

**The Governor's Mental Health Initiative  
Regional Recovery Center for  
Region 1  
is comprised of 58 counties covered by:  
AMHC, The Center, Central KS, High Plains, Horizons, Iroquois, Prairie View and SWGC  
11/25/13**

***Statement of Need***

Covering over half of the State, Region 1 contains 58 Kansas counties comprised of frontier, rural and densely settled rural populations. Eight CMHC's provide comprehensive behavioral health care within this Region and all have submitted their area's needs assessment. A list of Region 1 needs was developed by utilizing needs assessments from individual CMHCs whose responses were gleaned from service provision data and reflected unique community needs, coupled with those generated through the Governor's Mental Health Initiative regional tour where consumers and families, state government, local leaders, and consumer service providers were present to provide input, share information and voice concerns.

Data sources to assess and document needs included: AIMS data; Psychiatric inpatient data; PRTF admission data; client satisfaction surveys; County budget presentations; Community advisory groups; Integrated community health collaborations; community health assessments; Local health Departments; community foundations; 2010 US Census data; SPQM local and Statewide data; internal process improvement findings; internal data reports on penetration of services by county; strategic planning processes; NIMH; US Conference of Mayors; State of KS Homeless Point in time count; KS Housing Resources Corporation ST Consolidated Plan; EBP annual audit and the Salina Area United Way survey. Consumers and stakeholders were specifically included in the Needs assessment in the following ways: Customer Feedback surveys; Community advisory groups; integrated community health collaborations; community health assessments; Marketing interactions with referral sources and colleague providers; Board input; local health departments and community foundations.

Previous needs assessments have utilized all mechanisms listed in the paragraph above plus periodically conducted discussion groups with various stakeholder groups including patients and families.

Region I currently has 6 dedicated Parent support specialists. We have numerous rehab staff including case managers and recovery specialists who also provide the parent support service. We will plan to develop this service within our Region. See attached Goal worksheet.

Peer support in Region I includes 6 persons trained to provide this service. It has been difficult for the Region to grow this service due to the excessive training requirements and difficulty recruiting people to fill the positions. At least two of the Regional CRO's have either dismantled recently or in jeopardy of such and this has been a source of possible service providers in the past. We will have this as a limited goal to increase in our Region.

Intensive case management is provided in all of our areas based on individual client need. SED Waiver facilitators and recovery staff provide services. The Region has discussed this service and believes that we are delivering some forms but would like to know the State's definition of this service. The Region will solicit feedback from the Regional Partners to better define and to share effectiveness of these services and to determine the value to grow such services.

Housing needs are addressed by the individual CMHC's which utilize Supported Housing funds. Each Center addresses needs presented at each community level. Prairie View has a robust housing program, funded through outside grants. The services are extended outside their area, since some of the funds allow that. Prairie View provides some consultation and guidance to other CMHCs. High Plains has a housing manager who manages the supported housing funds, has developed a PRN apartment and maintains 48 subsidized housing units for persons experiencing SPMI. ICHD provides Transitional Housing for consumers who have resided in NFMH's and State Hospitals. ICHD also owns and operates a 15 apartment complex for consumers experiencing SPMI through USDA low income support. The Center provides transitional housing supports. Area MHC has a housing manager which manages funds and provides oversight to 24 HUD Section 11 housing units and other subleased apartments specifically for those experiencing SPMI. Housing needs are often addressed by collaboration with local landlords and use available data and local and regional committees to develop further community programs to address gaps and benefit consumers; strong relationship with Housing Authority to assist consumers in maintaining participation in subsidy programs, one on one work between case manager and client to match client needs with available scattered site rental units. And utilization of State/ Federal/ Community partnerships for PATH funds for case manager to help homeless clients move toward resources and independent living. The structure of Region I is so vast and varied that it is our determination that we can not adequately address the different demographics but we will develop a goal of training one of the regional Housing managers to become a regional housing facilitator. We expect to use the resources locally and with the Regional Partners that have consulting expertise in housing programs that are able to share to the benefit of our Region.

