

Kansas Department of

# **Social and Rehabilitation Services**

Gary Daniels, Secretary

**Legislative Budget Committee**

October 4, 2006

**State Mental Health Programs**

**Health Care Policy**

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**State Mental Health Programs**

Chairperson Umbarger and members of the committee, thank you for this opportunity to present testimony regarding mental health initiatives in Kansas. I am Gary Daniels, Secretary of the Kansas Department of Social and Rehabilitation Services. Today I would like to provide you with information regarding the direction of mental health services and an update on existing programs.

**Mental Health Reform**

Mental health reform began in 1987 with the release of a study that showed extreme incongruence between mental health program and financing policy. Kansas was ranked 42<sup>nd</sup> among states in Mental Health Service Delivery. In response, the **Kansas Mental Health Reform Act of 1990** was passed; requiring screening of all State Mental Health Hospitals (SMHH) admissions and providing funding for community based mental health services to reduce the rate of hospitalization of adults with a SPMI and children with SED.

In Fiscal Year 1997, Mental Health (MH) initiated a performance contracting methodology with specific outcome measures to be accomplished by each CMHC. These measures include outcomes related to admissions to and discharges from the SMHHs, reports on services provided, community collaborations and education, employment and housing services, and medication services. Implementation of the Mental Health Reform Act of 1990 yielded the results it was intended to produce. Across the board, targeted results were met or exceeded. In order to build on the success of the last ten years, MH developed and implemented a comprehensive plan to improve accountability for publicly funded mental health services and improve desired outcomes in the lives of adults with SPMI and children with SED.

In FY 2000 and FY 2001, SRS gathered information from a wide range of community partners, hospitals, families, people with mental illness, and other state agencies. They all agreed it was time to take the next step in Kansas, to assure that people with mental illness got the help they needed, when they needed it, in order to live in their own communities. MH developed **Initiative 2000** to address some of these concerns and to improve access, accountability and crisis services across the state. Planning the direction of mental health programs in Kansas has involved multiple state agencies, consumers, consumers' families, mental health advocacy groups, the MH Adult Consumer Advisory Council, and children's groups putting together a dynamic, living plan that is built on every year. As the needs of consumers of mental health services constantly

evolve, so must the strategic plan. The Governor's Mental Health Services Planning Council (GMHSPC) is active in the continuing development of this plan, and continues to be a dynamic and directive voice for advocacy as well as change in the mental health system. All these activities marked a **new era of mental health reform**, based on a reliance on outcomes, data driven decisions, and real change in the lives of people with mental illness. The mental health system in Kansas today focuses on community-based services and recovery in home communities.

### **Transformation-The next step.**

In 2003, the President's New Freedom Commission (NFC) Report on Mental Health, "Achieving the Promise: Transforming Mental Health Care in America" was released and called for sweeping changes to the mental health system throughout the nation. This was regarded as the next step needed in mental health reform, listing goals and recommendations to improve the mental health system. Much of what is named in the report was already being implemented in Kansas. For example, The State of Kansas Social and Rehabilitation Services (SRS) first began contracting with Wichita's State University's Self Help Network for the purpose of building capacity among consumer run organizations (CRO's) and the CRO Network in 1999. At that time, there was no organized network of support among the 11 existing CROs in Kansas and management concerns existed in several programs. Today, Kansas boasts of 19 SRS funded CROs and an active CRO Network. In addition, for several years prior to publication of the NFC Report, Kansas was engaged in efforts to increase communication, provide transparent access to data, promote the recovery and resilience of adults with SPMI, and to focus on the early intervention and treatment of children and adolescents with SED, all of which is consistent with the NFC Report goals and recommendations.

