# MENTAL HEALTH TASK FORCE

Report to the Kansas Legislature

**January 8, 2018**

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# Table of Contents

# Acknowledgements

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- Wes Cole, Chair, Governor's Behavioral Health Services Planning Council

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# About the Report

In June 2017, the Kansas Legislature passed a budget that included a proviso directing the Kansas Department for Aging and Disability Services (KDADS) to establish an 11-member task force to review the mental health system in Kansas.

The purpose of the Mental Health Task Force was to assess the strengths and weaknesses of state's current mental health system and make recommendations for improvements in a report to the Kansas Legislature before January 8, 2018, concerning the following issues:

- The Kansas mental health system;
- The most effective ways to deliver mental health care services;
- The varied services required of individuals of varying ages;
- The certification process at Osawatomie State Hospital (OSH);
- A comprehensive strategy for delivery of mental health services;
- The maximization of federal and other funding sources for mental health services;
- The statewide absence of crisis stabilization centers to provide short-term mental health crisis care for 48 hours or less;
- Options for privatization of mental health services; and
- Other matters related to mental health services.

The Task Force was comprised of behavioral health providers, advocacy organizations, citizens with lived experience and other behavioral health experts. The group met eight times between September and December 2017 to discuss issues included in the proviso and develop recommendations. The meetings were facilitated by the Kansas Health Institute (KHI). KHI also provided research and summarized the information discussed during the meetings in the Mental Health Task Force's report to the Kansas Legislature. KHI's work was designed to supplement, not supplant, the Mental Health Task Force and KDADS' capacity. KHI services were provided as a form of professional consultation, and all decisions were made by the Mental Health Task Force.

The report includes seven topics informed by the proviso. Each section provides information about the topic, lists priority recommendations and details required actions, steps needed to implement recommendations, and potential impacts.

# Executive Summary

Behavioral health systems serve people with behavioral health conditions. These systems support a wide variety of specialized services delivered by providers in a range of care settings. For behavioral health systems to operate efficiently, they need adequate capacity, with an array of services for mental health and substance use disorder treatment, and individuals need to be able to access the appropriate service(s) for their condition(s). When there are capacity issues or barriers to behavioral health services, the resulting gaps can negatively affect patient, societal and system-level outcomes.[1]

"Behavioral health" refers to mental and emotional well-being, as well as actions that affect wellness. Behavioral health problems include substance use disorders and alcohol and drug addiction, in addition to mental illnesses, serious psychological distress, and suicide. To address the proviso and align with the state and national goals of more integrated behavioral health care – more seamless care for mental illnesses, substance use disorders and addictions, and primary medical care – the Mental Health Task Force made recommendations that aim to improve the behavioral health system in Kansas.

To efficiently utilize available resources, the creation of recommendations included revisiting and updating recommendations available in the reports developed by Kansas behavioral health experts over the past five years. Between September and December 2017, the Task Force reviewed 11 reports and approximately 150 recommendations. To ensure that new recommendations address the most critical issues, the Task Force screened the topics under consideration to identify existing issues and opportunities. After gaining insight into the current status, the Task Force assessed each recommendation in terms of its timing, magnitude of effect, resource requirements and potential to avoid costs. Recommendations that were most likely to strengthen and improve the behavioral health system in Kansas (that enable individuals to find effective treatment and services) were prioritized for further action. The list of priority recommendations (*Figure 1*, page vi) includes 26 recommendations. The Task Force considered other recommendations that had been generated from previous reports. While a number of those recommendations were not prioritized at this time due to the screening tool and consensus process, the Task Force recognizes their merit and has included them in Appendix B, page B-1.

*Figure 1.* **Mental Health Task Force Priority Recommendations Grouped by Topic**

| |
|---|
| **Topic 1: Maximizing Federal Funding and Funding From Other Sources.**<br><br>• **Proviso #5: The maximization of federal and other funding sources for mental health services.** |
| **Recommendation 1.1: IMD Waiver.** Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule. (page 6)<br><br>**Recommendation 1.2: Medicaid Expansion Models**. Adopt one or more models of Medicaid expansion to pursue solutions for serving the uninsured and underinsured. Such model(s) should improve access to behavioral health services. (page 8)<br><br>**Recommendation 1.3: Housing.** Instruct the Kansas Department for Aging and Disability Services (KDADS) to convene key agencies and the entities that currently provide housing programs, facilitate community collaborations, and prepare for federal funding opportunities. (page 10)<br><br>**Recommendation 1.4: Reimbursement Rates.** Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly. (page 11)<br><br>**Recommendation 1.5: Excellence in Mental Health Act.** Support expansion of the federal Excellence in Mental Health Act and then pursue participation. (page 12) |
| **Topic 2: Crisis Stabilization**<br><br>• **Proviso #6: The statewide absence of crisis stabilization centers to provide short-term mental health crisis care of 48 hours or less.** |
| **Recommendation 2.1: Regional Crisis Locations.** Develop community crisis locations in regions across the state, including co-located substance use disorder (SUD) services. (page 16)<br><br>**Recommendation 2.2: Access to Effective Practices and Support.** Deliver crisis and prevention services for children and youth in natural settings (e.g., homes, school, and primary care offices) in the community. (page 17)<br><br>**Recommendation 2.3: Comprehensive Housing.** Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness, and/or substance use disorders. (page 18)<br><br>**Recommendation 2.4: Funding for Crisis Stabilization Centers.** If Crisis Stabilization Centers are to be part of the state safety net system, the state must provide ongoing base funding for these services. The structure of Medicaid should be robust enough to sustain these services. Make sure that services are available to the uninsured and underinsured. (page 20)<br><br>**Recommendation 2.5: Warm Hand-Off.** Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model. (page 21) |

Topic 3: Inpatient Capacity

- Proviso #2: The most effective ways to deliver mental health services, including the varied services required for individuals of varying ages.
- Proviso #4: A comprehensive strategy for delivery of mental health services.

**Recommendation 3.1: Regional Model.** Implement a regional hospitalization model for provision of additional acute care and treatment to meet bed goals and geographic dispersion. (page 25)

**Recommendation 3.2: Number of Beds.** Develop a plan to add more than 300 additional hospital beds, or create and expand alternatives that would reduce the number of new beds needed. KDADS should execute a study to determine a Kansas-specific estimate of beds needed, while simultaneously moving forward with implementing other recommendations included in this report to provide a functioning safety net and eliminate the waiting list process for Osawatomie State Hospital (OSH). (page 26)

**Recommendation 3.3: Implementation of CIA.** Develop regulations and funding resources to implement the Crisis Intervention Act (CIA). (page 29)

**Recommendation 3.4: Suspension of Medicaid.** The state should 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. (page 30)

Topic 4: Privatization of Services

- Proviso #3: The certification process of Osawatomie State Hospital.
- Proviso #7: Options for privatization of mental health services.

**Recommendation 4.1: Comprehensive Approach.** While the Task Force appreciates the intention of the current request for proposal (RFP) to create better and safer treatment and work environments for patients and staff at Osawatomie State Hospital, any proposal involving new construction should only be executed as part of a comprehensive financing package addressing a full range of needs in the behavioral health system for mental health and substance abuse disorder treatment, including inpatient and outpatient community-based services, crisis stabilization, housing, and peer programs. (page 33)

**Recommendation 4.2: Regional Model.** In lieu of a single RFP, the Task Force recommends a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute psychiatric crisis. The state hospital setting must continue to provide both acute services as well as longer-term/tertiary specialized care. (page 35)

**Recommendation 4.3: Vigorous Oversight.** Any process that could result in privatized services – including requests for proposals as well as oversight of any resulting privatized facility – should include thorough and ongoing oversight, including an advisory board to include clinicians, accountants, legal counsel, persons with lived experience who are in recovery, persons with lived experience who have been voluntarily and involuntarily hospitalized, family members and guardians of persons with mental illness, Community Mental Health Center staff, law enforcement and community corrections, and advocacy organizations. If a single bidder responds to any RFP, additional oversight may be required. (page 36)

**Topic 5: Nursing Facilities for Mental Health (NFMHs)**

- **Proviso #2: The most effective ways to deliver mental health services, including the varied services required for individuals of varying ages.**
- **Proviso #4: A comprehensive strategy for delivery of mental health services.**

**Recommendation 5.1: Licensing Structure.** Update licensing structure to allow for necessary rehabilitative services in NFMHs and inclusion within continuum of care. (page 39)

**Recommendation 5.2: Presumptive Approval of Medicaid.** Coordinate with the Kansas Department of Health and Environment (KDHE) and determine if a policy could be developed that allows presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs. (page 40)

**Recommendation 5.3: Crisis Services at NFMHs.** Develop a process for crisis services to be accessed/provided for individuals in NFMHs to include the creation of additional crisis stabilization units with medical and mental health abilities to help stabilize people up to 14 days. (page 41)

**Topic 6: Continuum of Care for Children and Youth**

- **Proviso #2: The most effective ways to deliver mental health services, including the varied services required for individuals of varying ages.**
- **Proviso #4: A comprehensive strategy for delivery of mental health services.**

**Recommendation 6.1: Expand Service Options.** Create additional options such as therapeutic foster care and home-based family therapy, among others, in regions across the state. (page 44)

**Recommendation 6.2: Intensive Outpatient Services.** Expand community-based options, such as intensive outpatient services. (page 45)

**Recommendation 6.3: Quality of Care.** Managed care organization (MCO) contracts should incentivize reduced Psychiatric Residential Treatment Facility (PRTF) readmissions instead of reduced lengths of stay. (page 46)

**Recommendation 6.4: Early Intervention.** Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment, and treatment. Ensure children and caregivers are screened and assessed at regular intervals in early childhood programs. Based on the screening results, work in collaboration with partners to address Adverse Childhood Experiences (ACEs) and sources of toxic stress. (page 47)

| Topic 7: Other Recommendations<br><br>• Proviso #1: The Kansas mental health delivery system. |
| --- |
| **Recommendation 7.1: Workforce:** Encourage integration of peer support services into multiple levels of service, including employment services at the CMHC's, hospitalization, discharge, and transition back to the community. (page 49)<br><br>**Recommendation 7.2: Health Homes:** The state should take steps to ensure that all Kansas adults with mental illness, including those with co-occurring substance use disorders, and children and adolescents with serious emotional disturbance are enrolled in a health home to provide access to activities that help coordinate their care. (page 50) |

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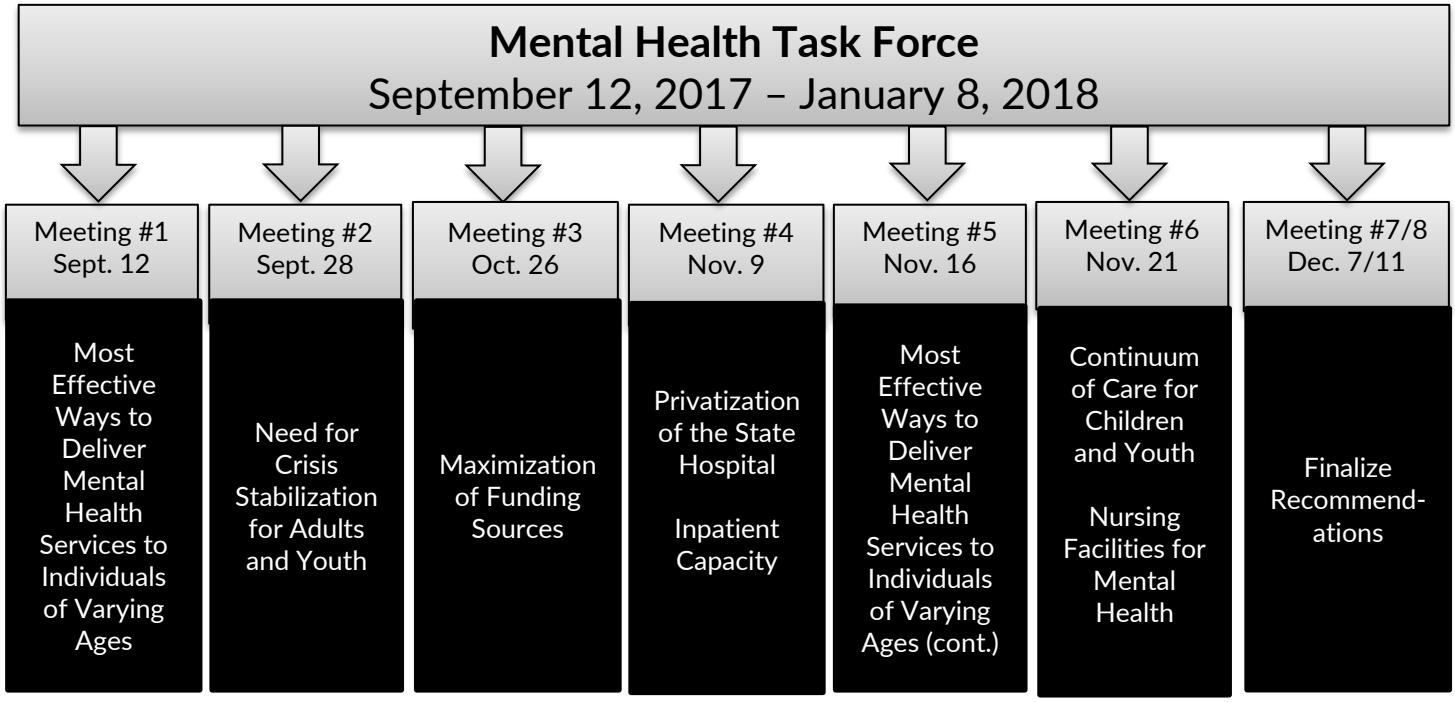
## Overview of the Process

Beginning September 12, 2017, the Mental Health Task Force met eight times (*Figure 2*). In general, the meetings were held bi-weekly on Thursday from 2:30 p.m.-4:30 p.m. or 11:30 a.m.-4:30 p.m. in the New England Building. Six out of eight meetings were conducted in person, while two meetings were held over the phone. The meetings' topics were informed by the legislative proviso and were determined at the beginning of the process. During the four-month process, the Task Force reviewed, discussed, and made recommendations related to seven topics.

