

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State SAPT DUNS Number

Number

878195098

Expiration Date

12/31/2020 12:00:00 AM

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name

Kansas Department for Aging and Disability Services

Organizational Unit

Behavioral Health Services

Mailing Address

503 S. Kansas Ave.

City

Topeka

Zip Code

66603-3404

II. Contact Person for the SAPT Grantee of the Block Grant

First Name

Stacy

Last Name

Chamberlain

Agency Name

Kansas Department for Aging and Disability Services/Behavioral Health Services

Mailing Address

503 S. Kansas Ave.

City

Topeka

Zip Code

66603-3404

Telephone

785-296-0649

Fax

785-296-7275

Email Address

Stacy.Chamberlain@kdads.ks.gov

State CMHS DUNS Number

Number

878195098

Expiration Date

12/31/2020 12:00:00 AM

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name

Kansas Department for Aging and Disability Services

Organizational Unit

Behavioral Health Services

Mailing Address

503 S. Kansas Ave.

City

Topeka

Zip Code

66603-3404

II. Contact Person for the CMHS Grantee of the Block Grant

First Name

Stacy

Last Name

Chamberlain

Agency Name

Kansas Department for Aging and Disability Services/Behavioral Health Services

Mailing Address

503 S. Kansas Ave.

City

Topeka

Zip Code

66603-3404

Telephone

785-296-0649

Fax

785-296-7275

Email Address

Stacy.Chamberlain@kdads.ks.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

9/3/2013 11:59:58 PM

Revision Date

1/31/2014 1:57:50 PM

V. Contact Person Responsible for Application Submission

First Name

Stacy

Last Name

Chamberlain

Telephone

785-296-0649

Fax

785-296-7275

Email Address

Stacy.Chamberlain@kdads.ks.gov

Footnotes:

There is no expiration date on the State DUNS number. A date is required so we added a date in the future so we could save the form.

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="Gina Meier-Hummeel"/>
Title	<input type="text" value="Commissioner"/>
Organization	<input type="text" value="KDADS/Community Services and Programs"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

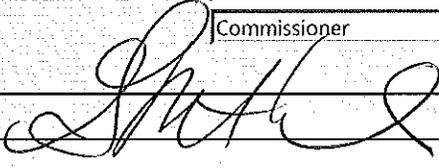
Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee: Gina Meier-Hummel
 Title: Commissioner

Signature of CEO or Designee¹:  Date: 7/8/13

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certification (Form 3) [MH]

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2014

I hereby certify that Kansas agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

- (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
- (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section.

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name

Gina Meier-Hummel

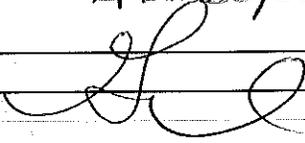
Title

Commissioner

Organization

KDADS/Community Services and Programs

Signature:



Date:

7/8/13

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	<u>Gina Meier-Hummel</u>
Title	<u>Commissioner</u>
Organization	<u>KSAAD/Community Services and Programs</u>
Signature:	
Date:	<u>7/13</u>

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certification (Form 3) [SA]

FY 2014 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Kansas will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name

Gina Meier-Hummel

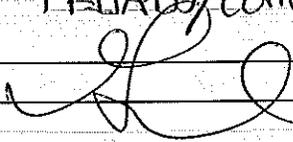
Title

Commissioner

Organization

KDADS/Community Services and Programs

Signature:



Date:

7/8/13

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §5794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §51271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §5469a-1 et seq.).

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

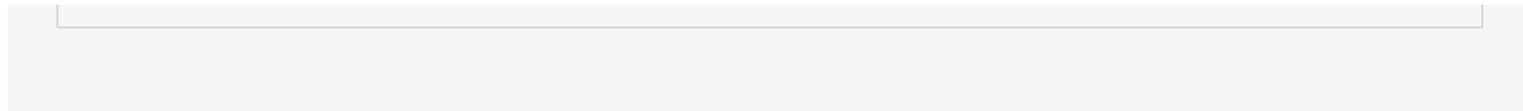
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Gina Meier-Hummel
Title	Commissioner
Organization	KDADS/Community Services and Programs

Signature: _____ Date: _____

Footnotes:



I: State Information

Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant: Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Gina Meier-Hummel

Title

Commissioner

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Step 1: Assess the strengths and needs of the service system to address the specific population

Agency Reorganization

In July of 2012, Disability and Behavioral Health Services was moved under Kansas for Aging and Disability Services/Community Services and Programs. Social and Rehabilitation Services also changed its name to the Department for Children and Family Services. With this move, Mental Health and Addiction and Prevention Services became integrated into a newly formed division named Behavioral Health Services. A single Director was named to provide oversight of the new division. The Director acts as the Single State Authority (SSA), and as the State Mental Health Authority (SMHA). An Assistant Director was hired to help with the integration and oversight of staff.

This integration is in line with the National movement for a holistic focus on the individuals we serve. The new Director is currently working with the division's management staff to identify where integration of duties can occur and plans to make changes accordingly.

Staff Structure

In addition to the Director and Assistant Director the following describes our current staff structure and their responsibilities:

Five Community Quality Improvement staff and one supervisor hold community mental health centers (CMHCs) accountable for licensing regulations and contract outcomes. This is done by; 1) reviewing policy and procedures, 2) interviewing consumers, family members, board members and staff, 3) addressing, tracking and trending complaints, 4) investigating adverse incidents, 5) observing and evaluating CMHC services and delivery, 6) gathering and analyzing outcome data, and requiring CMHCs to appropriately, timely and successfully correct poor performance and failure to meet outcome standards.

Three Facility Quality Improvement staff, one supervisor, and one Mental Health Nurse hold the 14 Psychiatric Residential Treatment Facilities (PRTFs), the 25 Residential Care Facilities (RCFs), and the 3 free standing Private Psychiatric Hospitals (PPH) accountable to basic requirements of health and safety, licensing regulations, and active treatment standards for participating in Medicaid funding. This is done by completing routine and special surveys, investigating critical incidents and serious occurrences, and ensuring the facilities appropriately, timely and successfully address critical incidents and correct substandard care and treatment.

The SUD Clinical Services Coordinator and assigned staff (one administrative specialist, one program consultant located in Central Office and 5 program consultants located in the field) hold licensed substance use disorder treatment programs accountable for licensing regulations. This

is done by annual licensing site visits with each of the licensed programs throughout Kansas. During these visits clinical files are reviewed for compliance, a review of policies and procedures is completed, as well as an inspection of the physical location. Based on those visits corrective action plans are implemented to ensure quality of care and compliance. Through this same process of site visits, programs that receive Block Grant funds are also monitored on site. This occurs every other year and includes review of clinical files and program policies and procedures. These reports are then forwarded to the Contracted Management organization for any needed follow up.