Through the Governor's Executive Order #04-10, the Governor's Mental Health Services Planning Council (GMHSPC) created a Transformation Subcommittee to examine and coordinate transformational activities within and across the Subcommittees of the Planning Council. The Transformation Subcommittee is charged with assuring the implementation of the NFC goals in Kansas' mental health system. The transformation subcommittee of the GMHSPC has also worked with SRS to provide some much needed funding for consumers and family members throughout the state that would like to be involved with the council subcommittees but cannot afford to participate without help with travel expenses. Kansas is committed to having a mental health system that is in a process of continuous improvement and is person-centered, performance-driven, and evidenced-based. The NFC report helps to integrate information and organize activities across the state in a common manner that is embraced by stakeholders.

Kansas' mental health system is one that recognizes the importance of family and consumer input; promotes recovery and resiliency for adults with SPMI; and encourages early intervention for children with SED. The NFC report supported Kansas in enhancing communication among stakeholders about unmet needs and promoted coordination of activities across the state. This tool is giving all concerned stakeholders a common mechanism for organizing and

communicating about unmet needs and expectations for the future of the mental health system in Kansas.

Kansas recognizes and embraces the need for family and consumer driven mental health care with comprehensive state planning, stakeholder input, and accountability to the consumers and families the system serves. Kansas also recognizes that there is still more to be done. The GMHSPC will continue to work with the State Mental Health Authority as it seeks to further improve and refine the State Mental Health Five-Year Strategic Plan and to develop strategies to improve the mental health system across the state.

### **Medicaid State Plan/Waiver Changes**

As we have previously discussed with you, starting in the Spring of 2004 the federal Centers for Medicare and Medicaid Services (CMS) notified SRS that substantial portions of the current Medicaid State Plan governing mental health, behavioral health and substance abuse services are now considered out of compliance with their practice standards. Left unaddressed, these now-identified deficits in Kansas' approved Medicaid State Plan services would render the state and particularly the mental health, behavioral health, and substance abuse service systems – vulnerable to negative funding decisions by CMS that would ultimately cripple our ability to provide these services to Kansans in the greatest need.

*In response to the 2006 Legislative Proviso concerning Mental Health Services* and in order to comprehensively address the myriad of issues about which CMS had expressed concern, throughout the first half of this year a collaborative and focused work group of staff from SRS and the Kansas Health Policy Authority (KHPA), assisted by consultants with CMS and state plan expertise, explored available responsive options. Guided by extensive prior stakeholder input, as well as the leadership guidance of state agencies and the legislature, a foundation for responding to CMS was developed.

In the context of addressing CMS' concerns, SRS purposed to develop a foundation of response that would be consistent with the values that have guided system partners in developing sturdy community-based services, and would support future transformation goals. The guiding values in building the policy foundation are these:

- The existing public mental health and substance abuse treatment systems will be supported;
- Community Mental Health Centers (CMHCs) will retain primary responsibility for meeting the needs of all Kansans accessing the public mental health system;
- A single statewide substance abuse contractor will have primary responsibility for meeting the needs of all Kansans accessing the public substance abuse system;
- The public mental health and substance abuse systems will make effective and efficient use of all treatment resources available;
- Stakeholders will be actively encouraged to participate in shaping public policies and the

- functional design of these public service systems;
- The solutions we craft will be supportive of the goals and recommendations identified in the New Freedom Commission report, *Achieving the Promise: Transforming Mental Health Care in America*; and
- Be responsive to and build upon direction from the 2006 Kansas Legislature regarding the development of this foundation by requiring any willing provider to associate with a CMHC to provide services to consumers.

Having developed the foundation for response to CMS, in June SRS sponsored a series of stakeholder meetings to fully review the pending issues, the core infrastructure we had built for responding, and discuss next steps. Hundreds of stakeholders participated in those meetings, and similar meetings are continuing with smaller interested groups.

At the end of June, our comprehensive package of proposals was submitted to CMS, including extensive amendments to the Kansas Medicaid state plan, an application to amend our existing waiver for youth with Serious Emotional Disturbance, and an application for a selective services contracting waiver for all public mental health/substance abuse services.