The Task Force was convened by the Kansas Department for Aging and Disability Services (KDADS). The Task Force consisted of 11 legislatively appointed members that included behavioral health providers, advocacy organizations, citizens with lived experience, and other behavioral health experts. In addition, the attendees included several KDADS staff members and a representative from the Kansas Legislative Research Department (KLRD). The meetings were facilitated by the Kansas Health Institute (KHI). The role of KHI was to develop and provide materials in advance of the meetings, facilitate discussions, research information, and ensure that the objectives of each meeting had been met.

*Figure 2.* Overview of Mental Health Task Force Meetings by Dates and Topics



# Meeting Materials and Decision-Making Process

Over the past five years, more than ten behavioral health reports have been developed by various task forces, councils, committees, and workgroups. Each report included a set of recommendations. Given the breadth and depth of these reports, the Mental Health Task Force began identifying priority areas by reviewing relevant recommendations included in 11 reports. The recommendations were compiled by KHI before each meeting. Over the course of the four months, the Task Force reviewed about 150 recommendations.

To further identify priority recommendations or create new ones, the Task Force was asked to characterize existing recommendations based on potential impact and the level of required resources. Recommendations that were characterized as "low impact and high resources" were excluded from further consideration.

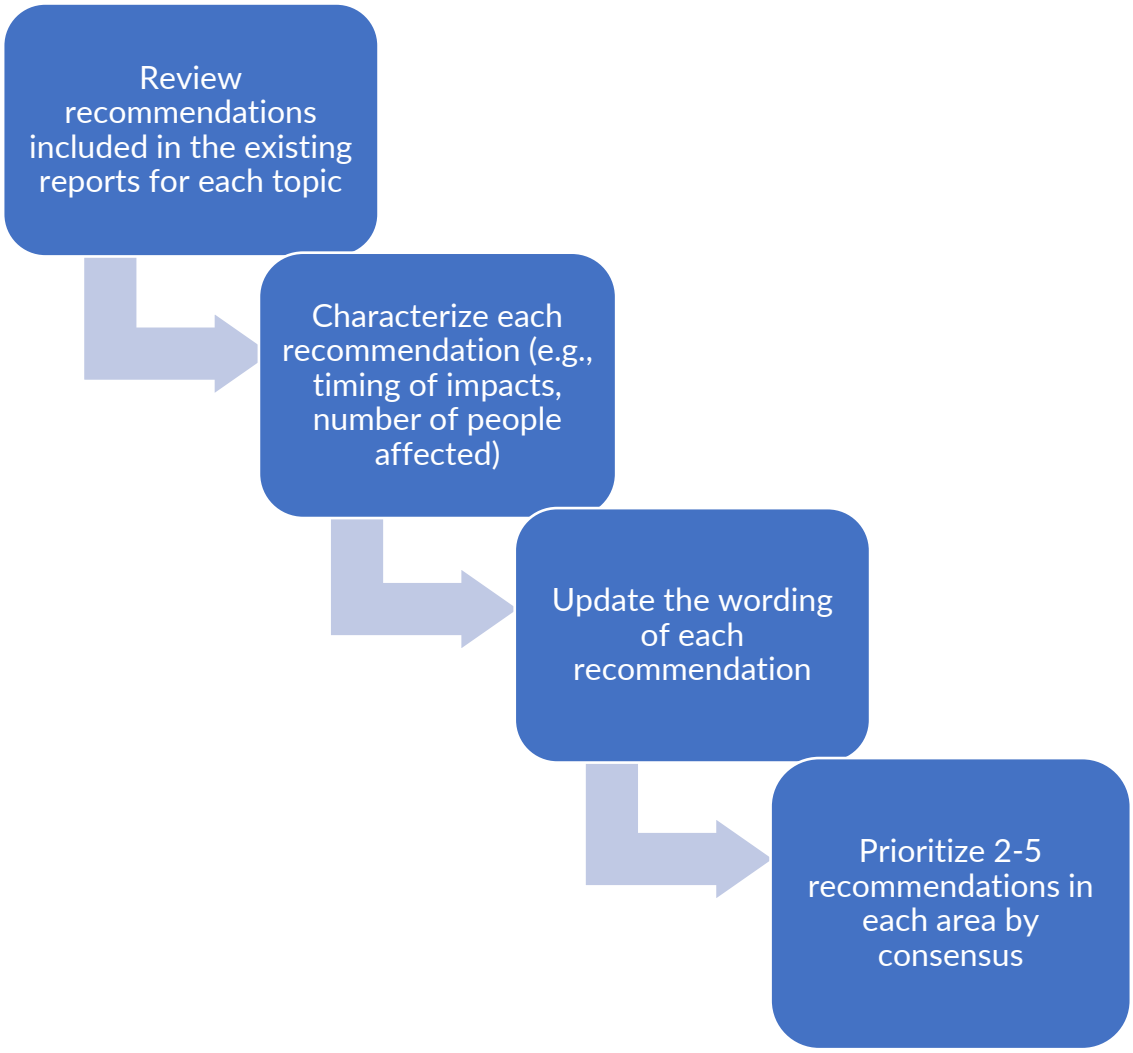
After characterizing the first set of recommendations, the Task Force expressed interest in considering additional criteria for characterizing recommendations. The criteria described in *Figure 3* allowed the Task Force to assess each recommendation's impact in terms of its timing, magnitude of effect, and potential to avoid costs. Additionally, the Mental Health Task Force noted if the implementation of each recommendation could be done within the existing system or process and identified the level of initial investment required to implement the recommendation.

*Figure 3.* Characterization Matrix Used to Assess Each Recommendation

| Characterization Matrix | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Recommendation (Example)** | **When Do We Expect to See a High Impact?** | | | **Is There an Existing System/Process to Support the Implementation of Recommendation?** | | **What Level of Initial Investment Will be Required?** | | **How Many People Are Likely to Be Affected by This Recommendation?** | | **Avoid Costs?** | |
| | Short Term (1-2 years) | Long Term (more than 3 years) | Neither (low impact is anticipated) | Yes | No | Low | High | Small Number | Large Number | Yes | No |

After the completion of the characterization process, the Mental Health Task Force prioritized two to five recommendations in each topic area. The decision on each priority recommendation was made by consensus. *Figure 4* describes the decision-making process that was used to prioritize recommendations.

*Figure 4.* **Decision-Making Process Used to Prioritize Recommendations**



## Past Behavioral Health Reports

The following reports were used to inform the development of recommendations.

1. Governor's Mental Health Task Force Report (April 15, 2014)[2]
2. Adult Continuum of Care (ACC) Committee, Final Report (2015)[3]
3. Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016)[4]
4. Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2016-2017)[5]
5. Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)[6]
6. Governor's Behavioral Health Services Planning Council, Subcommittee on Housing and Homelessness, 2017 Annual Report (June 2017)[7]
7. Governor's Behavioral Health Services Planning Council, Vocational Subcommittee, Report (2017)[8]
8. Governor's Behavioral Health Services Planning Council Update, Justice Involved Youth and Adults – Subcommittee Report (2017)[9]
9. Governor's Behavioral Health Services Planning Council, Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC), Annual Report (2017)[10]
10. Governor's Behavioral Health Services Planning Council, Prevention Sub-Committee (2017)[11]
11. Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017)[12]

Note that the Children's Continuum of Care Task Force was meeting concurrently, and the information developed by that task force was not available for this report.

# Topic 1: Maximizing Federal Funding and Funding From Other Sources

*Proviso #5:* The maximization of federal and other funding sources for mental health services.

*Goal of Topic:* To identify opportunities for sustaining and/or pursuing and securing federal or other funding sources for services related to behavioral health.

Reviewed reports: The following reports informed the development of priority recommendations.

- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)
- Governor's Behavioral Health Services Planning Council, Subcommittee on Housing and Homelessness, 2017 Annual Report (June 2017)
- Governor's Behavioral Health Services Planning Council, Kansas Citizen's Committee on Alcohol and Other Drug Abuse (KCC), Annual Report (2017)

*Introduction:* The Task Force reviewed 14 recommendations from prior reports that would provide new or sustained funding to support the behavioral health system, and created five new or revised recommendations based upon needs and opportunities identified by Task Force members.

Funding for behavioral health services for many years was primarily the responsibility of states and local governments. Over time, the federal government began to take an increased role. The National Institutes of Mental Health was founded in 1949, one of the first four National Institutes of Health. Community Mental Health Centers (CMHC) were created by law in 1963. When the Medicaid program was founded in 1965, psychiatric inpatient care expenses for adults were excluded from federal reimbursement, but Medicaid today is still the largest behavioral health services payer. Federal funds for mental health and substance use disorder treatment and rehabilitation programs became block grants in the early 1980s and are now provided in two annual noncompetitive formula block grants to the states under purview of the Substance Abuse and Mental Health Services Administration (SAMHSA).

However, as treatment has moved from an institutional model to community-based services, more and more agencies and funding streams have become essential to behavioral health services. For example, housing programs are financed through housing departments, income support is administered by the Social Security Administration, and job training programs are available through the departments of labor and education.[13]

The Task Force prioritized five recommendations in this topic area, two of which seek to extend additional Medicaid funding, one of which seeks to extend a federal grant program, one of which is focused on funding for housing, and one of which is more broadly focused on ensuring that reimbursement rates are sufficient to cover the cost of services.

*Priority Recommendations:*

- **Recommendation 1.1: IMD Waiver.** Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule.
- **Recommendation 1.2: Medicaid Expansion Models.** Adopt one or more models of Medicaid expansion to pursue solutions for serving the uninsured and underinsured. Such model(s) should improve access to behavioral health services.
- **Recommendation 1.3: Housing.** Instruct the Kansas Department for Aging and Disability Services (KDADS) to convene key agencies and the entities that currently provide housing programs, facilitate community collaborations, and prepare for federal funding opportunities.
- **Recommendation 1.4: Reimbursement Rates.** Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.
- **Recommendation 1.5: Excellence in Mental Health Act.** Support expansion of the federal Excellence in Mental Health Act and then pursue participation.

Recommendation 1.1: IMD Waiver. *Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule.*

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change - state agency<br>☒ Reg./policy change - federal agency<br>☐ Funding |

| Category | Details |
|---|---|
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Section 1115 demonstration authority.<br>o RFP provisions to address the inclusion of benefits in KanCare.<br>o IT system and policy changes to not dis-enroll beneficiaries upon admission to an IMD. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Provide stability for people admitted to mental health facilities that currently are affected by the IMD exclusion, including Larned and Osawatomie state hospitals, and a smooth transition for Medicaid beneficiaries transitioning out of inpatient settings.<br>o Preserve continuity of care, reduce churn in the system, and keep beneficiaries covered before, during, and after their treatment.<br>o Increase access to clinically appropriate care, reduce emergency department use, reduce the total cost of care, and improve health outcomes.<br>o Allow for the expansion of community crisis residential care facilities, which now are limited to 16 beds.<br>o KDADS estimates that a full waiver of the IMD exclusion would bring in more than $23 million in federal Medicaid funding for nearly 1,500 affected admissions at Larned and Osawatomie state hospitals alone. |

*Background:*

Federal law prohibits the use of federal Medicaid financing for care provided to most patients age 21-64 in mental health facilities with more than 16 beds, which are termed Institutions of Mental Disease (IMDs). The prohibition is referred to as the "IMD exclusion." The Managed Care Final Rule released in 2016 opened the door for individuals enrolled in managed care to not lose eligibility during inpatient hospital stays up to 15 days as long as the admissions could be considered "in lieu of" services that would offset other costs. In 2015, Kansas Medicaid considered requesting a waiver in its Section 1115 demonstration to allow federal matching funds for patients with longer stays as well, but at the time CMS was working on what ultimately was released as the Final Rule the next year. Arizona currently has a proposed Section 1115 demonstration amendment that would waive the IMD exclusion in its entirety for Medicaid patients.[14]

Currently, individuals admitted to Osawatomie and Larned state hospitals, or other IMDs, lose their Medicaid eligibility. A process has been put in place to have eligibility reinstated upon discharge, but some individuals leaving the hospital without benefits are homeless and many lack access to care.

Nationally, there is renewed interest in modifying the IMD exclusion. The exclusion was modified in the Managed Care Final Rule released in 2016. Arizona requested a waiver of the IMD exclusion in a proposed Section 1115 demonstration amendment. The idea of waiving the IMD exclusion nationally was included this summer as a recommendation in the report to the president from the Commission on Combating Drug Addiction and the Opioid Crisis.

The draft KanCare 2.0 renewal application posted for public comment on October 27, 2017, included a proposal allowing Medicaid coverage of otherwise-covered services provided to Medicaid-eligible adults who are enrolled in a Medicaid managed care organization and who are receiving services in a publicly owned or non-public IMD.

Recommendation 1.2: Medicaid Expansion Models. Adopt one or more models of Medicaid expansion to pursue solutions for serving the uninsured and underinsured. Such model(s) should improve access to behavioral health services.

| Category | Details |
|---|---|
| **Required Actions** | ☒ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Pass legislation.<br>o Update eligibility groups and thresholds. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve access to care statewide, and to crisis services specifically.<br>o Ensure that individuals access treatment when symptoms first occur.<br>o Help to fill identified gaps in the continuum of care: crisis care and substance use disorder treatment.<br>o Increase state access to available federal funds. |

| Category | Details |
|---|---|
| | o Access federal Medicaid matching funds for some behavioral health services currently paid for by grants or state funding. |

*Background:*

With the passage of the Patient Protection and Affordable Care Act (ACA), Medicaid eligibility was expanded to all adults under the age of 65. In June 2012, the Supreme Court ruled that states could not be required to expand their Medicaid programs, making the expansion optional.[15]

As of November 2017, 32 states and the District of Columbia had expanded Medicaid. Of that group, 26 had expanded their Medicaid under traditional Medicaid rules with no waivers, while seven had expanded using waivers. Eighteen states had not expanded Medicaid.

