KANSAS MENTAL HEALTH COALITION

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

Minutes

Click on underlined items for web links.

September 23, 2015 Monthly Meeting **Valeo Behavioral Health Center, 330 SW Oakley, Topeka, KS**

9:00 a.m.

Introductions and sign-in sheet

Susan Crain Lewis, Vice President
Eric Harkness
Amy Campbell, KMHC
Rick Cagan, NAMI, KS
Mark Wiebe, Wyandot
Steve Christenberry, FSGC
David Elsbury, Kanza MHC
Andy Brown, Headquarters Inc.
Nick Reinecker, Inman
Ken Kerle, CIT
Sheli Sweeney, ACMHCK
Chad Benhardt, Cenpatico
Chris Wills, Valeo
Rob Mealy, KS Psych Society
Mike Burgess, DRC
Patrick Yancey, KHS
Alexandra Simmons, MHAH
Marcia Epstein
Sky Westerlund, KS NASW
Sally Anne Schneider, Stormont Vail
Susanna Honaker, Little Govt Relations
Christy McMurphy, Housing
Carol Manning, MHA of SCK
Susan Zalenski, J & J
Ira Stamm, Ph.D.
Wes Cole, GBHSPC
Bob Chase, SEKS MHC
Lynn Lemke, Marillac
Guests:
Ted Jester, KDADS
Dave Ranney, KHI
Julie Solomon, Wyandot
Capt. Borchers

Financial Report adopted Andy Brown, Treasurer Motion by Schneider, second Yancey.

Please renew your membership at KMHC website - the site will generate an invoice to pay by check. Contact Amy if you have questions.

Minutes of the previous meeting adopted with amendment. Replace "T code" on Page 4 with "CBST code" Motion by Cagan, second Wiebe.

9:15 a.m. Reports

Board of Directors - Meets today. Will consider officer nominations for president. Sue Lewis has volunteered to stand for president, Eric Harkness vice president, Mark Wiebe secretary. Review and consider Advocacy Committee recommendations.

There is consensus from the membership that they are comfortable allowing the Board to move forward with appointing new officers to fill the existing terms.

Advocacy Committee –Grassroots Advocacy Network - Sue Lewis is handing over the chairmanship of the Advocacy Committee to Eric Harkness. The Committee held a meeting in August and established 3 working groups. The Committee also agreed to

Advocacy Training November 6 in Hays, Kansas.

Eric Harkness and Nancy Ross have volunteered to attend NAMI Train the Trainer education next month.

Carol, Corinna, Sue and Amy will be developing member request for advancing the objectives of the Advocacy Committee, asking members outside the committee to help with their objectives.

The Advocacy Committee is a small but mighty group of volunteers who mounts the annual Mental Health Advocacy Day, conducts training for the Grassroots Advocacy Network, and facilitates and informs the Advocacy Network with the goal of empowering the members of the network to advocate with their public officials.

Scott Wituk developed a one page document summarizing the Advocacy work and it will be circulated to the membership.

Kansas Health Foundation Fellows - Tobacco Cessation Initiative *Read more here. Online only*
The Fellows VIII class has developed recommendation to the Kansas Health Foundation to pursue policy and funding initiatives to promote smoking cessation. The recommendations would primarily require executive branch advocacy.

At the beginning of the class, the group studied extensive data and information regarding smoking and its negative health effects on people in the mental health and prevention community. The data was sobering. The class identified a shortage of smoking cessation programs for Medicaid participants, as well as a need for training and best practices. Ultimately, this would require involvement and leadership of KDHE

There is not a smoking cessation billing code for behavioral health. There is education required for health homes, but no treatment code and a lack of qualified professionals.

There has been an inquiry to Rick Cagan and Sue Lewis, who did serve with this Fellows class, if the Kansas Mental Health Coalition might be willing to take on some leadership role with the initiative.

Members are encouraged to think about this issue in preparation for our consensus recommendations process scheduled to begin in October.

Governor's Behavioral Health Services Planning Council – Rick Cagan reported the Council will meet October 9 in Wichita. They will receive a report on the KDADS Prevention Collaborative. Will receive report from ComCare and also look at the work of the CROs. The next meeting is November 6 at Osawatomie State Hospital. Will be looking at the upcoming report from CMS, tour the facility.

10:00 a.m. Guest Topic: Proposal for Emergency Observation and Treatment Legislation

- Julie Solomon, Chief Strategic Mgmt Officer, Wyandot, Inc. and Cpt. Wade Brochers, Lenexa Police Dept.
- Read the KHI Article
- Read the Proposal

Discussed the need for expediting the transition from transportation (by law enforcement or other) to actual treatment. Shared the practical need to be able to utilize EOT to help with this. In most communities of our state, if law enforcement chooses to transport someone in crisis to an emergency room, they may end up staying with that patient for 8 hours or even days waiting for a psychiatric hospital admission. During this time, law enforcement has to stay with that individual while they are not receiving any treatment. While there is more individual dignity in the hospital than the jail, there is little incentive for officers to divert a person with mental illness from the jail if the delays in treatment are too long.

