

REGIONAL RECOVERY CENTER PROPOSAL

8/15/13

Region 4 - Regional Hub(s): Family Service and Guidance Center/Valeo Behavioral Health Care

Region 4 consists of four community mental health centers (CMHC) (i.e., Family Service and Guidance Center (FSGC), Kanza Mental Health and Guidance Center, Pawnee Mental Health Services and Valeo Behavioral Health Care) and 15 counties (i.e., Jewell, Mitchell, Republic, Cloud, Washington, Clay, Marshall, Riley, Geary, Nemaha, Pottawatomie, Brown, Jackson, Shawnee and Doniphan) in Northeast Kansas. Operating budgets for the CMHCs vary from 3 to 16 million dollars. Staffing levels vary from 60 to 349 employees.

Statement of Need

Upon reviewing the region's strengths and weaknesses and the overall vision of the Regional Recovery Center initiative, three areas of improvement have been prioritized: (1) increasing capacity for crisis, respite and necessary supports, (2) increasing access to child psychiatry and (3) enhancing services and emerging/best practices through collaboration and training among CMHCs in the region.

Crisis and respite resources differ vastly within Region 4. Capacity is strongest in Shawnee County. FSGC has 8 crisis/respite beds available for children and adolescents and Valeo has recently expanded crisis and transitional beds for adults to 17 and 23, respectively. With this expansion, Valeo has the ability to serve individuals outside of Shawnee County. Further expansion of crisis/respite services is planned by both FSGC and Valeo. While Pawnee has resources for crisis and respite beds for children and adolescents (i.e., five beds in Junction City and two beds in Concordia), a need for crisis beds for adults exists. A task force of eight stakeholders has been formed to explore options for meeting this need. As the smallest CMHC, Kanza has minimal resources in regards to crisis and respite beds. A contract arrangement is in place to access respite services for children and adolescents through TFI in Kansas City, though families have historically

The development of SMART outcomes helped identify methodologies/services targeted for expansion. With the short time frame associated with the first year of this initiative (i.e., nine months of data collection), efforts to increase capacity within the region needed to focus on methodologies/services that were most relevant and attainable. As a result, areas targeted for expansion focused on those that related to the regional needs prioritized and goals developed. It should be noted that some of the methodologies/services that were not identified for regional expansion under this initiative, have current efforts to increase capacity under way at the individual CMHC level (e.g., Kanza is in the process of developing a program to provide employment support and Valeo is exploring expanding their employment support program). Increasing supported employment capacity was not included in this proposal since the expansion is part of the CMHC contract and not specifically related to the region's focus with this initiative.

For the other items not targeted for expansion, current staffing appears to be meeting the need (e.g., FSGC requires all outpatient clinicians to complete the HBFT training, resulting in nearly 30 HBFT trained clinicians being available at any given time). As demand exceeds capacity in any area, expansion will be explored.

Additional services provided, though not necessarily by each CMHC in the region, include Mental Health First Aid, Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy and Anxiety Treatment Program (CBT/ATP), Certified Parent Child Interaction Therapist (PCIT), Supported Education, Crisis Intervention Training (CIT), Integrated Dual Diagnosis Treatment Program (IDDT), Family Psychoeducation, Illness Management and Recovery (IMR) and treatment for substance use disorders (SUD).

For the KU originated Evidenced Based Programming, fidelity is ensured through KU's regular feedback, leadership meetings and annual fidelity reviews. Effectiveness of methodologies/services that were noted on page two as being present though not EBPs as well as services such as Mental Health First Aid, DBT, etc. will be monitored as part of the quarterly evaluation of regional performance. It will be expected that all CMHCs within the region evaluate effectiveness of these services (e.g., admissions, re-admissions, housing, employment, etc.). CMHCs will also be expected to ensure staff have required training. If training is not available within the CMHC's area, regional training will be provided. A portion of each quarterly meeting will be devoted to ensuring best practices continue.

lacking in 14 of the counties include PRTFs, NFMHs, RCFs, inpatient treatment of substance use disorders and general acute inpatient psychiatric treatment), (5) a large veteran and military dependent population which corresponds to an increased number of individuals covered by Tricare (Pawnee and Valeo are not recognized as a SUD provider within Tricare's network.) and (6) lack of reimbursement for secure transportation when an individual needs access to services outside of their immediate area (e.g., admission to a state hospital).