The Project Coordinator works across the state to develop a system of recovery support. The Coordinator promotes Recovery Oriented Systems of Care throughout the state. This includes the support of Oxford Houses, development of Peer Mentors and Person Centered Case Management, and development of the Kansas Voices and Faces of Recovery group. The Project Coordinator also has developed partnerships with the Kansas Department of Corrections and DCFS-Economic and Employment Supports to provide treatment and case management for individuals they serve such as those with third or subsequent DUIs or families receiving Temporary Aid to Needy Families (TANF). This position provides oversight of the grants supporting Consumer Run Organizations in the state, serves as liaison for the Governors Mental Health Planning Council, and for the Kansas Citizens Committee.

The Prevention Manager and assigned staff (2.5 FTE program consultants) provide management and oversight to all aspects of the SAPTBG prevention set aside. Kansas dedicates approximately 24% of the total SAPTBG to the prevention infrastructure which consists of training and technical assistance providers and evaluation and logistics contractors. The prevention team ensures that the providers are accountable for implementing effective community level prevention initiatives that utilize the Strategic Prevention Framework (SPF) to achieve established outcomes. The team also oversees SAMHSA discretionary grants and partners with other staff to integrate prevention to all behavioral health services. Along with the BHS staff, KDADS/BHS depends heavily on services being provided by the community based SUD providers; the Community Mental Health Centers (CMHC), and the contracted managed care organizations.

The Forensics Specialist coordinates and oversees planning and implementation of programs specific to forensics, suicide prevention and five (5) Title XIX Medicaid contractors in the provision of training, research and evaluation of mental health services in Kansas. This position works closely with stakeholder groups such as adult and juvenile corrections, law enforcement, consumers, community mental health centers (CMHCs), Governor's Mental Health Services Planning Council's Forensic Subcommittee, and the courts. They assist with the coordination of the All Hazards Interagency Agreement between KDADS and KDHE to increase capacity of behavioral health providers to adequately respond to natural disasters in the state of Kansas.

The Housing and Homelessness Specialist is responsible for formulating organizational and operational plans, grants, contracts and procedures to increase community-based housing options for persons experiencing mental illnesses. This position is responsible for identifying housing related funding resources that eliminate gaps and barriers in the mental health system that as a result create or prolongs institutional-based care or homelessness. This position works collaboratively with other teams within SRS-Mental Health Service, other KDADS programs, state and local agencies, mental health service providers, advocacy groups, consumers and families to ensure that consumers are served in the least restrictive environment in communities of their own choice. This person also writes RFP's for state funded housing programs, reviews proposals, awards grants and monitors both programmatically and fiscally. They write and submit annually the PATH applications/reports. This position is also the identified state representative for the SOAR program.

Another position is designated to develop and implement policies and programs for in patient, residential, and community treatment for adult mental health. This position gathers and analyzes data to influence improvement in outcomes for consumers and to uphold Olmstead compliance. They develop and provide oversight for contracts with agencies providing inpatient services. This position oversees NFMH programs and conducts screens for continued stay process. They also serve as a liaison to SMHH and children's SH alternative programs and assists with difficult to discharge cases.

One position is dedicated to monitor the Managed Care contract for compliance in the following areas; data, quality assurance, Establish standards for evaluation of Managed Care Contractual obligations. They identify non-compliance issues of the Managed Care contract and works with contractor to develop and implement corrective action plans. The position monitors, reviews, and provides feedback on activities of corrective action plans for the Managed care contractors. They review and provided feedback and approval on Managed Care Contractors policy and procedures, provider notices and other contractual documents. In addition, this position provides oversight of SED/PRTF-CBA waivers by conducting; onsite reviews, approval of eligibility exceptions, response to federal entities and technical assistance to providers. They review all relevant reports from Managed Care Contractor on performance activities. They monitor data deficiencies during an established time frame. This position conducts onsite and desk review on relevant data, trends and Managed Care contractual requirements.

The Problem Gambling Coordinator directs problem gambling prevention, treatment and research grants to assure efficiency and effectiveness toward the reduction of the prevalence and severity of problem gambling in Kansas. This position manages the linkage of the continuum of care for problem gamblers including prevention, outreach, outpatient care and inpatient care in the development and management of resources for consumers requiring any level of care. They serve as the KDADS representative and spokesperson regarding the mission, goals and objectives of BHS Problem Gambling Services to national groups, other state personnel, the Legislature, community mental health programs, community alcohol and drug programs, consumers, advocates and other interested parties.

Contract Staff

Behavioral Health Services is fortunate to have four contract staff who work in various capacities in the division. Their duties are explained below.

The Data manager plans, organizes and directs mental health relevant quantitative and qualitative data research. They assign staff to data research projects and monitor their work. This position ensures accuracy and completion of data, and prepares reports and recommendations based on their work. They also plan, organize, and direct the creation of a broad range of statistical, evaluative, and operational reports covering all aspects of mental health. This position also plans and directs the revisions and updates to the Automated Information Data System (AIMS). They create agendas, lead meetings, solicited feedback and implement the processes as defined.

Another contract employee researches standards to assist providers with the effectiveness of supports, services, and therapies relating to children and youth with an SED at risk for State Psychiatric Residential Treatment, including positive behavioral supports and professional family resource care. Their work involves developing and approving operating policies, procedures, objectives, and goals within KDADS and/or CMS regulatory guidelines and recommending changes to program policies or regulations relating to the utilization of PRTFs. They conduct SED Waiver quality assurance case reviews.

A third contract employee plans, organizes, directs, manages and administers the Kansas' PRTF and state hospital alternatives for children. They research, develop and maintain state and federal Medicaid and licensing standards in cooperation with Mental Health Quality Assurance. They oversee and maintain federal reporting. They direct and implement research regarding PRTFs and state hospital alternatives. This position utilizes the research results in the developing efficient and effective policies, procedures, and standards. They maintain and report accurate information about PRTFs and state hospital alternatives. They plan, organize, lead, and coordinate PRTF provider meetings. This position formulates proposed solutions to problems related to the proper and appropriate utilization of PRTF's. They ensure the solutions improve the positive outcomes and quality of life of children receiving mental health services. This position proficiently writes and prepares miscellaneous reports by researching, analyzing and compiling data from various sources to support children's mental health programs

The fourth and final contract position establishes and expands evidence-based practice for Parent Support and Training Specialists and assists community mental health centers in implementing best practices in serving children and families. This position facilitates the states Universal Training Advisory Team (UTAG) which is tasked with providing recommendations and information to inform KDADS/BHS on training policy and increasing communication between stakeholders to improve training for mental health service providers. The position also serves as contact and liaison for families; provides resources, advocates and support children and families in a family-driven system which embraces prevention, recovery and resiliency through planning and policy implementation. This position supports families and assists treatment teams with youth who are difficult to discharge from inpatient facilities. They support communication and collaboration with other child system departments in the state to educate and improve outcomes and quality of life measures for children involved in multiple systems.

Provider/Service Structure, and Prevention Infrastructure

As of January 1, 2013, all Medicaid funded services have been moved under KanCare, a managed care environment overseen statewide by 3 managed care organizations. These services were managed by BHS staff and their contracted management organizations prior to that date.

