# Strategic Framework for Modernizing the Kansas Behavioral Health System

*Working Groups Report to the Special Committee on Mental Health Modernization and Reform*

December 9, 2020

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# Report Overview

The Special Committee on Mental Health Modernization and Reform (Special Committee) was tasked with analyzing the state's behavioral health system and developing a strategic effort to modernize the system.

> The behavioral health system refers to the system of care that includes the promotion of mental health, resilience and well-being; the prevention, referral, diagnosis, and treatment of mental and substance use disorders; and the support of persons with lived experience in recovery from these conditions, along with their families and communities.
>
> *Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)*

To achieve this directive, the Special Committee established three Working Groups to review and update recommendations from five previous collaborative efforts to improve components of the behavioral health system. The Working Groups established by the Special Committee included those on Finance and Sustainability (WG1), Policy and Treatment (WG2) and System Capacity and Transformation (WG3). This report summarizes the work of those groups. This effort was made possible by the previous work of the Child Welfare System Task Force, the Governor's Behavioral Health Services Planning Council, the Governor's Substance Use Disorder (SUD) Task Force, the Mental Health Task Force and the Crossover Youth Working Group. Recommendations from these past efforts provided the foundation for this report.

**Navigating this Report**: High-priority recommendations are included in Figure 1 (page vi) and are designated as either:

- **Immediate Action** are those that the Working Groups believe can be completed in the next two years.
- **Strategic Importance** are those that should be initiated in the near term but will be completed in the longer term.

In addition to high-priority recommendations, the group also offered one high-priority discussion item to urge the Special Committee to consider the potential contribution of Medicaid expansion to a modernized behavioral health system. Recommendations not considered a high-priority are available in *Appendix A*, page A-1.

This report summarizes the efforts of the three Working Groups to put forward recommendations to the Special Committee. High-priority recommendations are sorted by topic, either for immediate action or for strategic importance. Topics around which the Working Groups were asked to make recommendations include workforce, funding and accessibility, community engagement, prevention and education, treatment and recovery, special populations, data systems, interactions with the legal systems and law enforcement, system transformation and telehealth.

Recommendations in this report collectively form a strategic framework that can be considered a 'living document' to support ongoing collaboration between the many contributing partners in the behavioral health system, government agencies and state Legislature.

## *Vision for Modernization*

At meetings of the Special Committee between August and October 2020, Working Group, roundtable and Special Committee members discussed each of the ten identified topics to articulate a vision for modernization. The following key points summarize those discussions. More detail related to the vision discussion is included in the section of the report corresponding to each topic.

- **Workforce**. A modernized workforce is one where behavioral health staffing is adequate to meet needs across rural, frontier and urban areas of the state. Telehealth will play a role in meeting needs, but local staffing will remain important. Modernization will require both growing the workforce and retaining staff. (*See page 7*).

- **Funding and Accessibility**. A modernized approach to funding behavioral health will require continuous and timely pursuit of new funding mechanisms to ensure that reimbursement rates are competitive. Accurate and appropriate funding of care for Kansans is a key element of a sustainably funded, modern behavioral health system. A modern system will identify the right populations to serve, make services meaningfully accessible and rely on measurable outcomes to drive decisions. (*See page 11*).

- **Community Engagement**. Effective community engagement in a modernized behavioral health system will include a collaboration of individuals in recovery and behavioral health providers to support key efforts. Key efforts include those to support employment, re-entry planning for incarcerated individuals, behavioral health supports and education for foster homes. (*See page 17*).

- **Prevention and Education**. Modernized prevention efforts will seek to meet the behavioral health needs of populations at increased risk for poor outcomes, requiring a collaborative, trauma-informed approach and appropriate funding. (*See* *page 22*).

- **Treatment and Recovery**. A modernized behavioral health system will deliver an expanded array of early, affordable, accessible, evidence-informed behavioral health services for all, with an emphasis in serving consumers in the settings that are most likely to support effective engagement with treatment, and with meaningful coordination and collaboration across disciplines and settings. (*See* *page 26*).

- **Special Populations**. To serve special populations in a modernized behavioral health system, data, consumers and families will drive the system. Building on existing strengths, a modernized approach will be integrated, proactive and responsive whenever there is a need or a self-identified crisis, and data will be used to understand disparities. (*See* *page 30*).

- **Data Systems**. A modernized system will require a seamless, real-time data system with multi-directional data sharing among behavioral health providers, other health care providers and systems, community organizations, social service providers and payers. A collaborative data system will support reporting of measurable outcomes while maintaining privacy protections. (*See* *page 35*).

- **Interactions with the Legal System and Law Enforcement**. Through collaboration, a modernized behavioral health system will have the ability to make timely connections for individuals in crisis to services in the least restrictive setting appropriate to ensure safety. (*See* *page 40*).

- **System Transformation**. A modernized system will work in both evidence-based treatment and prevention with focus on the patients to address a continuum of needs. Transformation will result in a mission-driven, rationally funded and outcome-oriented system that uses data to identify problems and develop solutions. (*See* *page 44*).

- **Telehealth**. A modernized behavioral health system will deliver technologically current telehealth services as a strategy to provide meaningful access to care across rural, frontier and urban areas. These services will be high-quality, integrated with other modes of care delivery and ensure consumer choice and privacy, in addition to supporting the full spectrum of behavioral health care. (*See* *page 49*).

# High-Priority Items for Special Committee Consideration

*Figure 1.* **Working Group High-Priority Recommendations by Topic**

| WORKFORCE |
|---|
| **Immediate Action** |
| **Recommendation 1.1 Clinical Supervision Hours**. Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers. |
| **Recommendation 1.2 Access to Psychiatry Services.** Require a study be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses. |
| **Recommendation 1.3 Provider MAT Training**. Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT. |
| **Strategic Importance** |
| **Recommendation 1.4 Workforce Investment Plan**. The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include:<br>• Develop a career ladder for clinicians, such as through the development of an associate's-level practitioner role; and<br>• Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency. |
| **Recommendation 1.5 Family Engagement Practices.** Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| FUNDING AND ACCESSIBILITY |
|---|
| **Immediate Action** |
| **Recommendation 2.1 Certified Community Behavioral Health Clinic Model.** Support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model. |
| **Recommendation 2.2 Addressing Inpatient Capacity.** Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings. |
| **Recommendation 2.3 Reimbursement Rate Increase and Review.** Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a Working Group to regularly review the reimbursement rates available for behavioral health services, including mental health and substance use disorder treatment. |
| **Recommendation 2.4 Suicide Prevention.** Allocate resources to prioritized areas of need through data driven decision-making. Assist local suicide prevention efforts and promote local support groups in fund-raising efforts, building capacity, and increasing availability for survivors of suicide loss. Dedicate resources and funding for suicide prevention. |
| **Recommendation 2.5 Problem Gambling and Other Addictions Fund.** Recommend the State continue to incrementally increase the proportion of money in the Problem Gambling and Other Addictions [Grant] Fund that is applied to treatment over the next several years until the full fund is being applied as intended. |
| **High-Priority Discussion** |
| In addition to these recommendations for immediate action and of strategic importance, the Finance and Sustainability Working Group also puts forward the issue of Medicaid expansion as a high-priority discussion item for the Special Committee. The recommendation discussed by the Working Group related to Medicaid Expansion read, “Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans.”<br>More information on this item is available in the Funding and Accessibility section beginning on page 16. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| COMMUNITY ENGAGEMENT |
|---|
| **Immediate Action** |
| **Recommendation 3.1: Crisis Intervention Centers**. Utilize state funds to support the expansion of crisis centers around the state. |
| **Recommendation 3.2 IPS Community Engagement**. Increase engagement of stakeholders, consumers, families, and employers through the Kansas Department of Health and Environment (KDHE) or Kansas Department for Aging and Disability Services (KDADS) by requiring agencies implementing the Individual Placement and Support (IPS) program to create opportunities for assertive outreach and engagement for consumers and families. |
| **Strategic Importance** |
| **Recommendation 3.3 Foster Homes**. The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth. |
| **Recommendation 3.4 Community-Based Liaison.** Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and co-occurring conditions. |
| **PREVENTION AND EDUCATION** |
| **Immediate Action** |
| **Recommendation 4.1 988 Suicide Prevention Line Funding.** Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources. |
| **Recommendation 4.2 Early Intervention**. Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover early childhood mental health screening, assessment, and treatment. |
| **Recommendation 4.3 Centralized Authority.** Centralize coordination of behavioral health – including substance use disorder and mental health – policy and provider coordination in a cabinet-level position. |
| **Strategic Importance** |
| **Recommendation 4.4 Behavioral Health Prevention.** Increase state funds for behavioral health prevention efforts (e.g., SUD prevention, suicide prevention). |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| TREATMENT AND RECOVERY |
|---|
| **Immediate Action** |
| **Recommendation 5.1 Psychiatric Residential Treatment Facilities.** Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools. |
| **Strategic Importance** |
| **Recommendation 5.2 Service Array.** Explore options to expand the behavioral health service array, including the expansion of MAT in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured. |
| **Recommendation 5.3 Frontline Capacity.** Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs. |
| **Recommendation 5.4 Housing.** Expand and advance the SSI/SSDI Outreach, Access, and Recovery (SOAR) program (including additional training regarding youth benefits) and the Supported Housing program. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| SPECIAL POPULATIONS |
|---|
| **Immediate Action** |
| **Recommendation 6.1 Domestic Violence Survivors.** Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies and community providers serving individuals impacted by domestic violence. |
| **Recommendation 6.2 Parent Peer Support.** Increase access to parent peer support for caregivers and families of youth in the behavioral health system, including ensuring appropriate supports for fathers of dependent children. |
| **Strategic Importance** |
| **Recommendation 6.3 Crossover Youth.** Continue to develop linkages between the behavioral health system, juvenile justice system and the child welfare system to increase understanding of treatment options available to youth externalizing trauma in the crossover youth population as current treatment options are not meeting the needs of this population. Then, develop specialty services to meet the needs of this population. |
| **Recommendation 6.4 I/DD Waiver Expansion**. Fully fund the I/DD waiver and expand I/DD waiver services. Increase reimbursement rates for I/DD services to support workforce expansion. |
| **Recommendation 6.5 Family Treatment Centers**. Increase the number and capacity of designated family SUD treatment centers as well as outpatient treatment programs across the state. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| DATA SYSTEMS |
|---|
| **Immediate Action** |
| **Recommendation 7.1 State Hospital EHR.** The new state hospital electronic health record (EHR) system should be interoperable with other data systems in the state. Interoperability should include the ability to automate the current process to reinstate Medicaid benefits following discharge. |
| **Recommendation 7.2 Data and Survey Informed Opt-Out.** Collect, analyze, use, and disseminate surveillance data to inform prevention. Change legislation regarding public health and behavioral health state surveys, including changing the Kansas Communities That Care (KCTC) and Youth Risk Behavior Surveillance System (YRBSS) surveys from an opt-in consent to an informed opt-out consent, to allow for meaningful data collection. |
| **Recommendation 7.3 Information Sharing**. Utilize Medicaid funds to incentivize participation in health information exchanges (e.g., LACIE/KHIN). Explore health information exchanges as information source on demographic characteristics, such as primary language and geography for crossover youth and other high priority populations. |
| **Recommendation 7.4 Needs Assessment.** Conduct a statewide needs assessment to identify gaps in funding, access to SUD treatment providers and identify specific policies to effectively utilize, integrate and expand SUD treatment resources. |
| **Strategic Importance** |
| **Recommendation 7.5 Cross-Agency Data.** Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| LEGAL SYSTEM AND LAW ENFORCEMENT |
|---|
| **Immediate Action** |
| **Recommendation 8.1 Correctional Employees.** Expand training provided in correctional facilities to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services. |
| **Recommendation 8.2 Criminal Justice Reform Commission Recommendations.** Implement recommendations developed by the Criminal Justice Reform Commission (CJRC) related to specialty courts (e.g., drug courts) and develop a process for regular reporting on implementation status and outcomes. |
| **Recommendation 8.3 Law Enforcement Referrals.** Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact (this includes securing funding to increase access to services for this population). |
| **Strategic Importance** |
| **Recommendation 8.4 Defining Crossover Youth Population.** Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| SYSTEM TRANSFORMATION |
|---|
| **Immediate Action** |
| **Recommendation 9.1 Regional Model.** Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas. |
| **Recommendation 9.2 Long-Term Care Access and Reform.** Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care. Increase access to long-term care (LTC) facilities, particularly for individuals with past involvement with the criminal justice system or those with a history of sexual violence. |
| **Recommendation 9.3 Integration.** Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. Adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions. |
| **Strategic Importance** |
| **Recommendation 9.4 Evidence Based Practices.** Kansas should continue and expand support for use of evidence based practices (EBP) in the state, including for housing and supported employment. Coordinate EBP utilization across systems (e.g., law enforcement, SUD, mental health care) with a goal of implementing programs with fidelity, when possible. |

*Figure 1 (continued)*. **Working Group High-Priority Recommendations by Topic**

| TELEHEALTH |
|---|
| **Immediate Action** |
| **Recommendation 10.1 Quality Assurance.** Develop standards to ensure high-quality telehealth services are provided. This includes:<br>• Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies.<br>• Requiring standard provider education and training.<br>• Ensuring patient privacy.<br>• Educating patients on privacy-related issues.<br>• Allowing telehealth supervision hours to be consistently counted toward licensure requirements.<br>• Allowing services to be provided flexibly when broadband access is limited. |
| **Recommendation 10.2 Reimbursement Codes.** Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services. |
| **Recommendation 10.3 Telehealth for Crisis Services.** Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities. |
| **Strategic Importance** |
| **Recommendation 10.4 Originating and Distant Sites.** The following items should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations:<br>• Adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act.<br>• Allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met.<br>• Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts. |
| **Recommendation 10.5 Child Welfare System and Telehealth.** Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Consider how the unique needs of parents of children in the child welfare system can be met via telehealth. |

# Introduction

The 2020 Special Committee on Mental Health Modernization and Reform (Special Committee) was directed as follows:

> *"Analyze the Kansas behavioral health system to ensure that both inpatient and outpatient services are accessible in communities, review the capacity of the current behavioral health workforce, study the availability and capacity of crisis centers and substance use disorder treatment facilities, assess the impact of recent changes to State policies on the treatment of individuals with behavioral health needs, and make recommendations on steps needed to make Kansas a nationwide leader on behavioral health delivery, specifically focusing on how Kansas should modernize its behavioral health delivery system." Legislative Coordinating Council, June 18, 2020*

To achieve this directive, the Special Committee utilized a roundtable format and established three Working Groups. The roundtable format engaged a wide range of experts in the discussion at each meeting of the Special Committee. From a combined pool of Special Committee members, roundtable members and state agency staff, three Working Groups were established to review and update recommendations from five previous collaborative efforts to improve components of the behavioral health system. The Working Groups established included those on Finance and Sustainability (WG1), Policy and Treatment (WG2) and System Capacity and Transformation (WG3). Additionally, volunteers from each of the three Working Groups came together in a subgroup to discuss the topic of telehealth. This report summarizes the work of those groups. This effort was made possible by the previous work of the Child Welfare System Task Force, the Governor's Behavioral Health Services Planning Council, the Governor's SUD Task Force, the 2017 and 2018 Mental Health Task Force and the Crossover Youth Working Group. Recommendations from these past efforts provided the foundation upon which this report has been built.