All CMHCs typically address employment in one of two ways – we make referrals to KS Rehabilitation Services for vocational services planning and counseling. KRS in turn makes referrals to us for services provided through written contractual agreements. CSS also provides a range of services from employment specialists from pre-employment to supported employment. Prairie View's educational support system does provide consultation and guidance and will do so for Regional partners as able and as requested. As is with Housing, our Region sees this need more adequately addressed locally.

Medication assistance is available throughout the Region and addressed by CNAs to RNs to Midlevel providers and Doctors. Loss of FCSC dollars has created a critical need for medical assistance to children experiencing SED as much of our Region used FCSC dollars for those services. We use Community Support Medication Program, Prescription Assistance, and Relationships with Drug representatives and local resources including 2 centers with in house pharmacies. This need points to one of our adopted primary Regional goals.

20 or more employees are trained in SOAR. All Centers will train and house an ACA Navigator. It is regionally determined that our current level of resource for this function is adequate.

The process for selecting EBP's: Our region would select an EBP that would be applicable for a wide range of populations (Frontier through Semi-Urban). Any selected EBP would need to be sustainable in regard to both financial and provider resources. Since many other programmatic approaches meet or exceed the EBP outcomes through other means, the end may not justify the additional expense. In addition, a selected EBP would need to be accepted by our funding partners (MCO's) to further address sustainability. Finally an EBP that has been promoted/ funded in part or totally by the State would be considered. In this vast region it is appropriate to assume that our entire dollar allocation would not be sufficient to implement an EBP. We will continue to provide the EBPs that are programmatically viable and plan to share the use of such by each CMHC to the Regional partners.

Collaboration efforts in Central and Western Kansas continue to be fruitful and numerous. This includes but is not limited to: County Coalitions, County Partnerships (Pregnancy Prevention, Alcohol and Drug Abuse Prevention, Suicide Prevention), Child Advocacy Center, LECs, NAMI, USDs, CDDOs/ IDD entities, , CASA, AAAs, AAs, USDs, Courts, Faith community partnerships, Primary care providers, Homeless shelters, private practice groups, St Francis Services Liaison, CISDs, MHFA, Community based Treatments, Liaison to County Courts, etc. We continually build and will continue to build those constant and ongoing relationships that identify needs and points toward important and effective responses.

Over the past 20 years, Western KS has been dedicated to building and providing a strengths based system of care. This work is evident through the strengths based philosophy utilized by both child and adult case management staff. Centers have incorporated the principles of Wraparound as a model of "how we do business" rather than simply a billable service code. Addressing the need of rural/frontier areas requires extensive community collaboration and innovative thinking due to the lack of other formal resources available to individuals with mental illness. Building upon strengths has enabled the Centers of Region 1 to positively impact consumers, and develop strong partnerships within our individual communities. The State has a wealth of information regarding effectiveness of this strengths based system of care. Success has been verified in the data collected through AIMS, achievement of the bed day allocations required by Mental Health Reform, client satisfaction surveys, and information gathered by KU School of Social Welfare in multiple research projects (including the current study regarding the impact of Parent Support Services). Furthermore, integration of the strengths based philosophy into our system of care has been demonstrated by its continued existence despite devastating losses of grant funds as well as symptom focused operations imposed by the MCO's.

In lieu of expensive and sometimes non accessible EBPs, we rely upon our unique and intimate knowledge of our communities and their needs to develop innovative and creative approaches to identified gaps in services and unmet needs! In a number of areas of our Region we are working with the FQHC after visiting the Tennessee model to be more innovative. We are working to identify current strategies and develop new strategies to better engage customers who are high risk.

Stakeholder involvement includes Peer support and parent support as a good resource in future planning. Consumer feedback survey information will continue to be utilized. Consumer seats on boards of directors provides additional strategic input.

There is no research or evidence demonstrating effectiveness of EBPs for Rural and Frontier areas. Fidelity issues are multiple and are addressed in different ways. Supervisors and EBP staff are who are trained in fidelity are included in strategic planning and ongoing service provision. They along with KU, as a number of our programs work with KU, provide input and recommendations whenever an idea comes up that will either enhance or could threaten fidelity. But even more important for our Region is that Client outcomes and funding will ensure fidelity to EB programming. Region 1 is prepared to move into the realm of "Accountable Care". Providing accountable care is based upon achieving positive client outcomes defined by our funding sources (contract, grant and insurance dollars). EB programming will be one mechanism by which we achieve the established outcomes and therefore secure our financial stability. It is critical to note that selection and implementation of EBP is **DEPENDENT** upon the applicability and sustainability of the model in regard to the population and service area. Region I will work with KDADs to a research design to measure outcomes of a cohort of Region I people compared to another strengths based case management site that is meeting fidelity selected as a comparable area with rural and frontier counties.