The KanCare program is the State of Kansas' plan to transition Kansas Medicaid into an integrated care model. Kansas has contracted with three new health plans, or managed care organizations (MCOs), to begin coordinating health care for nearly all Medicaid beneficiaries. The administration of KanCare within the State of Kansas is carried out by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS). KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for Disability Services, Mental Health and Substance Abuse, and State Hospitals and Institutions. Each Medicaid consumer will be assigned to one of the KanCare health plans. Consumers will receive all of the services they currently receive through their new health plan. The health plans can also offer additional new services not typically covered under Kansas Medicaid to their assigned members. These are called value-added services. Consumers will have the option to change to a different KanCare health plan if they prefer to do so. A consumer can make a change any time after their initial assignment until April 4, 2013. After a 90-day choice period, consumers will be with their health plan for one year. Consumers can change to a different plan annually during an open enrollment period.

All current Medicaid services will be provided through the KanCare health plans. This will include physical health services such as doctors' appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care. All the services offered through the State's Home and Community Based Services waivers will also be in KanCare (with the exception of the waiver services for people with I/DD, which will be in KanCare in 2014). The current HealthWave and HealthConnect Kansas programs will end, and all of these services will be provided through the KanCare health plans.

The KanCare health plans will be required to coordinate all of the care a consumer receives. The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The health plans will focus on ensuring consumers receive the preventive services and screenings they need, helping consumers manage their chronic conditions, and reducing unnecessary and duplicative services.

SUD Treatment Providers

Beginning in 2007, AAPS contracted with a managed care entity to manage its funded provider network which included AAPS funded (SAPT and State General Funds) and Medicaid treatment providers. With the change that occurred January 1, 2013 regarding Medicaid funded services, this contractor will now manage AAPS funded SUD treatment, treatment for those individuals

with 3rd and subsequent DUI's which is funded by the Department of Corrections, and treatment for those individuals with Problem Gambling issues. The AAPS Funded providers are required to be Medicaid providers to ensure continuity of services. This contract will be overseen by the SUD Clinical Services Coordinator and her designated staff.

There are 267 licensed SUD treatment providers across the state. Of these 267, forty three providers, with a total of 103 locations statewide, are designated to provide AAPS funded treatment services. These providers offer a range of funded services including assessment, outpatient, intensive outpatient, reintegration, social detox, and intermediate. They are also able to provide support services (transportation), person centered case management, and overnight boarding for children in residential services at the designated women's programs. Medicaid funded providers are able to offer and bill for Medicaid case management. These services are all based on clinical need/medical necessity and providers must obtain authorization to provide the services. There are plans to add service codes for sub-acute detox and SBIRT. Licensed Addiction Counselors are approved to provide SBIRT outside of SUD programs.

Several of the programs licensed to provide substance use disorder treatment are also Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs). SUD providers have begun to collaborate with primary care providers and health care facilities to work toward providing more cohesive care across the state.

Prevention Infrastructure

State and Federal funding supports a prevention infrastructure comprised of data management and evaluation systems, mentoring, and a network of prevention specialists responsible for providing training, and assistance for community level mobilization, coalition development, and the implementation of evidence-based prevention strategies.

The Kansas prevention infrastructure is comprised of a multi-disciplinary array of grantees and service providers who provide content expertise, education, skill development, guidance, and consultation, and a wide range of resources to communities across Kansas that ranges from assessment, capacity development, planning, implementation of evidence-based prevention programs and environmental approaches, and evaluation. This infrastructure is designed to provide training and technical assistance to community-based coalitions in support of each step of the Strategic Prevention Framework, and allows communities to employ a data-driven assessment approach to identify priority prevention outcomes and populations, and respond to the needs of these targeted groups efficiently and effectively through the implementation of evidence-based prevention strategies.

This network has over twenty years of experience providing prevention supports across the state. Experiences include: data collection, aggregation, and reporting of Kansas Communities That Care (KCTC) student survey data being made available and utilized for community-level prevention planning (since 1995), statewide adoption of community-based prevention planning

approaches, and utilization of epidemiological data to guide assessment of the burden of alcohol, tobacco, and illicit drug use consumption and consequences since the award of the Strategic Prevention Framework State Incentive Grant that was initiated in 2006. The alignment of processes and the adoption of effective strategies for guiding the work of the Kansas Prevention Network that resulted from lessons learned from SPF-SIG implementation represent another notable strength, and a hallmark feature of both the K-SPF initiative and the current SPF Partnerships for Success II initiative.

Further, data and information management services in support of community, county, regional, and state-level assessment and outcome evaluation are provided through an online data portal maintained by the Southeast Kansas Education Service Center (Greenbush), process and system change evaluation services are made available to community coalitions and technical assistance providers through the Kansas Workgroup on Community Health and Development, the Kansas RADAR network and access to prevention resource information is provided by Kansas Family Partnership, and prevention training and technical assistance is provided to coalitions and communities throughout Kansas by the Regional Prevention Center system. The Regional Prevention System is comprised of a workforce of prevention consultants trained and experienced in the delivery of science-based prevention services to communities, with a proportion of service providers maintaining ICRC certification as prevention specialists. All 105 Kansas counties have access to resources to conduct comprehensive community-level prevention planning processes, as data concerning substance abuse prevalence and the levels of associated risk and protective factors is available online and can be used to analyze rate, trend, and comparison to state averages. Archival and epidemiological data for risk and protective factors beyond student survey information is also immediately accessible via the online data portal. This data management system enables community coalitions, schools, youth serving organizations, and other prevention providers to easily access information to target priority populations, establish prevention priorities, create outcome targets, and address needs through appropriate evidence-based prevention programs, policies, and practices.

Another significant strength lies in the effort to extend, enhance, and sustain impact of state and local prevention to prevention and reduce underage drinking through the SPF-PFS funding awarded by SAMHSA in October 2012.

Problem Gambling

In 2007, K.S.A. 79-4805 established the Problem Gambling and Addictions Grant Fund from a percentage of net revenues from three state-owned casinos. The problem gambling services program employees 4.5 FTEs. Through this funding, Kansas provides problem gambling treatment, a public awareness campaign, helpline services, crisis intervention, prevention programs in the state-owned casino regions, workforce development for certified gambling counselors, research and grants for strategies developed by community problem gambling task forces.

Community Mental Health Centers (CMHC's)

Under Kansas Statutes Annotated (KSA) 19-4001 et. seq., and KSA 65-211 et. seq., 27 licensed Community Mental Health Centers (CMHCs) currently operate in the state. These Centers have a combined staff of over 4,000 providing mental health services in every county of the state in over 120 locations. Together they form an integral part of the total mental health system in Kansas. Each of the 27 licensed CMHCs operating in Kansas have a separate duly elected and/or appointed board of directors. Each of these boards is accountable to the citizens served, its county officials, the state legislature, and the governor; and all have reporting responsibilities to the national level of government.

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals with mental health problems in the least restrictive environment. The Centers provide services to all those needing it, regardless of their ability to pay, age or type of illness. The Centers strongly endorse treatment at the community level, to allow individuals to experience recovery and live safe, healthy lives in their homes and communities.