Of the seven states (Arizona, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire) that have approved non-traditional expansion through waivers, four states (Arizona, Arkansas, Indiana, and New Hampshire) have some form of premium assistance. All seven of these states have some provision for copay or premiums that varies based on conditions set out by the states (e.g., family poverty guidelines for payments or non-emergency emergency department usage). Three states (Indiana, Iowa, and Montana) have provisions for lockout (in Indiana, for those above poverty line) or disenrollment for nonpayment.[16]

Several features have not yet been approved through the waiver process: work requirements, time limit coverage, lockout for failure to timely renew eligibility, and tobacco surcharge. As part of a waiver extension, Arkansas also requested a change which would put a cap on eligibility at 100 percent of the federal poverty level.[17]

Whether Kansas was to expand Medicaid through traditional or alternative models, the Task Force recommends that the specific effect on access to behavioral health care must be considered. A Government Accountability Office analysis of four states that expanded in 2014 (Iowa, New York, Washington, and Virginia) found that 17 to 25 percent of enrollees covered by expansion had behavioral health (mental or substance use disorder) diagnoses.[18] Expansion, paired with a successful waiver of the IMD exclusion (see page 6) for mental health treatment

and substance use disorder treatment, would allow for more of the needs of the behavioral health Medicaid population to be covered.

Recommendation 1.3: Housing. Instruct the Kansas Department for Aging and Disability Services (KDADS) to convene key agencies and the entities that currently provide housing programs, facilitate community collaborations, and prepare for federal funding opportunities.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Set up an interagency commission.<br>o Allocate funding to KDADS (one FTE) so it can support the interagency commission and leverage federal grant funding.<br>o Convene stakeholders. |
| **Characterization** | o High impact will be observed in long-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Increase state access to available federal funds.<br>o Additional federal funding will allow expanded housing options for people with behavioral health issues.<br>o The expansion of housing will lead to decreased admissions to state psychiatric hospitals, reduced rates of incarceration, and will prevent people becoming homeless in the first place. |

*Background:*

As noted, the services that support a community-based model of behavioral health care are not all administered within a single agency, whether at the state or federal level. For example, funding opportunities that could provide supported housing for people with behavioral health conditions may be available through housing programs administered by the Department of Housing and Urban Development (HUD).

Because funding opportunities may come from a patchwork of federal agencies and programs, collaboration and integration is required to ensure that opportunities are recognized. States that more actively coordinate housing efforts across agencies may be more successful in obtaining funding to support housing programs.

The Task Force recommends the creation of a dedicated grant writer/coordinator as a critical element to secure grant funding by providing the opportunity to collaborate and pool resources, bringing agencies and providers together to secure grants. Additionally, a grant writer benefits multiple service providers by allowing those providers with fewer resources to have greater access to funding opportunities.[19]

The Task Force also recommends that an interagency commission be created to better coordinate among agencies with a stake in housing programs. Kansas has several committees or councils in existence that could be used as a framework for the establishment of a commission. One example for the interagency council could be the Kansas Interagency Coordinating Council. This council is responsible for advising and assisting the Kansas governor and Legislature on matters that affect Kansas families with children, ages birth to five, who have, or are at risk for, developmental delays. Statute for this council defines the membership of the council at K.S.A 74-7801.[20]

Another possible approach is the creation of a subcommittee as part of an established council. An example of a subcommittee established as part of an existing council is the Housing & Homelessness Subcommittee under the Governor's Behavioral Health Services Planning Council. The subcommittee was authorized as part of the statute creating the Governor's Behavioral Health Services Planning Council at K.S.A 39-1605.[21]

Recommendation 1.4: Reimbursement Rates. Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.

| Category | Details |
|---|---|
| **Required Actions** | ☒ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Require KDADS and the Kansas Department of Health and Environment (KDHE) to establish a system that provides for regular reviews of the cost of services and reimbursement rates.<br>o Update reimbursement rates based on results of rate study. |
| **Characterization** | o Not Rated. |

| Category | Details |
|---|---|
| What Impacts Will This Recommendation Have if Implemented? | o Increase regional access to evidence-based treatment for mental illness and substance use disorders.<br>o Increase availability of qualified practitioners.<br>o Increase ability to retain workforce.<br>o Increase practitioners' ability to deliver comprehensive services that meet patients' needs.<br>o Increase access to behavioral health services. |

*Background:*

Access to behavioral health services depends upon the availability of an array of specialized treatment options and providers, which is affected by a broad range of factors.[22] While workforce issues affect availability, the level of reimbursement can be a key driver in determining access. Differences in reimbursement rates create imbalances, incentivizing some services over others and leading some providers to forego participating in insurance markets.[23,24]

Regular reviews of reimbursement rates can help payers, including the Medicaid agency, ensure the sufficiency of rates and the availability of providers. A framework of policy regarding rate review and adjustment already exists in Kansas law. Kansas statutes and regulations define how rates are to be calculated for certain services.

For example, K.S.A. 75-5958 defines the process for setting rates for nursing facilities (K.A.R. 129-10-18 operationalizes the law).[25,26] Another example is included in the Developmental Disability Reform Act at K.S.A. 39-1806(a)(3), which requires an independent review of rate structures on a biennial basis.

Recommendation 1.5: Excellence in Mental Health Act. Support expansion of the federal Excellence in Mental Health Act and then pursue participation.

| Category | Details |
|---|---|
| Required Actions | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☐ Funding |
| What Steps Should be Put in Place to | o Ask Kansas congressional delegation to support expansion of the federal Excellence in Mental Health Act. |

| Category | Details |
|---|---|
| Implement the Recommendation? | o Develop an application to participate in the pilot program. |
| Characterization | o Not Rated. |
| What Impacts Will This Recommendation Have if Implemented? | o Improve Kansans access to integrated care.<br>o Improve outcomes for Kansans with mental illness and/or substance use disorders.<br>o Attract and retain qualified staff.<br>o Increase access to mental health and substance use disorder treatment.<br>o Expand capacity to address the opioid crisis.<br>o Reduced rates of incarceration.<br>o Reduced rates of homelessness. |

*Background:*

In 2014, the Excellence in Mental Health Act was implemented as a demonstration project as part of the Protecting Access to Medicare Act, providing 25 states with two-year grants of up to $2 million each with eight of the 25 states being awarded demonstration grants in 2017. Services covered include: 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. Kansas did not apply for the grants available through the demonstration. [27]

In October 2017, bipartisan legislation was introduced in both the House and Senate to extend the Excellence in Mental Health Act demonstration project funding for the eight pilot states and expand it to an additional 11 states.[28]

# Topic 2: Crisis Stabilization

*Proviso #6:* The statewide absence of crisis stabilization centers to provide short-term mental health crisis care of 48 hours or less.

*Goal:* To expand and enhance access to crisis stabilization services across Kansas.

*Introduction:* The Task Force reviewed 11 recommendations from prior reports that would expand or enhance access to crisis stabilization services across the state, and created four new or revised recommendations based upon needs and opportunities identified by Task Force members.

Crisis stabilization is a short-term service that allows a person in distress to receive services over a period of days before transitioning to community-based care. Depending on length of stay, crisis stabilization is an inpatient service, but as it is not necessarily provided in a traditional hospital setting, it can be an alternative to psychiatric hospitalization. Crisis observation, a similar service, can be provided for up to 23 hours, allowing symptoms to ease before a patient is connected to community-based follow-up services. Kansas has three non-hospital crisis stabilization centers located in Kansas City, Topeka, and Wichita.

For the purpose of this report, the proviso term "crisis stabilization center" is used interchangeably with the terms "community crisis center" and "community crisis residential care facility" to describe a unit that provides short-term care for patients experiencing an acute psychiatric and/or substance use crisis that could escalate to a point of requiring hospitalization.

The Task Force prioritized five recommendations in this topic area, two of which were focused on crisis stabilization centers, one on a model for children and youth, and one which recommends a comprehensive array of housing services that could reduce crises.

*Reviewed Reports:* The following reports informed the development of priority recommendations.

- Governor's Mental Health Task Force Report (April 15, 2014)
- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)

- Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016)
- Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017)
- Governor's Behavioral Health Services Planning Council, Subcommittee on Housing and Homelessness, 2017 Annual Report (June 2017)

*Priority Recommendations:*

- **Recommendation 2.1: Regional Crisis Locations.** Develop community crisis locations in regions across the state, including co-located substance use disorder (SUD) services.
- **Recommendation 2.2: Access to Effective Practices and Support.** Deliver crisis and prevention services for children and youth in natural settings (e.g., homes, school, and primary care offices) in the community.
- **Recommendation 2.3: Comprehensive Housing.** Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness, and/or substance use disorders.
- **Recommendation 2.4: Funding for Crisis Stabilization Centers.** If Crisis Stabilization Centers are to be part of the state safety net system, the state must provide ongoing base funding for these services. The structure of Medicaid should be robust enough to sustain these services. Make sure that services are available to the uninsured and underinsured.
- **Recommendation 2.5: Warm Hand-Off**. Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model.

Recommendation 2.1: Regional Crisis Locations. Develop community crisis locations in regions across the state, including co-located substance use disorder (SUD) services.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Implement regulations and licensing related to the Crisis Intervention Act (CIA).<br>o KDADS should issue an RFP for underserved areas where there is not a sufficient population to sustain a Rainbow Services, Inc. (RSI)-type center.<br>o Secure additional state dollars for building/implementation of community crisis locations in regions across the state.<br><br>*Revocation or waiver of the federal IMD exclusion rule would be one way to enhance funding for crisis centers. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Provide a supportive and more cost-effective approach to crisis services.<br>o People with mental illness and co-occurring disorders would be able to go through recovery in their community.<br>o Divert costs from other state hospitals and psychiatric beds in community hospitals. |

*Background:*

Evidence suggests that increasing access to regional crisis locations can reduce wait times for emergency room treatment and decrease inpatient psychiatric admissions. Further, by increasing access to crisis services in community settings, inpatient capacity needs may be reduced.[29] To be successful, funding and support structures are necessary to provide these services.[30]

Regional crisis centers could be developed based on the Rainbow Services, Inc. (RSI) model in Wyandotte County, which provides services such as 24-hour assessment and triage for individuals experiencing a mental health crisis, crisis observation, and short-term crisis stabilization for adults.[31]

RSI absorbed 4,543 admissions from 2,480 individuals from the time it opened in April 2014 to August 2016. In 2015 alone, it is estimated that RSI saved about $4 million in state hospital costs, $2 million in emergency room visits, and $75,000 in jail costs.[32]

In Sedgwick County, COMCARE anticipated saving $4 million after it opened its crisis center. However, a recent report indicates a savings of $8.1 million.[33]

The KDADS Hospital and Home Team issued a report on May 3, 2013, entitled "Mercer Study Review and Recommendations for Alternative Use of Rainbow MHF." This 12-page report includes recommendations for the services and functions that should be provided at state supported crisis facilities based on the results of the Mercer actuarial analysis of hospital and community-based services in Kansas.

Recommendation 2.2: Access to Effective Practices and Support. Deliver crisis and prevention services for children and youth in natural settings (e.g., homes, school, and primary care offices) in the community.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☐ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Provide opportunities for community partners to develop a plan for how to increase behavioral health services in schools.<br>o Review reimbursement for in-home behavioral health services. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve the physical and psychological safety of students and schools, as well as academic performance and problem-solving skills.<br>o Prevent suicides.<br>o Reduce child welfare caseloads.<br>o Keep children in their homes.<br>o Reduce foster placements. |

*Background:*

The Task Force believes that providing crisis intervention and prevention services to children in a natural setting such as school, home, or community is necessary to effectively treat children and promote healthy development. The Substance Abuse and Mental Health Services Administration (SAMHSA) echoes this sentiment, listing provision of services in the least restrictive manner as an essential value for crisis intervention practice.[34] The same report stresses that least-restrictive emergency interventions both avoid coercion and preserve the individual's connectedness with their world.[35]

For prevention services, there is also evidence of improved outcomes from interventions in a more natural setting. Some examples of these effects are found with school-based interventions and functional family therapy. School-based interventions have been shown to alleviate symptoms and increase positive coping skills for children at risk for behavioral and emotional problems. School-based interventions also have been shown to reduce the risk of conduct problems.[36] Further, some evidence suggests that community-based treatments with environmental interventions (e.g., physical, social, or cultural impacts) and environmental interventions alone had a positive impact on mental health outcomes.[37] Functional family therapies have also been found to be effective in mental health prevention and outcomes, including for disruptive behaviors and substance use disorders.[38]

Recommendation 2.3: Comprehensive Housing. Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness, and/or substance use disorders.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☒ Reg./policy change federal agency<br>☒ Funding |

| Category | Details |
|---|---|
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Provide Medicaid coverage and payment for housing-related service. |
| **Characterization** | o High impact will be observed in short-term.<br>o No existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Decrease admissions to state psychiatric hospitals.<br>o Reduce incarceration rates.<br>o Reduce rate of individuals becoming homeless. |

*Background:*

The Task Force believes that lack of access to safe, affordable, and stable housing is often a barrier to individuals and families seeking behavioral health treatment, particularly for those who have experienced long-term or repeated homelessness, which can increase the risk of mental health crises. This sentiment was echoed in another report released this year.

The Governor's Behavioral Health Services Planning Council Subcommittee on Housing and Homelessness 2017 Annual Report indicated that the expansion of housing will lead to decreased admissions to state psychiatric hospitals, reduced incarceration rates, and reduced rates of individuals becoming homeless due to disability. This, in turn, will save tax dollars and help Kansans achieve recovery. If housing is not expanded, the report suggests that this may possibly force Kansans with behavioral health needs into environments not favorable to their needs and desires.[39]

Housing support allows for those in need of treatment to maintain stable housing while receiving care for medical and behavioral health needs.[40] Housing placements for homeless populations have been found to reduce emergency department (ED) usage by residents and reduce the average and total number of ED visits. Housing placement was also associated with a decreased likelihood of hospitalizations and average number of admissions.[41]

Kansas could look to neighboring Missouri, where the Department of Mental Health provides federally funded permanent supportive housing through rent assistance, rental assistance

programs for those with mental illnesses and substance use disorders, and zero-cost technical assistance to help communities seeking to develop affordable or supportive housing across the state.[42]

Recommendation 2.4: Funding for Crisis Stabilization Centers. If Crisis Stabilization Centers are to be part of the state safety net system, the state must provide ongoing base funding for these services. The structure of Medicaid should be robust enough to sustain these services. Make sure that services are available to the uninsured and underinsured.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Ensure Medicaid covers services at crisis centers.<br>o Create additional funding stream for uninsured and underinsured. |
| **Characterization** | o High impact will be observed in long-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Decrease admissions to state psychiatric hospitals.<br>o Reduce rates of incarceration.<br>o Prevent people from becoming homeless in the first place. |

*Background:*

This recommendation mirrors the Special Committee on Larned and Osawatomie State Hospitals Report to the Kansas Legislature in 2017, which also recommended Kansas provide full funding for all crisis centers, including the three centers currently in existence.