AIMS, SPQM and Benchmarking data will be used to evaluate processes and measure goals/objectives. Quarterly reviews as a Region of our SMART Goal process will be utilized. The Regional Plan we submit will guide our activities, which are intended to achieve some regional efficiencies. We do not see this initiative leveraging much additional dollars. There may be some Medicaid dollars possible and we will share in a Regional Grant writer to secure and leverage more funds. County funding is static and/or decreasing. Counties are not interested in subsidizing this regional initiative. Regionally providing programs like Mental Health First Aid, sharing other local initiatives and treatment modalities, and sharing in training events will maximize existing resources, increase access and avoid duplication across CMHC's.

A Needs assessment summary representing the beliefs and values of Regional stakeholders, providers, peer support, parent support, and consumers follow. Our primary goals have been driven by the identified greatest needs of the Region.

	Check if this need applies to your County							ST	vote		
	HPC	AM	Iroq	The	HM	CK	SW				
	MC	HC	uois	Cent	HC	PV	MH	GC			
<b>NEED ASSESSMENT for Region I</b>											
<i>from KDADS Regional Meetings</i>											
Frontier area –	x	x	x	x			x	x	s	5	
Need for employment		x	x	x			x	x	s	5	
<b>Crisis stabilization - if crisis passed would not need to be hospitalized</b>	x		x	x	x	x	x	x	X	7	
Methamphetamine capital – high Methamphetamine user population		x		?				x			
high crime rate increases the need to connect with behavioral health					x			?	x		
Poverty – see data from Regional Prevention Centers	x			?	x			x	x		
Evidence-based practice looks different in communities that have high percentage of methamphetamine users; rural; especially related to housing and homeless					x			x	x		
Demographics are changing – those new to communities from different cultures/counties have strong family connections and keep mental health issues “within” the family. As this population grows how will it impact the community?				x				x	x		
<b>Difficult to find qualified staff</b>	x	x	x	x	x		kee	x	x	X	7
Translation services not readily available		x	x	x				x	x	s	4
Fewer resources available – Note: Cannot call four to five places/organizations, but just one organization in the community that provides services	x	x	x	x				x	x	X	5
Lack of internet connection				x				x	x		
Lack of cell phone connection				?					x		
<b>Transportation</b>	x	x	x	x	x	x	x	x	x	X	8
Differences within the region (Garden City, Dodge City, Colby, Hays, Hutchinson and the frontier communities)	x			x	x				x		4
Providers take services further than “across town”			x	x	x			?	x		3
Transient population→between border states (Oklahoma , Colorado and Nebraska)	x	x	x				x 2		x	X	4
Safe and affordable housing is not available. (quality of housing)		x	x	x	x				x	X	4
Lack of education/understanding by parents, siblings, etc. as to how they can be helpful			x	?	x			x	x		
Not as many 12-step, support groups→some in just 1-2 areas			x	?							
Some counties do not have a pharmacy	x								x		
<i>from Specific CMHCs</i>											
Integrated services for those experiencing co-occurring disorders of MH and SUD.		x	x	x		x		x	x	X	5
<b>Managing limited resources to be able to provide prevention services</b>	x	x	x	x	x	x		x		X	7
Sexual offender treatment	(no	x		x					x		
<b>Foster Care placements in our region from other regions</b>	x	x	x	x	x			x	x	X	6
Crisis services for youth and adolescence		x	x	x	x			x		X	5
Integrated services for the dually diagnosed group of MR/DD and MH consumers				x	x			x			
Services for the consumer who was a SED adolescent that is not a SPMI consumer as an adult					x			x			
CBS consumers that are insured, but are not eligible for Waiver services					x			x			
<b>Goals for Region I to consider: Primary Heading then specific goals:</b>											
<b>Family Services</b>											
<b>Children and youth access to medication services</b>		x	x	x	x	x	x	x		X	7
In home Family Therapy Services				x	?						
Transportation for appointments and other needs	x	x	x	x		x				X	5
Housing services				?		x					
Outreach services with community and consumers								x	x		
<b>Prevention Services</b>											
Mental Health First Aid presentations to communities			x	x		x		x			3
<b>Integration Services for Co-occurring disorders</b>											
Medical and Social detox beds and other services to address needs	x	x	x	x		x				X	5
Suboxone treatment in the Region						x					
More integration and coordination with SU services							x				
<b>Crisis Services</b>											
<b>Crisis beds for children and adolescents</b>	x	x	x	x	x	x				X	6
Transportation to and from Hospitalization s	x	x	x	x			x		x	X	5
Adult Crisis beds	x		x	x	x	x				X	5