Extensive stakeholder input will be required over the next several months to successfully build implementation tools that will spell out exact service codes, practice guidelines, reimbursement rates, service authorization and operating limitations, such as:

- Provider manuals;
- Contractual expectations;
- Associate agreements;
- Utilization management tools;
- Practice guidelines and forms; and
- Service standards for Psychiatric Residential Treatment Facilities

Following submission of waiver applications and state plan amendments to CMS at the end of June, SRS has continued with stakeholder information and implementation readiness activities, including:

- Presented information and engaged in Q&A sessions with over 500 stakeholders in various settings, including mental health and behavioral health practitioners, consumers, family members, and private practitioners;
- Developed implementation work groups to focus on preparing service system for changes, including: PRTF service standards and payment methodology; contract development for future services and system management, with related rate review and administrative payment methodology; and provider manual changes and claims payment system readiness. Each work group has engaged in extensive pre-work, both internally and cross agency work with the Juvenile Justice Authority, Kansas Health Policy Authority, and Kansas Department of Health and Environment staff; and each has designated external members, based upon feedback from stakeholders, who will

- participate when the pre-work phase has been completed;
- Worked with Wichita State University to host a web site that includes informational materials about what has been submitted to CMS, as well as updates about readiness activities and some interactive features when feedback is sought. We anticipate that a broader range of stakeholders can experience a more transparent and timely involvement with the process by use of this site; and
- Interacted with CMS (both Regional Office and Central Office staff), in concert with KHPA, to respond to informal inquiries/clarifications regarding our submissions. This included numerous conference calls to cover all substantive portions of the submissions, and follow up by providing additional detail and/or replacement language.

Overall, our comprehensive package of responses to CMS have been very well received. As you may be aware, CMS has fully approved our selective services contracting waiver application, which will govern all public mental health and substance abuse services in Kansas effective July 1, 2007. As to the related state plan amendments and SED waiver amendments, we have received some additional technical questions from CMS, all of which have been answered, and we anticipate timely approval of those changes will be forthcoming.

### **In-Home Family Treatment – Model Service for Provider Partnerships**

Last Spring, I spent a considerable amount of time working with Community Mental Health Center (CMHC) leaders and Child Welfare Community Based Service (CWCBS) leaders, with the goal of improving access to mental health services for youth needing them. We purposed to identify a “model service” that we could focus on which would enhance the critical partnership between those provider groups to deliver services that were timely and effective to meet the needs of youth in turbulent and complex situations.

We spent time as a group focusing on the broader context of their services and the needs of the people they support; exploring the system issues that sometimes trip up access to meaningful services in a timely way; factoring in the real impact of CMS-based concerns related to medical necessity and service settings; and building a solution that could be used on a trial basis for a short term period and be consistent with the bigger fixes we were building to comprehensively address CMS requirements. The result of that dialogue was that we agreed to focus on In-Home Family Treatment services and craft an agreement that would accomplish the following goals:

- Provide a standardized template for parties to use in accessing and delivering this service;
- Clarify and expand the usability of that service for youth experiencing intense mental health treatment needs;
- Streamline and strengthen the foundation for that service by enhancing the medical necessity determination process in a way that both uses existing information and ensures a quick response time; and
- Specify the roles of the parties that are consistent with the future of public mental health services in Kansas.

In July, we presented the near-final draft of this agreement to the Kansas Health Policy Authority (KHPA), and the construct we proposed was favorably considered by Dr. Nielsen and her staff. KHPA then assessed the proposed agreement, as well as some implementation suggestions, to determine the best way technically to achieve the desired outcomes. Following that, we met with Juvenile Justice Authority (JJA) and KHPA staff to discuss ways to effectively apply the terms of the agreement to all In-Home Family Treatment services being delivered. JJA Commissioner Jordan and his staff also favorably considered the construct, and agreed to join us in the process to finalize this agreement related to like services provided to youth they support.

The parties have finalized the agreement and, effective October 1<sup>st</sup>, the terms of that agreement are being applied to In-Home Family Treatment Services. We are anticipating a successful trial run with this enhanced service and provider arrangement, resulting in improved In-Home Family Treatment Service access/delivery, and in effective practice for the new waiver-related system relationships that will govern this service in the future.