The Working Groups made recommendations based on the following topics: workforce, funding and accessibility, community engagement, prevention and education, treatment and recovery, special populations, data systems, interactions with the legal systems and law enforcement, system transformation and telehealth. Throughout this report, high priority recommendations have been designated for immediate action or of strategic importance.

- Recommendations for immediate action are those that can be completed in the next two years.
- Recommendations of strategic importance are those that should be initiated in the near-term but will be completed in the longer term.

Collectively these high priority recommendations form a strategic framework that should be considered a 'living document' to support ongoing collaboration between the many contributing partners in the behavioral health system, government agencies and state Legislature. This document is further intended to provide long-term strategic direction for the modernization and reform of the behavioral health system in Kansas.

## *Working Group Process*

The Special Committee established the Working Groups on Finance and Sustainability, Policy and Treatment and System Capacity and Transformation. The three Working Groups reviewed, updated and prioritized recommendations related to each of the topics assigned to them and reported back to the Special Committee on progress. Membership in all Working Groups was voluntary and fall in the categories of content experts and legislative members. Additionally, individuals with supplemental expertise were invited to attend Working Group meetings to provide information on specific topics. From among content expert members of each Working Group, co-chairs were selected.

The Working Groups structured their discussions around the ten topic areas defined by the Special Committee. The Finance and Sustainability workgroup examined workforce, funding and accessibility, and community engagement. The Policy and Treatment addressed prevention and education, treatment and recovery, and special populations. The System Capacity and Transformation Working Group discussed data systems, interaction with the legal system and law enforcement, and system transformation. Lastly, members from each of the three Working Groups participated in the telehealth subgroup. Related to the assigned topics, the Working Groups reviewed and updated past recommendations, and proposed new recommendations as needed based on identified barriers. *Figure 2 (*page 3) illustrates the structure of the Working Group process, including a list of meetings held by each group, as well as the topics addressed.

All Working Group decisions were reached based upon consensus. Each of the Working Groups adopted the following meeting commitments: to come ready to discuss and compromise, keep remarks succinct and on topic, not to hesitate to ask clarifying questions, and

to start and end meetings on time. As members discussed each topic and recommendations, decisions were made based on proposals offered by Working Group members and adopted by verbal agreement or absence of objections.

In order to guide discussion and ensure consistency across Working Groups, each of the three Working Groups adopted the Recommendations Rubric (*Appendix B,* page B-1*)* as a tool to assist in ranking and modifying existing recommendations or when writing new recommendations. Using the rubric, Working Groups were able to assign numeric values to recommendations based on a 1-10 scale for both ease of implementation and potential for high impact. Working Groups utilized these scores as they prioritized recommendations. Recommendations that were not scored during Working Group meetings were scored by a Qualtrics survey. Average scores and discussion items were reviewed at the next meeting. After review of the scored recommendations, Working Groups determined up to five high-priority recommendations for each topic.

***Figure 2***. Working Group Process Diagram

| **Special Committee on Mental Health Modernization and Reform** | | |
|---|---|---|
| **Working Group on Finance and Sustainability (WG1)** | **Working Group on Policy and Treatment (WG2)** | **Working Group on System Capacity and Transformation (WG3)** |
| • **Meeting #1, 9/16/2020,** Establish Group and Brainstorm Barriers<br>• **Meeting #2, 10/01/2020,** Discuss Workforce<br>• **Meeting #3, 10/14/2020,** Discuss Funding and Accessibility<br>• **Meeting #4, 10/28/2020,** Discuss Community Engagement<br>• **Meeting #5, 11/02/2020,** Prioritization Meeting<br>• **Meeting #6, 11/19/2020,** Prioritization Meeting<br>• **Meeting #7, 12/04/2020,** Finalize Report | • **Meeting #1, 9/15/2020,** Establish Group and Brainstorm Barriers<br>• **Meeting #2, 9/29/2020,** Discuss Prevention and Education<br>• **Meeting #3, 10/13/2020,** Discuss Treatment and Recovery<br>• **Meeting #4, 10/23/2020,** Discuss Special Populations<br>• **Meeting #5, 11/04/2020,** Prioritization Meeting<br>• **Meeting #6, 11/19/2020,** Prioritization Meeting<br>• **Meeting #7, 12/08/2020,** Finalize Report | • **Meeting #1, 9/18/2020,** Establish Group and Brainstorm Barriers<br>• **Meeting #2, 9/30/2020,** Discuss Data Systems<br>• **Meeting #3, 10/09/2020,** Discuss Interactions with the Legal System and Law Enforcement<br>• **Meeting #4, 10/22/2020,** Discuss System Transformation<br>• **Meeting #5, 11/06/2020,** Prioritization Meeting<br>• **Meeting #6, 11/17/2020,** Prioritization Meeting<br>• **Meeting #7, 12/08/2020,** Finalize Report |
| **Telehealth Subgroup** | | |
| • **Meeting #1, 11/10/2020, Identify Recommendations**<br>• **Meeting #2, 11/13/2020, Prioritize Recommendations** | | |

# Data Profile

Across meetings the Special Committee discussed the value of using data to closely monitor outcomes related to the behavioral health system. In addition, these data could provide the information needed to ensure that Kansas is on track to achieve a high-quality, modernized behavioral health system and that funds expended toward this end have appropriate impact.

KHI convened two meetings with state agency staff from Kansas Department for Aging and Disability Services (KDADS), Kansas Department of Health and Environment (KDHE), Kansas Department for Children and Families (DCF), Kansas Department of Corrections (KDOC), Kansas State Department of Education (KSDE) and the Kansas Attorney General's office to identify measures for two purposes: (1) to prepare a high-level data profile that would provide a systemic assessment of the state's behavioral health system (see *Figure 3,* page 5); and (2) to provide a list of process and outcomes measures that could measure the impact of many of the high priority recommendations identified by the Working Groups if implemented (see recommendation summary tables starting on page 8). Please note that the impact of COVID-19 on the behavioral health system is likely not yet reflected in the data or proposed measures included in this report, but specific measures could be added in subsequent years.

The following process measures are identified to monitor the progress on the work completed by this committee and its convened Working Groups:

- Number of recommendations implemented and
- Number of recommendations implemented with identified key collaborators.

In addition, the high-level data profile presented in *Figure 3* (page 5) would provide a systemic assessment of the state's behavioral health system, and includes only a subset of the wide range of data that are available about the Kansas behavioral health system.

*Figure 3.* **Select Measures to Assess the Kansas Behavioral Health System**

| **PROCESS MEASURE** | | | | |
|---|---|---|---|---|
| **Measure:** | **Number** | | **Percent** | |
| Kansas counties recognized as a Mental Health Professional Shortage Area.<br>*Lower number/percentage of counties is better.* | 99 (2019) | | 94.3% (2019) | |
| Counties served by Mobile Response and Stabilization Services.<br>*Higher number/percentage of counties is better.* | Data are available from KDADS. | | Data are available from KDADS. | |
| Counties served by Crisis Intervention Centers.<br>*Higher number/percentage of counties is better.* | * | | * | |
| **OUTCOME MEASURES** | | | | |
| **Measure:** | **Kansas current (year)** | **Kansas previous (year)** | **U.S. current (year)** | **U.S. previous (year)** |
| Uninsured rate (adults age 19-64).<br>*Lower rates are better.* | 13.1% (2019) | 12.6% (2018) | 12.9% (2019) | 12.5% (2018) |
| Uninsured rate (children age 0-18).<br>*Lower rates are better.* | 5.8% (2019) | 5.1% (2018) | 5.7% (2019) | 5.2% (2018) |
| Statewide age-adjusted mortality rate for suicide per 100,000 population.<br>*Lower rates are better.* | 19.9% (2017) | 19.2% (2016) | 15.2% (2017) | 14.7% (2016) |
| Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities (i.e., criteria for and predictors of clinical depression).<br>*Lower percentage is better.* | 32.5% (2019) | 24.8% (2017) | 36.7% (2019) | 31.5% (2017) |
| Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.<br>*Higher percentage is better.* | 55.9% (2018-2019) | 52.7% (2017-2018 | 53.2% (2018-2019) | 52.7% (2017-2018) |
| Individuals with SPMI that have been enrolled in supportive housing and have not had an ER or Psychiatric Hospital admission in the last 12 months.<br>*Higher percentage is better.* | * | * | NA | NA |
| | | | | |

*Figure 3 (continued)*. **Select Measures to Assess the Kansas Behavioral Health System**

| **OUTCOME MEASURES (continued)** | | | | |
|---|---|---|---|---|
| **Measure:** | **Kansas current (year)** | **Kansas previous (year)** | **U.S. current (year)** | **U.S. previous (year)** |
| Individuals with SPMI that have been enrolled in supportive employment and have not had an ER or Psychiatric Hospital admission in the last 12 months. *Higher percentage is better.* | * | * | NA | NA |
| Percent of individuals with an inpatient psychiatric stay in the previous year, that have returned to and remain in the community without additional hospitalizations. *Higher percentage is better.* | ** | ** | NA | NA |

| **MENTAL HEALTH in AMERICA RANKINGS of 50 states and Washington D.C. by report year** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Select Measure:** *States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes.* | **2021** | **2020** | **2019** | **2018** | **2017** | **2016** | **2015** |
| Kansas rankings: overall. | #29 | #42 | #24 | #19 | #21 | #15 | #19 |
| Kansas ranking: Adult (prevalence and access to care). | #38 | #43 | #28 | #22 | #23 | #16 | #23 |
| Kansas ranking: Youth (prevalence and access to care). | #26 | #37 | #21 | #19 | #18 | #15 | #8 |
| Kansas ranking: Adults with mental illness who report unmet needs. | #51 | #46 | #29 | #39 | #38 | #28 | #51 |
| Kansas ranking: Youth with at least one major depressive episode who did not receive mental health services. | #18 | #47 | #40 | #29 | #12 | #12 | NA |

Note: The asterisk (*) indicates that data are reportable by a state agency. The double-asterisk (**) means that the measure could be reported in the future, assuming implementation of certain recommendations related to data interoperability and higher rates of participation in health information exchanges. NA stands for not available.

The Mental Health in America overall ranking uses national data from surveys including the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). The overall ranking is comprised of 15 measures for adults and youth around mental health issues, substance use issues, access to insurance, access to adequate insurance, as well as access to and barriers to accessing mental health care. A rank of 1-13 indicates lower prevalence of mental illness and higher rates of access to care, and an overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. Data in each reporting year come from previous reporting periods. For example, in the 2021 report, most indicators reflect data from 2017-2018, while the 2020 report includes data from 2016-2017 and so forth. The baseline report year is 2015. For more information, go to https://www.mhanational.org/issues/2021/ranking-guidelines.

*Source: Data as reported by the Kansas Department for Aging and Disability Services (KDADS), Kansas Department of Health and Environment (KDHE), Kansas Department of Corrections (KDOC), Kansas State Department of Education (KSDE) and KHI analysis of data from the U.S. Census Bureau 2018-2019 American Community Survey Public Use Microdata Sample files for uninsured rates and 2015-2021 Mental Health in America Rankings.*

# Finance and Sustainability Working Group (WG1)

The Finance and Sustainability Working Group made recommendations related to the topics of workforce, funding and accessibility and community engagement.

## *Workforce*

A modernized workforce is one where behavioral health staffing is adequate to meet needs across rural, frontier and urban areas of the state. Telehealth (discussed beginning on page 49) will play a role in meeting needs, but local staffing remains important. Modernization will require both growing and retaining the workforce.

The Finance and Sustainability Working Group discussed and made recommendations recognizing the ongoing importance of studying and investing in the behavioral health workforce in the state. Steps to modernize the State's behavioral health workforce include: addressing regional provider shortages, particularly in underserved areas; expanding inpatient psychiatric emergency services by recruiting more staff; prioritizing care in the community and developing mobile crisis teams; and expanding recruiting and "grow-your-own" programs. Further, the group repeatedly discussed the importance of establishing measures to track the success of any new efforts.

*Recommendations*

The Working Group advanced five recommendations as highest priority, with three highlighted for immediate action, and two for strategic importance. Items highlighted for immediate action are recommendations that should be completed within the first two years of the strategic plan. Items of strategic importance are recommendations for which work should begin in the near-term, but will take longer to implement.

*Workforce Recommendation 1.1:* **Clinical Supervision Hours [Immediate Action]**

| | |
|---|---|
| **Recommendation:** Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers. | |
| **Rationale**: A version of this recommendation was originally developed by the Committee on Alcohol and Other Drug Abuse of the Governor's Behavioral Health Services Planning Council.[1] A similar change was made for social workers in 2019 and has made recruitment of social workers easier in some parts of the state. BSRB intends to support legislation that would enact this change in the 2021 Legislative Session. This change would bring Kansas licensing requirements in alignment with neighboring states. | |
| **Ease of Implementation** *(Score 1-10):* 8 | **Potential for High Impact** *(Score 1-10):* 8 |
| • Would require a program change and change in legislation.<br>• Cost is not a barrier to implementation. | • Would impact the entire state.<br>• Could lead to a reduction in workforce inequities by geography, particularly in rural and frontier counties. |
| **Measuring Impact:**<br>Percent or number of master's-level behavioral health clinicians practicing in Kansas. | |
| **Action Lead:** BSRB | **Key Collaborators:** Legislature, KDADS |

*Return to Figure 1 or Figure C-1.*

*Workforce Recommendation 1.2:* **Access to Psychiatry Services [Immediate Action]**

| | |
|---|---|
| **Recommendation:** Require a study be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses. | |
| **Rationale**: A version of this recommendation was originally developed by the Mental Health Task Force.[2] Multiple areas in the state are struggling to recruit and retain psychiatrists and psychiatric nurses, with an additional 54 psychiatrists needed to eliminate the Mental Health Care Health Professional Shortage Areas (HPSAs) in Kansas.[3] An important next step once the study is completed would be exploring implementation of the strategies outlined in the report. | |
| **Ease of Implementation** *(Score 1-10): 9* | **Potential for High Impact** *(Score 1-10): 8* |
| • Would be relatively easy to implement once funding is available. | • Implementing strategies from the report could impact frontier and rural communities that struggle to recruit psychiatric providers. |
| **Measuring Impact:**<br>• Percent or number of mental health care professionals participating in the Kansas State Loan Repayment Program.<br>• Number of Kansas counties recognized as a Mental Health Professional Shortage Area.<br>• Number of adult and child/adolescent psychiatry residents in Kansas. | |
| **Action Lead:** KDHE | **Key Collaborators:** Educational institution |