The most prominent needs identified for Region 1 are highlighted on the summary and include:

1. Transportation
2. Crisis stabilization and crisis beds for adults and youth
3. Recruiting and retaining quality staff
4. Managing limited resources to be able to provide prevention services
5. Children and youth access to medication/psychiatric services
6. Meeting needs of persons experiencing co-occurring disorders
7. Foster Care Placements in our Regions from other areas

The identified goals from this list of prioritized needs include:

1. We will provide quality services both medically necessary and non-medically necessary services.
2. Increase the number of crisis services and crisis beds for adults and/or youth
3. Increase the number of programs available to those experiencing co-occurring disorders
4. Region I will provide 10 Training, Development and/or Prevention programs for providers and/or stakeholders in FY 2014
5. Transportation study committee will be developed tasked with exploring Regional options for transportation problems
6. One regional housing manager will be trained in our region to be a Housing Facilitator.
7. We will work with KDADs staff to set up a research project to compare Region I service outcomes to another Region's fidelity based outcomes of services.

All CMHCs have made selections from the identified goals best fitting their geographical, cultural and consumer needs. They then selected all or part of the goals, and all or some of the objectives for each goal. Each will participate in the global tracking of data and global sharing of knowledge, trainings, prevention, and other later to be determined initiatives. Regional Goals will be the responsibility of the RRC with reporting assistance from Regional Partners.

### ***Regional Recovery Initiative Design***

The Region 1 Initiative Design will be multi-faceted out of a desire to minimize the loss of Family Centered System of Care services, while maximizing impact for the largest number of individuals and families with re-purposed resources. Our chosen approaches to meet the identified primary goals are based upon the Needs assessment and the fact that the value of effective child and family services is well documented. Studies show that intact families and predictable home environments are pivotal for children's sense of security and perception of environmental mastery. Region 1 Community Mental Health Centers believe that most of the Family Centered System of Care services are necessary if society hopes to see another generation of healthy, well-adjusted, and productive citizens. You will see goals and action steps that address these needs in our Needs assessment as well as in the Goal Worksheet that follows in a later section.

We recognize that our regions, resources and services are quite diverse. Therefore, one essential component of our plan is an inventory of the many unique service programs and SAMHSA identified best or promising practices used and/or represented across the eight CMHC's. This Region 1 inventory will match the services found in each area with similar service needs not yet met in another. This gives each community the information and knowledge to make informed decisions about the services and

promising practices utilized across central and western Kansas. Cooperative alignments/partnerships will be put in place to best serve the people of our region.

**Evidence-Based Practices currently guiding the treatment philosophy of CMHC’s within Region 1**

<b><i>Evidence Based Practice including SAMHSA – promising practices</i></b>	<b><i>Number of CMHC’s utilizing this practice as a Guide to Services</i></b>	<b><i>Fidelity and numbers of people benefitting from practice!</i></b>
Illness Management and Recovery	1	
Strength Based Case Management	8	Yes; over 300 individuals
IDDT	2	Yes; 10
Acceptance and Commitment Therapy	1	Follow SAMHSA guidelines; 30
Parent-Child Interaction Therapy	1	Yes
SITCAP-ART	1	Evidence informed; 10
Cognitive Behavioral Therapy- Adolescent Depression	1	SAMHSA Guidelines; 90
Coping Cat	1	SAMHSA Guidelines; 15
Behavior Management Through Adventure-for CBS services and PRTF	1	
Trauma informed CBT	3	>30
Mindfulness Based Cognitive Therapy	2	Evidence informed; 25
Supported Employment	8	No, Most CSS consumers
Home based and/or Functional FT	4	?
Positive Behavioral Support	5	TBD
Dialectical Behavioral Therapy	4	Yes; >40
Peer Support/peer delivered and/or / Parent support services	6	>50
Mental Health First Aid	8	>300
Second Step Curriculum for youth	1	>300