### **Admissions and Census Capacity Issues**

The three State Mental Health Hospitals are Larned State Hospital (LSH), Osawatomie State Hospital (OSH) and Rainbow Mental Health Facility (RMHF).

SRS' three state mental health hospitals provide critical services to Kansans with severe mental illnesses as part of the social services safety net which includes a wide range of community and in-patient services.

Efforts to manage the census have been undertaken from a systems perspective. It has been understood that the responsibility to manage the census at the state mental health hospitals is not just that of SRS but the responsibility of the entire system including the community mental health centers who are the primary "gatekeepers" to these hospitals.

Today's testimony will focus on the systemic efforts to work with the entire mental health system, inpatient and community based services to reduce lengths of stay and facilitate discharges.

To give you some perspective of the scope of the problem, certain data elements will be presented as well.

### **Background Data**

Psychiatric Services admissions to LSH, OSH and RMHF have been on the rise over the past few years.

### Psychiatric Admissions to State Mental Health Hospitals

| Hospital      | FY 04 | FY 05 | % Increase | FY 06 | % Increase | FY 07 - Projected | % Increase Projected |
|---------------|-------|-------|------------|-------|------------|-------------------|----------------------|
| OSH - Adults  | 1404  | 1767  | 25.9%      | 1853  | 4.9%       | *2155             | *16.2%               |
| RMHF - Adults | 535   | 434   | (18.9)%    | 450   | 3.7%       | *480              | *6.6%                |
| RMHF - Youth  | 180   | 247   | 37.2%      | 214   | (13.4%)    | *220              | *2.8%                |
| LSH - Adults  | 711   | 765   | 7.6%       | 839   | 9.7%       | *912              | *8.7%                |
| LSH - Youth   | 135   | 134   | (0.7)%     | 152   | 13.4%      | *144              | *(5.2%)              |

\* = Best estimate based on current admissions data.

With the increase of admissions to OSH and RMHF, census management issues continue to be a problem both from the perspectives of capacity and budgetary constraints.

### System-Wide Census Management Initiatives

In September 2005, in collaboration with Community Mental Health Centers, a census management protocol was implemented.

The protocol initiated the following actions:

1. Communication e-mails are regularly sent to CMHC's to keep them apprised of the census situation on an ongoing basis. The issue of census increases are no longer a surprise to the CMHC's.
2. When census reaches certain "trigger" points, the Superintendent notifies each CMHC in its catchment area that a critical census level has been reached.
3. Reports are sent electronically to the CMHC's detailing the patients who have achieved discharge criteria and are ready to be discharged. The reports also contain information regarding upcoming discharges in order for the CMHC's to be ready for these patients to re-enter the community.

The results of this approach to managing census are a decrease of 55 days over budgeted census for OSH, and a decrease of 16 days over budgeted census for RMHF from September 2005 to August of 2006.

In addition to the census management protocol, the state mental health hospitals have also been

reviewing treatment methods and practices to assure patients are as stabilized as possible before re-entering the community. This preventive approach assists in decreasing the number of admissions that may re-admit to a state mental health hospital:

1. Developed Recovery Paths - class schedules focusing on Trauma, Co-occurring Disorders, and Psychiatric Rehabilitation (LSH).
2. Social Services Department hold quarterly meetings with CMHC liaisons to discuss process issues which include timely discharges (LSH, OSH, RMHF).
3. Increased the amount of intensive treatment primarily within the Psychology and Social Work Department (LSH, OSH, RMHF).
4. Triage - developed to admit patients to Crisis Stabilization Unit, when the expected LOS is less than 15 days (LSH, OSH, RMHF).
5. Utilize Mental Health Quality Enhancement Coordinators (QEC) to problem solve with difficult discharges (LSH).
6. Utilize Developmental Disability QEC's to expedite discharges of those patients who have mental illness and are developmentally disabled (LSH).
7. Meet regularly with the Mental Health Center Directors to discuss challenges in providing services in our catchment area which includes Admissions and Discharges (LSH, OSH, RMHF)
8. Provides transportation for patients who have no "timely" way to leave the hospital (LSH).
9. Implemented WRAP (Wellness Recovery Action Plan) for all patients in coordination/awareness with CMHC's to assure continuity in care (LSH).
10. Re-organized all treatment programming to reflect active focused treatment that targets the presenting problems for admission and sets discharge criteria based on stabilization of the presenting problem (OSH, RMHF).