*Return to Figure 1 or Figure C-1.*

*Workforce Recommendation 1.3:* **Provider MAT Training [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[4] MAT, in conjunction with therapy, can help treat and sustain recovery for SUD.[5] MAT was added to KanCare billable services in October 2020, and expanded treatment options will be important for Kansas as the opioid epidemic continues. Additional steps should be taken to recruit and train providers, including capacity of primary care providers, to offer this treatment. Providers may currently be reluctant to serve MAT patients — who may be viewed as high-risk — and may not understand the benefits or evidence base associated with MAT, which could be mitigated via training.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 6</td></tr>
<tr><td><ul><li>Could require expansion of existing programs.</li><li>Funds may be needed for training and to cover medications.</li></ul></td><td><ul><li>High impact for a smaller population, including increased survival, retention in treatment and ability to gain and maintain employment.</li><li>Could result in cost savings, including reducing inpatient services.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of providers who have completed MAT prescriber training.</li><li>Number of caseload carriers who have completed MAT prescriber training.</li><li>Number of age-adjusted non-fatal drug overdose emergency department admissions per 100,000 population.</li><li></li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, KDOC</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Workforce Recommendation 1.4:* **Workforce Investment Plan [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include:<ul><li>Develop a career ladder for clinicians, such as through the development of an associate's-level practitioner role and</li><li>Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency.</li></ul></td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Child Welfare System Task Force.[6] Kansas is struggling to maintain an adequate behavioral health workforce across the state, particularly as surrounding states recruit Kansas clinicians. Working Group members discussed the importance of utilizing a "grow-your-own" approach, increasing reimbursement and salaries, financing provider education and training, and promoting entry to the behavioral health workforce in young students. Additionally, a modernized workforce should include a diverse group of practitioners to better serve an increasingly diverse Kansas population. An adequate workforce is key to ensuring access to services within the behavioral health system.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 1</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Could include program changes and pilot programs.</li><li>Cost will be a barrier to implementation.</li><li>Could changes in a legislative session, federal approval process, agency budget development and grant cycles.</li></ul></td><td><ul><li>Would impact a large population.</li><li>Would impact multiple special populations, including those in foster care, those with limited English proficiency, children and those with low-income.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of behavioral health providers practicing in Kansas by age, race/ethnicity, language and sexual orientation.</li><li>Number of students enrolling in post-secondary behavioral health education/training programs in Kansas schools.</li><li>Number of community colleges offering a behavioral health track associates degree.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, BSRB, Legislature, providers, clinics, educational institutions</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

*Workforce Recommendation 1.5:* **Family Engagement Practices [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Children's Subcommittee of the Governor's Behavioral Health Services Planning Council.[7] Parent and family engagement practices can create shared responsibility between providers and families, such as by involving families in decision making. It can lead to improved clinical outcomes, as well as improved educational outcomes and health behaviors when parents and families are engaged by schools.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Cost could be a barrier to implementation.</li><li>Could require changes in a legislative session and agency budget development.</li></ul></td><td><ul><li>High impact for pediatric behavioral health population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of families served.</li><li>Percent of children and parents whose functionality scores improved (over set time period).</li><li>Rate of provider turnover.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, Legislature</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

## *Funding and Accessibility*

In a modernized behavioral health system, the State will need to proactively pursue new funding mechanisms, including alternative models such as the Certified Community Behavioral Health Clinic (CCBHC) model, to ensure that reimbursement rates are competitive. The State has the expertise, research and recommendations in place to support changes to how behavioral health is funded in Kansas, and implementation should be pursued across administrations.

The Working Group asserted that accurate and appropriate funding of Kansans who currently lack coverage is a key element of a sustainably funded, modern behavioral health system, and a modernized system will successfully identify the right populations to serve and make services meaningfully accessible. Likewise, a modernized system should rely on measurable outcomes to drive decisions. Key challenges related to funding and accessibility requirements for budget neutrality on the 1115 Medicaid Waiver, limited availability of SUD block grant dollars, and low reimbursement rates at community mental health centers and for SUD providers.

*Recommendations*

The Working Group advanced five high priority recommendations for funding and accessibility, all highlighted for immediate action, as well as one high-priority discussion item regarding Medicaid expansion.

*Funding and Accessibility Recommendation 2.1:* **Certified Community Behavioral Health Clinic Model [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).[8] Passed in 2014, the Excellence in Mental Health Act was a demonstration project that provided funding to establish CCBHCs, which receive cost-based reimbursement for providing: 1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization; 2) screening, assessment and diagnosis, including risk assessment; 3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; 4) outpatient mental health and substance use services; 5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; 6) targeted case management; 7) psychiatric rehabilitation services; 8) peer support and counselor services and family supports; and 9) intensive, community-based mental health care for members of the armed forces and veterans.<br><br>Working Group members expressed interest in Kansas pursuing a CCBHC model, which would provide a modern payment system to support the behavioral health system in the state. Ideally, this would be done under an expansion of the Excellence in Mental Health Act, so that additional federal funds could be used to support its implementation. If the Act is not expanded, Working Group members recommended pursuing the CCBHC model through a state plan amendment or change to the Section 1115 Waiver, similar to an approach taken by Texas.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would be a new program.</li><li>Cost could be a barrier to implementation, assuming no federal funds are available.</li><li>Would require a legislative session, federal approval process, regulatory process and agency budget development to implement.</li></ul></td><td><ul><li>Would impact a large population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of CCBHCs</li></ul></td></tr>
<tr><td>Action Lead: KDHE</td><td>Key Collaborators: KDADS, Providers</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Funding and Accessibility Recommendation 2.2:* **Addressing Inpatient Capacity [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force.[9] A related recommendation was prioritized by the System Capacity and Transformation Working Group under the topic of System Transformation. That recommendation (9.1) is related to a regional model for the provision of inpatient mental health services. This may be one strategy within a comprehensive plan to address voluntary and involuntary hospital inpatient capacity. Working Group members highlighted the need to address inpatient capacity as a high priority for the behavioral health system long term. Of particular importance was ensuring that facilities have the capacity to care for individuals who are both a danger to themselves and a danger to others, with Working Group members indicating that the latter can be difficult for smaller facilities. Working Group members acknowledged and expressed support for the work that the Kansas Department for Aging and Disability Services (KDADS) has done to develop a plan to lift the moratorium at Osawatomie State Hospital (OSH), the implementation of which could begin to address the recommendation.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 4</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Cost will be a barrier to implementation.</li></ul></td><td><ul><li>Would impact a large population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of private hospitals enrolled in KanCare as State Institution Alternatives.</li><li>Number of new private psychiatric hospital (PPH) beds licensed in Kansas.</li><li>Number of new state mental health hospital (SMHH) beds added at state hospitals.</li><li>Increases in community-based treatment service delivery or utilization like supported employment and supported housing.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: Legislature</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Funding and Accessibility Recommendation 2.3:* **Reimbursement Rate Increase and Review [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a Working Group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).[10] The MHTF recommendation included a detailed review of reimbursement rates and recommended rates be updated accordingly. Working Group members, however, felt that a pressing need was an overall increase to reimbursement rates for behavioral health services in order to maintain the Community Mental Health Center (CMHC) system in the state. In discussion, Working Group members highlighted that few changes to reimbursement rates had occurred in the last 20 years and were overdue. Once reimbursement rates are increased, Working Group members recommend having a task force review the behavioral health reimbursement structure of both the uninsured and Medicaid populations to ensure long-term sustainability. In the 2020 Legislative Session, the final budget bill included a proviso requiring KDHE to complete a detailed review of costs and reimbursement rates for behavioral health services in the state.[11] This review is due in January 2021 and may include information to be reviewed by a Working Group or task force.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Cost will be a barrier to implementation.</li></ul></td><td><ul><li>Would impact a large population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Frequency of reimbursement rate updates</li></ul></td></tr>
<tr><td>Action Lead: Legislature</td><td>Key Collaborators: KDADS, KDHE, CMHCs</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Funding and Accessibility Recommendation 2.4:* **Suicide Prevention [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Allocate resources to prioritized areas of need through data driven decision-making. Assist local suicide prevention efforts and promote local support groups in fund-raising efforts, building capacity, and increasing availability for survivors of suicide loss. Dedicate resources and funding for suicide prevention.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council.[12] The rate of suicides in Kansas has increased in recent years, particularly among veterans and children and adolescents.[13] Working Group members highlighted the importance of supporting suicide prevention activities, and acknowledged that the Kansas Department for Aging and Disability Services (KDADS) has multiple efforts happening around the state related to suicide prevention but that ongoing funding is needed to support and expand these efforts. Further, Working Group members and members of the Special Committee repeatedly highlighted the importance of data to drive ongoing decisions related to policy and prevention efforts in a modernized behavioral health system.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would require a program change.</li><li>Would require a legislative session, contracts and agency budget development to implement.</li></ul></td><td><ul><li>Would impact special populations, including those in foster care, children frontier communities, rural communities—particularly those in the agricultural sector—and veterans.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Percent change in the age-adjusted mortality rate for suicide per 100,000 population.<ul><li>Subsets of data: suicide rate by gender, age group, socio-demographics (marital status, veteran, and education), occupational classification, cause of death (firearm, suffocation, etc.), and circumstances (mental health, substance use, and interpersonal problems).</li></ul></li><li>Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: Legislature, local efforts</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Funding and Accessibility Recommendation 2.5: Problem Gambling and Other Addictions Fund [Immediate Action]*

<table>
<tr><td colspan="2">Recommendation: Recommend the State continue to incrementally increase the proportion of money in the Problem Gambling and Other Addictions Grant Fund (PGOAF) that is applied to treatment over the next several years until the full funding is being applied as intended.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Committee on Alcohol and Other Drug Abuse of the Governor's Behavioral Health Services Planning Council.[14] Currently, two percent of lottery gaming facility revenues are to be allocated to the PGOAF to support addiction services. Working Group members indicated that in practice, however, the funds are often used to support other service areas beyond addiction. To bring the use of funding in line with the original intent, Working Group members recommended that the full two percent be used to support the services for which it was originally intended. This could include additional clarification of which services are eligible for money from the PGOAF.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 5</td></tr>
<tr><td>• Would require a legislative session to implement.</td><td>• Would have a high impact on a small population.</td></tr>
<tr><td colspan="2">Measuring Impact:<br>• Number of calls to problem gambling hotline.<br>• Of the two percent lottery gaming facility revenues, funds appropriated ($) to problem gambling and addiction treatment.</td></tr>
<tr><td>Action Lead: Legislature</td><td>Key Collaborators: Providers, KDADS</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Funding and Accessibility High Priority Discussion Item*: **Medicaid Expansion**

<table>
<tr><td colspan="2">Rationale: Medicaid expansion has been recommended by previous task forces, including the Mental Health Task Force, the Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force. Medicaid Expansion was flagged by the Working Group as a high priority discussion when considering opportunities to modernize the behavioral health system due to the opportunity that it represents to improve access to behavioral health services at all levels of care and allow investment in workforce and system capacity. Expanding Medicaid under the terms of the Affordable Care Act would provide insurance coverage to an estimated 130,000 to 150,000 Kansans. Working Group members noted that many of these individuals may already be utilizing services within the behavioral health system, but in many cases those services are uncompensated or subsidized by state grants. Ninety percent of Medicaid expansion costs would be covered by the federal government. Other Kansans with behavioral health needs may be foregoing care completely until they reach a crisis. The Working Group considered Medicaid expansion as a high priority discussion item for the Special Committee, as the Kansas Legislature is the body to determine whether expansion will move forward.</td></tr>
<tr><td>Action Lead: Legislature</td><td>Key Collaborators: Working Group members</td></tr>
</table>

*Return to Figure 1 or Figure C-3.*

## *Community Engagement*

Effective community engagement in a modernized behavioral health system will include collaboration between individuals in recovery and behavioral health providers to support key efforts. Key efforts include those to support employment, re-entry planning for incarcerated individuals, behavioral health supports and education for foster homes. Another important activity for a modernized behavioral health system will include making strategic connections between the criminal justice system and behavioral health resources. Effective community engagement will require greater collaboration to involve and utilize the resources of cities, counties, health departments, community advisory boards, law enforcement, and the criminal justice system. Additionally, work will be needed to promote understanding among consumers, behavioral health providers and community partners. This understanding will ensure that behavioral health consumers are able to effectively navigate the system, and the professionals working in that system are able to engage consumers productively to meet their needs and continuously improve care delivery. The Working Group also discussed the need to make services available to those in crisis, as well as supports for foster parents. foster parents.

### *Recommendations*

The Working Group advanced four high-priority recommendations for community engagement, with two highlighted for immediate action and two for strategic importance.

*Community Engagement Recommendation 3.1:* **Crisis Intervention Centers [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Utilize state funds to support the expansion of Crisis Intervention Centers, as defined by state statute, around the state.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Finance and Sustainability Working Group. Expanding the reach of Crisis Intervention Centers would allow more behavioral health needs to be met locally, by providing consumers with access to critical services closer to home. Increasing access to crisis services can reduce wait times for emergency room treatment and decrease inpatient psychiatric admissions.[15] Existing crisis stabilization services in Kansas rely on multiple, varied funding streams, including Medicaid, county and city funding, and funds generated by lottery ticket vending machines in the state. The current funds available to Kansas Department for Aging and Disability Services (KDADS) for Crisis Intervention Centers from the lottery ticket vending machines are fully allocated to current crisis centers, requiring additional state investment to expand or develop new Crisis Intervention Centers in the state, particularly in rural and frontier areas.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 7</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Cost could be a barrier to implementation.</li><li>Could likely require a legislative session and agency budget development to implement.</li></ul></td><td><ul><li>Could impact a large population.</li><li>Could produce cost savings by reducing need for stays at state hospitals or psychiatric beds in community hospitals.</li></ul></td></tr>
<tr><td colspan="2">Measuring impact:<ul><li>Percent or number of counties served by Crisis Intervention Centers.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, Legislature</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Community Engagement Recommendation 3.2:* **IPS Community Engagement [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase engagement of stakeholders, consumers, families, and employers through the Kansas Department of Health and Environment (KDHE) or Kansas Department for Aging and Disability Services (KDADS) by requiring agencies implementing the Individual Placement and Support (IPS) program, an evidence-based supported employment program, to create opportunities for assertive outreach and engagement for consumers and families.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Vocational Subcommittee of the Governor's Behavioral Health Services Planning Council.[16] An important predictor of positive outcomes in recovery is employment, and the IPS program is an evidence-based supported employment program that can help individuals with behavioral health conditions find employment. Working Group members indicated that a modernized behavioral health system is one that should consider the impact of the social determinants of health, including employment.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Could require a program overhaul to improve supported employment statewide.</li><li>Could require a legislative session, federal approval process, regulatory process and agency budget development to implement.</li></ul></td><td><ul><li>Would impact a large population, given the size of the veteran population in Kansas.</li><li>Could produce savings by preventing a need for crisis services or hospitalizations.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of individuals participating in an IPS program.</li><li>Percent of individuals with SPMI that have been enrolled in supportive employment and have not had an ER or Psychiatric Hospital admission in the last 12 months.</li><li>Number of counties served by an IPS program.</li></ul></td></tr>
<tr><td>Action Lead: KDHE & KDADS</td><td>Key Collaborators: Legislature</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Community Engagement Recommendation 3.3:* **Foster Homes [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Child Welfare System Task Force.[17] Providing additional training and support to foster homes caring for youth with behavioral health needs, particularly SED youth, could improve retention of foster homes as well as incentivize placement of youth who may be more difficult to place otherwise.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Would require a program change.</li><li>Could require a legislative session, regulatory process and contracts to implement.</li></ul></td><td><ul><li>Would have a high impact on a small population (foster care youth).</li><li>Could produce savings through reductions in hospitalizations and residential care.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Placement stability rate for children entering care.</li><li>Percent or number of foster youth on the SED waiver.</li></ul></td></tr>
<tr><td>Action Lead: DCF</td><td>Key Collaborators: KDADS</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

*Community Engagement Recommendation 3.4:* **Community-Based Liaison [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and co-occurring conditions.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[18] A community-based liaison position has been added to community mental health center (CMHC) participating agreements to support pre-release services, but additional funding was not provided to support the position. KDADS is currently using the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant technical assistance (TA) funds to support the creation of a Kansas Stepping Up Initiative TA Center, which is focused on reducing the number of individuals in jails with mental illnesses through local government policy change and training efforts.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Would require a program change.</li><li>Funding could be a barrier to implementation, although recent SAMHSA guidance indicates that block grant funds can now be used to provide services to individuals in jail settings.</li><li>Could be impacted by a legislative session and agency development.</li></ul></td><td><ul><li>Would have a high impact on a relatively small population. (incarcerated individuals).</li><li>Could produce savings through a reduction in recidivism.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of contacts with the CMHC liaison prior to release.</li><li>Number of patients that continue services upon release.</li><li>Reduced recidivism for SPMI patients/offenders.</li><li>Number of CMHCs with a community-based liaison.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDOC, CMHCs, Legislature</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

# Policy and Treatment Working Group (WG2)

The Policy and Treatment Working Group made recommendations related to the topics of prevention and education, treatment and recovery, and special populations.