All eight CMHCs will work cohesively to serve those complex patients from anywhere in the region. For example, if a patient from one service area in the region proves difficult to maintain in the community and has consequently been hospitalized with an extended length of stay, the varied or unique community resources from another area will be made available so that community care may be offered to the patient outside of their traditional “county of responsibility.” Our Region is committed to enhanced outreach efforts and the development of patient navigator or engagement specialist roles.

Region 1 meetings will occur on the afternoon of each Larned State Hospital (LSH) Mental Health Reform meeting. LSH MHR Meetings are usually done by noon or 1 p.m. Region 1 Regional Recovery Center meetings will convene afterwards and meet from 1 to 4 p.m. or as otherwise decided and agreed upon. The KDADs staff; LSH designee; CMHC’s and consumers are always welcome.

**Implementation Plan**

<b>Region I – Goals for the GMHI</b>						
<b>GOAL</b>	<b>ACTION STEPS</b>	<b>RESPONSIBILITY</b>	<b>TIMELINE</b>	<b>Outcome / Measure</b>	<b>CMHC Selection</b>	<b>\$\$'s budgeted</b>
<b>1. Through enhanced use of nontraditional service and resources in combination with traditional services consumers of Region 1 will receive appropriate services at the appropriate times as defined in the action steps listed below.</b>	<b>a. Develop "flex funds" for nontraditional and non-medical adult and youth client needs</b>	<b>AMHC  CCC</b>	<b>12/31/13</b>	<b>CMHCs will use flex fund to assist in the non-traditional and non-medical needs of clients that help reach the goals of the integrated treatment plan. FY 2014 will be the baseline year</b>	<b>AMHC CCC</b>	<b>\$3,000 \$2,000</b>
	<b>b. High Plains and Area will research and lead a task group to explore and implement Regional tele-Communication abilities and develop a formal report for CMHC's in region by 6/30/14</b>	<b>RRC coordination</b>	<b>6/30/14</b>	<b>Region 1 will utilize telecommunications and telemedicine to perform screens to allow timely access for consumers. 2014 will be the baseline year.</b>	<b>Regional Goal</b>	<b>Horizons, High Plains and Area MHC</b>

	<i>c. the number of medication services available for children and youth will be baselined for FY 2014</i>	<i>RRC coordination</i>	<i>6/30/14</i>	<i>Baseline the number of medication services for consumers during FY 2014.</i>	<i>CCC HPMMC CKCMHC HMHC PV</i>	<i>\$26,300 \$53,527 \$36,163 \$47,937 \$60,000</i>
	<i>d. Complete a transportation cost study and need assessment; determine volume by 6/30/14. Provide services needed</i>	<i>RRC coordination</i>	<i>6/30/14</i>	<i>Area, The Center and High Plains will work this task group to explore goal needs and costs of Secure Transport or other transportation We will gather baseline data to move towards increasing accessibility for consumers.</i>	<i>AMHC HPMHC HMHC PV  Regional Goal!</i>	<i>\$5,194 \$7,500 \$5,000 \$15,000</i>
	<i>e. The number of parent support, peer support, wrap around and respite care services will increase by 2% in FY 2014.</i>	<i>CMHC selection</i>	<i>6/30/14</i>	<i>Regional needs assessment will be completed to determine high need areas for both parent and peer support services.  We will increase the number of parent support, peer support, wrap around and respite care services in FY 2014.</i>	<i>AMHC CCC ICHD CKCMHC HMHC SWG</i>	<i>\$90,000 \$41,000 \$15,000 \$43,432 \$25,000 \$67,500</i>

