current committee, but looking at the work itself.

Kansas Mental Health Coalition will continue to be focused on the need for state level conversations about the critical role of the State Hospitals and what happen within the hospitals and hope to work with the agency to establish how and where that conversation takes place. Not so much a concern about the screening in and the screening out. Also, very interested in knowing what is happening along the lines of reform in the hospitals – and where the recommendations of the consultants are taking place.

Recognize the work of the administration to invest in RSI and other services in the past several months – equating to millions of dollars.

Cagan – Agreed - Our members continue to worry that the level of community based services are not robust enough.

Ira Stamm – talking about the DSM-V and nature of the changes to the codes.

5% Increase in the Mental Health Block Grant – requires the increase is focused on early intervention. Have put out an RFP for a single 18 month grant. Must develop regional team to support prevention for early psychotic encounters. RFP was just posted and is due October 14, 2014. Goal is to create a pilot project for clinical services for interventions with youth 15 to 25.

Identification of High Risk Communities – KDADS identified 11 communities at risk for behavioral health needs. Reaching out to those communities to identify which communities want to participate to work on a project in collaboration with the state and will have access to an RFP for $500,000 for at risk behavioral health grants. This is a part of the Governor's new Law Enforcement Behavioral Health Council.

10:30 a.m. <u>Continued Reports</u>

Returned to the Children's Hospital discussion – questions for Jason

Jane Adams – parents don't expect services to work and don't see that services are connected. Not a reflection of KVC, because the staff there have been extremely supportive. The schools for the most part are a nightmare to deal with. They aren't trained to deal with the kids, they don't want to deal with kids. It almost seems like there is a time when we should stop working with the kids and work with the parents. All of these kids are expected to go home, and the parents get nothing – even from the best facilities.

Jason – didn't mean my statement about hopelessness to reflect as a value statement, but just a general view of the world by these kids. They believe the world is heavier. I agree with the Secretary that inpatient treatment isn't the answer. Don't want kids to grow up in a brick building. We have a saying "hurry, but don't rush".

Your statements are right on every level. We are looking at things like home-based hospital care as a possibility. You look at the ACA and integrated models. Look at the five percenters – the five percent of people who make up 80% of our health care costs. Don't want to really build more hospitals, or wash our hands of the kids. Have to drill down with every child where their needs are and what we can do.

Rick Cagan – is KVC represented on the Children's Subcommittee? Yes.

Ira Stamm – I heard you say that average stay is 6 to 8 days. I know your group offers quality services, but how realistic is the task that you are being asked to do? In 1983, the average length of stay was 18 months. When I left there, you were lucky to get 30 to 60 days. But what you can do it 6 to 8 days, even to get them on medications how can you know if they are working? If there was any input from this group, would hope that people who know about hospital care would weigh in on what is possible.

Jason – what I have found around length of stay is to avoid medians or averages. The biggest goal for me is that each child that we touch isn't going to operate on an assumed length of stay. If their clinical team believes they need more, we will pursue that. To date, we have found the MCOs to be responsive. They have been able to recognize that many clinically complex cases need more time.

Bill Cochran – parental involvement is there when kids are brought in voluntarily. When a kid is court-ordered, those parents are less likely to be involved. I notice an increase of Missouri kids in your trends report. How does that work?

It is a flexible issue based on a number of complicated factors involving where kids come from.
Do we have the right number of psychiatric beds? Don't know – can tell you that most of the beds are going to be full, especially in the fall and spring-time.

There is no difference between the acute beds and the STAR beds. In Northeast Kansas, there are several facilities offering children's beds, but they are always in high demand.

SallyAnne – Stormont Vail has added children's beds and the demand has also increased.

Hospital and Home – Amy Campbell – We need to have a conversation about what questions we want dealt with and how. Should be a part of H to H discussion and can be incorporated in our Issue Papers. Recommend that everyone read the NAMHSPD Report – Critical Role of State Hospitals that is posted on the website. We need to be clear about what we are recommending and what questions need to be answered.

Governor's Behavioral Health Services Planning Council – Rick Cagan – Council is being asked by KDADS to establish a prevention oversight group. This is a response to the federal emphasis (through the block grant) on prevention. The group had discussions about how to avoid duplicating the work of other subcommittees. There was brief discussion about rolling in the Suicide Prevention subcommittee.

The Council will have its federal review.

Discussion of how the agency can more meaningfully incorporate Council members in the annual Block Grant application.

GBHSPC Subcommittees

Suicide Prevention Subcommittee did not meet in September due to the Suicide Prevention Week activities.

Veterans Subcommittee met last week. Looking at promoting cultural sensitivity training. Glea Ashley and Steve Christenberry are members.

Justice Involved Youth Subcommittee – looking at collecting local data about diversion programs in place. Johnson County is the only one that has a formal program in place, but believe others also use their own programs.

Kansas Citizens Committee on Substance Abuse – working to get integrated into the other subcommittees. Need more members. Will be giving a presentation to the Governor's Council at the November meeting.

The Aging Subcommittee dissolved in deference to the MH and Aging Subcommittee.

Mental Health and Aging Coalition – Eric Harkness - Might want to have them meet for a report in the near future.

11:00 a.m. Lobbyist Report -
Elections Topics
Amy is urging members of the Coalition to participate in elections at any level that they feel comfortable – specifically, you can host a fundraiser, attend fundraisers, walk districts door to door with a candidate, distribute fundraisers

Proposed SPTP Position Paper (Cagan) See Draft. Hoping to test the waters with the Coalition about whether or not our Coalition would support the ideas of the Family and Friends of the SPTP group, a group of family members and others who came forward with the activities of the SPTP Task Force. KDADS has created an Advisory Group which will include 7 members of this group. They believe the program is in dire need of overhaul. The Legislative Post Audit will complete the second stage of their study this fall. Expected to be on the October agenda.

Procedure to consider changes to the Consensus Recommendations - KMHC will consider amendments at the October, November and December meetings. Please review the current Recommendations here. Please review the current Issue Papers here. If your proposed amendment is a simple update to current language, please draft the amendment as it would be inserted into the current document. If it is a new topic or action item, please draft an Issue Proposal Paper - see format here - and submit to KMHC at this link by the Friday before the meeting. See these active links by going to http://kansasmentalhealthcoalition.onefireplace.com/event-1697060 or in your email meeting notice.

11:25 a.m. Announcements:
Valeo will host ribbon cutting Thursday, October 2, from 10 a.m. to noon for the new Valeo Crisis Center for short term crisis and transitional unit. These are more beds to operate similar to the 6th Street facility. That facility has 16 beds.

This is not an RSI facility. Valeo did apply for funds to implement that model, including sobering beds, but did not succeed. The current Valeo detox beds are virtually always full.

11:14 a.m. Adjourned

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 4th Wednesdays (March 26, July 23, Sept 24, Dec 17)

For more information, contact: Kansas Mental Health Coalition

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