As admissions increase and discharge planning reaches its optimal levels, reducing lengths of stay will not be as possible without serious consequences to the discharged patients, their families and their communities.

Current discussions are underway between SRS and the Association of CMHC's to agree on

further protocols regarding admissions when census reaches certain levels.

Some of these ideas and discussions include:

1. When census reaches critical levels, identify those most in need for admission and possibly wait list those who are in safe environments elsewhere (i.e., in other inpatient facilities) and admit when a bed opens up.
2. Automatic discharge of all patients whose presenting problem for admission is stabilized. CMHC's accept responsibility and pick them up.
3. Re-define or clarify what is an appropriate admission to a state hospital and support the state hospital to deny referrals not meeting criteria to assure appropriateness.
4. Allocate maximum number of beds a CMHC may use at any given time (not bed days over a year period). If the CMHC has maximum beds full and want to admit, they must: a) discharge a patient first, or b) "borrow" a bed by agreement from a CMHC who is not using all beds at that time.

Further Barriers to Discharging Patients:

1. A renewed emphasis on state hospitals avoiding discharging patients into homelessness will result in more and more patients staying longer in state hospitals due to no identifiable place to live even though they have stabilized in the state hospital..
2. People with mental illness released from corrections facilities are often excluded from community based programs due to their criminal history. Once admitted to a state hospital, they are still refused admission to community based programs which results in longer lengths of stay even though they have stabilized in the state hospital.

## **Forensics**

In April, 2006, SRS created a new position "Coordinator of Forensics". SRS determined the need for a position specifically focused on the increasing numbers of individuals with mental illness entering the criminal justice system. This newly created position involves collaboration with multiple agencies to address issues from pre-arrest jail diversion to the re-entry of offenders from prison.

One example of a successful collaboration has been with the Kansas Department of Corrections. Each year, over a thousand inmates with mental illness and/or substance abuse issues are

released from Kansas prisons and into the community. Upon their release, these individuals must access needed services and resources to reduce their risk of returning to prison. SRS has a critical role in making sure such resources are in place in the community. Approximately three years ago, SRS and KDOC received a two year technical assistance grant from the Council of State Government and the National Institute of Corrections. This grant assisted both KDOC and SRS to collaboratively develop a plan designed to help ensure offenders with mental illness receive the services they need upon returning to the community. To further enhance this effort, KDOC received a two year grant for two Mental Health/Substance Abuse Specialist positions (one position within SRS and one at KDOC). Both positions have been recently filled.

Other successful collaborative efforts between SRS and KDOC have included blended funding for a shared grantwriter position, as well as two COR-Pathway Reintegration Specialist located at the Lansing and El Dorado Correctional Facilities. These specialist work with inmates with mental illness several months prior to their release from prison and remain available for assistance after their release into the community, if needed. SRS looks forward to its continued work with KDOC and the many other agencies and stakeholders committed to reducing the number of Kansans with mental illness entering the criminal justice system

For the past three years, SRS has collaborated with the Mental Health Association of the Heartland, Kansas Jail Association, and the Kansas Law Enforcement Training Center to provide law enforcement officers, jail personnel, parole/probation officers, and SRS Adult Protective Services training on the major mental illnesses, suicide risk reduction, accessing community mental health and substance abuse services, and commonly prescribed psychotropic medications.

These trainings are offered throughout the state and are approved for continuing education for law enforcement officers. The most recent training was held September 27, 2006 in Liberal.

This concludes my testimony. I will be glad to stand for questions from the committee.