	<i>f. Define services and establish baselines for the identified service provision of PRFC, outreach CM and other Services that might be considered non-traditional</i>	<i>CMHC selection</i>	<i>6/30/14</i>	<i>Track outreach services to build capacity to providing services such as PRFC, outreach CM, Intensive CM, to decrease admissions to Higher level of care such as SMHH and PRTF's) Creative services documented in consumer's charts</i>	<i>CKCMHC HPMHC PV</i>	<i>\$48,254 \$20,069 \$5,000</i>
<i>2: Region I will train one of our housing managers as a Housing Facilitator/ Regional Consultant</i>  <i>Region 1 will increase educational housing supports and resources offered by a regional consultant</i>	<i>Have one person in Region I as a Housing consultant</i>  <i>Utilize Regional Expert to educate housing liaison in each region</i>	<i>RRC selection</i>	<i>6-30-14</i>	<i>Provide one trained Housing facilitator</i>  <i>Increased knowledge of housing resource in each regional center. At least one consultation to each center to help provide housing resources to consumers in the region.</i>		<i>Cost will be out of admin fees from the RRC</i>
<i>3: Increase the number of Crisis beds for adults and/or youth in FY 2014 by 3%</i>  <i>Track the number of Crisis Services and determine influencing factors for change from baseline data with current data</i>	<i>a. Crisis beds will be available for adults and youth and will increase 3% during FY 2014.</i>	<i>RRC Coordination</i>	<i>6/30/14</i>	<i>Increase number of crisis beds available on 7/1/13 until 6/30/14</i>	<i>AMHC HPMHC</i>  <i>Regional Goal!</i>	<i>\$52,000 \$87,382</i>

	<i>b. Crisis services will be tracked for adults and youth</i>	<i>RRC coordination and count by each CMHC</i>	<i>6/30/14</i>	<i>Track the number of crisis services delivered from 7/1/13 to 6/30/14 and compare with previous years.</i>	<i>AMHC CCC CKCMHC HMHC PV</i>	<i>\$25,000 \$16,384 \$33,352 \$30,000 \$19,315</i>
	<i>c. Social Media and electronic communications will coordinate and communicate the crisis beds available to the Regional participants</i>	<i>RRC</i>	<i>12/31/13</i>	<i>By January 1, 2014 – Electronic solutions ( web page and/or facebook, etc) will communicate and coordinate the crisis beds in Region 1 that are available.</i>	<i>Regional Goal</i>	<i>Admin Dollars</i>
<i>4: Increase skills and knowledge to develop and improve services for consumers with the number of co-occurring MH and substance use disorder programs in our Region increasing during FY 2014</i>	<i>a. RRC will provide a consultant to assist in training and development of co-occurring programs in Region</i>	<i>RRC</i>	<i>6/30/14</i>	<i>Provide training to at least 30 staff about treatment of co-occurring issues to all centers in Region 1 and ensure at least 25 certified in the region .</i>	<i>RRC hub HMHC PV Regional Goal!</i>	<i>\$15,000 \$25,000 \$5,000 Admin dollars for Consultant</i>
	<i>b. All CMHC Partners will be educated in SBIRT codes in FY 2014.</i>	<i>RRC and consultant</i>	<i>6/30/14</i>	<i>SBIRT trainings will occur for all CMHC Partners by June 30, 2014.</i>	<i>RRC - hub Regional Goal!</i>	<i>\$10,000 of Admin funds</i>

<p><b>5. Region 1 will Provide 10 Training, Development and/or Prevention programs for providers and/ or stakeholders and 200 people will be trained in MHFA and YMHA in FY 2014</b></p>	<p><b>a. Region 1 participants will readily share the in-service and/ or training initiatives located in any part of our Region.</b></p> <p><b>HMHC to provide self-regulation trng to elementary age children within there catchment area.</b></p>	<p><b>RRC</b></p>	<p><b>by 6/30/14</b></p>	<p><b>Social Media or other online tracking will be initiated to coordinate and share the trainings available in Region 1 for any promising or best practice trainings available.</b></p>	<p><b>AMHC</b> <b>ICHD</b> <b>HPMHC</b> <b>CKCMHC</b> <b>HMHC</b> <b>SWGC</b> <b>PV</b>  <b>CCC</b></p> <p><b>Regional Goal</b></p>	<p><b>\$15,000</b> <b>\$2,000</b> <b>\$13,910</b> <b>\$2,000</b> <b>\$35,000</b> <b>\$2,000</b> <b>\$5,000</b>  <b>\$2,000</b></p>
<p><b>Admin costs up to 10%</b></p>		<p><b>RRC to monitor</b></p>	<p><b>FY 2014</b></p>		<p><b>CCC</b> <b>ICHD</b> <b>SWGC</b> <b>AMHC</b></p>	<p><b>\$10,300</b> <b>\$905</b> <b>\$7,062</b> <b>\$22,244</b></p>