Adult Services

The Adult Inpatient Manager oversees eleven Nursing Facilities for Mental Health (NFMH) in the state. In addition this individual reviews and approves continued stay screens on all 640 individuals in the NFMH annually. This position also administers and monitors two contracts with private psychiatric hospitals to provide inpatient psychiatric treatment to individuals when the state hospitals are at capacity. The adult inpatient manager also administers and monitors a contract that helps individuals with no other payment source access atypical antipsychotics. The last major responsibility of the adult inpatient systems manager is to administer and monitor a contract for Intensive Case Management services that is provided to individuals with co-occurring mental health and Substance Use Disorder issues.

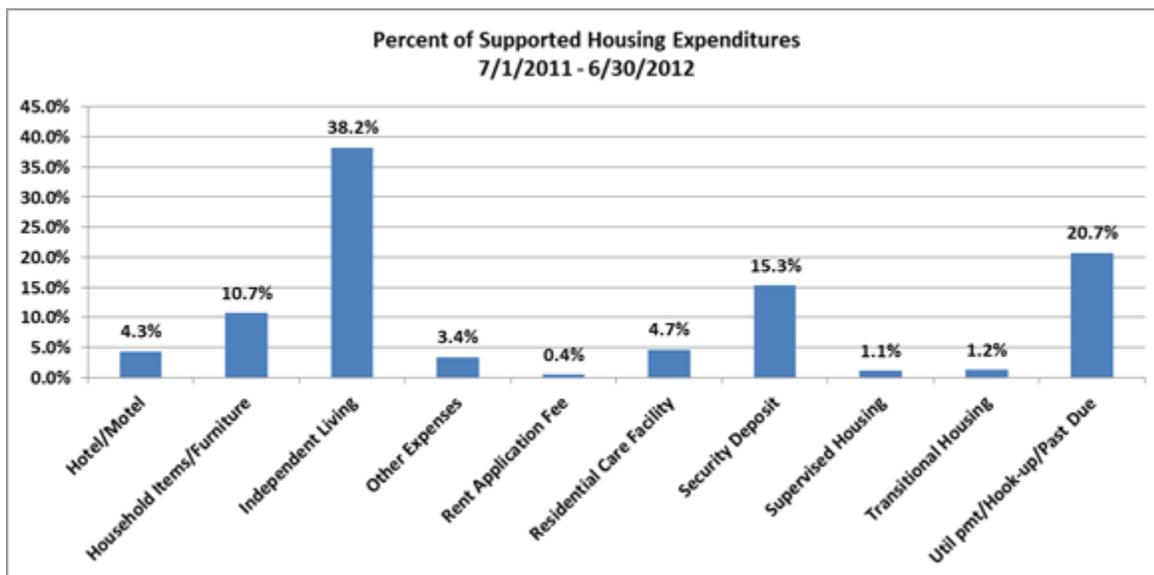
Projects and Services in Kansas for Children and Families

A KDADS/BHS staff is assigned to assist and support the development of funding programs for children and families which includes the Youth Leaders in Kansas Program (YLinK). This program is for youth ages 12 to 18; with the support and guidance of their parents/guardians; to support them with information, education and development of individual and group leadership skills in their community, statewide and nationally. They also oversee the Family Care Treatment (FCT) which was replicated from the Oregon Model of Intervention with Antisocial Youth and their Families. This program trains therapists in providing interventions to youth who are experiencing severe challenging behaviors which threaten their continued success in a family setting and their families who reside in Kansas to increase their pro-social behaviors and their families' ability to positively support them. The target population of this effort is children who have had or are at serious risk of having multiple foster care placements and/or children referred to state hospitals or other in-patient treatment or Juvenile Justice Programs due to severe challenging behaviors.

Housing and Homelessness Services

Supported Housing Fund Program

The Kansas Department for Aging and Disability Services, Behavioral Health Services fund the Supported Housing Fund Program (SHF) with state general funds in the amount of \$580,303. The SHF is able to provide “tenant-based housing first” assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is accomplished by providing temporary flexible funds for their housing needs. In 2012, 1,065 individuals obtained or maintained housing with the SHF program assistance at an average of \$357 a payment. Below is a breakdown of how the SHFs were used in FY 2012:



Interim Housing Program

The Kansas Department of Social and Rehabilitative Services, Division of Disability and Behavioral Health Services also fund an Interim Housing Program. As a response to the DBHS policy to prevent discharging individuals into homelessness, Kansas’ mental health system saw a need to create more “interim” housing options for individuals leaving Nursing Facilities for Mental Health or State Psychiatric Hospitals who are without permanent housing arrangements. In FY 2013, DBHS funded nine Interim Housing (IH) projects. Four Interim Housing funded centers are PATH providers: Valeo, Wyandot Center, ComCare, and Pawnee. Interim Housing is defined as short-term housing that is used until a more permanent housing arrangement can be made. Unlike Supported Housing Funds, which provide tenant-based assistance, these funds provide “project-based rental assistance.” Project-based housing provides immediate assistance, without the need for the individual to undergo a housing search, traditional tenant screening process, and acquisition of the furniture and items necessary to establish a household while still in-patient in a hospital setting. Upon entering the IH project, the CMHCs Housing and Homeless Specialists and other case managers immediately begin providing the assistance

necessary for the resident to obtain more permanent housing. Collectively, the FY 12 IH grantees assisted 111 individuals gain housing in the community. Ninety-five participants moved into a community-based living situation by the end of the grant term. Of those 95 individuals, 94 moved into the community within six months. The IH program assisted 14 individuals who were chronically homeless.

Kansas Balance of State Continuum of Care

KDADS-BHS contracts with the Kansas Statewide Homeless Coalition (KSHC) to coordinate the Balance of State Continuum of Care planning process and the annual Homeless Assistance Grant submissions (\$54,000 State General Funds). Since 2004, the applicants represented by KSHC have generated \$16,516,130 in homeless assistance funds from HUD. These funds have supported and or created 18 housing projects, 1 supportive services only project and 1 Homeless Management Information System project which cover 101 counties. A total of 289 transitional housing beds and 120 permanent housing beds have been created with awarded HUD funds for the Balance of State in Kansas.

Annual Statewide Summit on Housing and Homelessness

KDADS-BHS also partially underwrites the annual Kansas Statewide Summit on Homelessness and Housing with \$8,000 in state general funds. Approximately 300 people attend and local, state and national speakers present workshops on the latest information to end homelessness and increasing affordable housing.