CMHCs in the region have utilized members of the community (i.e., consumers and family members, state government, local leaders and consumer service providers) to continually evaluate service provision and plan for this initiative. Throughout the planning process, the CMHCs have provided updates and solicited feedback from their Board of Directors, which include representation from consumers, family members and community members as well as the various community task forces and work groups for which they are involved. Social media (e.g., CMHC Facebook page) has also been utilized to promote information regarding this initiative.

On May 15, 2013, KDADS sponsored a Regional Recovery and Support Center meeting in Manhattan for Region 4. Forty-five community members, including consumers, family members, state government, local leaders and consumer service providers, participated, 42 participated in person and three participated via phone. From this meeting, issues related to the need for better access for crisis and medication services, lack of transportation, the need to share resources and to continue to enhance evidence based practices were identified. Data from this meeting and that obtained from the 2012 Annual Needs Assessment which focused on Crisis Services has served to be the primary guides for this proposal. Other tools and methods utilized to collect data from members of the community regarding the unique needs of the region include community health assessments, KIDS count data, Communities That Care data, AIMS data, Juvenile Corrections Advisory Board (JCAB) survey data, meetings with community partners/other providers, feedback from Consumer Run Organizations (CRO) and CMHC Quality Management data (e.g., data from program outcomes, risk management, utilization review, consumer satisfaction surveys and complaints). The CMHC's sharing of information, collection of data and pursuit of feedback from community members will continue throughout the Regional Recovery Center initiative.

Regional Recovery Initiative Design

Pawnee will increase capacity of Parent Support by increasing the number of staff with Parent Support responsibilities (i.e., all case management staff will be expected to provide this service).

- Capitalize on intensive case management to support preventative efforts, including assisting individuals access needed services. Services accessed will be based on the needs, desires and goals of the individual. Examples of services the intensive case manager may assist the individual access include natural/community supports, medical, mental health, SUD treatment and recovery support services. Components of IDDT will be utilized when appropriate. Although only one CMHC in the region (i.e., Valeo) currently meets fidelity for this evidence based practice, Pawnee staff have been trained in IDDT.

The CMHCs of Region 4 will also educate community stake holders as to the mental health and SUD treatment services available. Gaps and barriers in accessing mental health and SUD services will be identified in each community and solutions sought. To assist with transitions between levels of care, systems (e.g., mental health and SUD) and providers, Valeo's Recovery Center, which is a statewide resource for SUD treatment, will expand its SUD case management program on October 1, 2013. This service will provide a critical role in coordinating care and assisting consumers connect with needed services and supports. Pawnee has also applied for a grant with community corrections to hire a care coordinator to facilitate coordination between corrections, the court and mental health. If funded, this position would provide case management, SUD evaluations and treatment, and facilitate inpatient admissions, as necessary.

- Utilize flex funds to help meet needs (e.g., rent assistance) and remove barriers to services.

Three outcome measures have been set to monitor performance on this goal. Outcome A: Increase crisis, respite and transitional beds within the region by 10% by June 30, 2014. The 10% (6 bed) increase in crisis, respite and transitional beds will be targeted for children and adolescents and will be located at Family Service and Guidance Center. Although the number of adult beds will not be increased, access to beds currently available within the region will be made possible through this proposal (i.e., Pawnee and Kanza will have the ability to utilize adult crisis and transitional beds at Valeo). Expansion of adult beds is planned within the region though will not be accomplished within the first year of the

- Initiate a Mental Health Court.
- Expand strengths based case management for children and youth.
- Increase availability of Positive Behavioral Supports.
- Enhance capacity for SUD services.

One outcome has been set to monitor performance on this goal (i.e., Provide 100 person hours of collaboration and training to enhance practice within the region by June 30, 2014).

For an overview of the goals and objectives that have been set to meet the identified needs of the region refer to the logic model diagram found in **Attachment A**. (NOTE: Region 4 will utilize the first year of implementation of the Regional Recovery Center initiative to identify consumer outcomes produced as a result of goals and outcomes identified. For example, with increased access to child psychiatry, do families experience an increased sense of services being shaped around individual/family wants, needs and goals? Consumer outcomes will then be incorporated into the second year of the initiative.)

Unique needs and performance on identified goals will be monitored at both the community and regional levels. CMHCs in the region will work within their communities through participation on various task forces and work groups to continue to improve collaboration across organizations. These collaborative efforts will be utilized to leverage resources to achieve goals set for the region. During regional quarterly meetings, CMHCs will share their work with community partners and identify how needs have been met within their area. Barriers to expected performance will be reviewed, unmet needs identified and strategies for addressing needs explored. Of the needs identified, thus far, plans have been made to expand some of the evidence based practices/programs identified under other methodologies and services. Areas of expansion identified are detailed above under the proposed activities for each goal.

