

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

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Special Committee on Ways and Means/Appropriations

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State Mental Health Hospitals

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Introduction

Chairman Morris, I am Laura Howard, Deputy Secretary of Health Care Policy at the Kansas Department of Social and Rehabilitation Services (SRS). Thank you for the opportunity to provide testimony related to your review of whether or not state mental health hospital bed capacity is being effectively and efficiently utilized and whether or not consolidation or closure of certain facilities or programs should be considered.

SRS operates three state hospitals for persons with mental illness: Larned State Hospital, Osawatomie State Hospital, and Rainbow Mental Health Facility. In coordination with 27 community mental health centers (CMHCs), SRS also funds, regulates, monitors, and helps manage an array of community services for persons with mental illness across the state.

Philosophy

SRS' vision for people with mental illness is that they live healthy, successful, and self-determined lives in their homes and communities. To achieve this vision, SRS must fund and CMHCs must provide services that are state-of-the-science, responsive to individual wants and needs, and available in the person's home community. We know that treatment works best, especially for children, when it is provided as close to the person's home, family, and friends as possible.

Community Capacity

The Kansas Mental Health System includes a community-based system of care that serves adults with severe and persistent mental illness (SPMI) and children and adolescents with Serious Emotional Disturbance (SED). Community-based service providers focus on helping these people achieve what most people want; stable housing, employment, education and success in being members of their communities and their families.

The community-based mental health system includes case management, psychiatric services, medications, evaluations and crisis services, as well as many other specialized services. CMHCs throughout the state work in partnership with SRS to provide these services.

The services provided through CMHCs help to reduce the need for hospitalization and reduce the number of days people stay in the hospital when hospitalization is necessary, while improving individual quality of life. Each CMHC designates a liaison to the state hospital. Liaisons work with state hospital staff to coordinate services between the

community and the state hospital and coordinate continuous discharge planning. This helps to reduce the number of days that people stay in the state hospital by ensuring that community-based services are available upon discharge. In addition, CMHCs are required to plan for and implement mechanisms to deal with urgent and emergent service needs. Throughout Kansas CMHCs work to quickly respond to mental health emergencies by stabilizing crisis situations and providing follow-up services. The community-based system of services has been improved over the past several years to be more focused on reducing the use of hospitalization. Improvements to the system continue to be made within the scope of available resources. Any further reductions in state MH hospital beds would require even further improvement of the community mental health system.

Housing

For many people experiencing hospitalization, housing is an issue. Increasing the availability of affordable housing would help create stability for people with serious mental illness and their families.

Community Support and Crisis Stabilization Services

Increases in the availability of community support and crisis stabilization services would make the use of hospital services less necessary and would make discharge for state hospitals occur faster. In addition, local capacity to provide support and crisis management will need to be expanded should facility consolidation be implemented. The capacity for CMHCs to provide crisis services must be expanded if we are going to successfully divert most people away from state hospital services and into community services. SRS is working closely with CMHCs to enhance and increase crisis and community-based services within available resources. SRS believes progress can be made in this area. However, as public and private psychiatric hospital services become increasingly unavailable, transfer of funds to bolster community resources may need to be considered.

To obtain a more complete perspective on these issues, the Committee may want to consider hearing from people affected by the closure of Topeka State Hospital and their families. They can provide more information about the need for community-based services to support consumers and family members during the transition from state hospital to the community.

Loss of Private Acute In-Patient Care

One serious challenge to providing services close to the persons home has been the loss of many local psychiatric in-patient hospital services. Kansas has experienced many closures of these programs over the past several years. Recently, two more hospitals in Lawrence and Overland Park have announced that they will close their psychiatric units. SRS is very interested to do what it can to ensure that people have this valuable service in their local communities. Any discussion of state MH hospital capacity must include discussion of this critical community resource.

The Steering Committee on the Future of the State Mental Health Hospitals

Makeup and Progress of the Task Force

During the last legislative session SRS was asked by both the Social Services Budget Committee and the Ways and Means Committee to convene a group of stakeholders from a variety of perspectives in an attempt to reach a consensus regarding the role of the state hospitals. SRS has begun this process by convening the *Project Steering Committee on The Future of State Mental Health Hospitals*. The working charter for the Committee and a list of its diverse membership are contained in Attachment A and B. The whole Committee has met twice and has divided its work into three parts that are being worked on by task teams. The task teams include Committee members plus additional resource people with special knowledge or interest in the task, including consumers and family members. Each team has addressed its set of distinct service issues and designated representatives to meet later this month to begin bringing the work of the three groups together.

The Committee is scheduled to meet three more times. At its November 17, 2003 meeting, the Committee hopes to discuss a final draft of its report. A final Committee report is expected before the legislature convenes in January 2004.