RSI has been a wonderful resource in the KC metro region, but they are not able to take involuntary commitments, so anyone who needs involuntary treatment sits and waits.

What has changed for admissions that would make this EOT important?

Funding reductions mean that social workers are unable to see people in their homes frequently, the hospitals are not admitting voluntary patients, and options are very limited. The 72 hour EOT creates a longer window to allow for treatment and avoid the need to go to Osawatomie State Hospital. Osawatomie has a freeze on voluntary admissions.

Could it be more cost effective for counties to support the mental health centers with less expensive workforce than the police? We would support more funding for that pay and staffing, but it doesn't eradicate the need for an expedited process to care for people who are in crisis.

This isn't a substitute for proper community based care. And we shouldn't let up in our advocacy for funding for community based treatment, but the policy issues are not mutually exclusive.

Wyandot crosschecks the RSI admissions with the county jail numbers.

KU will not take someone who is combative or requires extra supervision, and so they are often going to the jail. The risk that presents to our community is high. There is risk of personal harm, risk of accumulating additional violations and charges while in the jail and a spiraling of problems for the individual.

How long can you hold someone before charging them with something? 48 hours.

One of the things we don't have in Shawnee County when we cut people loose from the jail who have mental health needs or substance use needs, is someone who follows up with these folks. We now have a CIT officer on two shifts who can do some of this, but it isn't fully covered. Does Johnson County have this covered? JoCo has coresponders. Waiting on a grant for Lenexa and Shawnee to share a coresponder. We don't have monitoring of the releases. The mental health program in the jail is not handled by JoCo MHC, it is a private provider. There is supposed to be a soft handoff. There is a little bit of backend support.

Wyandotte County jail MH provider does not discharge any recipient with any medication. There is a delay until they get into the mental health system to get their charts opened and medication prescribed.

Kansas allows anyone in the jails to use generic drugs and they may not be the drugs prescribed by their own physician. How often

What is the funding, where would it come from? The proposal indicates a "state authorized facility", which seems to indicate the funding would come from the local entities.

This bill only provides for the opportunity to designate the receiving center. If they chose to do that, there would be cost associated with that.

Is this a risk of diluting the county and local funding already available?

RSI is not a county facility. Someone somewhere would have to go somewhere to find funding.

In San Antonio and Arizona, they utilize a combination of state, county and city funding. Data from other states show a drastic reduction of involuntary commitments overall. In Arizona, data shows that 80% of individuals were able to be stabilized during EOT and did not need court process for involuntary commitment to state hospital.

What is the standard under this proposal to deprive someone of their civil rights. One of the concerns of some of the sponsors has been: what is the right number of hours? 72 hours? And how do we carefully craft the standard? The EOT examples we viewed rely on officer observation and MH professional consultation, typically now with the local mental health center. The crisis center would then also make their assessment. The only difference with how this is done now is that it increases the window for the facility to handle that crisis.

Current options for civil commitment at state hospitals are in place – why not use that existing process and expand that to local facilities? Add RSI to the list of places?

Proposal includes "up to 72 hours" because the data indicates that most behavioral crises can be stabilized in 72 hours, giving the individual a chance to receive treatment in a community setting – not in a jail or a state hospital.

One of the benefits seen by the proponents is that the court involvement is often not helpful for a person who is experiencing a behavioral health crisis – it inserts a 72 hour period.mm

DRC has a concern regarding the deprivation of the individual's liberty. Proponents feel that the deprivation of liberty is already happening because they are being put into the jail. Stakeholders have great concerns about this and removing the role of the judge.

There is a good deal of concern among the consumer community about the expense to individual liberty. Rocky Nichols was quoted in the press saying it would make more sense to create a robust crisis intervention system.

Many comments in support of this concept and many concerns against it raised in our discussion.

If someone is in a psychiatric break, they typically need medication and we already have a shortage of prescribing professionals.

Battery within a jail leads to an automatic felony. What is the rationale that this won't happen in a treatment facility? Saw this in Arizona – the process was very similar to KU Psychiatric Service and Osawatomie containment process. That is what our existing system has and if there was a receiving center designated – it would be a true "no wrong door" approach unless there is an extreme need to go to the ER for an extreme medical emergency. There is an ER just down the road from RSI, which is important.