Innovative and non-traditional approaches will also be explored when needs have not been met traditionally. CMHCs utilizing innovative and non-traditional approaches will serve as a training and technical assistance resource for other CMHCs to improve practice within the region. Examples of innovative and non-traditional approaches currently utilized

Implementation Plan

Region 4's plan for implementing the Regional Recovery Center initiative is detailed in **Attachment B**. This plan as well as the Statement of Need section of this proposal identifies the manner and degree to which members of the community (i.e., consumers and family members, state government, local leaders and consumer service providers) have been and will continue to be involved in the planning, implementation and evaluation of this initiative. Also serving a critical role within this initiative are the staff of the CMHCs who will participate at all levels of this project.

CMHC staff will be responsible for implementing the proposed activities to meet the needs of the region, working with consumers and community partners as well as being tasked with collecting performance measures for the identified goals. Data regarding Goal 1 will be collected by reporting the (1) total number of crisis, respite and transitional beds each CMHC in the region has on the last day of the reporting period, (2) number of requests for crisis, respite and transitional beds outside of the CMHC catchment area though within the region, (3) number of above requests for crisis, respite and transitional beds that were met within the region and (4) number of individuals trained in Mental Health First Aid. Data regarding Goal 2 will be collected by reporting the number of consultation, clinical supervision and direct service hours provided by a child psychiatrist to areas of the region lacking child psychiatry. Data regarding Goal 3 will be collected by reporting the number of person hours of collaboration and training provided within the region. The focus of such collaboration and/or training will also be detailed.

Each CMHC will provide their agency's data to the Regional Recovery Center (i.e., the Regional Hub), via the Quarterly Tracking form (**Attachment C**), the first week of the month following the end of the quarter. Data from the CMHCs will be summarized and presented at the quarterly regional meetings with key CMHC staff. Performance as a system on the identified goals will be reviewed and adjustments made based upon needs and performance. Quarterly program and financial reports will then be provided to KDADS utilizing the template provided by the 30th of the month following the end of the quarter. Reports provided to KDADS will be shared with CMHC Board of Directors and designated CMHC staff. Performance on goals set for the region including barriers, challenges and successes will also be shared with the various community task forces and work groups for which the CMHCs are involved.

Performance/Outcome Measures

Information regarding performance/outcome measures has been detailed in previous sections of this proposal.

Outcomes to measure progress on identified goals can be found in the Regional Recovery Initiative Design section. And the plan for collecting and reporting on performance measures as well as how data will be used to manage the project, assuring goals and objectives are tracked and achieved, can be found in the section detailing the Implementation Plan.

Budget Detail and Narrative/Justification

Distribution of Regional Recovery Center funds was determined based on each CMHC's expectation of needs related to their individual portions of each goal. An annual amount was identified so as to allow CMHCs to set needed staffing patterns in a manner to offer stable employment to the grant-funded positions while meeting outcomes. With this being the first year of the Regional Recovery Center initiative, each CMHC in the region will report expenses on a quarterly basis to the regional hub utilizing the form agreed upon by CMHC and KDADS representatives in the spring of 2013. It is assumed that this reporting process will allow for any needed adjustments in allocations in order to achieve goals and meet the needs of consumers, accordingly. This budget is merely an estimate. Adjustments will be made as needed. Projected expenses tied to each goal are as follows:

Description	Estimated Cost
Goal 1: To allow maintenance at the least restrictive level of care within the region, capacity for crisis, respite and necessary supports for adults, youth and children will be increased.	
Outcome A – Increase crisis/respite/transition beds by 10%. 6 beds staffed full time plus on call and benefits.	\$340,689
Outcome B – Requests for beds met 50% of the time. 2 adult and 2 youth per month at 72 hour stay.	\$120,960
Outcome C – 200 individuals trained in MHFA. 12 classes, 2 trainers, 16 hours including prep time. \$25 per trainee supplies.	\$18,824
Additional activities in Goal 1 without specific outcomes – Training of staff, increase parent & peer support, utilize flex funds, etc.	\$96,000
Goal 2: To provide specialized care to youth and children, access to child psychiatry, including	