Currently, the state has three crisis centers, which are located in Kansas City (Rainbow Services, Inc.), Topeka (Valeo), and Wichita (COMCARE), leaving much of the western and southern parts of the state without local access to crisis centers. There is no long-term designated funding stream established to provide services for existing locations.

For example, Rainbow Services Inc., formerly the Rainbow Mental Health Facility, was initially funded by KDADS through a grant, but at the end of the grant period, the goal had been for RSI to become self-supporting.[43,44] COMCARE in Wichita was provided grant funding to customize the model for Sedgwick County.[45]

Other funding opportunities also exist through non-Medicaid funding sources such as mental health block grants and social service block grants, but these programs are also short-term.[46]

In the Adult Continuum of Care Workgroup Report Update, it was stated that if the state does not fund the crisis stabilization centers, then the burden falls on the shoulders of local governments and private providers. This would put the sustainability of the programs and the array of services they provide at risk. The report goes on to say that if a crisis stabilization program were to end due to funding problems, this could jeopardize the state safety net system.[47]

Recommendation 2.5: Warm Hand-Off. Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☒ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Develop a "warm hand-off" model.<br>o Issue RFP. |
| **Characterization** | o Not rated. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve access to care.<br>o Improve health outcomes.<br>o Avoid escalation of potentially dangerous situations. |

*Background:*

The development of a 24-hour uniform mental health hotline in Kansas could be modeled based on existing 24-hour crisis hotlines for Community Mental Health Centers.[48] Evidence from an

evaluation of outcomes for crisis hotlines for non-suicidal and suicidal crisis suggests that hotlines provide a decrease in hopelessness and crisis states for non-suicidal callers and for hopelessness and psychological pain for suicidal callers, indicating hotlines can provide help to those in need of crisis intervention.[49,50]

To better implement access to care for those in crisis, a warm handoff for the 24-hour hotline could be based on the warm hand-off for integrated care. In the integrated care model, the patient is introduced by one provider to the next to better provide continuity of care.[51] While in the integrated care model, there is a direct introduction, often involving family or other relevant parties, the call center member would keep the caller on the line while connecting them to the appropriate provider assuring that the caller is connected with the appropriate care provider.

# Topic 3: Inpatient Capacity

*Proviso #2:* The most effective ways to deliver mental health services, including the varied services required for individuals of varying ages.

*Proviso #4*: A comprehensive strategy for delivery of mental health services.

*Goal:* To identify strategies to enhance inpatient capacity and improve timely access to inpatient services.

*Introduction:* The Task Force reviewed 15 recommendations from prior reports related to inpatient capacity and services, and created four new or revised recommendations based upon needs and opportunities identified by Task Force members.

Historically, mental health services were primarily administered in state and private psychiatric hospitals on an inpatient basis. In 1990, the Kansas Mental Health Reform Act fundamentally changed the system in Kansas with the goal of transitioning care from institutional services to community-based care.[52] Community Mental Health Centers became the gatekeepers to state psychiatric hospitals and to community mental health services, which increased the number of patients served in the community and reduced hospital use. The number of available state hospital beds decreased from more than 1,000 beds in 1990 to 258 staffed beds in 2017 (excluding forensic beds).

However, even before the decertification of Osawatomie State Hospital in December 2015, the supply of inpatient psychiatric beds necessary to serve Kansans had been called into question. The hospital often operated well over its licensed capacity, and when it ended voluntary admissions and later reduced the number of staffed beds available, the impact was seen in the form of waiting lists and increased pressure on hospital emergency departments, community providers, and jails.

The Task Force prioritized five recommendations in this topic area, including a recommendation to add as many as 300 psychiatric hospital beds while implementing other recommendations in this report that could reduce the need for additional beds over time.

*Reviewed Reports:* The following reports informed the development of priority recommendations.

- Governor's Mental Health Task Force Report (April 15, 2014)
- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)
- Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016)

*Priority Recommendations:*

- **Recommendation 3.1: Regional Model.** Implement a regional hospitalization model for provision of additional acute care and treatment to meet bed goals and geographic dispersion.

- **Recommendation 3.2: Number of Beds.** Develop a plan to add more than 300 additional hospital beds, or create and expand alternatives that would reduce the number of new beds needed. KDADS should execute a study to determine a Kansas-specific estimate of beds needed, while simultaneously moving forward with implementing other recommendations included in this report to provide a functioning safety net and eliminate the waiting list process for Osawatomie State Hospital (OSH).

- **Recommendation 3.3: Implementation of CIA.** Develop regulations and funding resources to implement the Crisis Intervention Act (CIA).

- **Recommendation 3.4: Suspension of Medicaid.** The state should 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.

Recommendation 3.1: Regional Model. Implement a regional hospitalization model for provision of additional acute care and treatment to meet bed goals and geographic dispersion.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☐ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Issue an RFP to solicit interest of regional partners. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Increase partnerships at the regional level.<br>o Increase access to services and reduce wait times.<br>o Decrease admissions to state psychiatric hospitals if community alternatives are expanded.<br>o Decrease emergency department use.<br>o Reduce incarceration rates. |

*Background:*

Kansas' 2.9 million residents are spread across around 82,000 square miles, in population densities ranging from frontier to urban instead of urban to frontier. The state is divided into two state hospital catchment areas. Larned State Hospital's catchment area covers about two-thirds of the state's geographic area, including some communities hundreds of miles from Larned, which is in west-central Kansas. The catchment area for Osawatomie State Hospital, in eastern Kansas, covers a smaller geographic area (36 counties) but a larger population.

The Task Force believes that Kansas must develop a more balanced system to address behavioral health needs in Kansas. To address the needs of the Kansas population statewide, a regional model should be developed to provide access closer to home for more patients. Regional short-term, acute-care facilities that accept both voluntary and involuntary admissions would allow the two state hospitals to dedicate more beds to longer-term inpatients.

To have a balanced system of care that provides appropriate access to treatment, the model developed must assure more services are available locally, including access to acute care.[53] Both community and hospital services are needed, though different models may be used to provide the services.[54] Further, evidence suggests that rural psychiatric inpatient units improve access to community-based mental health services.[55]

Recommendation 3.2: Number of Beds. Develop a plan to add more than 300 additional hospital beds, or create and expand alternatives that would reduce the number of new beds needed. KDADS should execute a study to determine a Kansas-specific estimate of beds needed, while simultaneously moving forward with implementing other recommendations included in this report to provide a functioning safety net and eliminate the waiting list process for Osawatomie State Hospital (OSH).

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Invest in additional state hospital capacity or invest in regional short-term, acute-care hospital bed capacity.<br>o Implement other recommendations in this report that could decrease the demand on inpatient beds.<br>o Replicate the study conducted by the University of North Carolina at Chapel Hill and Duke University to identify "supply-side" solutions. |
| **Characterization** | o Not rated. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Increase access to services and reduce wait times.<br>o Decrease admissions to state psychiatric hospitals if community alternatives are expanded.<br>o Decrease emergency department use.<br>o Reduce incarceration rates. |

*Background:*

A report from the Treatment Advocacy Center in 2016 solicited the input of experts in the field of mental health to establish an appropriate number of beds for inpatient mental health. These experts estimated that a range of 40 to 60 state hospital inpatient beds (including forensic beds) per 100,000 people was necessary to provide appropriate mental health services.[56] Research

from North Carolina found that, without expansion of community-based psychiatric resources or other treatment options, the number of beds needed there to reach appropriate capacity for same-day admissions to inpatient psychiatric beds was 39 beds per 100,000, in line with the lower estimates from the Treatment Advocacy Center, although the study excluded forensic beds and included non-governmental inpatient beds. The increase in beds was necessary to decrease the waiting period for beds below one day and represented a 165-percent increase in the number of beds in the area studied.[57,58]

The Task Force recommends that there be a study similar to the analysis for North Carolina to determine exact bed needs in Kansas. In the meantime, the state should work toward a goal of 39 beds per 100,000 adults (18 and older) until such time that a larger analysis is completed. The Task Force further recommends that the beds be geographically dispersed based on population density to best provide services to those in need.

Research from the Kansas Health Institute finds that the current psychiatric hospital bed rate for the adult population of Kansas is 25.0 beds per 100,000 (see *Figure 7, page 28*). To increase the bed rate by 14 beds per 100,000 to a rate of 39 beds per 100,000, Kansas would need an additional 307 hospital beds.[59] However, the Task Force noted that the need for additional beds could be reduced if the state were to invest in the creation or expansion of alternatives, including many of the priority recommendations in this and prior reports.

*Figure 7.* Kansas Adult Psychiatric Hospital Beds (excluding forensic) in Kansas by Population and Facility Type, 2017

| | | |
|---|---|---|
| Counts | **Population 18+: 2015 Population Estimates** | 2,192,084 |
| | **State Psychiatric Hospital Beds** | **248** |
| | **Larned State Hospital** | **90** |
| | **Osawatomie State Hospital** | **158** |
| | **Psychiatric Hospital Beds (Adult) General Hospitals** | **204** |
| | **St. Catherine (Garden City)** | **10** |
| | **Hutchinson** | **13** |
| | **KU Hospital** | **26** |
| | **Salina** | **15** |
| | **Shawnee Mission** | **42** |
| | **Stormont-Vail** | **38** |
| | **Via Christi** | **60** |
| | **Hospital Beds (Adults) Free Standing Psychiatric** | **96** |
| | **Cottonwood Springs** | **24** |
| | **KVC (Adult)** | **12** |
| | **Prairie View** | **60** |
| Total | **Total Adult Psychiatric Hospital Beds** | **548** |
| Rate | **Rate (Total Adult Psychiatric Hospital Beds)** | **25.0** |

Rates per 100,000.

**Sources:**
**Population Estimates:** U.S. Census Bureau's Vintage 2015 Population Estimates
**State Psychiatric Hospital Beds:** KDADS (2017)
**Psychiatric Hospital Beds (Adult) General Hospitals:** KDADS (2017). Directory of Mental Health Resources
**Hospital Beds (Adults) Free Standing Psychiatric:** KDADS (2017)

Recommendation 3.3: Implementation of CIA. Develop regulations and funding resources to implement the Crisis Intervention Act (CIA).

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Develop regulations.<br>o Allocate funding. |
| **Characterization** | o Not rated. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Help individuals access treatment.<br>o Reduce waiting lists for inpatient beds.<br>o Allow people in crisis to remain in or closer to home communities. |

*Background:*

In the 2017 legislative session, the Legislature passed the Crisis Intervention Act, which was signed by the governor in May 2017 and became effective July 1, 2017. This bill provides that adults 18 and older may be placed in crisis intervention centers for up to 72 hours for emergency evaluation and treatment. After 72 hours, patients must then be released or transferred to a facility authorized for involuntary admissions.[60]

The act also includes requirements for evaluation at regular, mandatory intervals to determine whether the person meets criteria to be detained—including likelihood to cause harm to self or others—and requires that within 48 hours the center must file an affidavit with the district court if the person still meets criteria. The crisis center is required to discharge a person admitted under the act if they no longer meet the criteria or no later than 72 hours after admission, whichever comes first, unless it files a petition and finds an appropriate placement, including at a state hospital.[61]

The act did not lay out how to fund the services under the new law, and regulations need to be developed for the new law.

Recommendation 3.4: Suspension of Medicaid. The state should 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.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☐ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Update policies regarding termination of coverage.<br>o Modify KEES system. |
| **Characterization** | o Not rated. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Make it easier for a person leaving the criminal justice system or an inpatient psychiatric facility to regain health coverage.<br>o Quicker access to mental health services, prescribed medicine, and other health-related needs.<br>o Reduce the chance of returning to prison. |

*Background:*

The Task Force supports the creation of statute and regulations allowing for suspension of Medicaid benefits when residing in a state public institution (e.g., mental facility or correctional facility) instead of termination of their coverage. This recommendation mirrors recommendations in the Governor's Behavioral Health Services Planning Council Justice Involved Youth and Adults – Subcommittee Report in 2015 for incarcerated individuals and from the Nursing Facility for Mental Health Work Group Report in 2016.[62,63]

Evidence indicates that most states have historically had a termination policy, though suspension policies are increasing. These suspension policies allow for immediate access to services upon release and allow for easier access to federal funds for inmates receiving inpatient services while in custody.[64] As of 2016, 31 states and D.C. had some form of policy to allow for suspension of coverage. Fifteen of those were for a temporary length of time (e.g., 30 days or the first year of incarceration) while only 16 (including D.C.) suspended coverage during the entire length of incarceration. Nineteen states terminated coverage completely at the time of the report.[65]

Termination policies stem from federal rules surrounding the use of funding for populations in IMD and in correctional facilities. For adults in a mental health institution, care cannot be provided using federal dollars due to the IMD exclusion (see Recommendation 1.1, page 6), though inpatient care can be provided using federal dollars outside of the mental health institution under certain conditions. Currently, under Kansas Medicaid regulations defined in K.A.R. 129-6-60, residence in a state public institution in Kansas results in termination of Medicaid benefits. For mental health patients in state facilities, adults cannot receive services funded through federal dollars, and in state correctional facilities, services provided in the correctional institution are not eligible for Medicaid, but inmates may be eligible for assistance for inpatient hospital services outside of the correctional institution. While Kansas currently terminates benefits for those in public institutions, the Kansas Department of Corrections, as part of inmate release, does coordinate with KDHE to help inmates with re-entry by helping to complete benefits applications pre-release so offenders can access disability and Medicaid resources.[66] However, the reapplication process for obtaining benefits can be time-consuming. Many providers cannot afford to serve individuals without current coverage. Lack of current coverage can affect access to services as well as medications that may be needed upon discharge.

The framework for the statute already exists in Senate Bill (SB) 195 from the 2017 Kansas legislative session. This bill, which died in committee, proposed to suspend Medicaid and disability benefits instead of terminating those services for individuals in public institutions.[67]

# Topic 4: Privatization of Services

*Proviso #3:* The certification process of Osawatomie State Hospital.

*Proviso #7*: Options for privatization of mental health services.

*Goal:* To provide the Legislature with recommendations related to Osawatomie State Hospital and potential privatization of services.