Asked for data re: number of people who take medications and how many are prescribed medications against their will. That data is available. The thing to know is that this is happening anyway, it just happens in the state hospital, and law enforcement now has to transport the individual in a police car

Lots of dimensions to this, and it is a complicated proposal. Holding people in a jail cell is a traumatizing experience. Think and hope that a treatment facility

Arizona and Texas both said that the facilities absolutely have to have peer support to work

Extra observations – different standard includes lack of language about ability for decision-making. May not be clear that CMHCs wouldn't be required to develop this option in their area. Important to recall that CMHCs are not exempt from civil liability as are the state hospitals – might be important to consider.

One member's observation - Are Arizona and Texas a good model of civil rights for Kansas?

Kansas and Arizona are among the states who eliminated jail standards and inspections.

People with mental illness are more likely to be victims of violence within a jail setting. Once in jail, people are then fined and ordered to appear in court, and they are unlikely to follow up with that, which leads to accumulating violations and legal problems.

10:30 a.m. Legislative Update Amy Campbell

- Ongoing Continuum of Care Committee possible
- Kansas Hospital Association – new Behavioral Health Task Force - Oct. 27
- KDHE Mental Health Medication Advisory Committee - First meeting September 1, next meeting October 28 2-4 pm

Agenda/Members

Proposed Prior Authorization Policies

1. PA Proposal for Antipsychotic Dosing Limits
2. PA Proposal for Age Criteria
3. PA Proposal for Dosing of Concurrent Antipsychotics

Powerpoint from KanCare HCBS Waiver Integration Public Information Session -Link **to Handout** ***online only***
- 1115(c) waiver amendment posted 9-30-15
- CMS Comment Period 9-30-15 through 11-30-15

Kansas Health Foundation Fellows - Tobacco Cessation Initiative *Read more here. Online only*

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

-Block grant application – majority of funding is for our SUD programs. Application was accepted for the next two years. Did not have significant changes to programs of interest that have been funded under the grant.

-CMHC contracts in place.

-Mental Health Excellence Act provided a competitive grant opportunity to implement certified behavioral health centers – integrating mh and substance use treatment, requiring peer support and other evidence based practices. Concept is to bundle services at different reimbursement rates to expand the scope of treatment provided to our participants.

We were on a very tight window – six weeks – to complete an application. If we were to apply, there was no guarantee that we would be one of the 14 states accepted for the first year's planning grant, nor one of the 8 states to then implement it. The proposed program was very prescriptive and wasn't a very good fit for Kansas.

Secretary Mosier and Secretary Bruffett, along with ACMHCK, would still like to move forward with a Kansas specific model providing increased access to a variety of services with better health outcomes. Want this to be broader than Medicaid. Held a soft kickoff meeting with MCOs and the CMHCs. Forming a subgroup involving 24 team members – already identified – charged with bringing back recommendations by November 1. Will be looking at outcomes, partners and players, areas of service w I/DD v MH v SUD, and how do health homes become a part of this.

-Need for RCF standards and regulations? Moving forward? Had to start over twice do to changeovers at the Attorney General's office. KDADS transition required rewriting again. The statute that provides for the agency authority to implement regulations also needed to change from SRS to KDADS. ComCare and Valeo, RSI, are operating under regulations under development at this point.

-IMD Exclusion Waiver – part of the 1115 waiver application that we are doing. Will move SED waiver out of BH back to HCBS. That 1115 Waiver will include the HCBS Global Waiver Integration. CMS has proposed Medicaid regulations right now that we provided feedback – allowing up to 15 days Medicaid reimbursement in an IMD. Used their arguments regarding short stays, dwindling private inpatient resources, and included the state hospitals. The proposal would allow complete reimbursement – not just the 15 days. Discussions have been relatively positive. May not get the state hospital waiver, but perhaps private. Can't predict how this might turn out, but the request shoots for the moon.

In general, Medicaid is trying to follow Medicare in moving away from fee for service toward bundled payment, value based care, etc. This is the wave of the future. It is happening whether we want it or not. The medicare model utilizes ACOs, but the Excellence in MH Act stopped just short of requiring ACOs. Electronic Medical Records are very important in these models. Another key piece to the model is some buy-in from primary care physicians. PCPs are prescribing mental health medications, but often this doesn't lead to accompanying mental health treatment.

-Prevention Model Tour – Ted attended in Lawrence. Seemed to go well across the state. Can call in to the GBHSPC on the 29th to listen in.

- The new Hospitalization Screening policies go into effect October. Sept 20 Wichita CDDO. Oct 1 Independence. Oct 8 Garden City Compass Behavioral Health. Oct 9 Manhattan.

KHA Webinar – recorded – get a link.

-OSH Renovations – about 2 weeks ahead of schedule on the first phase. Census is 146 now. Will go up to 176 when first phase is completed within a few weeks. Expect to be back to 206 by end of year.

11:25 a.m. Announcements

11:30 a.m. Adjourn

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

For more information, contact: Kansas Mental Health Coalition

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