## *Prevention and Education*

Modernized prevention efforts will seek to meet the needs of special populations at increased risk for poor outcomes. This will require a collaborative, trauma-informed approach to prevention with appropriate reimbursement and other funding. Modernized prevention and education will entail improving suicide prevention outreach and engagement; examining points of entry and access within the system; taking a population-based approach which can operate developmentally across a lifetime and deliver trauma informed services; and bolstering employment supports including skills identification. The Policy and Treatment Working Group identified and discussed additional barriers, including the need to fund prevention services, improve information sharing between providers, and expand early intervention.

*Recommendations*

The Working Group advanced four high-priority recommendations for prevention and education, with three highlighted for immediate action and one for strategic importance.

*Prevention and Education Recommendation 4.1:* **988 Suicide Prevention Lifeline Funding [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. The NSPL is a national network of local crisis centers that provides support to people in suicidal crisis or emotional distress. The NSPL will transition from a 10-digit phone number to 988 by July of 2022, making it easier for individuals to know what number to call when in crisis; some phone providers have already begun making this transition.[19] The change is expected to contribute to an increase in the number of individuals using the NSPL, which currently attempts to match callers to in-state crisis centers when possible. Between October 1, 2019, and December 31, 2019, 60 percent of NSPL calls initiated in Kansas were answered by Kansas providers.[20] Increasing the in-state answer rate will ensure that Kansans in crisis are connected to providers who can direct them to local resources.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would likely involve a program overhaul, involving additional staff and training.</li><li>Sustainability is considered in the recommendation via fee collection. The recommendation does not include funding for a crisis text line.</li><li>Could require a legislative session, contracts, grant cycles and systems to implement.</li></ul></td><td><ul><li>Will benefit a large population.</li><li>Could produce savings in other areas.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>National Suicide Prevention Lifeline Answer Rate</li><li>Percent change in the statewide age-adjusted mortality rate for suicide per 100,000 population.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: Crisis centers, CMHCs, Legislature</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Prevention and Education Recommendation 4.2:* **Early Intervention [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover early childhood mental health screening, assessment and treatment.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force, and action steps that could support this recommendation can be found in Recommendation 3.4 of the Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.[21]<br><br>Early identification of behavioral health symptoms can allow for earlier intervention, leading to better outcomes for youth. Additional funds would be needed to continue and expand this work statewide, which was partially piloted via the Substance Abuse and Mental Health Administration (SAMHSA) Systems of Care grant.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 3</td><td>Potential for High Impact (Score 1-10): 10</td></tr>
<tr><td>• Would require a program change and potentially new services if additional diagnosis codes are approved.<br>• Cost could be a barrier to implementation.<br>• Could require a federal approval process, agency budget development and systems to implement.</td><td>• Would benefit a large population.<br>• Would impact individuals in foster care, low-income individuals, children and those with limited English proficiency.<br>• Could produce cost savings via reductions in ER visits, pediatrics visits, and use of the criminal justice system and state hospitals.</td></tr>
<tr><td colspan="2">Measuring Impact:<br>• Percent of Medicaid-eligible children age 0-5 receiving initial trauma and mental health screen within 90 days of entering coverage.<br>• Utilization of early childhood mental health screening, assessment, and treatment Medicaid codes.</td></tr>
<tr><td>Action Lead: KDHE & KDADS</td><td>Key Collaborators: DCF, MCOs</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Prevention and Education Recommendation 4.3:* **Centralized Authority [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Centralize coordination of behavioral health – including substance use disorder and mental health – policy and provider coordination in a cabinet-level position.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[22] Creating a centralized authority for behavioral health would help ensure that behavioral health efforts in the state are consistently prioritized, coordinated and reported on to the Governor. Responsibilities of this position would be to ensure collaboration across the state agencies (e.g., KDHE, KDADS, DCF, KDOC) and other partners involved in the behavioral health system (e.g., community mental health centers, federally qualified health centers, managed care organizations, private insurers and behavioral health consumers). This could allow for coordinated efforts to modernize the behavioral health system, as well as additional coordination of the various behavioral health funding streams spread across entities.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 2</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Could require a new program.</li><li>Could require a regulatory process, agency budget development and systems to implement.</li></ul></td><td><ul><li>Would benefit a large population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>More work is needed to identify measures appropriate to capture the impact of this recommendation.</li></ul></td></tr>
<tr><td>Action Lead: Office of the Governor</td><td>Key Collaborators: KDADS, KDHE, KSDE</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Prevention and Education Recommendation 4.4:* **Behavioral Health Prevention [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Increase state funds for behavioral health prevention efforts (e.g., substance use disorder [SUD] prevention, suicide prevention).</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Working Group members highlighted the importance of a balance between prevention and treatment in a modernized behavioral health system in Kansas. Prioritizing prevention efforts is needed in the behavioral health system broadly, and it was highlighted that currently only the minimum amount of funds within the SUD block grant are allocated toward prevention activities, and the state has not allocated any money from the state general fund for SUD prevention efforts. Other steps toward prioritizing prevention could include expanding the number of Certified Prevention Specialists in the state and allocating funding for a state suicide prevention coordinator, a position for which the Kansas Department for Aging and Disability Services (KDADS) has already created a job description.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Could require a program overhaul.</li><li>Cost could be a barrier to implementation.</li><li>Sustainability is contingent on ongoing funding.</li><li>Could require a legislative session and agency budget development to implement.</li></ul></td><td><ul><li>Would benefit a large population.</li><li>Would benefit multiple special populations, including foster care, rural communities, frontier communities, urban communities, and children.</li><li>Could produce cost savings in the child welfare and corrections systems.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of age-adjusted non-fatal drug overdose emergency department admissions per 100,000 population.</li><li>Select indicators from the Kansas Behavioral Health Indicators Dashboard (KBHID.org)</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, Legislature, providers</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

## *Treatment and Recovery*

A modernized behavioral health system will deliver an expanded array of early, affordable, accessible, evidence-informed behavioral health services for all, with an emphasis in serving consumers in the settings that are most likely to support effective engagement with treatment. Modernized treatment and recovery will include a data-driven, person-centered approach that improves health outcomes for persons served through access to evidence-based treatment and other promising practices, regardless of income or ability to pay. This system will include timely information exchange to support meaningful coordination across settings (e.g., schools, primary care providers, law enforcement and the judicial system). Additionally, entry into and navigation of the behavioral health system should be clear and consistent. The Working Group also

discussed the need to offer additional crisis services, including: intensive outpatient programs (IOP), partial hospitalization, day programs, substance use disorder (SUD) family residential treatment, respite and crisis beds. The system should have the flexibility to be adaptive to changing trends and needs in behavioral health indicators and service needs such as suicide rates, substance use trends or pandemic impacts.

*Recommendations*

The Working Group advanced four high-priority recommendations for treatment and recovery, with one highlighted for immediate action and three for strategic importance.

*Treatment and Recovery Recommendation 5.1:* **Psychiatric Residential Treatment Facilities [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Treatment and Recovery Working Group that updates language originally included in Recommendation 3.3 from the Mental Health Task Force Report to the Legislature, January 14, 2019.[23] Working Group members highlighted the progress made by the KDADS in recent years to bring down the waitlist to enter PRTFs. Ongoing effort is still needed, however, to ensure that youth who require PRTF-level care can access it when needed. Focusing on reintegration and discharge planning, in partnership with community partners, like schools, could help reduce the need for additional PRTF stays in the future. Additionally, the implementation of other recommendations — such as Recommendation 5.2 Service Array, below — could help youth receive needed services earlier and prevent potentially unnecessary PRTF stays.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 7</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would require a program overhaul.</li><li>Cost may be a barrier to implementation.</li><li>Would require agency budget development and systems to implement.</li></ul></td><td><ul><li>Would have a large impact on a small population (youth requiring PRTF-level care).</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Average length of stay in a PRTF.</li><li>Number of individuals served by a PRTF.</li><li>Average number of individuals on the three MCO PRTF waitlist per month.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KSDE, KDHE, CMHCs, managed care organizations</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Treatment and Recovery Recommendation 5.2:* **Service Array [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Explore options to expand the behavioral health service array, including the expansion of medication-assisted treatment (MAT) in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Treatment and Recovery Working Group that builds on language originally included in Recommendation 3.2 from the from the Mental Health Task Force Report to the Legislature, January 14, 2019.[24] Increasing the service array within the behavioral health system could help ensure that Kansans can access the appropriate level of care when needed. For example, the expansion of crisis stabilization services, intensive outpatient services and other community-based options may reduce the need for stays in institutional settings. Expanding the service array could include an expansion of MAT, which has been shown to lead to better outcomes. Additional MAT could include a focus on specific populations and settings, such as pregnant women or jails. Additionally, when expanding the service array, the group discussed the value of providing services in natural settings (e.g., homes, schools, primary care offices) in the community.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Could require program overhauls or new programs.</li><li>Cost could be a barrier to implementation, as could workforce shortages.</li><li>Could require regulatory processes or agency budget development to implement.</li></ul></td><td><ul><li>Would benefit a large population.</li><li>Could produce costs savings by reducing need for inpatient or PRTF stays.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Average number of expanded services provided to an individual.</li><li>Number of counties offering services by type.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, DCF, providers, private insurers.</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Treatment and Recovery Recommendation 5.3:* **Frontline Capacity [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Treatment and Recovery Working Group. Kansas Department of Health and Environment (KDHE) currently has two federal grants focused on this issue, one focused on providers who work with pregnant and postpartum individuals, and another focused on pediatric primary care providers. These grant programs are modeled after two psychiatric access programs developed in Massachusetts, where they proved to be effective.[25,26] While federal grants have covered initial implementation activities (e.g., provider-to-provider consultation), these funds will expire in 2023. North Carolina has added provider-to-provider consultations as a reimbursable service under Medicaid, which could be one path forward for sustainability. Private insurers may also be interested in this service and could be collaborated with to move this recommendation forward. Additionally, see Appendix A (page A-1) for a recommendation related to Screening, Brief Intervention and Referral to Treatment (SBIRT).</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Could require an expansion of an existing program.</li><li>Existing programs are currently grant funded, making long-term sustainability contingent upon additional funding streams, such as Medicaid reimbursement.</li><li>Could require federal approval processes and agency budget development to implement.</li></ul></td><td><ul><li>Would benefit a large population.</li><li>Could produce cost savings through early intervention and a reduction in need for crisis services.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of pediatric primary care providers who enroll in a pediatric mental health care access program.</li><li>Number of perinatal providers who enroll in a perinatal psychiatric access program.</li><li>Utilization of Maternal Depression Screening Medicaid codes.</li></ul></td></tr>
<tr><td>Action Lead: KDHE</td><td>Key Collaborators: Private insurers, providers, KDADS</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

*Treatment and Recovery Recommendation 5.4:* **Housing [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Expand and advance the Supported Housing program and the SSI/SSDI Outreach, Access, and Recovery (SOAR) program, including additional training regarding youth benefits.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Housing and Homelessness Subcommittee of the Governor's Behavioral Health Services Planning Council.[27] The Supported Housing program provides affordable housing linked to services for low-income, homeless, or potentially homeless individuals with a severe mental illness. SOAR is a federal program designed to help states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and have a mental illness or other co-occurring disorders. Preventing or mitigating homelessness can support recovery and result in improved outcomes. The expansion of support housing could include allowing non-waiver individuals to participate in programs. While making funding available to support expansion of these program is an important step, funding alone does not mitigate other barriers to housing in some parts of the state, including a lack of available housing in western Kansas.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would require a program change or overhaul.</li><li>Could require federal approval processes, regulatory processes, and agency budget development to implement.</li></ul></td><td><ul><li>Would have a high impact on those involved in the programs, including low-income individuals, transition-age youth children, veterans and justice-involved individuals.</li><li>Could produce cost savings via a reduction in uninsured services.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of individuals served by the SSI/SSDI Outreach, Access, and Recovery (SOAR) program.</li><li>Percent of individuals with SPMI that have been enrolled in supportive housing, and have not had an ER or Psychiatric Hospital admission in the last 12 months.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: Homelessness Subcommittee of Governor’s Behavioral Health Services Planning Council, ACMHC, Association of Addiction Professionals, KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

## *Special Populations*

To serve special populations in a modernized behavioral health system, data, consumers and families will drive the system. Building on existing strengths, a modernized approach will be integrated, proactive and responsive whenever there is a need or a self-identified crisis. Additionally, data will be utilized to understand where there are disparities that should be

addressed. Changes may be needed to education, training, and agency requirements to enable service providers to serve people in a more comprehensive manner. Ultimately, a modernized system will provide wraparound services which meet all the behavioral health needs of an individual such as treating co-occurring disorders and providing housing. The Policy and Treatment Working Group discussed that some special populations to consider include, but are not be limited to, victims of domestic violence, children of incarcerated parents, individuals with limited English proficiency, pregnant women experiencing perinatal mood and anxiety disorders, and others listed on the Recommendation Rubric *(Appendix B*, page B-1*)*.

*Recommendations*

The Working Group advanced 5 high priority recommendations for special populations, with 2 highlighted for immediate action and 3 for strategic importance.