*Introduction:* The Task Force reviewed recommendations from previous reports related to the certification process for Osawatomie State Hospital and the proposal to privatize the hospital. After discussion, the Task Force created three recommendations by consensus to assist the Legislature in its review of any proposal involving hospital privatization or new construction.

In December 2017, Osawatomie State Hospital regained federal certification for the 60-bed Adair Acute Care Treatment (AAC) unit after two years of working to address safety and patient care issues and undergoing federal inspection during the summer and fall of 2017. Overall, Osawatomie State Hospital has the staffing capacity to treat 158 patients, but only the AAC beds can receive federal funds.

*Reviewed Reports:* The following reports informed the development of priority recommendations.

- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)
- Presentation by Secretary Tim Keck (October 26, 2017)

*Priority Recommendations:*

- **Recommendation 4.1: Comprehensive Approach.** While the Task Force appreciates the intention of the current request for proposal (RFP) to create better and safer treatment and work environments for patients and staff at Osawatomie State Hospital, any proposal involving new construction should only be executed as part of a comprehensive financing package addressing a full range of needs in the behavioral health system for mental health and substance abuse disorder treatment, including inpatient and outpatient community-based services, crisis stabilization, housing, and peer programs.

- **Recommendation 4.2: Regional Model.** In lieu of a single RFP, the Task Force recommends a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute psychiatric crisis. The state hospital setting must continue to provide both acute services as well as longer-term/tertiary specialized care.

- **Recommendation 4.3: Vigorous Oversight.** Any process that could result in privatized services – including requests for proposals as well as oversight of any resulting privatized facility – should include thorough and ongoing oversight, including an advisory board to include clinicians, accountants, legal counsel, persons with lived experience who are in recovery, persons with lived experience who have been voluntarily and involuntarily hospitalized, family members and guardians of persons with mental illness, Community Mental Health Center staff, law enforcement and community corrections, and advocacy organizations. If a single bidder responds to any RFP, additional oversight may be required.

Recommendation 4.1: Comprehensive Approach. While the Task Force appreciates the intention of the current request for proposal (RFP) to create better and safer treatment and work environments for patients and staff at Osawatomie State Hospital, any proposal involving new construction should only be executed as part of a comprehensive financing package addressing a full range of needs in the behavioral health system for mental health and substance abuse disorder treatment, including inpatient and outpatient community-based services, crisis stabilization, housing, and peer programs.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Develop comprehensive financing package to improve behavioral health system.<br>o Appropriate funds. |

| Category | Details |
|---|---|
| Characterization | o Not Rated. |
| What Impacts Will This Recommendation Have if Implemented? | o Increase access to services.<br>o Decrease demand for state hospital beds.<br>o Decrease use of emergency departments. |

*Background:*

A request for proposal (RFP) that was released by the Kansas Department of Administration on November 14, 2016, for the operation of Osawatomie State Hospital included operation of at least 206 beds (the current licensed capacity of the hospital). Per the RFP, 94 of the beds must be at the current Osawatomie location with the remaining beds located at the current campus or elsewhere in the Osawatomie State Hospital catchment area. The RFP also specified that the bidder must provide maintenance and upkeep of the physical plant and grounds and allowed for several options for operation, including leasing existing facilities on the grounds, construction on the current grounds or in the catchment area, or through contracting of services with other entities.[68]

On October 26, 2017, Secretary Tim Keck of the Kansas Department for Aging and Disability Services presented the Task Force an Overview of the Options for Osawatomie State Hospital. In the presentation, he presented the background of the hospital, including its history and current status, including its decertification in December 2015. During the presentation, Secretary Keck discussed the costs of new construction and demolition. As the final part of the presentation, he discussed bidders that responded to the RFP. Two bidders submitted proposals to assume operations of Osawatomie. However, one bidder was late in its submission, so its proposal was not accepted. One bidder, Correct Care Recovery Solutions, remained.[69]

Correct Care provided plans for the construction of new facilities, including a design for a patient unit, as part of its bid. Total construction costs are estimated at $100 million to $150 million. However, the Task Force noted the RFP does not account for any other facilities or services needed to address the continuum of care needs for behavioral health populations.[70]

Recommendation 4.2: Regional Model. In lieu of a single RFP, the Task Force recommends a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute psychiatric crisis. The state hospital setting must continue to provide both acute services as well as longer-term/tertiary specialized care.

| Category | Details |
|---|---|
| Required Actions | ☐ Statutory change<br>☐ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| What Steps Should be Put in Place to Implement the Recommendation? | o Issue an RFP to solicit interest from regional partners. |
| Characterization | o Not Rated. |
| What Impacts Will This Recommendation Have if Implemented? | o Increase partnerships at the regional level.<br>o Increase access to services and reduce wait times.<br>o Decrease admissions to state psychiatric hospitals if community alternatives are expanded.<br>o Decrease emergency department use.<br>o Reduce incarceration rates. |

*Background:*

The Task Force recommends a regional model, which it believes can provide a more balanced mental health system, reducing strain on the state hospitals, decreasing transportation issues, and allowing for more effective discharge and reintegration in communities. A more balanced mental health system is necessary to provide treatment for behavioral health in Kansas.

Evidence suggests that a more balanced model of care requires that more services are available locally for mental health delivery, including access to acute care.[71] Both community and hospital services are necessary in all areas, though differing models may be used to provide the services.[72]

While higher-resource, usually urban, counties may be more able to successfully implement a balanced model of care, lower resource, usually rural, counties may have more difficulty establishing a balanced model of care. This requires an emphasis on providing care away from

specialist settings and the establishment or enhancement of community health services as well as population- and community-level platforms for appropriate treatment.[73]

Recommendation 4.3: Vigorous Oversight. Any process that could result in privatized services – including requests for proposals as well as oversight of any resulting privatized facility – should include thorough and ongoing oversight, including an advisory board to include clinicians, accountants, legal counsel, persons with lived experience who are in recovery, persons with lived experience who have been voluntarily and involuntarily hospitalized, family members and guardians of persons with mental illness, Community Mental Health Center staff, law enforcement and community corrections, and advocacy organizations. If a single bidder responds to any RFP, additional oversight may be required.

| Category | Details |
|---|---|
| **Required Actions** | ☒ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☐ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o KDADS should appoint an advisory board with staggered terms to provide oversight.<br>o Establish mechanisms for the advisory group's input into bidder selection and mechanism for ongoing oversight. |
| **Characterization** | o Not Rated. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve patient safety and quality of care. |

*Background:*

The Task Force recommends that an advisory board be established to assist state agencies in the oversight of any privatization process or resulting privatized state hospital. The advisory board should be comprised of members with appropriate knowledge and experiences, including clinicians, accountants, legal counsel, consumers, and families.

Oversight boards have been used in a variety of scenarios including for Behavioral Health (Connecticut), Child Welfare (Philadelphia), and Veterans Affairs. Models such as these could be explored to evaluate which elements would benefit the development of an advisory board.[74,75,76]

The Task Force is aware of the Citizen's Advisory Board associated with Osawatomie State Hospital. The Citizen's Advisory Board meets three times a year and consists of local legislators, hospital and chamber representatives, and local and state organizations.[77] The development of an oversight council for the potential privatization of Osawatomie State Hospital could use the Citizen's Advisory Board as a framework. Any determination of scope and membership of the advisory board should include clinicians, accountants, legal counsel, persons with lived experience who are in recovery, persons with lived experience who have been voluntarily and involuntarily hospitalized, family members and guardians of persons with mental illness, Community Mental Health Center staff, law enforcement and community corrections, and advocacy organizations.

# Topic 5: Nursing Facilities for Mental Health (NFMHs)

*Proviso #2:* The most effective ways to deliver mental health services, including the varied services required for individuals of varying ages.

*Proviso #4*: A comprehensive strategy for delivery of mental health services.

*Goal:* To ensure that nursing facilities for mental health are integrated into the behavioral health continuum of care.

*Introduction:* The Task Force reviewed six recommendations and updated or created three recommendations related to Nursing Facilities for Mental Health (NFMHs), focusing on how the facilities can be better integrated into the behavioral health continuum of care.

To be eligible for admission to an NFMH, adults must be screened, using the Preadmission Screening and Resident Review (PASRR) process conducted by an Aging and Disability Resource Center.[78] After initial admission, annual assessments are completed by screeners from Community Mental Health Centers to determine whether the level of care remains appropriate. Kansas has 10 such facilities as of December 2017, per the Kansas Department for Aging and Disability Services' online directory.

*Reviewed Reports:* The following reports informed the development of priority recommendations.

- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)
- Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016)

*Priority Recommendations:*

- **Recommendation 5.1: Licensing Structure:** Update licensing structure to allow for necessary rehabilitative services in NFMHs and inclusion within continuum of care.

- **Recommendation 5.2: Presumptive Approval of Medicaid:** Coordinate with the Kansas Department of Health and Environment (KDHE) and determine if a policy could be

developed that allows presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs.

- **Recommendation 5.3: Crisis Services in NFMHs:** Develop a process for crisis services to be accessed/provided for individuals in NFMHs to include the creation of additional crisis stabilization units with medical and mental health abilities to help stabilize people up to 14 days.

Recommendation 5.1: Licensing Structure. Update licensing structure to allow for necessary rehabilitative services in NFMHs and inclusion within continuum of care.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☒ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Seek revocation or waiver of the federal IMD exclusion rule.<br>o Review and update licensing structure. |
| Characterization | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Decrease use of state-only funds to pay for psychiatric services in NFMHs.<br>o Improve quality of care.<br>o Improve discharge into community services. |

*Background:*

The Task Force recommends a thorough review of the regulations for Nursing Facilities for Mental Health to assure that regulations are in line with the purpose of NFMHs within the continuum of care and ensure the facilities can provide appropriate, high-quality treatment. NFMHs provide residential care and rehabilitation treatment for persons with serious mental illness with 24-hour supervision and care.[79]

While NFMHs are a structure unique to Kansas, acting as a nursing facility with some mental health services provision and care, the federal government considers NFMHs to be IMDs.[80] The

IMD classification is currently a barrier to care, preventing the state from accessing federal matching funding for care for adults age 21-64.[81] However, this barrier could be removed with a successful IMD exclusion waiver (see Recommendation 1.1, page 6).

The licensing requirements to be reviewed are established under K.A.R. 28-39 Sections 100 through 169c, and were last updated in 1994 (although a subset was updated between 2009 and 2011).[82]

Recommendation 5.2: Presumptive Approval of Medicaid. Coordinate with the Kansas Department of Health and Environment (KDHE) and determine if a policy could be developed that allows presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☒ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Establish coordination of efforts between KDADS and KDHE. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve access to care.<br>o Improve discharge into community services.<br>o Decrease emergency department use.<br>o Improve health outcomes. |

*Background:*

Although some patients with mental illness have Medicaid coverage prior to admission to public institutions, most states have policies that require Medicaid coverage to be terminated. This termination is because states cannot receive federal financial participation (FFP) for individuals age 21-64 in an Institution of Mental Disease (IMD). Most states interpret the rules as meaning individuals entering into IMDs are ineligible for Medicaid.[83]

For states, terminating eligibility or allowing it to lapse after entry into an institution provides an unambiguous designation and avoids the potential for (1) erroneous payment for non-FFP Medicaid services for which the state would be fully responsible, or (2) erroneously billing the federal government for Medicaid services provided to individuals who were not eligible for federal matching payments at the time of the service.[84]

To allow for more seamless reentry into the Medicaid program upon release from an IMD, states can facilitate the Medicaid application process for those potentially eligible (e.g., those eligible upon entry or who appear to meet eligibility criteria on discharge). Through presumptive eligibility, applicants can begin to receive services before conclusive determination of eligibility, allowing for more seamless integration of care for those in need of medical treatment.

Presumptive eligibility was expanded as part of the Patient Protection and Affordable Care Act to include adults covered under Medicaid expansion. Those states that expanded presumptive eligibility to women and children can then extend it to parents and caretaker relatives or other adults that qualify under the expanded Medicaid.[85] However, those populations must be covered under the state's Medicaid program; states that have not expanded Medicaid do not offer presumptive eligibility to people who would only be eligible in an expansion.

Recommendation 5.3: Crisis Services in NFMHs. Develop a process for crisis services to be accessed/provided for individuals in NFMHs to include the creation of additional crisis stabilization units with medical and mental health abilities to help stabilize people up to 14 days.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Establish contracts between NFMHs and Community Mental Health Centers (CMHC).<br>o Create a payment mechanism. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |

| Category | Details |
|---|---|
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve quality of care.<br>o Could decrease need for hospitalization.<br>o Improve outcomes. |

*Background:*

The NFMH Workgroup identified several areas where the process for connecting residents of Nursing Facilities for Mental Health to crisis services was lacking. This included a lack of services for veterans, inconsistent services across Community Mental Health Centers (CMHCs) (e.g., some sites have mobile services available while others do not), and lack of crisis services onsite. The workgroup identified the need to develop an appropriate payment system to reimburse that type of crisis service.[86]

NFMHs could explore models involving partnerships with other service providers, including informal partnerships or formal consortia. In informal partnerships, staff members from several agencies work collaboratively, but informally, as a temporary team constituted to provide multiple services for needy clients on a case-by-case basis. Alternatively, a formal consortium links providers through a formal contract. To ensure coordination among consortium members, a single agency typically takes the lead in coordinating activities and maintains final control over selected resources and interagency processes. Both approaches have strengths and weaknesses, but these models can be explored to determine how best to provide behavioral services for individuals in need.[87]

Some of the issues revolving around payment may be addressed through the successful waiver of the IMD exclusion (see Recommendation 1.1, page 6) which currently prevents federal dollars from being spent for adults in IMDs such as NFMHs.

# Topic 6: Continuum of Care for Children and Youth

*Proviso #2:* The most effective ways to deliver mental health services, including the varied services required for individuals of varying ages.

*Proviso #4*: A comprehensive strategy for delivery of mental health services.

*Goal:* To enhance the array of community-based services available to children and youth with behavioral health needs.

*Introduction:* The Task Force initially reviewed recommendations from previous reports specific to Psychiatric Residential Treatment Facilities (PRTFs), which provide out-of-home residential psychiatric treatment to children and adolescents.

After review, the Task Force expanded the topic area to include a more complete assessment of the continuum of behavioral health services for children and youth.