SSI/SSDI, Outreach, Access, and Recovery

In 2009, Kansas KDADS-BHS applied for technical assistance funding from Bazelon Mental Health Center and Homeless Resource Center to secure the services of Policy Research Associates (PRA). Both applications were approved. PRA conducted a SSI/SSDI, Outreach, Access, and Recovery (SOAR) a statewide planning forum with stakeholders in August 2009 and conducted a train-the-trainer (TTT) workshop for 24 people in October 2009. As of May 2013, Kansas SOAR trainers had trained over 300 mental health, homeless, and human service providers in all areas of the state. KDADS-BHS is working with all trained individuals/agencies to track SOAR data for PRA. As of May 2013, Kansas’ outcomes were:

Kansas SOAR 2009-2013 Data	
Total decisions	424
Number approved	336
Number disapproved	88
Approval rate	79%
Average days to decision	119

Recovery Oriented Services

Recovery oriented services have been recognized as more effective and efficient than the traditional medical model. Over the years, Kansas has made significant progress in creating a recovery oriented service infrastructure. Certification programs for MH peer specialists to learn to provide peer support have become an established vehicle at community mental health centers

to adopt a recovery model of service provision with certified peer specialists in meaningful, effective roles. A peer-run infrastructure of nineteen (19) recovery oriented consumer run organizations that are consumer-operated and consumer-governed providing peer supports are supported by KDADS-BHS through funding, technical assistance and support. State University participation in State Medicaid Administration contribute invaluable expertise to help support implementation and fidelity of evidence based practices such as Strengths Model CPST, IDDT, IMR, Family Psychoeducation, Supported Housing and Supported Employment. Consumer and family education, referral and supports are obtained through contractual agreements between KDADS-BHS and the Kansas Consumer Advisory Council, National Alliance on Mental Illness - Kansas, and KEYS for Networking.

Suicide Prevention

According to 2010 statistics from the Kansas Department of Health and Environment (KDHE), suicide trailed only unintentional injuries as the second leading cause of death in Kansas for 15 to 44 year olds. The state's suicide rate of 13.38 deaths per 100,000 people exceeded the national average of 11.8 per 100,000 residents. There were 409 suicides recorded in Kansas in 2010, and several thousand friends and family members were changed forever by losing a loved one. In Kansas, problem gamblers have a suicide rate of over 20%, higher than any other clinical population. According to the Fiscal Year 2012 report "Kansas Problem Gambling Treatment Enrollments" from the Kansas Department for Aging and Disability Services, nearly ¼ (23%) of all people seen said they were currently suicidal or had thoughts about harming themselves. Over the years, KDADS-BHS has leveraged staff resources to work closely with the Suicide Prevention Subcommittee (SPS) of the Governor's Behavioral Health Services Planning Council (GBHSPC) to prioritize goals and activities around transforming policy, programs and services, and funding. Areas of focus have included:

- Community based evidence-based and best practice strategies on suicide prevention
- Awareness and education on suicide prevention at conferences, workshops
- Outreach, education and awareness to middle school and high school youth on teen suicide prevention
- Adoption of the Kansas Suicide Prevention State Plan
- Signing of annual Suicide Prevention Proclamations with the Kansas Governor and in many city commissions/councils and county commissions across the state
- Access to care and service capacity through funding (\$100,000.00) a Resource Center for Kansans across the lifespan

Kansas has experienced significant accomplishments in suicide prevention influenced by the SPS, including:

- Creation of the Kansas Youth Suicide Prevention Resource Center funded by the Garrett Lee Smith (GLS) Grant
- Annual Kansas Suicide Prevention Week Proclamation signing with the Governor

- Expansion of Suicide Prevention Coalitions to 7 urban, rural and frontier communities across the state
- Free, 24/7 suicide prevention hotline access to over 5,000 children, teens and adults in 2012.
- Bereavement supports to survivors of suicide loss through Kansas Suicide Support Groups.
- Expansion of Suicide Hotlines to two (2) community mental health centers (CMHCs) - Wyandot and Johnson County.
- Increased availability and usage of suicide data from KDHE Vital Statistics.
- Increased awareness on linkage between problem gambling and suicide risk.
- Increased information sharing among stakeholders and other GBHSPC subcommittees via e-mail on suicide prevention updates, resources, webinars, etc.
- Understanding of the importance of trauma informed care to reduce suicide risk.
- Strong Kansas contingent at national, state and local conferences and workshops on suicide prevention

Primary goals for 2013-2015 include 1) review and update of the State Plan, 2) increased outreach and education at conferences and/or annual meetings, 3) public policy, and 4) development of strategies to expand the scope of the Suicide Prevention Resource Center being created through the SAMHSA Garrett Lee Smith grant to promote access to care and service capacity across the lifespan.

Forensics

Significant numbers of individuals, both youth and adult, living with serious mental illness experience encounters with law enforcement agencies and end up in the criminal justice system where the recognition and treatment of mental illness is not the primary mission. In FY12, 38% of the KDOC inmate population is mentally ill, and 10% of this number is severely and persistently mentally ill. Since 2006, the mentally ill population has increased by 126%. KDOC mental health facilities are consistently full and have waiting lists for inmate placement. KDADS-BHS, in collaboration with the newly formed Justice Involved Youth and Adult (JIYA) SC of the Governor's Mental Health Services Planning Council work closely together to carry out the vision that justice involved youth and adults with behavioral health needs achieve recovery. Efforts include creating a recovery oriented system of care for individual's with behavioral health needs in or at risk for involvement in the justice system through policy recommendations and planning focused on prevention, diversion, treatment and reentry through close collaboration with constituents representing behavioral health services, juvenile and adult corrections, law enforcement, courts, education, consumers and families, regional prevention centers, and treatment providers.

PRTF's and RCF's

Mental Health PRTF-CBA Grant provides State and Federal funds that support two positions that manage and coordinate the services of the Psychiatric Residential Treatment Facility and Community. While continuing to develop and implement policies and programs for inpatient, residential, and community treatment for children's Mental Health staff actively support implementation of programs for transitioning recovering youth to the Serious and Emotional Disturbance Waiver (SED) and to other community services and resources. Currently Kansas is

implementing the best practice of Positive Behavioral Supports into Community Based Mental Health Centers supported by a statewide tiered support structure for systems.

Additionally MH staff direct and implement research regarding PRTFs and state hospital alternatives for recovering youth utilizing the results in developing efficient and effective policies, procedures, and standards. Rate Setting, payment, Grant and financial documentation are all part of the recovery processes mental health staff have responsibility for maintaining along with reporting accurate information to fed and state agencies. Mental Health Staff plans, organizes, leads, and coordinates PRTF provider and stakeholder meetings, along with planning organizing, managing and administrating the Kansas' state hospital alternatives for children. Staff approves payment for state hospital alternatives that are the responsibility of Mental Health Services to ensure all necessary services are provided to recovering youth. Mental Health assumes responsibility for forecasting and projecting current and future usage. The goal is to ensure quality effective and efficient mental health services that support recovery in children and their families to live safe, healthy, successful, self-determined lives in their home, school, and community.

SED Waivers

The Serious Emotional Disturbance (SED) Waiver is designed as a hospitalization diversion program. The goal of the SED waiver is to divert psychiatric hospitalization through the provision of intensive home and community based supportive services in an effort to maintain children and youth in their homes and communities. The Kansas SED waiver provides six services to participants and their families that are not available to other Medicaid youth. These services are: wraparound facilitation, short term respite care, attendant care, independent living/skills building, parent support and training and professional resource family care. Participants eligible for the waiver are between the ages of 4 and 18. An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through age 21 who are experiencing a serious emotional disturbance and are at risk for inpatient psychiatric hospitalization.