Attachment A

REGIONAL RECOVERY CENTER
LOGIC MODEL
Region 4

Inputs	Activities	Outputs (Projected & Actual)	Outcomes
<p>Resources a program uses to achieve its objectives</p>	<p>What a program does with its inputs – The services it provides to fulfill its mission</p>	<p>Products of a program's activities, such as the number of meals provided, classes taught, brochures distributed or participants served</p>	<p>Benefits for participants during or after their involvement with a program</p>
<p>RESOURCES:</p> <p><u>Human Resources:</u> CMHC Staff (Management, Clinical, Administrative and Grant Writer)</p> <p><u>Other Resources:</u> Consumers/Family Members/Significant Others Community Partners FQHCs/Healthcare Providers Schools CROs</p> <p><u>Financial Resources:</u> RRC Funding Grant Funding, as available/appropriate</p> <p><u>Facilities:</u> CMHC Facilities Community Resources</p> <p><u>Technology:</u> Computer Hardware and Software Communications Websites Telemedicine</p> <p><u>Materials/Other:</u> Office Supplies</p>	<p>● Increase crisis, respite and transitional bed availability.</p> <p>● Share resources and training of staff.</p> <p>● Increase training and awareness of families and community stakeholders (i.e., Conduct MHFA classes).</p> <p>● Utilize parent and peer support as preventative efforts.</p> <p>● Capitalize on intensive case management to support preventative efforts.</p> <p>● Utilize flex funds to help meet needs and remove barriers to services.</p> <p>● Utilize resources to recruit child psychiatry within areas lacking this resource.</p> <p>● Utilize telemedicine to share resources.</p> <p>● Remove barriers to accessing child psychiatry.</p> <p>● Explore creative means to leverage child psychiatry resources.</p> <p>● Provide training/consultation to increase availability of DBT.</p> <p>● Expand CIT.</p> <p>● Initiate a Mental Health Court.</p> <p>● Expand strengths based case management for children and youth.</p> <p>● Increase availability of Positive Behavioral Supports.</p> <p>● Enhance capacity for SUD services.</p>	<p>● Increase crisis, respite and transitional beds within the region by 10% by June 30, 2014.</p> <p>● Requests for utilization of crisis, respite and transitional beds outside of the CMHC catchment area will be met 50% of the time within the region by June 30, 2014.</p> <p>● Provide MHFA training to 200 people by June 30, 2014.</p> <p>● Provide 6 hours of child psychiatric consultation, supervision, and direct-service per month to areas of the region lacking child psychiatry by June 30, 2014.</p> <p>● Provide 100 person hours of collaboration and training to enhance practice within the region by June 30, 2014.</p>	<p>● To allow maintenance at the least restrictive level of care within the region, capacity for crisis, respite and necessary supports for adults, youth and children will be increased.</p> <p>● To provide specialized care to youth and children, access to child psychiatry, including consultation, clinical supervision and direct service, will be increased within the region.</p> <p>● To provide the highest quality of care for consumers, enhancing and/or developing services and emerging/best practices will be explored within the region by June 30, 2014.</p>

**REGIONAL RECOVERY CENTER
QUARTERLY TRACKING**

Region 4

CMHC: _____

Reporting Period: _____

Goal 1: To allow maintenance at the least restrictive level of care within the region, capacity for crisis, respite and necessary supports for adults, youth and children will be increased.

Outcome A: Increase crisis, respite and transitional beds within the region by 10% by June 30, 2014.

Number of crisis, respite and transitional beds available as of the **LAST DAY** of the reporting period: _____

Outcome B: Requests for utilization of crisis, respite and transitional beds outside of the CMHC catchment area will be met 50% of the time within the region by June 30, 2014.

Number of requests for crisis, respite and transitional beds outside the CMHC catchment area though within the region: _____

Number of above requests for crisis, respite and transitional beds that **WERE MET** within the region: _____

Outcome C: 200 individuals will be trained in Mental Health First Aid by June 30, 2014.

Number of individuals trained in Mental Health First Aid: _____

Goal 2: To provide specialized care to youth and children, access to child psychiatry, including consultation, clinical supervision and direct service, will be increased within the region.

Outcome: Provide 6 hours of consultation, clinical supervision and direct service per month to areas of the region lacking child psychiatry by June 30, 2014.

Number of hours of consultation, clinical supervision and direct service provided by a child psychiatrist: _____

Goal 3: To provide the highest quality of care for consumers, enhancing and/or developing services and emerging/best practices will be explored within the region by June 30, 2014.

Outcome: Provide 100 person hours of collaboration and training to enhance practice within the region by June 30, 2014.

Number of person hours of collaboration and training **PROVIDED** within the region: _____

Focus of collaboration and/or training: _____

Person Completing Form: _____

Date: _____