In addition, the Task Force noted that the Governor's Behavioral Health Planning Council convened a special Children's Continuum of Care Workgroup in 2017. The workgroup's report to the planning council was in draft form while this report was being drafted but may include other recommendations of interest to the Legislature.

The Task Force prioritized four recommendations in this topic area, one of which addressed length of stay and readmissions to PRTFs, one of which focused on alternative placements, one that recommended additional models of intensive outpatient services, and one that focused on early childhood intervention and the recognition of adverse childhood experiences (ACEs).

*Reviewed reports:* The following report informed the development of priority recommendations.

- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)
- Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2016-2017)

*Priority Recommendations:*

- **Recommendation 6.1: Expand Service Options.** Create additional options such as therapeutic foster care and home-based family therapy, among others, in regions across the state.
- **Recommendation 6.2: Intensive Outpatient Services.** Expand community-based options, such as intensive outpatient services.
- **Recommendation 6.3: Quality of Care.** MCO contracts should incentivize reduced PRTF readmissions instead of reduced lengths of stay.
- **Recommendation 6.4: Early Intervention.** Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment, and treatment. Ensure children and caregivers are screened and assessed at regular intervals in early childhood programs. Based on the screening results, work in collaboration with partners to address Adverse Childhood Experiences (ACEs) and sources of toxic stress.

Recommendation 6.1: Expand Service Options. Create additional options such as therapeutic foster care and home-based family therapy, among others, in regions across the state.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Provide technical assistance to communities to look at potential home-based models or alternatives to inpatient or residential care. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve access to care.<br>o Decrease emergency department use.<br>o Improve health outcomes. |

*Background*

The Task Force believes that there should be more options for Kansas children and youth in need of behavioral health services.

PRTFs such as KVC include psychiatric inpatient and residential treatment services, in addition to ongoing case management, therapy, family education and support, transportation, and aftercare services.[88] However, these options are limited to very few geographic locations in the state (mostly limited to eastern and east-central Kansas).[89]

To supplement the current capacity, a crisis residential service model could be developed for Kansas. Crisis residential services are short term, out-of-home placements intended to provide an alternative to inpatient psychiatric services for children.[90]

Foster or kinship care options could also be explored or expanded to allow for appropriate out-of-home services and placement to address behavioral health needs of youth.

Recommendation 6.2: Intensive Outpatient Services. Expand community-based options, such as intensive outpatient services.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Provide facilitators to communities to lead discussions on potential community or home-based options for care for youth.<br>o Ensure transportation to intensive day programs is provided.<br>o Evaluate additional services for Medicaid reimbursement.<br>o Update the 1915(c) waiver to expand array of available services. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve access to care.<br>o Decrease emergency department use.<br>o Improve health outcomes. |

*Background*

Kansas Medicaid home and community-based services for children and adolescents with serious emotional disturbances include wraparound facilitators, parent support and training, independent living skills, attendant care, professional resource family care (crisis), and short-term respite care. [91]

However, the Task Force said the range of options available was limited, restricting the continuum of care. Members also felt that other services such as intensive outpatient services and family-based therapies could be provided to expand the array of resources available to Kansas children. These could include approaches such as Extended Day Treatment programs which provide after-school style programs with behavioral health treatment.[92] Additional services that could be utilized to provide behavioral health care to youth include person plus environment interventions and environment-only interventions, such as trained home visitors and home visitation programs and one-on-one mentoring, and after-school or other community interventions.[93]

Recommendation 6.3: Quality of Care. MCO contracts should incentivize reduced PRTF readmissions instead of reduced lengths of stay.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☐ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Amend contracts with MCOs |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Decrease rates of hospital readmissions.<br>o Decrease cost to the health care system.<br>o Improve quality of care and transition care. |

*Background*

Evidence suggests that lengths of stay in PRTFs have dropped in Kansas. According to testimony presented to the Kansas Child Welfare Task Force in October 2017, the average length of stay for foster youth in psychiatric residential facilities declined from 120 days in 2013 to 45 days in 2017. Related to this is a decline in the number of initial authorized days, down from 90 in 2013 to 14 in 2017, and a decline in renewal days, from 60 in 2013 to 7 in 2017. At the same time, the percentage of children discharged to a family-like setting has also declined, decreasing from 80 percent in 2013 to 20 percent by 2017.[94]

Kansas could impose readmission penalties to ensure length of stay is appropriate and based on children's needs. Penalties could also apply to other related adverse outcomes. For example, a framework could be based on Texas' Hospital Quality-Based Potentially Preventable Complications and Readmissions program, which imposes financial penalties on Medicaid managed care organizations (MCOs) or providers for potentially preventable events.[95]

Recommendation 6.4: Early Intervention. Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment, and treatment. Ensure children and caregivers are screened and assessed at regular intervals in early childhood programs. Based on the screening results, work in collaboration with partners to address Adverse Childhood Experiences (ACEs) and sources of toxic stress.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Develop educational opportunities to communities on ACES and the need for early detection of adverse events experienced by children. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |

| Category | Details |
|---|---|
| **What Impacts Will This Recommendation Have if Implemented?** | o Earlier identification of behavioral health symptoms.<br>o Potential for earlier intervention.<br>o Better outcomes when treatment is received when symptoms appear. |

*Background*

Traumatic events in childhood can have an adverse effect on functioning, including disruption of development and long-term consequences.[96] These Adverse Childhood Events (ACEs) include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, mother treated violently, substance misuse within household, household mental illness, parental separation or divorce, and incarcerated household member. Higher cumulative ACEs are associated with health, social, and behavior problems including substance use disorders. ACEs are also often co-occurring.[97]

These adverse events, if not addressed, can lead to physiological stress that becomes toxic. This toxic stress can then impact behavior, as the individual undergoing toxic stress attempts to counter the stress response. Such behaviors can include smoking, overeating, promiscuity, and substance abuse. These behaviors can moderate the stress response but lead to maladaptive behaviors and chronic health issues or mortality.[98]

To improve outcomes, it is important to educate a variety of sectors about trauma-informed practices. This approach can be achieved by trauma-informed-promoting education across multiple sectors in Kansas. For example, professional psychologists could be utilized to integrate their knowledge base on traumatic stress and skills for trauma-informed practice into core educational experiences for professional psychology, mental health, and other human service and child-serving professions.[99] Some informational resources for trauma-informed care already exist in Kansas and can be accessed online through the Community Engagement Institute at Wichita State University.[100]

Community-based organizations working in partnership have been identified as an essential element to help address trauma and prevent revictimization. Providers within a community or system of care must also work together to develop a trauma-informed referral network.[101]

# Topic 7: Other Recommendations

*Proviso #1: The Kansas mental health delivery system.*

*Introduction:* The Task Force reviewed and categorized a number of additional evidence-based recommendations from all reviewed reports. Some of the resulting prioritized recommendations were subsequently moved within other related topics for this report. Two remaining evidence-based recommendations that did not easily fit within another topic are presented below.

In addition, other evidence-based recommendations were reviewed by the Task Force but not prioritized for the Legislature's action. Rather than grouping those recommendations within other topics, they are presented together in table form.

*Priority Recommendation:*

- **Recommendation 7.1: Workforce.** Encourage integration of peer support services into multiple levels of service, including employment services at the CMHC's, hospitalization, discharge, and transition back to the community.
- **Recommendation 7.2: Health Homes:** The state should take steps to ensure that all Kansas adults with mental illness, including those with co-occurring substance use disorders, and children and adolescents with serious emotional disturbance are enrolled in a health home to provide access to activities that help coordinate their care.

Recommendation 7.1: Workforce. Encourage integration of peer support services into multiple levels of service, including employment services at the CMHC's, hospitalization, discharge, and transition back to the community.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☐ Funding |
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Ensure there are sufficient training opportunities for those interested in providing peer support services.<br>o Enhance incentives to CMHCs that hire and supervise peer support workers. |

| | |
|---|---|
| **Characterization** | o Not rated. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve employment outcomes.<br>o Improve health outcomes. |

*Background*

A similar recommendation was reported by the Nursing Facilities for Mental Health Report in 2016.[102]

Peer specialists are individuals with a lived experience of mental illness or substance use disorder who can serve as models for successful recovery after receiving treatment and progressing to a stage where they can manage their conditions. Evidence suggests that peers with similar lived experiences are associated with improved outcomes, including reduced inpatient service use, improved relationships with providers, better engagement with care, higher levels of empowerment, higher levels of patient activation, and higher levels of hopefulness for recovery.[103]

Training opportunities to prepare a peer workforce already exist in Kansas. For example, a Certified Peer Specialist Training is provided at Wichita State University in the Community Engagement Institute. The qualifications for the program include: self-identifying as having direct, first-hand experience of living with a psychiatric diagnosis, being hired in a Medicaid system such as a CMHC or other qualifying state agency, and being over age 18 with a GED or high school diploma.[104]

Recommendation 7.2: Health Homes. The state should take steps to ensure that all Kansas adults with mental illness, including those with co-occurring substance use disorders, and children and adolescents with serious emotional disturbance are enrolled in a health home to provide access to activities that help coordinate their care.

| Category | Details |
|---|---|
| **Required Actions** | ☐ Statutory change<br>☒ Reg./policy change state agency<br>☐ Reg./policy change federal agency<br>☒ Funding |

| Category | Details |
|---|---|
| **What Steps Should be Put in Place to Implement the Recommendation?** | o Select and implement a health home model.<br>o Establish a reimbursement mechanism.<br>o Add requirement to KanCare 2.0 managed care contracts. |
| **Characterization** | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **What Impacts Will This Recommendation Have if Implemented?** | o Improve access and quality of care.<br>o Improve patient experiences.<br>o Decrease emergency department use.<br>o Decrease inpatient admissions. |

*Background*

The Task Force believes that health homes are an important tool to improve the health of Kansas adults with mental illness, including those with co-occurring substance use disorders, and children and adolescents with serious emotional disturbance.

Health homes are activities that help coordinate care for individuals with serious behavioral health diagnoses who also have chronic medical conditions. It is a team-based approach to providing care that includes the consumer, providers, and family, when it is appropriate to the treatment. These health homes provide linkages to community supports and resources and provide better integration and coordination of care for those in need.[105] These health homes are part of an expansion of Medicaid benefits to help provide care to those with multiple chronic conditions, a chronic condition and the risk for another, or serious mental illness.[106] Evidence suggests that collaborative care is more effective for mental disorders such as depression and anxiety than care as usual, that is helps to improve physical function, and is more cost-effective than usual care.[107]

As of June 2017, 21 states and D.C. had established health homes. Of these states (and D.C.), 19 had covered serious mental illness either by itself of in combination with chronic conditions (two states are restricted to adults), seven cover serious emotional disturbances (two states are restricted to children), and three states cover substance use disorders.[108]

A model for health homes in Kansas already exists, as the state previously had a pilot health home project in the state. This pilot ran from August 2014 to June 2016 and used enhanced federal matching funds to incentivize development of health homes for serious mental illness.[109,110]

Health homes expenditures qualified for a 90-percent federal match during the first eight quarters of implementation in each population; in subsequent quarters the match would have been reduced. Toward the end of the pilot program, KDHE performed an actuarial analysis of the cost-effectiveness of the health homes pilot. KDHE reported that its analysis found the model did reduce costs associated with emergency room utilization and inpatient admissions, but that the improvements were similar for a control group of people who had opted out of health homes.

Advocates for the health home program felt that the two-year period was not long enough to determine the effectiveness of health homes in Kansas.[111]

# Appendix A: Implementation Status of Previous Recommendations

*Figure A-1,* page A-2*,* developed by the Kansas Department for Aging and Disability Services (KDADS), provides a summary of the implementation status of recommendations from eight reports developed between 2015 and 2017 and two other sources. The figure is organized by topic areas that have been discussed by the Mental Health Task Force throughout the report.

- Adult Continuum of Care (ACC) Committee, Final Report (2015)
- Governor's Behavioral Health Services Planning Council Veteran's Subcommittee, Annual Report (2015)
- Governor's Behavioral Health Services Planning Council Update, Justice Involved Youth and Adults – Subcommittee Report (2016)
- Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016)
- Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017)
- Governor's Behavioral Health Services Planning Council, Subcommittee on Housing and Homelessness, 2017 Annual Report (June 2017)
- Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017)
- Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2017)
- Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) 2017 Policy Academy
- Feedback from Stakeholder Meeting with Kansas Association of Addiction Professionals