*Special Populations Recommendation 6.1:* **Domestic Violence Survivors [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies and community providers serving individuals impacted by domestic violence.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. According to the CDC, one in four women and one in 10 men have experienced some form of intimate partner violence, also known as domestic violence.[28] Domestic violence has multigenerational impacts as well, impacting children and youth live in homes where domestic violence occurs. Given its prevalence and multigenerational impact, Working Group members expressed a desire to better support the behavioral health needs of domestic violence survivors. Working Group members highlighted that multiple community resources are currently available to support domestic violence survivors, but these resources could be better coordinated across agencies and entities to ensure individuals receive the care they need.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would require a pilot program or program overhaul to connect existing systems.</li><li>Would require contracts, agency budget development and systems to implement.</li></ul></td><td><ul><li>Would benefit a large population, including multiple special populations.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>More work is needed to identify measures appropriate to capture the impact of this recommendation.</li></ul></td></tr>
<tr><td>Action Lead: DCF</td><td>Key Collaborators: KDADS, KDHE, community- based organizations, providers</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Special Populations Recommendation 6.2:* **Parent Peer Support [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase access to parent peer support for caregivers and families of youth in the behavioral health system, including ensuring appropriate supports for fathers of dependent children.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Peer support would connect parents with lived experience to parents or other caregivers currently navigating the behavioral health system on behalf of their child. Supporting parents is an integral component of behavioral health treatment, and parent peer support for parents with substance use disorders have proven to be effective in other states. Exploring opportunities to expand peer support could provide a cost-effective strategy to improving care outcomes, in addition to providing an outlet through which parents can receive additional support when navigating the behavioral health system. Further, increasing access to peer support services also creates additional job opportunities for those with lived experiences.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Would require a program change.</li><li>Cost could be a barrier to implementation, as well as workforce capacity.</li></ul></td><td><ul><li>Would impact a large population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of children entering care of the Secretary of DCF.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: DCF, KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Special Populations Recommendation 6.3:* **Crossover Youth [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Continue to develop linkages between the behavioral health system, juvenile justice system and the child welfare system to increase understanding of treatment options available to youth externalizing trauma in the crossover youth population as current treatment options are not meeting the needs of this population. Then, develop specialty services to meet the needs of this population.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Although not a large population, the Working Group highlighted the large amount of resources invested by multiple state agencies currently to support this population. While recent efforts have begun to improve communication and information sharing between agencies regarding this population, gaps in services still exist. Providing additional services to meet the unique needs of this population, including preventive services, could assist crossover youth in working through unresolved trauma and potentially reduce juvenile justice system involvement.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 4</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would require a new program.</li><li>Cost would be a barrier to implementation.</li><li>Could require a federal approval process, regulatory process, contracts and grant cycles to implement.</li></ul></td><td><ul><li>High impact to a small, resource-intensive population.</li><li>Could create cost savings within the juvenile justice system.</li><li>Could produce cost savings in other areas, including within the justice system.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of crossover youth</li><li>Number of EBP programs available for crossover youth</li><li>Percent of crossover youth with a mental/behavioral condition who receive a referral to services</li></ul></td></tr>
<tr><td>Action Lead: DCF</td><td>Key Collaborators: KDADS, KDOC, KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

*Special Populations Recommendation 6.4:* **I/DD Waiver Expansion [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Fully fund the Intellectual and Developmental Disabilities (I/DD) waiver and expand I/DD waiver services. Increase reimbursement rates for I/DD services to support workforce expansion.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Working Group members highlighted that individuals with I/DD who have co-occurring disorders are not adequately served within the behavioral health system currently. This is partially due to challenges with finding providers who can address both behavioral health issues and I/DD, but also underfunding of the I/DD waiver. Working Group members highlighted a current lack of services to support individuals with I/DD within the behavioral health system, which can cause parents and families to seek out services provided under other waivers as a last resort. Further, this lack of services has led to some children entering the foster care system, because they are unable to receive the level of supports needed to remain at home, and this lack of services is often not resolved by entering foster care. These issues are exacerbated by workforce issues within the I/DD system, which could partially be addressed through increase reimbursement rates.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 4</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Would require a program change and potentially the addition of new programs.</li><li>Would require a federal approval process, regulatory process and agency budget development to implement.</li></ul></td><td><ul><li>High impact for the targeted population, which includes families of those with I/DD.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number of individuals on the waiting list for the I/DD waiver and average length of wait time.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: DCF, KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

*Special Populations Recommendation 6.5:* **Family Treatment Centers [Strategic Importance]**

| | |
|---|---|
| **Recommendation:** Increase the number and capacity of designated family SUD treatment centers, as well as outpatient treatment programs across the state. | |
| **Rationale**: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[29] Expanding access to family SUD treatment centers would allow more individuals to receive treatment, by not requiring parents to choose between caring for their family and receiving treatment. Treating individuals in a family setting can also benefit the entire family, by allowing family members to participate in the treatment process and therapy sessions. | |
| **Ease of Implementation** *(Score 1-10): 5* | **Potential for High Impact** *(Score 1-10): 5* |
| • Would require an expansion of an existing program.<br>• Would require systems changes to implement, including information sharing between agencies. | • Would impact special populations, including foster care, low-income individuals and children. |
| **Measuring Impact:**<br>• Number of family SUD treatment centers in Kansas.<br>• Number of family outpatient treatment programs in Kansas. | |
| **Action Lead:** KDADS | **Key Collaborators:** DCF, KDHE |

*Return to Figure 1 or Figure C-2.*

# System Capacity and Transformation (WG3)

The System Capacity and Transformation Working Group made recommendations related to the topics of data systems, interactions with the legal system and law enforcement and system transformation.

## *Data Systems*

A modernized system requires a seamless, real-time data system with multi-directional data sharing among behavioral health providers, other health care providers and systems, community organizations, social service providers, law enforcement and payers. The highest priorities for modernizing data systems within the Kansas behavioral health system are to promote information sharing across the system, particularly between state agencies by incentivizing providers to use electronic health records (EHR) and to participate in health information exchanges. Additionally, modernized data systems will require that prevention data surveys be collected with an informed opt-out consent process rather than opt-in consent. A modernized data system will support the ability to assess and aggregate data between service

providers to ensure the individual is getting appropriate and coordinated care and to ensure that health care providers are notified when patients are hospitalized. Modernized data systems should make all appropriate considerations for privacy protection and support measurement of key outcomes. The System Capacity and Transformation Working Group additionally discussed the need for data systems at the state hospitals to support automation of key functions and interoperability with other systems, when appropriate.

*Recommendations*

The Working Group advanced five high-priority recommendations for data systems, with four highlighted for immediate action and one for strategic importance.

*Data Systems Recommendation 7.1:* **State Hospital EHR [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: The new state hospital electronic health record (EHR) system should be interoperable with other data systems in the state. Interoperability should include the ability to automate the current process to reinstate Medicaid benefits following discharge.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group. Kansas Department for Aging and Disability Services (KDADS) has already issued a request for proposals (RFP) to implement a new state hospital EHR, with the RFP indicating that the selected EHR should be interoperable with other data systems in the state. Initial funding has been authorized to support the adoption of a new EHR, but ongoing funding may be needed to sustain it, and challenges may occur during implementation.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 9</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Initial funding has been authorized to implement, but ongoing funding will be necessary for long-term sustainability.</li><li>Could require agency budget development to implement.</li></ul></td><td><ul><li>Would impact the state hospital populations and support continuity of care in other settings.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Percent or number of hospitals that have adopted the new state hospital EHR.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: EHR vendor, KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Data Systems Recommendation 7.2:* **Data and Survey Informed Opt-Out [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Collect, analyze, use, and disseminate surveillance data to inform prevention. Change legislation regarding public health and behavioral health state surveys, including changing the Kansas Communities That Care (KCTC) and Youth Risk Behavior Surveillance System (YRBS) surveys from an opt-in consent to an informed opt-out consent, to allow for meaningful data collection.</td></tr>
<tr><td colspan="2">Rationale: Previous versions of this recommendation were originally developed by the Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council and the Governor's Substance Use Disorders Task Force.[30,31] Due to the current protocol of opt-in consent, the amount of data collected via surveys like the KCTC is too limited to reliably inform policymaking. Collecting better surveillance data can inform which types of prevention activities are necessary to mitigate behavioral health issues, including work on suicide prevention and ongoing improvement of mental health programs in schools. The lack of reliable data also makes it difficult for state agencies to complete required activities for federal block grants. Relative to other recommendations, this would not require a high financial investment by the state to implement.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Cost would not be a barrier to implementation.</li><li>Would require a legislative session to implement.</li></ul></td><td><ul><li>Would impact a large portion of school-aged youth.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Percent or number of school districts participating in survey administration.</li><li>Survey response rate.</li></ul></td></tr>
<tr><td>Action Lead: Legislature</td><td>Key Collaborators: KDADS, KSDE</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Data Systems Recommendation 7.3:* **Information Sharing [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Utilize Medicaid funds to incentivize participation in health information exchanges (e.g., Kansas Health Information Network [KHIN] or Lewis and Clark Information Exchange [LACIE]). Explore health information exchanges as an information source on demographic characteristics, such as primary language and geography for crossover youth and other high priority populations.</td></tr>
<tr><td colspan="2">Rationale: Previous versions of this recommendation were originally developed by the Child Welfare System Task Force and the Crossover Youth Working Group.[32,33] Health information exchanges (HIE) can lead to better coordinated care, by allowing providers to access the most recent health records of their patients. Participating in an HIE requires investment in an electronic health record (EHR) system and interfaces to connect the EHR and HIE, which can be cost prohibitive for some providers. Working Group members did not want to mandate participation in either KHIN or LACIE, suggesting that incentives were a more effective way to encourage participation in an HIE. The working group noted that funding streams to incentivize EHR adoption were not available to all behavioral health providers, and federal funding to support incentives may be limited as earlier incentive programs have concluded. This recommendation encourages the state to pursue the most feasible option (e.g., waiver amendments, federal innovation models) to incentivize participation in an HIE.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Would require a program change.</li><li>Cost could be a barrier to implementation.</li><li>Incentives should be ongoing and could be offset by reductions in the Medicaid program.</li><li>Could require agency budget development to implement.</li></ul></td><td><ul><li>Could impact a large population, including special populations such as those in foster care, rural, frontier and urban communities, children, veterans, individuals with low-income and individuals with limited English proficiency.</li><li>Could potentially produce cost savings.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>More work is needed to identify measures appropriate to capture the impact of this recommendation.</li></ul></td></tr>
<tr><td>Action Lead: KDHE</td><td>Key Collaborators: KHIN, Providers</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Data Systems Recommendation 7.4:* **Needs Assessment [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers and specific policies to effectively utilize, integrate and expand SUD treatment resources.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[34] Working Group members highlighted a need to expand resources for SUD treatment, which could also lead to an increase in the number of providers offering SUD treatment in the state. Conducting a statewide needs assessment could help identify where to specifically target SUD treatment expansions. A needs assessment should be conducted soon, and on a rolling basis thereafter.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 7</td><td>Potential for High Impact (Score 1-10): 7</td></tr>
<tr><td><ul><li>Cost could be a barrier to implementation.</li><li>Could require a state plan amendment of agency budget development to implement recommendations from a needs assessment.</li></ul></td><td><ul><li>High impact to a small population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>More work is needed to identify measures appropriate to capture the impact of this recommendation.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Data Systems Recommendation 7.5:* **Cross-Agency Data [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council. Improved processes and policies on sharing data across agencies could lead to improved prevention efforts across the state, help establish common goals across agencies and increase efficiency. Additionally, it could highlight gaps in care for some vulnerable populations that are served by multiple agencies.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Could require systems and agency memoranda of understanding to implement.</li></ul></td><td><ul><li>Could impact a large population.</li><li>Could lead to increased efficiencies and improve decision making by highlighting needs across systems.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>More work is needed to identify measures appropriate to capture the impact of this recommendation.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, DCF, KDOC, KSDE</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

## *Interactions with Legal System and Law Enforcement*

Through collaboration among the legal system, law enforcement and others in an interdisciplinary behavioral health team, a modernized behavioral health system has the ability to make timely connections for individuals in crisis to services in the least restrictive setting appropriate to ensure safety. A modernized approach will increase treatment options for justice-involved adults and youth. Training will be made available to law enforcement officers, the courts and others in the legal system to increase awareness of mental health issues and to support timely connection to treatment opportunities. Treatment opportunities will include those for a full spectrum of behavioral health issues include mental health and substance use disorder (SUD). More collaboration between the criminal justice system and behavioral health professionals will be needed to ensure this. Sufficient community support services, such as housing, will also be necessary to maintain clients in least restrictive setting possible while maintaining safety. Key strategies may include expanding crisis intervention teams (CIT) and crisis centers so that first responders have robust and efficient options for responding to mental

health crises, expanding specialty courts, utilizing robust data system to help communities identify high utilizers of crisis services so that those individuals can be connected to services.

*Recommendations*

The Working Group advanced four high priority recommendations for interactions with the legal system and law enforcement, with three highlighted for immediate action and one for strategic importance.