Needs Assessment

Prevention

Based upon the magnitude of prevalence of alcohol consumption among youth as defined by reported lifetime use, past 30-day use, and binge drinking on the KCTC Student Survey, as well as through consideration of the health and behavioral consequences associated with alcohol use as outlined in the epidemiological profile for the State, in addition to the elevation of intervening variables (that is, risk factors and influencing factors) at the state and community level, underage drinking was identified as a primary priority for the Substance Abuse Prevention and Treatment (SAPT) Block Grant funded prevention infrastructure supported by BHS. This aligns with the selection of underage drinking as a prevention priority for the Kansas Strategic Prevention Framework Partnerships for Success grant, and allows for a synergistic impact of state and community-level prevention efforts in addressing underage drinking in an intentional and an

optimally-leveraged fashion. In addition, based on prioritization of the updated State Epidemiological Outcomes Profile in early 2013, marijuana use among children, youth, and young adults between the ages of 12-25 was identified as a secondary state-level priority, in those communities in which past 30-day use of this substance exceeds the state average and demonstrates and upward trend.

Specific populations currently addressed most commonly by community coalitions supported by the Kansas prevention infrastructure include, but are not limited to: students in grades 6-12 at risk for underage drinking and marijuana use (universal population), active duty and returning military (selected population), individuals at risk for prescription drug abuse (selected population), and drug-endangered children and youth (selected population).

SUD Treatment

SUD Treatment needs continue to be determined by the evaluation of treatment demand as collected from the AAPS integrated data system. This information system collects real time client level data from every funded provider receiving SAPT block grant funds. This data allows for a rich data set in which to evaluate trends over time and direct available funds where they are most needed. Because the client data is linked to provider billing on a fee for service grant reimbursement method, a high degree of accountability exists to ensure that the data is reliable. AAPS was able to utilize the statewide needs assessment completed in 2007 to assess treatment needs across the state. It enabled AAPS to look at secondary data and assess the need for those persons who not captured in the current information system. The comprehensive needs assessment also provided synthetic estimates to help with strategic planning.

The AAPS State Quality Committee Cultural Competency Subcommittee met from March 2010 until December 2010. The Subcommittee's focus was to uncover any racial/ethnic disparities that may exist within the Kansas Medicaid and AAPS funded substance use disorder treatment system, specifically as it related to the federally identified underserved populations. After reviewing multiple data sets from different sources, the Committee found that no substantial evidence of disparity had been reflected in the data sets brought to the Subcommittee. The Subcommittee was concluded and AAPS Cultural Competency work folded into AAPS Prevention Cultural Competency initiatives at a systemic level.

AAPS will continue to use data obtained through the State data collection system and reports submitted by the managed care entity to make decisions regarding the treatment system/services utilized by our clients. This data will also allow AAPS to address the diverse needs of Kansans to include racial and ethnic minorities.

Mental Health

Mental Health Reform statute provides for an annual needs assessment to be conducted by each Community Mental Health Center.

39-1608. Mental health centers to develop community assessment of needs and plan to provide community based mental health services; approval by secretary; annual reviews and reports; amendments to plan; rules and regulations; guidelines for conduct of assessments of need, for development and operation of system of services and for periodic reporting to the secretary.

(a) On or before October 1, 1991, and in accordance with rules and regulations adopted by the secretary each mental health center shall prepare and adopt a community assessment of needs and a plan to provide community based mental health services for persons who are residents of the service delivery area of the mental health center and shall submit such assessment of needs and plan to the secretary for approval. Among other provisions, such plan shall include the provision of services to all targeted population members who apply therefor.

(b) Each mental health center shall conduct annual reviews of the community assessment of needs for the service delivery area and shall report annually to the secretary the results of such reviews and any amendments to the community assessment of needs or the plan to provide community based mental health services which are adopted. The amendments to such plan shall be subject to approval by the secretary in accordance with criteria prescribed by rules and regulations adopted by the secretary.

(c) Prior to October 1, 1991, the secretary shall adopt rules and regulations prescribing guidelines for the conduct of community assessments of need, for the development and operation of systems to provide community based mental health services within the service delivery area of the mental health center, and for periodic reporting to the secretary on the operations under such systems in accordance with this act.

In 2012, the needs assessment focused on crisis services and a comparison with crisis services needs in 2009 in order to determine if there had been any changes and where those changes were. Improvement was found in the areas of mobile crisis response, and availability of individual crisis plans. Access to psychiatric consultation 24/7 decreased somewhat and may be directly related to challenges with retaining psychiatrists in rural and frontier locations.

In 2013, the needs assessment will be incorporated into a regional planning process as a part of the Governor's Mental Health Initiative. The 27 CMHCs have been grouped into five regions to share resources, develop community partnerships and implement evidence based and promising practices to meet the needs of the most challenging individuals. Each region will conduct a needs assessment covering all communities within the region. This information will inform a planning process to be completed in August with a working plan ready for implementation in September.

Planning

KDADS/Behavioral Health Services conducted several sessions with stakeholders. Based on the feedback and reflection as well as internal staff planning—the priorities (in order of stakeholder identified need) identified include the following:

Access to a full continuum of Care

- with special focus on the uninsured or those not covered by medicare—and non-congruent services
- continuum should be from prevention, intervention, treatment to recovery and peer services, including strong evaluation and data collection
- licensing flexibility to allow for further integration with primary health
- emphasis should be placed on dual diagnosis and co-morbidity

Evidence-Based strategies (Programs)

- move from capacity building (training) to implementation
- higher reimbursement rates for EBS/P Implementation
- inclusion of EBS/P criteria in grants an contract language
- data collection and outcomes achievement
- emphasis on fidelity

Reimbursement Rate Challenges

- need to consider reimbursement for selective and indicated prevention
- need to reimburse for family and support services
- need to enhance/improve PG reimbursement system

Special Populations

- Native American
- Veterans/Military
- Rural Challenges
- Adoption of Urban/Rural Definition
- Hispanic Population

BHS staff met and participated in internal planning consideration of all the data collected and feasibility of moving forward a proposal was submitted for Block Grant purposes that we include a priority around Evidence Based Services/Programs.

The following was identified as a potential Priority Statement: Creating an internal infrastructure that is supportive of EBS/P implementation, evaluation and outcomes achievement. Four goals were targeted: assessing the need, building staff capacity by adopting a formal definition,

creating an action plan to adopt a BHS policy guideline, provider training and beginning to infuse this language into all grants and contracts consistently. Final result would be an implementation plan.

Outcome measures include: baseline understanding of current EBS/P, development of internal strategic plan, revision to our vision and mission.

Council Planning

With the change of structure in 2013 to Behavioral Health Services, the Kansas statute for the Governor's Mental Health Council was revised to incorporate SUD services. It is now called the Governors Behavioral Health Services Planning Council (GBHSPC). The membership was expanded to include providers of SUD services, SUD Peer Mentors, a Prevention Specialist, consumers in long term recovery, and a family member of a person experiencing SUD.

The Governor's Behavioral Health Services Planning Council is expected to do the following:

- Review the mental health block grant applications and make recommendations.
- Monitor, review, and evaluate (not less than once a year) the allocation and adequacy of mental health services across the state.
- Serve as an advocate for adults with Severe and Persistent Mental Illness (SPMI), children with Serious Emotional Disturbance (SED), and other mental illnesses.