*Figure A-1.* **Status of Previous Stakeholder Group Behavioral Health Recommendations**

| Recommendations | Report | Status |
|---|---|---|
| **Maximizing Federal Funding and Funding From Other Sources (Related to Topic 1, page 5)** | | |
| Engage community stakeholders for the development of sustainable funding for additional behavioral health and housing options. | Adult Continuum of Care Committee, Final Report (2015) | • The Governor's Behavioral Health Council subcommittee is working with KDADS on a housing pilot program. |
| Develop a lead housing agency. | Adult Continuum of Care Committee, Final Report (2015) | • KDADS is working on pilot housing projects using the housing first model. |
| **Crisis Stabilization (Related to Topic 2, page 14)** | | |
| Increase number of diversion and crisis services at the community level. | Adult Continuum of Care Committee, Final Report (2015)<br><br>Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017) | • In addition to continuing funding for Rainbow Services, Inc. (RSI) and ComCare, Valeo was awarded funds to add beds. Salina has a proposal for crisis stabilization beds. |
| Offer Mental Health First Aid Training. | Adult Continuum of Care Committee, Final Report (2015) | • The state plans to expand Mental Health First Aid. KDADS is in the process of having Mental Health First Aid (MHFA) training for central office staff in the first part of 2018. |
| Offer Mental Health First Aid Training. | Adult Continuum of Care Committee, Final Report (2015) | • Will work with Community Mental Health Centers (CMHCs) to add additional Mental Health First Aid (MHFA) trainings. |
| Urge KDADS to create one new position within the agency to perform as a Veterans Representative and Program Manager. | Governor's Behavioral Health Services Planning Council, Veteran's Subcommittee Annual Report (2015) | • The position was approved by KDADS and filled in February 2017 and coordinates Crisis Intervention Training (CIT) and Veteran Services.<br>• KDADS continues to fund CIT training through the Kansas Law Enforcement Training Center (KLETC) and has initiated expansion of training to be presented in Western and Southeast Kansas and the inclusion of veterans-specific CIT training in Western Kansas. |

| Recommendations | Report | Status |
|---|---|---|
| Expand Crisis Stabilization Services Statewide | Governor's Behavioral Health Services Planning Council Justice Involved Youth and Adults Subcommittee Annual Report - 2016 | • The Kansas Legislature in the 2017 session appropriated funding for expansion of Crisis Centers. |
| Promote utilization of the National Suicide Prevention Lifeline (NSPL) including Veterans Crisis Line around the state, especially in rural areas. | Governor's Behavioral Health Services Planning Council Suicide Prevention Subcommittee Annual Report - 2017 | • A portion of the "It Matters" statewide campaign featured the NSPL number on its materials. The Kansas Prevention Collaborative also promotes the use of the NSPL through social media and websites. |
| Work to promote funding for suicide prevention. | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • Applied for Federal Zero Suicide Prevention Funding. Funded suicide prevention efforts through grant to Headquarters, Inc. |
| Encourage National Suicide Prevention Week activities in communities across Kansas | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • Secured Governor's proclamation and encouraged participation in activities through Kansas Prevention Collaborative. |
| Identify and develop relationships with other high-risk populations as well as rural and frontier geographical areas in Kansas to support evidence-based practices (EBP) that promote suicide prevention. | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • Worked to develop relationships between Substance Use Disorder (SUD), Problem Gambling, and Suicide Prevention networks through Kansas Prevention Collaborative. Explored opportunities with Veterans Affairs (VA) and CMHCs to expand suicide prevention with veteran and rural populations. Developed new "It Matters" campaign materials designed for use statewide. |

| Recommendations | Report | Status |
|---|---|---|
| Develop a sustainability plan for a cross-lifespans suicide prevention resource center in Kansas | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • The Kansas Protection Report Center (KSPRC) established in 2014 by federal Garrett Lee Smith (GLS) Campus Suicide Prevention Grant funding has now sustained operations for two years without federal funding. The recommended plan still calls for more formal support, but KDADS has helped in sustaining its operation. |
| 1. Invest, support, and expand housing infrastructure in the state of Kansas that includes an array of housing options. This would include options such as crisis facilities, group homes, residential care facilities, independent living, and home ownership. A component of these housing programs would be individualized skill-building to help ensure timely transition to less restrictive environments, and to maximize use of these options for an increased number of people.<br><br>2. Implement initial and ongoing housing training for Behavioral Health Staff, specifically Housing Specialists. Resume Housing Specialist meetings that have stopped over the last year.<br><br>3. Continue to support the funding of Supported Housing Funds to assist those with Severe and Persistent Mental Illness (SPMI) and persons with Serious Mental Illness (SMI) so they can obtain or maintain housing in the community.<br><br>4. Continue to support the provision of Training for SOAR case managers and explore funding opportunities to expand this program. Collaborate with | Governor's Behavioral Health Services Planning Council, Subcommittee on Housing and Homelessness, 2017 Annual Report (June 2017) | • KDADS will be convening a workgroup to develop a pilot project. |

| Recommendations | Report | Status |
|---|---|---|
| other state departments to expand the SOAR program by incorporating ongoing training to all SOAR specialists in the state.<br><br>5. Create a centralized location to easily access information on available housing programs across the state. At the same time, adopt a statewide homeless data collection process to ensure that homelessness data is accessible and easily obtained. | | |
| Increase the number of trainings and workshops to promote and support application of EBP among Behavioral Sciences Regulatory Board (BSRB) practitioners and community gatekeepers. | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • Funded additional training in Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) 50 for treatment of patients with suicidal behavior. Worked to promote additional Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills (ASIST) training around the state. Provided online learning modules for gatekeepers through Kansas Prevention Collaborative. |
| **Inpatient Capacity (Related to Topic 3, page 23)** | | |
| Restore capacity for services at Osawatomie State Hospital. | Adult Continuum of Care Committee, Final Report (2015)<br><br>Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017) | • In August 2017, Osawatomie State Hospital (OSH) began incrementally adding beds back into the system based on the ability to sufficiently staff additional patients. As of December, a total of 12 beds had been added at OSH, bringing the current capacity to 158. To date, the average wait time for admission is now about 30 hours (a decrease of about 16.3 hours prior to August) for involuntary, emergency orders and about 52.8 hours (a decrease of about 167.5 hours since August) for Outpatient Treatment Orders (OTOs), criminal cases, and individuals returning from the Severe |

| Recommendations | Report | Status |
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| | | Behavioral Unit (SBU) at Larned State Hospital.<br>• KDADS has provided additional support for Osawatomie State Hospital, including consultants with expertise in the Centers for Medicare and Medicaid Services (CMS) compliance and general hospital operations. Both hospitals have made changes with programing to ensure patients are receiving care seven days a week in acute units. As a result of these changes, Osawatomie has seen a decrease in the readmission rate of approximately 2 percent. |
| Support the development of community-based/local resources. | Adult Continuum of Care Committee, Final Report (2015) | • Funding RSI, ComCare, Valeo, and Salina.<br>• Through the Opioid State Targeted Response (STR) grant, four Substance Use Disorder (SUD) providers were funded to develop local collaborative relationships that increase access to local treatment and recovery services.<br>• KDADS is currently working with multiple Opioid Treatment Providers (OTP) (methadone clinics) and SUD providers to explore the feasibility of offering medication units at sites distant from where OTPs are currently located. |
| Discontinuing the Medicaid benefit termination policy and allowing for suspended benefit status during hospitalization or incarceration. | Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017) | • A process is in place with the central office and hospitals to assure that the individual has their benefits prior to discharge. This is the same process used in corrections. The state is considering an Institutions for Mental Disease (IMD) waiver. |
| Identify gaps in expansion and availability of treatment options for SUD. | Governor's Behavioral Health Services Planning Council, Kansas Citizen's Committee on Alcohol and Other Drug Abuse | • To better address gaps in the current SUD service system, the KDADS' contractor who manages federal and state SUD funding for the uninsured is currently bidding out their entire network. |

| Recommendations | Report | Status |
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| | (KCC), Annual Report (2017) | |
| **Nursing Facilities for Mental Health (NFMHs) (Related to Topic 5, page 38)** | | |
| Evaluate NFMHs (role, licensing model, services, barriers) | Adult Continuum of Care Committee, Final Report (2015)<br><br>Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016)<br><br>Adult Continuum of Care Task Force, Update to the ACC Final Report of July 2015 (January 5, 2017) | • In 2016, KDADS held a series of meetings with members from NFMHs, Nursing Facility (NF) Associations, CMHCs, MCOs and the Long-Term Care Ombudsman and recommendations were provided to the state as result of these meetings. KDADS has contracted with two entities to provide training in behavioral health to NFMH staff. KDADS is working on adding peer support to NFMHs with Consumer-Run Organizations (CROs) being in the NFMH. |
| Conduct community town hall meetings, forums, surveys to build relationships with law enforcement, court systems, Community Mental Health Centers, NFMHs, emergency rooms, medical providers. | Adult Continuum of Care Committee, Final Report (2015) | • Both Larned and Osawatomie State Hospitals hold quarterly Mental Health Reform meetings that are aimed at and include members from each of these groups.<br>• The superintendents of both hospitals also attend meetings as requested by these groups.<br>• The agency will begin a strategic planning session for both Larned and Osawatomie State Hospital in 2018 that will include input from community partners.<br>• KDADS will reinstate quarterly meetings with all licensed Substance Use Disorder (SUD) providers on Jan. 31, 2018.<br>• Via the Substance Abuse and Mental Health Services Administration (SAMHSA) prevention grant contractor, a day-long meeting was convened of first responders, other law enforcement, medical personnel, mental health, and SUD providers to |

| Recommendations | Report | Status |
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| | | plan Kansas' response to the opioid epidemic.<br>• Through utilizing the Statewide Opioid Workgroup as an Advisory Council for the Opioid State Targeted Response grant, developed relationships with state pharmacy association, state Emergency Medical Services (EMS) association, state prescription drug monitoring program, and other stakeholders. |
| Provide mental health training to NFMH staff. | Nursing Facility for Mental Health (NFMH) Workgroup Report (March 3, 2016) | • Mental Health Education Training will be provided to NFMHs and NFs direct staff over a three-year period. The training will consist of a three-hour "Core" Training on mental health facilitated by Mental Health America of Heartland and an eight-hour Mental Health First Aid Training facilitated by the Association of Mental Health of America beginning January 2018 ending December 2020. |
| **Continuum of Care for Children and Youth (Related to Topic 6, page 43)** | | |
| GBHSPC Children's Subcommittee: Promote interconnected systems of care that provide an integrated continuum of person and family-centered services. | Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2017) | • KDADS was awarded a four-year Substance Abuse and Mental Health Services Administration (SAMHSA) Cooperative Agreement for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (System of Care) beginning in federal fiscal year 2016. Federal funds are being used to focus on sustainability financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of evidence-based and evidence-informed services and supports. Kansas System of Care (SOC) efforts include peer support workforce development for youth and parents and exploring full- |

| Recommendations | Report | Status |
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| | | scale implementation of High Fidelity Wraparound. |
| Capitalize on upcoming managed care organization request for proposal process to implement opportunities to maximize and provide flexible funding. | Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2017) | • Drafted a System of Care Flex Funds policy to be used with SOC sub-grantees. Outcomes will be tracked to determine effectiveness of flex funds on service utilization.<br>• Offering parent peer support and youth peer support services to all youth and families involved in SOC. Will analyze potential system impact of parent support services offered on State Plan as opposed to the 1915c. |
| Support early childhood best practices that align with research such as: invest in family engagement strategies that value parents as experts in their children's development. | Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2017) | • Exploring full-scale implementation of High Fidelity Wraparound with SOC principles. Core values of this approach start with "voice and choice," which requires that the perspective of the youth and family be given primary importance during all phases and activities of Wraparound. |
| Continue to promote the education and implementation of trauma-informed practices across all child and family-serving sectors. | Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2017) | • Substance Abuse and Mental Health Services Administration (SAMHSA) requires that all SOC grantees establish formal partnerships across child-serving agencies. Kansas SOC offers trauma-informed training to all formal partners with an evaluation component, the TICometer. This instrument measures the level of trauma-informed care within human service organizations and can be used to track progress over time and areas for improvement. |
| Children's Continuum of Care | Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, | • KDADS staff participation with communication and coordination between school, community, providers, and out-of-home treatment. KDADS staff involved in interagency collaboration on KIDDOS 2, Core Leadership team. (Kansas Department of Health and Environment), High Needs Foster |

| Recommendations | Report | Status |
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| | Annual Report (2017) | Care Workgroup (Kansas Department for Children and Families), High Utilizer Solution Group Psychotropic Medication Workgroup, Kansas Maternal and Child Health Council (KMCHC) and State Agency Monthly Foster Care Discussions.<br>• Facilitate children's workgroup to ensure a continuum of care across all child and family services.<br>• Specific attention to Psychiatric Residential Treatment Facilities (PRTFs), an examination of capacity and provider issues, assessment/admission and length of stay, and waitlist. |
| Expanding Certified Peer Support Services for Youth | Kansas System of Care Advisory Council under the auspice of the Governor's Behavioral Health Services Planning Council, Children's Subcommittee, Annual Report (2017) | • Kansas SOC grantees have employed youth-peer support workers to provide individual and group peer support services. Specific training curriculum is being developed, with consultation from youth, youth peer support workers, supervisors, and other stakeholders. Similar work is in progress for enhancing parent peer support training through Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) 2017 Policy Academy |
| **Other Recommendations (Related to Topic 7, page 49)** | | |
| Expanding Certified Peer Support Services | Adult Continuum of Care Committee, Final Report (2015) Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) 2017 Policy Academy | • The Consumer-Run Organizations (CROs) are now in the state hospitals to meet with patients and will provide a warm hand off upon discharge if the patient wants. CROs will be working with Nursing Facilities for Mental Health (NFMH) patients in the NFMH. The state has funded a clubhouse model that is a peer run program.<br>• KDADS applied and was selected to participate in BRSS TACS 2017 Policy Academy with the action plan goal of expanding the peer support workforce to meet the needs of all |

| Recommendations | Report | Status |
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| | | Kansas Behavioral Health systems. June through September of 2017, the Kansas BRSS TACS Policy Academy team held numerous conference calls, knowledge building sessions, and onsite planning meetings to develop an action plan. A two-day stakeholder meeting was held in late September 2017 to collaborate and develop the curriculum for an Integrated Peer Support Training and related credential. KDADS continues to work with partners to implement a new training, curriculum, and certification protocol. |
| Workforce Development | Adult Continuum of Care Committee, Final Report (2015) | • In 2016, KDADS convened a Workforce Development Planning Committee. They met for 10 months, at the end of which time they developed a strategic plan consisting of short-term and long-term goals. Currently, KDADS is working with Washburn University to develop a partnership with the Health Occupations Student Association to increase students' exposure to behavioral health career opportunities. |
| For the Opioid State Targeted Response (STR) grant:<br>• Develop a regional approach.<br>• Develop/expand medication assisted treatment (MAT) in partnership with established providers.<br>• Provide counseling, peer support, case management, telehealth, mobile apps, and transportation. | Feedback from stakeholder meeting with Kansas Association of Addiction Professionals | • Four regional proposals were awarded to provide services that included peer support, case management, mobile apps, and barrier reductions funds for needs such as transportation. Many services are being provided via telehealth. Providers are developing partnerships with existing MAT providers, and awardees are recruiting additional prescribers. |
| Incentivizing professional training and accreditation. | Adult Continuum of Care Task Force, Update to the ACC Final Report of July | • Legislation was passed in 2016 to allow deemed status for Community Mental Health Centers (CMHCs) who are also accredited by an approved |

| Recommendations | Report | Status |
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| | 2015 (January 5, 2017) | accrediting body. As of November 2017, an application package is available on the KDADS website for CMHCs who meet the qualifications for deemed status. |
| Encourage the development of new coalitions and enrichment of collaboration among existing local coalitions. | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • Provided opportunities for collaboration and development through Kansas Prevention Collaborative and Prevention WorKS. |
| Increase collaboration between the Kansas Department of Health and Environment (KDHE) and KDADS with relation to the use of EBP and to disseminate data and act upon outcomes. | Governor's Behavioral Health Services Planning Council, Kansas Suicide Prevention Subcommittee, Annual Report (2017) | • Explored opportunities for KDHE and KDADS to collaborate on the National Violent Death Review System (NVDRS) data evaluation when the statewide data becomes available. Prevention Subcommittee is exploring state agency prevention efforts outside of KDADS and looking for opportunities to explore synergies to enhance prevention efforts. |