Our Implementation plan includes consumers and stakeholders on the needs assessment phase; we will continue to include them in the implementation phase. In conjunction with the Rural and Frontier Committee of the GMHSPC, we will work to enhance consumer representation in all things Rural and Frontier in Central and Western KS. Quarterly meetings will continue to share information / outcomes and continue to build regional goals and outcomes.

**Regional Structure**

Area Mental Health Center will serve as the Regional Center for all Region 1 provider organizations. We have a diverse group and span from mostly frontier counties to a number of significant and impactful densely settled rural counties. This first year will be a year to baseline many things and continue what has been good cooperation in the past – as members of the LSH Mental Health Reform group.

Each provider organization has agreed to sign a Memorandum of Understanding or similar contract with the regional center for purposes of engaging in this regional business collaborative. Along with such an understanding will be HIPAA-compliant Business Associate Agreements allowing for exchange of confidential information and the collective assurance that PHI from one organization will be treated with the same discretion as if from their own organization. Data points and/or aggregate data that can be de-identified prior to transfer will be modified accordingly to further protect patient confidentiality.

To insure regional providers are adequately resourced to participate in the collective pursuit of all goals and outcomes the regional center will allocate FY14 funding according to the chart below:

<b>Regional Provider</b>	<b>FY2014 Region 1 Allocation</b>
Area MHC	\$222,438
Center for Counseling and Consultation	\$97,984
Central Kansas MHC	\$149,733
High Plains CMHC	\$179,863
Horizons CMHC	\$167,937
Iroquois Center for HD	\$17,905
Prairie View MHC	\$109,315
Southwest Guidance Center	\$76,662
Admin Fee	\$50,000
<b>TOTAL</b>	<b>\$1,071,837</b>

In addition to a quarterly distribution of the annual allocation detailed above all provider organizations will be encouraged to enter into joint ventures regarding utilization of both financial and programmatic resources. A professional grant writer is employed by AMHC and their services will be made available, particularly in pursuit of region-wide funding and program opportunities.

***Performance/Outcome Measures***

Data collection for reporting on performance measures will occur at both the local and state level. The assigned KDADS field staff member for Region 1, Patrick Nickelson, has committed to assist in gathering the reports associated with state hospital bed-day utilization as well as the data needed from the state AIMS and CSR systems. This data will be monitored monthly and compiled for reporting on a quarterly basis. Additionally, each regional provider will compile and report to the regional center on a quarterly basis data unique to their organizational performance as it relates to the RRC Goal Worksheet, Community Satisfaction Survey, and Consumer Satisfaction Survey data. These data sources will be examined quarterly to monitor progress and insure desired goals are being achieved or program efforts are being modified as needed to achieve requisite outcomes.

***Deliverables/Reporting Requirements***

The CMHC region will submit quarterly program and financial reports on the template provided. The report will be submitted to KDADS on or before the 30th day of the month following the calendar quarter.

***Budget Detail Worksheet and Budget Narrative/Justification***

Regional providers will submit to the Regional Center quarterly budget/expense data utilizing the KDADS-approved budget/expense reporting worksheet. Each Center will submit a quarterly report to the RRC on the progress towards the adopted goals. This will be on the RRC reporting template. The Regional Center will compile the individual budget/expense data into a regional worksheet and submit the same to the State of Kansas within 30 days of the end of each calendar quarter.

The Budget/Expense Detail Worksheet will include an accounting of expenses that fall within the categories of: Personnel, Fringe Benefits & Taxes, Staff Development & Training, Mileage/Auto Expenses, Telephone, Computer & Other Equipment, Contractual, Allocated Administration Costs, and Flex Funds.