*Interactions with Legal System and Law Enforcement Recommendation 8.1:* **Correctional Employees [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Expand training provided in correctional facilities to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[35] The Kansas Department for Aging and Disability Services (KDADS) has existing training for employees of correctional facilities, and implementation of this recommendation would expand the current reach and breadth of those trainings for employees throughout the justice system. While the current training largely focuses on mental health, the Working Group spoke to the importance of educating employees on substance use disorders and incorporating a trauma-informed approach to identification of mental health needs. Expanding these trainings will require additional financial resources, and they should be offered on a consistent and ongoing basis.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Would require an expansion of existing training efforts.</li><li>Would be a low-cost recommendation.</li><li>Could require changes to grant cycles, state agency contracts and agency budget development.</li></ul></td><td><ul><li>Would benefit a large population.</li><li>Would benefit urban, rural and frontier communities.</li><li>Could generate cost savings by reducing recidivism, if individuals are connected to treatment.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number and percent of unit team counselors working in a correctional facility that received training on substance abuse programs and services</li><li>Number and percent of staff working in a correctional facility that received trauma informed training</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDOC, local law enforcement agencies.</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Interactions with Legal System and Law Enforcement Recommendation 8.2:* **Criminal Justice Reform Commission Recommendations [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Implement recommendations developed by the Criminal Justice Reform Commission (CJRC) related to specialty courts (e.g., drug courts) and develop a process for regular reporting on implementation status and outcomes.</td></tr>
<tr><td colspan="2">Rationale: This recommendation was newly developed by the System Capacity and Transformation Working Group. This recommendation was developed to recognize the value of aligning efforts to modernize the behavioral health system with parallel efforts related to criminal justice reform in the CJRC. The Working Group was particularly supportive of the CJRC recommendation to expand pre- and post-charge diversion sobriety and treatment options for first time, non-violent, simple drug possession charges.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Cost could be a barrier to implementation.</li><li>Would require training of courts and judicial staff.</li></ul></td><td><ul><li>Recommendation could produce cost savings through reducing KDOC population and connecting individuals to treatment services in a more timely manner.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Number and percent of judicial districts with one or more specialty courts (by type)</li><li>Consider tracking goals and outcomes using KDOC’s soon to be ATHENA system</li></ul></td></tr>
<tr><td>Action Lead: Legislature</td><td>Key Collaborators: KDADS, KDOC</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Interactions with Legal System and Law Enforcement Recommendation 8.3:* **Law Enforcement Referrals [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to services for this population.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.[36] Additionally, this recommendation is in alignment with recommendations from the Kansas Pre-Trial Justice Task Force that focus on behavioral health issues.[37] The Working Group discussed the value of this recommendation in highlighting the particular need for substance use disorder (SUD) treatment among those individuals with law enforcement contact. This recommendation could be co-implemented with Recommendation 2.3 toward the goal of installing the Certified Community Behavioral Health clinics (CCBHC) model in Kansas as a requirement of the CCBHC model is the development of partnerships between behavioral health providers and law enforcement.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 6</td></tr>
<tr><td><ul><li>Would require a program change and implementation of new programs.</li><li>Cost would be a barrier to implementation but would be needed to support new programs.</li></ul></td><td><ul><li>Would have a high impact for those individuals who would benefit.</li><li>Would address disparities, as this recommendation would provide the opportunity for individuals to be connected to services who are missing that opportunity in the current system.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>More work is needed to identify measures appropriate to capture the impact of this recommendation.</li></ul></td></tr>
<tr><td>Action Lead: KDOC</td><td>Key Collaborators: KDADS, providers</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*Interactions with Legal System and Law Enforcement Recommendation 8.4:* **Defining Crossover Youth Population. [Strategic Importance]**

| | |
|---|---|
| **Recommendation:** Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population. | |
| **Rationale**: A version of this recommendation was originally developed by the Crossover Youth Working Group.[38] Building upon the work of that group, this recommendation highlights the importance of having a clear definition for which individuals fit within the crossover youth population and incorporating behavioral health within the definition. Understanding the behavioral health needs of individuals dually involved with the juvenile justice and child welfare systems will be critical to serving that population. | |
| **Ease of Implementation** *(Score 1-10): 7* | **Potential for High Impact** *(Score 1-10): 6* |
| • Cost would not be a barrier to implementation. | • Understanding the needs of the crossover youth population will be important to have a high impact on those individuals. |
| **Measuring Impact:**<br>• Number of crossover youth | |
| **Action Lead:** KDOC, KDADS | **Key Collaborators:** DCF |

*Return to Figure 1 or Figure C-2.*

## *System Transformation*

A modernized system will work both in evidence-based treatment and prevention with focus on the patients to address a continuum of needs. Transformation will result in a mission driven, rationally funded and outcome-oriented system of providers that uses data as an asset to identify problems and develop solutions. An important strategy for system transformation will be addressing the continuum of care to ensure an integrated and coordinated approach to care delivery. The System Capacity and Transformation Working Group also discussed barriers related to cross system collaboration, infrastructure changes, and Medicaid payment for services to families.

*Recommendations*

The Working Group advanced five high priority recommendations for system transformation, with three highlighted for immediate action and two for strategic importance.

*System Transformation Recommendation 9.1:* **Regional Model [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).[39] It was a standalone recommendation in the 2018 MHTF report and then consolidated into Recommendation 1.1 and 1.2 in the 2019 MHTF report. The Working Group discussed that while cost is a primary barrier to implementation, there are opportunities for cost savings by reducing the high cost of transporting individuals to Osawatomie State Hospital (OSH) or Larned State Hospital. Both institutions are a significant distance from key population centers, particularly in the south-central region of the state. This recommendation could be implemented by a combined approach of state institution alternatives (SIAs) and smaller, regional state facilities.<br><br>Cost savings accrued via the recommendation could be redirected to the provision of evidence-based services. In addition to cost savings, a reduction in travel would increase safety of the individuals in need of care as well as those in the behavioral health workforce currently providing transportation services, as well as allow individuals to remain closer to local support systems. This recommendation is also seen as a key component to lifting the ongoing moratorium at OSH and is included in the current plan to do so.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td>• Cost would be a barrier to implementation based on the need for appropriation.</td><td>• Would benefit a large population.<br>• Could produce cost savings via reduction in transportation costs.</td></tr>
<tr><td colspan="2">Measuring Impact:<br>• More work is needed to identify measures appropriate to capture the impact of this recommendation.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: Providers</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*System Transformation Recommendation 9.2:* **Long-Term Care Access and Reform [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within the continuum of care. Increase access to long-term care (LTC) facilities, particularly for individuals with past involvement with the criminal justice system or those with a history of sexual violence.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group that updates language originally included in Recommendation 4.1 from the Mental Health Task Force Report to the Legislature, January 14, 2019.[40] The Working Group adapted this recommendation on NFMH reform to include new information on the need to increase access to LTC facilities, particularly for individuals with a history of involvement with the criminal justice system. The Working Group described the status quo as one where individuals are often required to stay in acute hospitals because there is not a nursing facility with the capacity to care for them. At times, these individuals may be discharged from acute hospitals into homelessness, so the Working Group discussed the importance of supportive housing. For more information on supportive housing see Recommendation 5.4 Housing. Increasing access to LTC facilities could include discharging individuals currently in LTC back to their communities, if appropriate discharge planning occurs to connect individuals with supports available within the community. Further, reformation of NFMHs could improve quality of care and discharge planning. This recommendation is a high priority to the Working Group due to the importance of protecting the rights of citizens by providing individuals with disabilities the opportunity to live and receive care in the least restrictive environment possible.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td>• Reforming the NFMH licensing structure may require a federal approval process.</td><td>• Would have a high impact for those who receive care at NFMHs or require access to LTC.</td></tr>
<tr><td colspan="2">Measuring Impact:<br>• Percent of individuals who transition back to the community.<br>• Percent of individuals with stability/tenure in the community.<br>• Average length of stay in NFMH.<br>• Rate of discharge back to community/supported housing placements.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*System Transformation Recommendation 9.3:* **Integration [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. Adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions.</td></tr>
<tr><td colspan="2">Rationale: Multiple previous collaborative efforts developed recommendations highlighting the importance of integration (e.g., Governor’s Substance Use Disorders Task force, Governor’s Behavioral Health Services Planning Council), and the System Capacity and Transformation Working Group built this recommendation from that work. SAMHSA describes integration as, “The care that results from a practice team of primary care and behavioral health clinicians and other staff working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”[41] Integrated care can lead to better outcomes for patients, as well as more streamlined care delivery. Adopting coding practices in support of integration is seen as critical to the goal of providing best practice, whole-person care.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td><ul><li>Would require legislation.</li><li>Would require a Federal approval process.</li><li>Also would require work related to agency budget development, grant cycles and system changes (e.g., IT).</li></ul></td><td><ul><li>Would benefit a large population.</li><li>Special populations who would benefit include: foster care, urban, rural and frontier communities, those with limited English proficiency, low-income individuals, children.</li><li>Could potentially produce cost savings by reducing duplicative care.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Percent or number of certified CCBHCs in the state of Kansas.</li><li>Percent or number of Counties served by Mobile Response and Stabilization Services.</li></ul></td></tr>
<tr><td>Action Lead: KDADS/KDHE</td><td>Key Collaborators: Legislature, CMHCS, FQHCs, other safety net providers</td></tr>
</table>

*Return to Figure 1 or Figure C-1.*

*System Transformation Recommendation 9.4:* **Evidence Based Practices [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Kansas should continue and expand support for use of evidence based practices (EBP) in the state, including for housing and supported employment. Coordinate EBP utilization across systems (e.g., law enforcement, SUD, mental health care) with a goal of implementing programs with fidelity, when possible.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group. The Working Group discussed the delivery of evidence based models of service as a key part of a modernized behavioral health system. With that in mind, the group also discussed that fidelity to these programs, as originally designed, can be challenging due to the variety of standards that exist between different EBPs. Regardless, the Working Group noted the importance of delivering evidence-based services throughout the behavioral health system and, in particular, for those in long-term care settings.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td><ul><li>Would require changes to existing programs.</li><li>Cost would be a barrier to implementation.</li></ul></td><td><ul><li>Would benefit a large population.</li></ul></td></tr>
<tr><td colspan="2">Measuring Impact:<ul><li>Percent of EBPs adopted by providers.</li><li>Number of EBP programs funded and appropriations.</li><li>Percent of individuals with SPMI that have been enrolled in supportive employment, and have not had an ER or Psychiatric Hospital admission in the last 12 months.</li><li>Percent of individuals with SPMI that have been enrolled in supportive housing, and have not had an ER or Psychiatric Hospital admission in the last 12 months.</li><li>EBP utilization across systems.</li></ul></td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: DCF</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

*System Transformation Recommendation 9.5:* **Family Psychotherapy [Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group, related to recommendations from the 2018 and 2019 Mental Health Task Force Reports to the Kansas Legislature.[42] This recommendation would allow for the provision of family therapy services without the child present. This was highlighted as important given that discussing the behavioral health needs of a child with a parent or guardian is an important part of care provision and, at times, inappropriate in the presence of the child. The group also noted how the code could support the implementation of an evidence-based program called Generation Parent Management Training – Oregon (PMTO). PMTO is an evidence-based structured intervention program designed to help strengthen families that has demonstrated positive outcomes throughout a nine-year follow-up period, including reductions in delinquency, depression and police arrests, among others.[43] This is a program of high interest to those in the state working to implement the Federal Families First Act and requires a significant amount of the services to be delivered to parent(s) or guardian(s), without the child present.<br><br>The Working Group also noted that the Centers for Medicare and Medicaid Services (CMS) has flagged this code as one with a high potential for fraud or abuse in some states. Working Group members were not overly concerned about the potential for fraud in Kansas, however, because the code was previously allowed under the Children's Health Insurance Program (CHIP). When allowed in Kansas under CHIP, the code was not highly utilized, but utilization may be higher if allowed again due to implementation of the PMTO program.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 10</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td>• Would require changes in the regulatory process.<br>• Cost would not be a barrier to implementation.</td><td>• Could potentially generate cost savings.</td></tr>
<tr><td colspan="2">Measuring Impact:<br>• Percent of families served by the Generation Parent Management Training – Oregon (PMTO) program.</td></tr>
<tr><td>Action Lead: KDHE, Division of Healthcare Finance</td><td>Key Collaborators: DCF</td></tr>
</table>

*Return to Figure 1 or Figure C-2.*

# Telehealth

The Special Committee on Mental Health Modernization and Reform recognized that telehealth was a topic of high importance that cut across the three Working Groups that had been created. As this was considered to be a topic of interest to each Working Group, members of each group volunteered to contribute to a telehealth subgroup. The topic was of high interest across

Working Groups due, in part, to the ongoing COVID-19 pandemic. The COVID-19 pandemic has created a unique situation due to the increased number of services provided via telehealth to ensure patient safety and to the temporary changes to reimbursement practices and other policies related to telehealth to support the change in service delivery. Subgroup members developed recommendations for modernizing the telehealth system based on experiences delivering telehealth during and prior to the COVID-19 pandemic.

The following recommendations are part of the strategic work that will be required to modernize the approach to delivering behavioral health services via telehealth in Kansas. In a modernized system, the delivery of sophisticated telehealth services will be a strategy to provide meaningful access to care across rural, frontier and urban areas of the state. While a key strategy to improving access, the delivery of behavioral health services via telehealth does not preclude the need for behavioral health clinicians to provide services in person across the state. A modernized behavioral health system will offer a balance between service delivery via telehealth and in person. Telehealth services provided will be high-quality, integrated with other modes of care delivery and allow for consumer choice, in addition to supporting the full spectrum of behavioral health care. The telehealth subgroup discussed the need to address telephonic access to services when needed, broadband access, long-term changes to reimbursement strategies, crisis services and issues related to care delivery across state lines.

*Recommendations*

The Working Group advanced five high-priority recommendations for telehealth, with three highlighted for immediate action and two for strategic importance.

The Working Group did not have previous task force recommendations to consider regarding telehealth, so all recommendations in this section were created by the task force with support from supplemental experts. Because these are new recommendations, additional rationale has been provided when available and the recommendation rubric was not used for these recommendations. As a result, information on ease of implementation and potential for high impact are limited and may need to be assessed in later discussion of these recommendations.

### *Telehealth Recommendation 10.1:* **Quality Assurance [Immediate Action]**

**Recommendation:** Develop standards to ensure high-quality telehealth services are provided, including:

- Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies.
- Implementing standard provider education and training.
- Ensuring patient privacy.
- Educating patients on privacy-related issues.
- Allowing telehealth supervision hours to be consistently counted toward licensure requirements.
- Allowing services to be provided flexibly when broadband access is limited.

**Rationale**: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts.

Due to the rapid expansion of telehealth services during the COVID-19 pandemic, Working Group members highlighted a variety of needs to address to ensure that high-quality telehealth services are provided in Kansas beyond the pandemic.

Relevant regulatory agencies and providers should develop guidelines for the provision of telehealth services that align with established best practices. Guidelines should recognize the value of consumer choice and provision of in-person services when needed or desired. Measures should be identified to assess the impact of telehealth on access, quality and equity within behavioral health care.

Providers should be trained on issues related to telehealth by existing professional organizations, telehealth resource centers and other providers of continuing education curriculum. This could include: completing a basic telehealth training with a focus on the clinical delivery of services; education about the basic parameters of telehealth billing, record keeping, and criteria for reimbursement; and training and support to mitigate the increased cognitive, physical, and emotional demands associated with a significant increase in productivity and use of technology to provide care.

The privacy of patients should be protected when telehealth is provided. This includes payers requiring utilization of platforms and other secure technologies that are compliant with all relevant State and Federal statute and regulations (e.g., HIPAA, 42 CFR Part 2), in addition to providers educating patients on privacy-related issues. Privacy issues extend beyond technology, however, and include ensuring that services are provided and received in locations that meet safety and privacy requirements.

Some behavioral health providers can use supervision hours conducted via telehealth to qualify for licensure, but this is not consistent across provider types licensed by the Kansas Behavioral Sciences Regulatory Board (BSRB). Consistently allowing telehealth supervision to meet licensure requirements could increase the number of high-quality providers in the state.

Working Group members indicated that video services are the preferred, and highest-quality, option for providing telehealth services. Given current broadband deficiencies in the state, however, telephonic behavioral health services should be allowed by payers when needed to address access issues, and guidelines for audio-only telehealth visits should be established.

Finally, it was noted that electronic health record (EHR) utilization is critical to support effective, high-quality delivery of telehealth, particularly to ensure care coordination across providers. Implementation of *Recommendation 7.3* **Information Sharing** could support this recommendation.