*Source: The Kansas Department for Aging and Disability Services, 2017.*

# Appendix B: Other Recommendations Not Prioritized

The Task Force considered other recommendations that had been generated from previous reports. While a number of those recommendations were not prioritized at this time due to the screening tool and consensus process, the Task Force recognizes their merit and has included them in *Figure B-1.*

*Figure B-1*. Other Recommendations Not Prioritized

| Maximizing Federal Funding and Funding From Other Sources (Related to Topic 1, page 5) | |
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| **Recommendations** | **Characterization** |
| o **Billing Medicaid**: Allow Consumer-Run Organizations (CROs) and other community organizations to have Certified Peer Specialists (CPS) on staff who can bill Medicaid for their services and other peer services, as well as other services provided within the CRO as a sustainable option for people who would rather be served in that type of setting. | o Not rated. |
| o **Reimbursement Rate:** Increase Medicaid reimbursement rate by 2 percent. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Standardized Process**: Create standard process to identify and pursue federal funds where such funding will enhance patient care and improve health outcomes through an effective continuum of care. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **Crisis Stabilization (Related to Topic 2, page 14)** | |
| **Recommendations** | **Characterization** |
| o **National Suicide Prevention Lifeline (NSPL):** Promote and increase utilization of the National Suicide Prevention Lifeline (NSPL), including the Veterans Crisis Line, across the state, especially in rural areas, in an attempt to establish consumer involvement on suicide prevention in those areas. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |

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| o **Transportation Needs:** Evaluate the transportation needs of patients utilizing local facilities and develop a plan for securing transport and/or working with law enforcement agencies to cover the costs of transportation. | |
| o **Early Detection:** Implement efforts aimed at helping communities better identify persons at risk of serious mental illness, serious emotional disturbance, or substance use disorders (e.g., mandatory use of screening tools), and expand roles to support these individuals to thrive in their communities. | |
| o **Crisis Intervention Teams:** Expand the use of Crisis Intervention Teams (CIT) to all police departments in Kansas. If CIT are not determined to be feasible for a particular community, steps should be taken to remove barriers to providing CIT or develop an alternative to provide police officers and first responders with the skills, methods, and tactics to safely de-escalate incidents involving persons experiencing a mental health crisis. | |
| o **Mental Health First Aid Training:** Expand Mental Health First Aid (MHFA) training in Kansas, including the creation of a plan to expand the number of instructors trained in MHFA and a mechanism to reach community groups who are most likely to come into contact with adults and children experiencing a mental health crisis (i.e., schools, churches, law enforcement, social service agencies, etc.). | o High impact will be observed in long-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Standardized Training in NFMHs:** Sustain standardized training and staff working in NFMHs on issues such as mental health first aid and CPI in addition to strengths-based case management, Wellness Recovery Action Plan (WRAP), Integrated Dual Disorder Treatment (IDDT). | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| o **Access to Effective Practices and Support:** Facilities such as a Crisis Stabilization Centers or other local inpatient psychiatric facilities may often be a better alternative for those in violation of their Outpatient Treatment Orders (OTO), or who otherwise meet criteria for involuntary commitment. | o High impact will be observed in short-term.<br>o No existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |

| Inpatient Capacity (Related to Topic 3, page 23) | |
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| **Recommendations** | **Characterization** |
| o **State Hospital:** The state hospital should function as an inpatient safety net. | o Not rated. |
| o **Admissions:** The state hospital should not limit admissions based on the individual's payor source. | |
| o **Number of Beds:** Return Osawatomie State Hospital to 206 beds. | |
| o **State Hospital and Appropriateness of Care:** The state hospital should provide individualized care, provide the appropriate settings for those who need acute crisis stabilization and those who need longer-term stabilization and specialized treatment. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **No Eject, No Reject Policy:** Need to determine where there is the greatest demand for state hospital beds and ensure that privately contracted inpatient beds operate within the no eject, no reject policy. | |
| o **Additional Beds:** Develop alternatives (e.g., crisis stabilization units and small regional state funded beds) at the local level for voluntary and involuntary inpatient treatment. | |
| o **Residential Care Facilities:** Create more residential care facilities that replicate the Evergreen House model (Emporia) and provide intensive supportive services. | |
| o **SUD Beds:** Increase number of substance use disorder beds throughout Kansas, as well as options for medical and social detox. Recommendations for bolstering community programs apply to both traditional mental health treatment and substance abuse disorder treatment. | |
| o **Integrated/Collaborative Treatment Model**: Create treatment options for those with co-occurring disorders and significant physical health diagnoses that are currently being turned away (screened out) from the hospitals. | |

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| o **Processes:** Evaluate admissions and discharge processes to align with patients' needs and treatment. | o High impact will be observed in long-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Workforce:** Educational partnerships should be part of hospital operations. Explore any potential partnerships with KU Med and other schools for trainings for workforce such as social workers and nursing professions. | o High impact will be observed in long-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **Privatization of Services (Related to Topic 4, page 32)** | |
| **Recommendations** | **Characterization** |
| o **Proposal Transparency:** Stakeholders, consumers, and families must have access to the proposal and selection process. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Certification vs. Accreditation:** Make sure that Osawatomie State Hospital maintains certified and/or accredited beds. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **Nursing Facilities for Mental Health (NFMHs) (Related to Topic 5, page 38)** | |
| **Recommendations** | **Characterization** |
| o **Billable Codes**: Increase access to billable codes 120 days prior to discharge to include: peer support, Screening, Brief Intervention, and Referral to Treatment (SBIRT), psychosocial groups, and attendant care (unless IMD exclusion is addressed). | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| o **Payment Model Incentives:** Payment model should incentivize moving individuals out of facilities, with discharge rates, job programs, medication management processes, and therapy appointments. Involve MCOs in this discussion. | o High impact will be observed in long-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |

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| o **Training for Guardians:** Develop or find a training for guardians by partnering with Kansas Guardianship Program or other similar programs with the goal of increasing guardians' understanding of NFMHs and available community resources. Utilize NFMHs to disseminate information about available training and resources. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **Continuum of Care for Children and Youth (Related to Topic 6, page 43)** | |
| **Recommendations** | **Characterization** |
| o Review the PRTF pilot for effective screening processes. | o Not Rated. |
| **Other Recommendations (Relevant to Topic 7, page 49)** | |
| **Recommendations** | **Characterization** |
| **Data/Research** | |
| o **KCTC: Policy Change:** Amend the law – remove opt in provision for the Kansas Communities That Care (KCTC). | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Core Set of Client Outcomes:** The state should establish a core set of client outcomes that could apply across state entities who have responsibilities to people with serious mental illnesses and serious emotional disturbance. These entities should include mental health, substance abuse, corrections, juvenile justice, vocational rehabilitation, state hospitals, and entities that contract directly with the state (e.g., nursing facilities for mental health, psychiatric residential treatment facilities, etc.) or through a state surrogate (i.e., managed care organizations). These outcomes would routinely be included in state agency reports and made available to the Legislature and the general public. These outcomes would also be explicitly written into contracts with entities that provide behavioral health care services. | o High impact will be observed in long-term.<br>o No existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |

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| o **Data System:** Create an inter-agency task force to complete a comprehensive analysis of the data systems currently in place within and across state agencies, and develop a plan for achieving integrated client level data systems. This task force should determine what data are needed to achieve specific state-set outcomes. | o High impact will be observed in long-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Research:** Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care. | o Not Rated. |
| o **Research:** Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. | |
| **Children** | |
| o **Education and Implementation of Trauma-Informed Practices:** Identify specific ways to promote the education of trauma-informed practices to all child and family-serving sectors in Kansas. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Support for Caregivers:** Provide support and education to caregivers, not just the child (early childhood programs). | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Family Engagement:** Invest in family engagement strategies that value parents as experts in their children's development. | |
| o **Early Childhood Programs Staffing:** Maintain appropriate staffing ratios (early childhood programs). | |
| o **Home Visiting Programs:** Expand access to voluntary, effective home visiting programs and services for new and expectant parents that model relationship building, engage parents in learning, and refer for additional supports as needed. | |
| o **Trauma-Based Behavioral Health Services:** The state should develop trauma-based behavioral health services for parents whose children are in the custody of the Kansas Department for Children and Families (DCF) or at risk of entering custody. | o Not Rated. |

| Evidence-Based Practices | |
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| o **Expand Evidence-Based Practices:** The state should expand evidence-based and emerging best practices for adults with serious mental illness that have demonstrated effectiveness in the following areas: competitive employment, post-secondary education, independent living (including housing retention), decrease in-patient state psychiatric hospitalization, increase in community involvement/inclusion, decrease in chronic health conditions. The state should provide financial incentives to make the expansion feasible, including ensuring reimbursement for components of specific evidence-based practices that are not currently reimbursable. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Evidence-Based Policies:** Policies and funding must be crafted to incentivize the services known to be effective at the community level. Funding models should align incentives with desired outcomes. | |
| o **Use of Evidenced-Based Behavioral Health Screenings:** The state should increase use of evidenced-based behavioral health screenings and brief intervention services to aid in early identification of mental health and substance use disorders within primary care clinics, medical settings, community health centers, and schools. The state should determine if there are effective behavioral health screening mechanisms currently in place (e.g., Screening, Brief Intervention, and Referral to Treatment [SBIRT], depression screenings, etc.) that help identify at-risk individuals who need behavioral health care. The state should consider expanding these outreach efforts if determined effective. | |
| o **Community-Based Interventions:** The state should increase the availability of evidenced-based, community-based interventions, targeted to strengthen family systems. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |

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| o **Pilot Programs:** If the research is limited or inconclusive, new practices or programs should be implemented on a small scale with a well-designed evaluation component prior to large scale implementation. | o Not rated. |
| o **Use of Evidence-Based Practices:** State agencies should ensure that practices used to assess, treat, or support individuals and/or families are based in evidence and are effective at achieving the desired outcomes. | |
| o **Substance Use Disorders:** The Task Force recommends that the state expand the use of evidence-based screenings for substance use disorders. | |
| **Integration of Behavioral Health and Primary Care** | |
| o **Role of Primary Care Providers:** Programs should facilitate opportunities for primary care providers to manage medications for individuals with simple regimens. | o Not rated. |
| o **Integrated Models:** The Task Force recommends that the state examine the viability of expanding the panel of behavioral health clinicians authorized to provide services in Kansas Federally Qualified Health Centers. | |
| o **Substance-Use Disorders:** Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| **Access** | |
| o **Tele-Psychiatry:** The state should develop a statewide policy for tele-psychiatry. | o Not rated. |
| **Suicide Prevention** | |
| o **Suicide Prevention:** Assist local suicide prevention efforts and promote local support groups in fundraising efforts, capacity building, and increasing availability of supports for survivors of suicide loss. | o Not rated. |

| Homelessness | |
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| o **SOAR Program:** KDADS should continue supporting the provision of training for SSI/SSDI Outreach, Access, and Recovery (SOAR) case managers. It should also collaborate with other state departments to expand the SOAR program and explore funding opportunities to expand SOAR so that SOAR case managers are available for statewide access. | o Not rated. |
| **Workforce** | |
| o **Workforce:** Quality training and accreditation programs attract and retain good employees and should be supported by state initiatives and funding. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **Behavioral Health Education of Various Sectors:** The state should strongly encourage behavioral health education of current front-line responders, police officers, corrections workers, nurses/doctors, educators, judges, and family law attorneys through required continuing education courses. | o Not rated. |
| o **State Local Repayment Options:** The University of Kansas psychiatry program could be incorporated into state loan repayment options through statute. | |
| o **Expand Psychiatric Residency:** Expanding psychiatric residency programs into state hospitals and CMHCs could aid with Kansas retention of graduates. | |
| o **Cross-Training:** Promote and expand cross-training for student nurses by adding psychiatric inpatient experience, exposure to substance use disorders, and treatment-mandatory training in trauma informed care and other behavioral health treatment settings. | |
| o **Workforce:** Promote and expand cross-training for mental health and addiction professionals through specialized education programs at universities and community colleges, pre- and post-graduation. | |

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| o **Project ECHO:** Project ECHO offers education and assistance for primary care providers hesitant to take on medication management for individuals with mental illness. This program could benefit Kansas health professionals and patients. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| **Employment** | |
| o **KanCare and Employment:** Implement statewide educational campaign to dispel the myth of working and losing benefits and decrease the barrier for consumers wanting to work. | o Not Rated. |
| **Incarceration** | |
| o **Transitional Services:** Integration of services from incarcerated status to community; focus on high acuity need individuals who may be difficult to house, including those with Severe and Persistent Mental Illness (SPMI). | o High impact will be observed in short-term.<br>o Existing system in place.<br>o Low initial investment.<br>o Positive impact on a small number of people.<br>o Avoid costs. |
| o **Mental Health Courts and Jail Diversion Programs:** The state should consider the feasibility of expanding mental health courts and jail diversion programs across Kansas. | |
| **School** | |
| o **Implementation of Expanded School Mental Health:** Support implementation of Expanded School Mental Health as part of traditional school mental health services through collaboration with other professionals and entities. | o High impact will be observed in short-term.<br>o Existing system in place.<br>o High initial investment.<br>o Positive impact on a large number of people.<br>o Avoid costs. |
| o **School-Based Intervention Systems:** Support Interconnected Systems Framework which is based on the premise that a greater array of mental health supports for students and families can become available through school-based intervention systems involving genuine collaboration and mutual support among school and community providers. | |
| o **School Mental Health Services:** The state should explore the feasibility of offering all school children access to school counseling, mental health counseling, and school nursing services. | |

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| o **Licensing of Educators:** The state should research the possibility of including new standards that address mental health knowledge in the licensing of educators. | o Not rated. |
| o **Trauma-Informed Assessment in Schools:** The state should support the development of trauma-informed assessment and systems of care in schools to identify at-risk youth. | |

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# Appendix C: Endnotes

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