In addition, the GBHSPC confers, advises, and consults with the Secretary of KDADS as well as the Commissioner and Director of Behavioral Health Services on policies concerning the management and operation of all state psychiatric hospitals, facilities, and Community Mental Health Centers (CMHCs). Members of the GBHSPC are to visit each of the state psychiatric hospitals on an annual basis and also visit and become familiar with other facilities including the CMHCs.

The Executive Committee of the GBHSPC is comprised of a Chair, Vice Chair, and four members appointed by the Chair and reflective of the composition of the Council.

Activities of the Council

The Governor's Behavioral Health Services Planning Council is actively involved in the planning, implementation, monitoring and evaluation of statewide mental health and substance use disorder initiatives. They meet at least quarterly, or more often as needed. Some of the duties of the Council include:

- To serve as coordinator of recommendations which may be brought forth by stakeholders, consumers, mental health service providers, SUD service providers and community service providers and others, and based thereon, to make any appropriate recommendations to the Governor; and

- To work with the State's Mental Health Authority/ State's SUD authority as well as other State departments, to improve and refine the State Behavioral Health Strategic Plan, and to also develop strategies to improve the behavioral health service system across all systems of state departments.

The GBHSPC has Subcommittees that are comprised of citizens, stakeholders and consumers that serve to inform the Council and Secretary on issues that are affecting the consumers and citizens. Each subcommittee is served by a liaison member from the Council and a staff member of KDADS. The Subcommittees submit a charter of their work plan for the committee and topics that they will be working on for approval to the Council. The Liaison then reports to the council on the work as it progress's during the year. The Subcommittee submits a final report to the Council and Secretaries at the end of the year. This report includes an overview of the work completed and recommendations. The recommendations are reviewed by the council and shared with KDADS as the block grant is developed for submission.

Subcommittees of the Council are:

- Housing & Homelessness
- Children's
- Supported Employment
- Aging Suicide Prevention
- Rural and Frontier
- Justice Involved Youth and Adults
- The Kansas Citizens Committee on SUD/Prevention and Problem Gambling

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
<p>SUD Treatment SAPT BG funded pregnant women, and women with children</p>	<p>Increase the number of pregnant women, and women with children admitted to designated women's treatment programs</p>	<p>Collect baseline data on the number of pregnant women and women with children assessed for treatment,</p> <p>Collect baseline data on the number of pregnant women and women with children who are referred to treatment to include the specific modality of care,</p> <p>Collect baseline data on the number of pregnant women and women with children who are admitted to SUD treatment,</p> <p>Collect baseline data on the number of pregnant women and women with children who are admitted to a Designated Women's treatment programs,</p> <p>Review and analyze data for percentage changes in admissions to designated women's treatment programs.</p> <p>The comparison data will be shared at quality committees,</p>	<p>Number of SAPTBG funded pregnant women and women with children served in DWP will increase by 4% in SFY2014/15.</p> <p>100% of the contracts will include language about requiring a referral to a DWP for priority population women.</p>	<p>Report from managed care entity showing the percentage of women referred to a designated women's facility by funder. The detailed report will include the place where the assessment took place and the facility where the treatment was received (if recommended). The summary portion of the report will include the following by pregnant women and women with children:</p> <ol style="list-style-type: none"> 1. Total recommended for treatment 2. Recommended for Level I – Level 3 3. Members who went to treatment 4. Members who did not go to treatment 5. Members who went to a designated Women's facility. <p>Provider Contracts.</p>

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		<p>Provider contracts will continue to include requiring the inclusion of a designated women's program in the list of providers priority clients can choose from.</p>		
<p>SUD Treatment SAPTBG Funded IVDU Clients</p>	<p>Decrease recidivism rates for the target population of IVDU clients.</p>	<p>Communicate with all federally funded providers state priorities. The communication will occur via electronically.</p> <p>Providers will enter the initial date of contact, assessment date and treatment admission date for all IVDU priority clients into the statewide data system.</p> <p>BHS / VO will provide aggregate reports to providers and quality committee about IVDU client's recidivism rates. The data will be posted on the managed care entity website.</p> <p>BHS will add contract language to providers about providing education to IVDU clients about medication assisted treatment.</p>	<p>The initial benchmarks were set consistent with HEDIS benchmarks; initiation 44.5% and engagement 12.4%.</p> <p>Decrease recidivism rates for IVDU clients by 5%.</p>	<p>Access to Care Report - There will be two versions of this report, one provided quarterly to show a monthly snapshot within the quarter, and one trended by fiscal year. Data is reported by funding source and in aggregate.</p> <p>The improvement target that is used is a "reduction in failure rate" calculator to determine the improvement target, based on the baseline and a 3% reduction in failure rate.</p> <p>Reports are due 75 days after quarter end Quarterly Due: FY13 Q1 = 12/15/12 FY13 Q2 = 3/15/13 FY13 Q3 = 6/15/13 FY13 Q4 = 09/15/2013 FY13 Annual due: 11/15/13</p> <p>Initiation and Engagement: This project is based on the HEDIS measure of initiation and engagement in substance abuse services. HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures for managed care organizations. The purpose is to determine the percentage of members with a new episode of treatment who received the following: Initiation – defined as the percentage of members who initiate treatment after either an assessment or a detox admission and Engagement – defined as the percentage of the above members who participate in two or more treatment services after initiation and within 30</p>

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		<p>BHS will send out booklet prepared by the Addiction Technology Transfer Center Network on Psychotherapeutic Medications to all licensed providers.</p> <p>BHS is implementing a new service code for Acute Detox. It is expected that this service will target the IVDU population. BHS staff will review admission and discharge level data and look for trends.</p>		<p>days of initiation above.</p> <p>Interim Services report developed and data gathered from the KDADS/BHS data system to measure whether IVDU were offered interim services if treatment was unavailable.</p>
<p>SUD Treatment TB screening on all KDADS/BHS funded clients.</p>	<p>100% compliance of all KDADS/BHS funded providers maintain policy and procedures for screening clients for TB risk assessments, referrals for TB screening when the results indicate further evaluations to include documentation of those results of screening tests and case-management if needed.</p>	<p>Tuberculosis screening is provided to all persons entering a substance abuse treatment service.</p>	<p>100% of all KDADS/BHS funded providers will meet contractual TB Block Grant requirements.</p> <p>100% of KDADS/BHS funded providers are monitored for TB Block Grant requirements during site visits.</p> <p>KDADS/BHS Consultants will ensure 100% compliance with providers regarding having both policies and protocol for TB risk assessments during KDADS/BHS funded on-site reviews.</p> <p>KDADS/BHS Consultants will ensure 100% compliance with providers when reviewing TB Logs at all</p>	<p>KDADS/BHS Funded Performance Reviews KDADS/BHS Funded Provider Tool State of Kansas yearly KDADS/BHS Funded Report State of Kansas licensing /certification site visits. State of Kansas yearly licensing/certification report.</p>