**Measuring Impact:** More work is needed to identify measures appropriate to capture the impact of this recommendation.

| | |
|---|---|
| **Action Lead:** Various | **Key Collaborators:** KDHE**,** KDADS, Providers, BSRB, Private insurers, regulatory agencies |

*Return to Figure 1 or Figure C-1.*

*Telehealth Recommendation 10.2:* **Reimbursement Codes [Immediate Action]**

| | |
|---|---|
| **Recommendation:** Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services. | |
| **Rationale**: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. While many behavioral health services could be provided via telehealth prior to the COVID-19 pandemic, additional codes (e.g., for the SED waiver, crisis intervention, tobacco cessation) have become eligible for reimbursement during the public health emergency (PHE).[44,45,46] Working Group members indicated that some of these services should be maintained after the PHE ends, though the changes were initially intended to be temporary. Additionally, the PHE has led to an expansion of the types of sites where patients can receive care, including at home. Services provided to patients in their homes are not eligible for a facility fee payment for the originating site. In situations where support (e.g., IT support, patient education and preparation) is provided to patients receiving telehealth services in their home, commensurate compensation should be made available to service providers. | |
| **Measuring Impact:**<br>• Number of telehealth codes open for Medicaid reimbursement pre- and post-pandemic<br>• Utilization of these telehealth codes | |
| **Action Lead:** KDHE Division of Healthcare Finance | **Key Collaborators:** KDADS, managed care organizations, community mental health centers |

*Return to Figure 1 or Figure C-1.*

*Telehealth Recommendation 10.3:* **Telehealth for Crisis Services [Immediate Action]**

| | |
|---|---|
| **Recommendation:** Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities. | |
| **Rationale**: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. Telehealth can create immediate access to services in an area where providers are not physically located. Working Group members highlighted a specific need for crisis services to be provided via telehealth, particularly in rural or frontier areas where these services are less likely to be available currently. Covering telehealth for crisis services could also support police departments or law enforcement agencies who frequently respond to behavioral health crises, such as through co-responder models that pair local law enforcement with remote clinicians. Some neighboring states have already implemented co-responder models, which have the potential to generate savings by reducing arrests, jail admissions and hospital stays.[47] Related to the measures indicated in the "Measuring Impact" field below, the group noted that many individuals in crisis will not be Medicaid beneficiaries, so additional measures should be developed to better capture the impact of this recommendation. | |
| **Measuring Impact:**<br>• Number of telehealth crisis codes open for Medicaid reimbursement<br>• Utilization of these telehealth crisis codes | |
| **Action Lead:** KDHE | **Key Collaborators:** KDADS**,** KDOC, DCF, local law enforcement, providers |

*Return to Figure 1 or Figure C-1.*

*Telehealth Recommendation 10.4:* **Originating and Distant Sites [Strategic Importance]**

**Recommendation:** The following items should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations:

- Adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act.
- Allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met and
- Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts.

**Rationale**: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. Issues related to where providers can offer care and where patients can receive care will need to be addressed in order for high-quality telehealth care to be provided flexibly to patients.

The definition of originating sites included in the Kansas Telemedicine Act is: "a site at which a patient is located at the time healthcare services are provided by means of telemedicine."[48] Prior to the COVID-19 pandemic, allowed originating sites were limited by some insurers, preventing patients from receiving care in places like their homes. Adopting a broad definition of "originating site" would ensure that patients can receive care in a wider variety of settings, if those settings meet patient privacy and safety standards.

Distant sites — the location from which a provider offers care — could also be expanded to allow providers to offer services from their home or other non-clinical sites, if patient privacy and safety standards can be met. Allowing providers to offer services in flexible locations could help address workforce issues by increasing access to providers in areas of the state with shortages.

The location of patients when telehealth is provided can be complicated by state lines. This could include scenarios in which a patient needs care while traveling or residing outside of their home state (e.g., if a Kansan goes to college in another state). The state in which the patient is located typically determines the criteria for licensure, and Kansas providers who want to continue offering services to their patients outside of the state must contact the licensing body in the state where their patient is located. Often, licensing bodies will want to ensure that providers can connect patients to local service or crisis resources, if needed, and other states may have options for temporary licensure. Exploring Kansas participation in interstate licensure compacts could address some of these issues.

Additionally, since the onset of COVID-19, multiple out-of-state providers have expressed interest in providing virtual-only services to Kansas residents. While these providers could potentially address access issues, they could result in reduced care coordination with in-state providers. Issues related to practicing and receiving services across state lines will need to be addressed as telehealth continues to evolve and grow.

**Measuring Impact:**
More work is needed to identify measures appropriate to capture the impact of this recommendation.

| | |
|---|---|
| **Action Lead:** Legislature | **Key Collaborators:** KDHE, KDADS, Providers |

*Return to Figure 1 or Figure C-2.*

*Telehealth Recommendation 10.5:* **Child Welfare System and Telehealth [Strategic Importance]**

| |
|---|
| **Recommendation:** Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Consider how the unique needs of parents of children in the child welfare system can be met via telehealth. |
| **Rationale**: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. It is exploratory in nature and will require further development to assess how telehealth can be used as a tool to provide consistent, high quality behavioral health services for individuals who interact with the child welfare system.<br>In situations where placements are unstable, foster youth may move frequently, resulting in a disruption of services as youth move from one behavioral health catchment area to another. Allowing telehealth to be an option for foster youth to continue receiving services from providers they have established relationships with could lead to better outcomes, as changing care providers can delay access to behavioral health care, impedes the benefit of the therapeutic relationship, and delays positive outcomes for child well-being. Additionally, parents of children in the child welfare system may have behavioral health treatment needs – substance use, mental health, or both - that need to be resolved in order to support reunification of the child back into the home. Consistent access and availability of telebehavioral health services for parents could significantly increase case plan compliance and support timely reunification for children. |
| **Measuring Impact:**<br>• Utilization of telehealth across foster children eligibility groups.<br>• When child comes into care or goes to a new placement the CMHC will provide therapy within 72 hours of receiving the request.<br>• Percentage of CINC children/adolescents, age 17 or younger, that received crisis intervention services 30 calendar days prior to a screen resulting in inpatient psychiatric admission, excluding PRTF (i.e., CINC crisis intervention rate).<br>• The percentage of CINC children/adolescents that received therapeutic intervention services (includes more than initial assessment and diagnosis such as Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, Therapy and/or Intake) within 30 calendar days prior to a screen resulting in an inpatient psychiatric admission, excluding PRTF (i.e., CINC Therapeutic Intervention Rate). |

| | |
|---|---|
| **Action Lead:** KDHE | **Key Collaborators:** KDADS, DCF |

*Return to Figure 1 or Figure C-2.*

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# Appendix A: Other Recommendations

Included below are other recommendations related to each of the ten topics. These recommendations were maintained by the Working Groups for future work but were not considered a high priority at this time.

*Figure A-1.* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **WORKFORCE** | |
| New Recommendation | **Tuition Reimbursement.** Establish tuition reimbursement for master's level behavioral health providers, including addiction counselors, that agree to practice for a set period of time in a rural and frontier area. This could be tested as a pilot program in order to assess impact on workforce shortages. |
| New Recommendation | **Workforce Promotion**. Establish programs for those 12-18 years of age to promote familiarity with and interest in careers in behavioral health. |
| Governor's Substance Use Disorder Task Force | **Workforce Development.** Implement workforce development programs to increase capacity of addiction professions. |
| **FUNDING AND ACCESSIBILITY** | |
| Governor's Substance Use Disorder Task Force | **K-TRACS Funding**. K-TRACS should be sustainably funded by the State General Fund after any available grant funding is exhausted. |
| Governor's Substance Use Disorder Task Force | **Senate Bill 123**. Assure adequate funding for SB 123 (2003) (provides certified SUD treatment for offenders convicted of drug possession who are nonviolent with no prior convictions) to allow appropriate provision of medically necessary treatment services and allow for an expanded list of qualifying offenses. |
| Child Welfare System Task Force | **Maximizing Federal Funding.** The State of Kansas should conduct an audit of potential funding streams by program area to ensure the State is maximizing federal benefits. |
| Governor's Substance Use Disorder Task Force | **Opioid Addiction Project ECHO.** Identify funding for Opioid Addiction Project ECHO telementoring. |

*Figure A-1 (continued).* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **FUNDING AND ACCESSIBILITY (CONTINUED)** | |
| Child Welfare System Task Force | **Access to Care.** The State of Kansas should require access to high-quality and consistent medical and behavioral healthcare for Medicaid-eligible high-risk youth through the state Medicaid state plan or other appropriate sources of funding. |
| Child Welfare System Task Force | **Service Setting.** The State of Kansas should prioritize delivering services for children and youth in natural settings, such as, but not limited to, homes, schools, and primary care offices, in the child's community when possible. The needs of the child and family should be the most important factor when determining the settings where services are delivered. |
| Governor's Substance Use Disorder Task Force | **Sober Housing.** Study the efficacy of sober housing and strategies for success from other states including funding mechanisms. |
| Mental Health Task Force, 2019 | **Regional Community Crisis Center Locations.** Develop regional community crisis centers across the state including co-located or integrated SUD services. |
| Governor's Behavioral Health Services Planning Council | **Vocational Subcommittee (VOS) Recommendations.** Actively seek out and provide grants to CMHCs from the State General Fund to offset costs initiating and implementing Individual Placement and Support (IPS) Supported Employment model. |
| Governor's Substance Use Disorder Task Force | **Mental Health Parity.** Review procedures for mental health parity laws to ensure compliance. |
| New Recommendation | **Maintenance of Effort.** Increase the state's Maintenance of Effort in the SUD Block grant for providers in the Beacon Network. Medicaid expansion may be one mechanism for additional funding. |
| Governor's Substance Use Disorder Task Force | **IMD Waiver.** Explore waiver of Medicaid Institutions for Mental Diseases (IMD) exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment. |
| Governor's Substance Use Disorder Task Force | **Addiction Treatment.** Create additional services for the treatment of addiction as well as any co-occurring mental health diagnoses. |
| Governor's Behavioral Health Services Planning Council | **CAODA Recommendation.** Facilitate a pursuit of grant funding. Recommend creating a new state-level grant-support position to work directly with agencies to help secure and maintain these opioid related funds as well as other addiction prevention and treatment opportunities. A state-level coordinator could provide the grant-specific expertise. |

*Figure A-1 (continued).* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **FUNDING AND ACCESSIBILITY (CONTINUED)** | |
| Child Welfare System Task Force | **Resources and Accountability.** The State of Kansas and DCF should provide services that are in the best interest of children in their care by supporting a system that is accountable and resourced well enough to provide the needed services. Considerations should include, but not be limited to, the awarding of funds based upon qualifications and not financial factors, improving workforce morale and tenure, and providing technology to improve efficiencies. |
| Governor's Behavioral Health Services Planning Council | **CAODA Recommendation.** Allow addiction counseling agencies to become approved providers for co-occurring issues providing they have the appropriate resources to do so. This expansion of services should only apply to addiction counseling clients with co-occurring issues, not to general mental health clientele. |
| Governor's Behavioral Health Services Planning Council | **CAODA Recommendation.** Adopt coding practices that allow for the integration of CMHC, primary care, and behavioral health services to reduce the waste and gaps in service. |
| Governor's Substance Use Disorder Task Force | **Prior Authorizations.** Remove prior authorization requirements for MAT (medication-assisted treatment). |
| **Community Engagement** | |
| Governor's Behavioral Health Services Planning Council | **Justice Involved Youth and Adult Subcommittee (JIYAS) Recommendations**. Engage community partners using three pilot communities that the workgroup identified, which would involve a coordinated effort between the Kansas Department of Corrections (KDOC), CMHCs, and SUD providers. |
| **PREVENTION AND EDUCATION** | |
| Governor's Behavioral Health Services Planning Council | **Children Subcommittee**. Support, encourage, and provide resources to early childhood programs in implementing and sustaining the Kansas Family Engagement and Partnership Standards for Early Childhood. |

*Figure A-1 (continued).* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **PREVENTION AND EDUCATION (CONTINUED)** | |
| Governor's Substance Use Disorder Task Force | **Coroner Letters**. Explore the feasibility of and consider a pilot program for coroners or medical examiners sending educational letters to prescribing providers upon their own patient's death from prescription drug or other illicit substance overdose. |
| Governor's Behavioral Health Services Planning Council | **Suicide Prevention Workgroup.** Write, distribute, and promote op-eds, and disseminate information about safe messaging covering suicide, and urge the development of effective materials including through local media outlets. Increase number of trainings and workshops to promote and support application of best practices and evidence-based approaches in the field of suicidology among Behavioral Sciences Regulatory Board (BSRB) licensed behavioral health practitioners and community gatekeepers when working to prevent suicides. |
| **TREATMENT AND RECOVERY** | |
| Mental Health Task Force, 2019 | **Care Management Program**. Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt into a health home to have access to activities that help coordinate care. |
| Governor's Substance Use Disorder Task Force | **Expand MAT**. Expand Access and utilization of medication assisted Treatment (MAT), including increasing access to MAT in jail settings and an expansion of MAT in block grant services |
| Governor's Behavioral Health Services Planning Council | **Housing and Homelessness Subcommittee.** Continue and expand Housing First in collaboration with KDADS, including an expansion of technical assistance and education to promote utilization. |
| Governor's Behavioral Health Services Planning Council | **Supported Housing.** Expand the Supported Housing Program, a program that provides affordable housing linked to services for low-income, homeless, or potential homeless people with severe mental illness. |
| Governor's Behavioral Health Services Planning Council | **Children Subcommittee.** Increase the availability of flexible treatment options (residential and outpatient) that allow children to stay with and participate in treatment with their parents, which also embrace a holistic and trauma-informed approach to treatment. |
| New Recommendation | **Co-Occurring Disorders:** Invest in community-based intellectual and developmental disability (I/DD) services and training around behavioral health. |

*Figure A-1 (continued).* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **TREATMENT AND RECOVERY (CONTINUED)** | |
| New Recommendation | **Supported Employment.** Expand the Supported Employment Program, a program that provides employment services to individuals suffering from a severe mental illness, including those with a mental illness and co-occurring substance disorder. |
| Governor's Behavioral Health Services Planning Council | **Housing and Homelessness Subcommittee.** Create a housing specialist certification and ongoing education training curriculum. |
| **SPECIAL POPULATIONS** | |
| Governor's Substance Use Disorder Task Force | **Neonatal Abstinence Syndrome (NAS).** Provide education, screening, intervention, and support to substance using women to reduce the number of infants born substance-exposed, while expanding coverage for family planning services, preconception services, and a variety of contraceptives, including long acting reversible contraceptives. Provide education on best practices to reduce stigma and promote standardized care regarding NAS cases, develop a standardized reporting process for NAS cases across the state. |
| Governor's Behavioral Health Services Planning Council | **Rural and Frontier Subcommittee (RFS) Recommendation**. Increase funding for crisis services and beds (youth respite, mobile crisis) statewide, being sure to address existing gaps in rural and frontier areas. |
| Mental Health Task Force, 2019 | **Access to Effective Practices and Support.** Deliver crisis, clinical, and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community. |
| Crossover Youth Working Group | **Child Welfare Placements.** The Working Group suggests exploring what supports/services are lacking and prevent permanency from being achieved regarding placement stability of crossover youth placed in foster care. |
| New Recommendation | **Children of Incarcerated Parents.** Build awareness of and responsiveness to the behavioral health needs and risks of children of incarcerated parents into the behavioral health system through data analysis, information sharing, workforce training, and targeted interventions and coordination between KDOC, DCF, KDADS, KDHE, KSDE and community partners serving children of incarcerated parents. |