Task Force Resources

In addition to the knowledge and experience of each of its members, the Committee is including in its consideration the recommendations of many other previous studies of the mental health system including but not limited to:

1. *Achieving the Promise: Transforming Mental Health in America* by President Bush's New Freedom Initiative July 2003
2. *Hospital Stakeholder Task Force Report* March 2001
3. *A Report from the Rainbow Redesign Task Force* October 2002
4. *Statewide Children's Hospital Committee Report* August 2003 draft
5. *A Review and Analysis of the Future of the Kansas Mental Health Institutions* by Garry A. Toeber, private consultant July 2003
6. *Forensics Subcommittee Report* by the Governor's Mental Health Services Planning Report August 2003 draft
7. A variety of position papers and responses provided by Stakeholders who are and are not members of the Committee

State Mental Health Hospital Capacity

My discussion of state MH hospital capacity is focused primarily on the in-patient psychiatric services provided by the state MH hospitals. Less emphasis is given to services provided by the State Security Hospital or the Sexual Predator Treatment Program.

Role of the State MH Hospital

In recent years the role of the state MH hospitals has changed. Admission rates are up and length of stays are shorter because treatment is more effective and CMHCs are more capable of successfully serving people discharged sooner. As more appropriate placement is found for those people who have remained at the MH hospitals for long periods of time the average length of stay will drop even further. The state MH hospitals

are adjusting their services to effectively meet these changing roles. Attachment C summarizes the admission and discharge data for each state MH hospital.

Services for Children

The number of children up to age 12 served by state MH hospitals continues to decline. The attached data from each of the hospitals reflects that RMHF and LSH admitted only 81 children in FY 2003. The combined average daily census for the two children’s programs combined in FY 2003 was less than 9 children. This level of utilization for children’s services is far below the current capacity of eighteen (18). The Senate Ways and Means Committee requested that SRS identify other models that would provide services to children in family-based settings rather than in state hospitals. SRS expects various models of service delivery will be discussed in the Steering Committee to serve these children closer to their families.

State MH Hospital Budgeted Capacity

The number of persons the state MH hospitals can effectively serve is determined by the number of staff they are authorized to hire to provided needed services. The number of staff they can hire is determined by their approved budgets. The MH hospitals can not serve a significant number of persons above what their staffing can support, especially for extended periods of time, without seriously compromising the quality of patient care and staff morale and safety. The MH hospital’s approved budgets provide sufficient staff for the MH hospitals to serve the following average daily census (ADC):

Hospital	Total ADC	Adult ADC	Adolescent ADC	Children ADC
Osawatomie State Hospital	160	160	0	0
Rainbow Mental Health Facility	40	27	8	5
Larned State Hospital				
• Acute psychiatric	99	79	12	8
• State Security Hospital	98	98	0	0
• Sexual Predator Treatment	85	85	0	0

Of necessity, however, the average daily census of the state MH hospitals must be flexible. Due to the short term emergency nature of admissions, MH hospitals are often required to serve more than their budgeted capacity and sometimes less.

The budgeted capacity of some of the state MH hospitals in-patient psychiatric programs have had to be reduced as part of recent budget reductions. For example, OSH’s budgeted ADC was reduced from 184 to the current 160 when they were required to cut staff in beginning in FY 2002. The budgeted ADC of LSH’s children and adolescent units was also reduced when they experienced similar budget cuts. At the same time, LSH’s

budgeted capacity in the state security hospital was also reduced by 42 beds. On the other hand, the LSH Sexual Predator Treatment Program (SPTP) continues to experience significant increases in ADC.

Building Capacity

The state MH hospitals psychiatric programs are very close to their building capacity. Additional capacity is being added, but only in the state security hospital and the SPTP. The legislature has approved and construction is underway on a new state security hospital at LSH. This new building will free up older buildings for the ever growing SPTP and provide much needed capacity expansion for the forensics program. OSH does have the physical capacity to increase back to its previous 184 ADC. Finally, RMHF does have a potential capacity to serve 60 persons, but several factors are practical limits to reaching this level. First, children and adolescents need to be housed and treated separately from adults. Due to limited demand for these services, vacancies will always occur in these programs. Second, the construction of RMHF and the limitations of its grounds prevent it from serving more long term or aggressive patients.

Mental Health Financing

Funding for community mental health remains fairly stable. The primary sources of funding including: state aid, consolidated grants, certified match grants, Medicaid fee-for-service, and county funding were not significantly affected by the recent budget allotments.

Funding for state MH hospitals continues to be challenging. Current projections are that the FY 2004 and FY 2005 Title XIX Medicaid and Fee Fund revenue will be sufficient to provide for the hospital's status quo budgets. However, Title XIX fund balances continue to decline and CMS deferrals remain unresolved. It now appears likely that between \$3 to \$6 million additional state general funds funding will need to be added to the state MH hospital budgets in FY 2006 to maintain current service levels. SRS is monitoring the situation very closely and will be doing all it can to reduce this potential demand on increased SGF in the future.

Now I would like to call upon Don Jordan, Superintendent of OSH, to further describe some of the actions they have taken to better control their ADC as well as the current role and service design of OSH.