*Figure A-1 (continued).* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **SPECIAL POPULATIONS (CONTINUED)** | |
| New Recommendation | **Perinatal Mood and Anxiety Disorders (PMAD).** Increase identification of perinatal mood and anxiety disorders (PMAD) and options for care provision, including workforce development and training on PMAD. |
| **Data Systems** | |
| Crossover Youth Working Group | **Child Welfare Placements.** The Working Group proposes future efforts to study data on outcomes for youth placed in group residential homes and to understand whether youth who might have been detained prior to SB 367 are now being placed in the child welfare system. |
| **INTERACTIONS WITH THE LEGAL SYSTEM AND LAW ENFORCEMENT** | |
| Mental Health Task Force, 2019 | **Suspension of Medicaid.** Implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care. |
| Governor's Substance Use Disorder Task Force | **Naloxone.** Promote Naloxone education and use for first responders and pursue all available funding. (Note: Working Group members indicated that this recommendation had largely been implemented.) |
| Governor's Substance Use Disorder Task Force | **Good Samaritan.** Enact a 911 Good Samaritan Law. This law must be crafted to avoid unintentionally allowing persons to avoid persecution for serious felony charges, especially when their actions directly involved providing illicit substance to the ill individual. |
| **SYSTEM TRANSFORMATION** | |
| Governor's Substance Use Disorder Task Force | **Kansas Placement Criteria Program.** Implement modern technology and data collection to replace the discontinued Kansas Placement Criteria Program (KCPC). |
| Governor's Substance Use Disorder Task Force | **Payment Reform.** Support substance use disorder payment reform targeted to improve population health. |
| Governor's Substance Use Disorder Task Force | **Screening, Brief Intervention and Referral to Treatment (SBIRT)**. Increase access to and utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT) by expanding who can be reimbursed for providing SBIRT (e.g., include in block grant funding) and where SBIRT can be provided (e.g., in the education system). |

*Figure A-1 (continued).* ***Other Recommendations***

| Source | Recommendation |
|---|---|
| **SYSTEM TRANSFORMATION (CONTINUED)** | |
| Child Welfare System Task Force | **Analysis of Service Delivery.** The State of Kansas should establish a work group or task force to conduct an analysis to: 1) determine what it costs to adequately fund high-quality child welfare services; 2) by 2021, evaluate the benefits of privatizing child welfare services; and 3) determine the best public/private collaboration to deliver child welfare services. DCF shall determine appropriate outcomes measures and periodic evaluations shall be conducted to ensure contractors are achieving set outcomes and provide opportunities for ongoing collaboration and review. Summary reports should be provided to the Legislature annually. |
| Mental Health Task Force, 2019 | **Learning Across Systems.** Create a position/entity to track information about adverse outcomes that occur and identify strategies for addressing them in a timely manner. |
| Crossover Youth Working Group | **Juvenile Intake and Assessment**. Their view of Juvenile Intake and Assessment Services was limited in scope to only FY2019. Data from intake and assessments completed throughout a youth's lifetime should be reviewed. Robust analysis from completed the Kansas Detention Assessment Instrument (KDAI) could be conducted when integrated into the data system. |
| **TELEHEALTH** | |
| New Recommendation | **Verbal Consent.** Recommend the opportunity to obtain verbal consent for care with written consent established as follow-up. |
| New Recommendation | **Telehealth Care Coordination.** Explore options to cover reimbursement for care coordination around the provision of telehealth services. |
| New Recommendation | **Broadband.** Expand access to broadband. |
| New Recommendation | **Jail Telehealth Services.** Explore challenges to address challenges (e.g., privacy, technology, funding) related to providing telehealth services in a jail setting. |

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# Appendix B. Recommendation Rubric

*Figure B-1.* **Mental Health Modernization and Reform, Working Group Recommendation Rubric, 2020**

<table>
<tr><td colspan="2">Recommendation:</td></tr>
<tr><td colspan="2">Rationale:</td></tr>
<tr><td>Ease of Implementation (Score 1-10):</td><td>Potential for High Impact (Score 1-10):</td></tr>
<tr><td>Consider:<br>☐Program Change (Easiest)<br>☐Pilot Program<br>☐Program Overhaul<br>☐New Program (Most difficult)<br><br>Will cost be a barrier to implementation?<br><br>Does the recommendation include strategies for continuity? (How does it consider sustainability?)<br><br>Which of the following mechanisms may affect the achievability of the recommendation?<br>☐ Legislative session<br>☐ Federal approval process<br>☐ Regulatory process<br>☐ Contracts<br>☐ Agency budget development<br>☐ Grant cycles<br>☐ Systems (e.g., IT)</td><td>Consider:<br>Will it benefit a large population? ☐Yes ☐ No<br><br>Will it significantly impact special populations?<br>☐Foster care<br>☐Frontier communities<br>☐Rural communities<br>☐Urban communities<br>☐Limited English Proficient (LEP) persons<br>☐Low-income individuals<br>☐Children<br>☐Veterans<br>☐Others? (List here)<br><br>Does it serve those who have been disproportionately impacted by the issue? (Does it address inequities?)<br><br>Could the recommendation produce savings in other areas?</td></tr>
</table>

*Figure B-1 (continued).* **Mental Health Modernization and Reform, Working Group Recommendation Rubric, 2020**

| | |
|---|---|
| **How does this recommendation contribute to modernization?** | |
| **Action Lead:**<br>*(Who takes point on this recommendation?)* | **Key Collaborators:**<br>*(Who should be included as decisions are made about how to implement this recommendation?)* |
| **Intensity of Consensus**:<br>*(Is there group consensus that this recommendation is important for the modernization and reform of the behavioral health system in the state? Does a wide cross-section of stakeholders feel that this recommendation would be mutually beneficial? To be addressed during final review)* | |

# Appendix C. High-Priority Topic Lists

The Working Groups have made recommendations related to the following topics for immediate action (*Figure C-1*). **Recommendations for immediate action are those that should be completed in the next two years.** The full text for each recommendation and Working Group rationale is available in the body of the report (beginning page 7).

*Figure C-1.* **Recommendation Topics for Immediate Action**

| Workforce | Funding and Accessibility | Community Engagement |
|---|---|---|
| ☐ Recommendation 1.1 Clinical Supervision Hours<br>☐ Recommendation 1.2 Access to Psychiatry Services<br>☐ Recommendation 1.3 Provider MAT Training | ☐ Recommendation 2.1 Certified Community Behavioral Health Clinic Model<br>☐ Recommendation 2.2 Addressing Inpatient Capacity<br>☐ Recommendation 2.3 Reimbursement Rate Increase and Review<br>☐ Recommendation 2.4 Suicide Prevention<br>☐ Recommendation 2.5 Problem Gambling and Other Addictions Fund | ☐ Recommendation 3.1 Crisis Intervention Centers<br>☐ Recommendation 3.2 IPS Community Engagement |
| **Prevention and Education** | **Treatment and Recovery** | **Special Populations** |
| ☐ Recommendation 4.1 988 Suicide Prevention Line Funding<br>☐ Recommendation 4.2 Early Intervention<br>☐ Recommendation 4.3 Centralized Authority | ☐ Recommendation 5.1 Psychiatric Residential Treatment Facilities | ☐ Recommendation 6.1 Domestic Violence Survivors<br>☐ Recommendation 6.2 Parent Peer Support |
| **Data Systems** | **Legal System and Law Enforcement** | **System Transformation** |
| ☐ Recommendation 7.1 State Hospital EHR<br>☐ Recommendation 7.2 Data and Informed Survey Opt-Out<br>☐ Recommendation 7.3 Information Sharing<br>☐ Recommendation 7.4 Needs Assessment | ☐ Recommendation 8.1 Correctional Employees<br>☐ Recommendation 8.2 Criminal Justice Reform Commission Recommendations<br>☐ Recommendation 8.3 Law Enforcement Referrals | ☐ Recommendation 9.1 Regional Model<br>☐ Recommendation 9.2 Long-Term Care Access and Reform<br>☐ Recommendation 9.3 Integration |
| **Telehealth** | | |
| ☐ Recommendation 10.1 Quality Assurance<br>☐ Recommendation 10.2 Reimbursement Codes<br>☐ Recommendation 10.3 Telehealth for Crisis Services | | |

The Working Groups have made recommendations related to the following topics (*Figure C-2*) and indicated that they should be considered of strategic importance. **Recommendations of strategic importance are those for which work should start immediately but will be completed in the long-term.** The full text for each recommendation and Working Group rationale is available in the body of the report (beginning page 7).

*Figure C-2.* **Recommendation Topics of Strategic Importance**

| Workforce | Funding and Accessibility | Community Engagement |
|---|---|---|
| ☐ Recommendation 1.4 Workforce Investment Plan<br>☐ Recommendation 1.5 Family Engagement Plan | n/a | ☐ Recommendation 3.3 Foster Homes<br>☐ Recommendation 3.4 Community-Based Liaison |
| **Prevention and Education** | **Treatment and Recovery** | **Special Populations** |
| ☐ Recommendation 4.4 Behavioral Health Prevention | ☐ Recommendation 5.2 Service Array<br>☐ Recommendation 5.3 Frontline Capacity<br>☐ Recommendation 5.4 Housing | ☐ Recommendation 6.3 Crossover Youth<br>☐ Recommendation 6.4 I/DD Waiver Expansion<br>☐ Recommendation 6.5 Family Treatment Centers |
| **Data Systems** | **Legal System and Law Enforcement** | **System Transformation** |
| ☐ Recommendation 7.5 Cross-Agency Data | ☐ Recommendation 8.4 Defining Crossover Youth Population | ☐ Recommendation 9.4 Evidence Based Practices<br>☐ Recommendation 9.5 Family Psychotherapy |
| **Telehealth** | | |
| ☐ Recommendation 10.4 Originating and Distant Site<br>☐ Recommendation 10.5 Child Welfare System and Telehealth | | |

*Figure C-3.* **High Priority Discussion Item**

**Medicaid Expansion**. In addition to these recommendations for immediate action and of strategic importance, the Finance and Sustainability Working Group also puts forward the issue of Medicaid expansion as a high-priority discussion item for the Special Committee. The recommendation discussed by the Working Group related to Medicaid Expansion reads, “Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans.”

More information on this recommendation is available in the Funding and Accessibility section beginning on page 16.

# Appendix D. Special Committee and Working Group Membership

### 2020 Special Committee on Mental Health Modernization and Reform

- Senator Larry Alley
- Representative Tory Marie Arnberger
- Representative Barbara Ballard
- Representative Will Carpenter
- Senator Dan Kerschen
- Representative Brenda Landwehr, Chairperson
- David Long, Committee Assistant
- Representative Megan Lynn
- Senator Carolyn McGinn, Vice-chairperson
- Senator Pat Pettey
- Representative Adam Smith
- Senator Mary Jo Taylor
- Representative Rui Xu

### 2020 Special Committee on Mental Health Modernization and Reform Roundtable Members

- Sandra Berg, Executive Director, United Behavioral Health – KanCare
- Kathy Busch, Chair, State Board of Education
- Wes Cole, Chair, Governor's Behavioral Health Services Planning Council
- Denise Cyzman, Chief Executive Officer, Community Care Network of Kansas
- Sheriff Jeff Easter, Sheriff of Sedgwick County, Kansas
- Sarah Fertig, State Medicaid Director, Kansas Department of Health and Environment
- Coni Fries, Blue Cross and Blue Shield of Kansas City, Vice President Governmental Relations
- B. Russell Harper, State Government Affairs, Representative of CVS Health on Behalf of Aetna
- Greg Hennen, Executive Director, Four County Mental Health Center, Inc.
- Secretary Laura Howard, Secretary, Kansas Department for Aging and Disability Services and Kansas Department for Children and Families

- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Kyle Kessler, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
- Sheriff Scott King, Sheriff of Pawnee County, Kansas
- Spence Koehn, Court Services Specialist, Office of Judicial Administration
- Rachel Marsh, Executive Director, Children's Alliance of Kansas
- Sunee Mickle, Vice President Government and Community Relations, Blue Cross and Blue Shield of Kansas
- Josh Mosier, Manager of Client Services, Kansas Health Information Network (KHIN)
- Secretary Lee Norman, Secretary of Kansas Department of Health and Environment
- Kandice Sanaie, Senior Director State Government Affairs, Cigna
- Chief Don Scheibler, Chief of Police, Hays, Kansas
- Sherri Schuck, Pottawatomie County Attorney
- Rennie Shuler-McKinney, Director of Behavioral Health, AdventHealth Shawnee Mission
- Lisa Southern, Executive Director and Licensed Clinical Psychotherapist, Compass Behavioral Health
- Deborah Stidham, Director of Addiction and Residential Services, Johnson County Mental Heatlh center
- William Warnes, Medical Director for Behavioral Health, Sunflower Health Plan

**Finance and Sustainability Working Group (WG1)**

- Senator Larry Alley
- Charles Bartlett, Director of Adult Services, Kansas Department for Aging and Disabilities Services
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Representative Will Carpenter
- Sarah Fertig, Medicaid Director, Kansas Department of Health and Environment
- Coni Fries, Vice President of Government Relations, Blue Cross and Blue Shield of Kansas City
- Greg Hennen, Co-Chair, Executive Director, Four County Mental Health Center

- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Representative Brenda Landwehr
- Representative Megan Lynn
- William Warnes, Co-Chair, Medical Director for Behavioral Health, Sunflower Health Plan

**Policy and Treatment Working Group (WG2)**

- Representative Barbara Ballard
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Wes Cole, Chairperson, Governor's Behavioral Health Services Planning Council
- Erin George, Person with Lived Experience
- Kellie Hans Reid, Director of Medicaid and Children's Mental Health, Kansas Department for Children and Families
- Gary Henault, Co-Chair, Director of Youth Services, Kansas Department for Aging and Disabilities Services
- Senator Dan Kerschen
- Representative Brenda Landwehr
- Rachel Marsh, Co-Chair, Chief Executive Officer, Children's Alliance of Kansas
- Senator Carolyn McGinn
- Sunee Mickle, Vice President of Government and Community Relations, Blue Cross and Blue Shield of Kansas
- Senator Pat Pettey
- Kandice Sanaie, Director of State Affairs, Cigna
- Rennie Shuler-McKinney, Director of Behavioral Health, AdventHealth Shawnee Mission
- Deborah Stidham, Director of Addiction and Residential Services, Johnson County Mental Health Center
- Lisa Southern, Executive Director and Clinician, Compass Behavioral Health
- Kelsee Torrez, Behavioral Health Consultant, Kansas Department of Health and Environment

**System Capacity and Transformation Working Group (WG3)**

- Representative Tory Marie Arnberger
- Sandra Berg, Executive Director, United Behavioral Healthcare
- Representative Elizabeth Bishop
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Andrea Clark, Co-Chair, CIT/Veterans Program Coordinator, Kansas Department for Aging and Disabilities Services
- Denise Cyzman, Chief Executive Officer, Community Care Network of Kansas, formerly known as Kansas Association for the Medically Underserved
- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Kyle Kessler, Co-Chair, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
- Spence Koehn, Court Services Specialist, Office of Judicial Administration
- Representative Brenda Landwehr
- Representative Rui Xu

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