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Reduce Underage Drinking	To reduce 30-day alcohol use and binge drinking among students in grades 6, 8, 10, and 12.	Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.	<p>KDADS / BHS funded on-site reviews.</p> <p>It is expected that a reduction in the risk and increase in the protective factors will result in a reduction in underage drinking and tobacco use. Targeted statewide risk and protective factors for primary prevention are:</p> <ul style="list-style-type: none"> • Decrease in attitudes favorable toward substance use • Decrease in peer’s substance use • Decrease in parental attitudes favorable toward substance use • Decrease in academic failure • Increase in perceived risk of harm • Increase in social skills • Decrease in poor family management 	<p>Collection and measuring of this performance measure come from the Kansas Communities That Care Survey.</p> <p>Decrease past 30-day alcohol use among students in grades 6, 8, 10, and 12 from a baseline of 25.63% in 2010 to 20% in 2014; currently 20.86% in 2013, target 19.5% in 2015.</p> <p>Decrease binge drinking among students in grades 6, 8, 10, and 12 from a baseline of 13.77% in 2010 to 11.1% in 2014; currently 10.61% in 2013, target 9.5% in 2015.</p> <p>*** Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).</p>
Reduce Underage Age Cigarette and Smokeless Tobacco Use	To reduce underage cigarette and smokeless tobacco use defined as past 30-day cigarette and smokeless tobacco use among students in grades 6, 8, 10, and 12.	Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.	<p>It is expected that a reduction in the risk and increase in the protective factors will result in a reduction in underage drinking and tobacco use. Targeted statewide risk and protective factors for primary prevention are:</p> <ul style="list-style-type: none"> • Decrease in attitudes favorable toward substance use • Decrease in peer’s substance use 	<p>Collection and measuring of this performance measure come from the Kansas Communities That Care Survey.</p> <p>Decrease past 30-day cigarette use among students in grades 6, 8, 10, and 12 from a baseline of 9.79% in 2010 to 7.3% in 2014; currently 6.55% in 2013, target 6.0% in 2015.</p> <p>Decrease past 30-day smokeless tobacco use among students in grades 6, 8, 10, and 12 from a baseline of 6.39% in 2010 to 5.9% in 2014; currently 5.05% in 2013, target 4.75% in 2015.</p>

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
			<ul style="list-style-type: none"> • Decrease in parental attitudes favorable toward substance use • Decrease in academic failure • Increase in perceived risk of harm • Increase in social skills • Decrease in poor family management 	<p>*** Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).</p>
Reduce Past 30-Day Marijuana Use	To reduce marijuana use among children and youth defined as past 30-day marijuana use among students in grades 6, 8, 10, and 12.	Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.	<p>It is expected that a reduction in the risk and increase in the protective factors will result in a reduction in marijuana use among children and youth. Targeted statewide risk and protective factors for primary prevention are:</p> <ul style="list-style-type: none"> • Decrease in attitudes favorable toward substance use • Decrease in peer’s substance use • Decrease in parental attitudes favorable toward substance use • Decrease in academic failure • Increase in perceived risk of harm • Increase in social skills • Decrease in poor family management 	<p>Collection and measuring of this performance measure come from the Kansas Communities That Care Survey.</p> <p>Decrease past 30-day marijuana use among students in grades 6, 8, 10, and 12 from a baseline of 8.29% in 2013 to 8.0% in 2015.</p> <p>*** Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).</p>
The per capita number of	To increase the penetration rate for serving consumers	CMHC will provide active outreach and early identification for consumers with an SPMI and provide necessary	The number of adults with SPMI being served in each CMHC catchment area will increase.	Community Mental Health Centers have focused on accessibility and have implemented “open intakes” which provides for scheduling the intake appointment the same day an initial contact is made. Subsequent appointments are also scheduled within shorter periods of time after intake

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
consumers with an SPMI served by the CMHC in the CMHC's catchment area.	with an SPMI served by the CMHC in the CMHC's catchment area.	services.	Numerator: Number of adults with SPMI who receive CMHC services Denominator: Total estimated adult population in Kansas Rate: Numerator/Denominator multiplied by 10,000	to facilitate engagement.
The per capita number of consumers with an SED served by the CMHC in the CMHC's catchment area.	To increase the penetration rate for serving youth with an SED served by the CMHC in the CMHC's catchment area.	CMHC will provide active outreach and early identification for youth with an SED and provide necessary services.	The number of youth with a SED being served in each CMHC catchment area will increase. Numerator: Number of youth with SED who receive CMHC services Denominator: Total estimated youth population in Kansas under age 18 Rate: Numerator/Denominator multiplied by 10,000	Community Mental Health Centers have focused on accessibility and have implemented "open intakes" which provides for scheduling the intake appointment the same day an initial contact is made. Subsequent appointments are also scheduled within shorter periods of time after intake to facilitate engagement.q
Decrease adult re-admissions to state mental health hospitals (SMHH)	Adult SMHH hospital readmissions within 30 days will remain stable or decrease.	Current contracts with each of the CMHCs include this performance measure, which will be monitored quarterly. Behavioral Health staff meet monthly with State Mental Health Hospital Directors and Directors of the Community Mental Health Centers to discuss census issues and strategies to reduce hospital admissions.	The percentage of adults readmitted to state mental health hospital within 30 days of discharge will remain stable or decrease during the fiscal year. Numerator: The number of adults readmitted to the SMHH within 30 days. Denominator: The total number of SMHH discharges during the fiscal year	The overall percentage of adults readmitted within 30 days during FY13 was reduced to 11.84% from 12.84% in FY12.
Decrease youth re-admissions to state hospital alternatives (SHA)	Youth SHA readmissions within 30 days will remain stable or decrease.	Current contracts with each of the CMHCs include this performance measure, which will be monitored quarterly.	The percentage of youth readmitted to an SHA within 30 days of discharge will remain stable or decrease during the fiscal year.	The overall percentage of youth readmitted within 30 days during FY13 has increased to an estimated 6.36% from 3.44% in FY12. The FY13 numbers represent 9 months of data. Final numbers for FY13 are not yet available.

Objectives, Strategies, and Performance Indicators

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
			Numerator: The number of youth readmitted to the SHA within 30 days. Denominator: The total number of SHA discharges during the fiscal year	
Behavioral Health Evidence Practices utilized by Service Providers	Creating an internal infrastructure that is supportive of EBS/P implementation, evaluation and outcomes achievement.	Four goals were targeted: <ul style="list-style-type: none"> • Assessing the need, • Building staff capacity by adopting a formal definition, • Creating an action plan to adopt a BHS policy guideline, • Provider training and beginning to infuse this language into all grants and contracts consistently. Final result would be an implementation plan.	Implementation plan for EBS/P	Outcome measures include: baseline understanding of current EBS/P, development of internal strategic plan, revision to our vision and mission.

Step 2: Identify the unmet service needs and critical gaps within the current system

SUD treatment

The following topics were identified as focus areas. The first three topics target the SAPT Federal priorities populations and continue to be areas that are reviewed closely. The last section addresses the needs assessment which discusses data that is used to determine treatment gaps and needs.

1. Increase the number of pregnant women, and women with children admitted to designated women's treatment programs

A report from the contracted managed care entity shows the percentage of women referred to a designated women's facility by funding source. This data is collected from the KCPC extract which is given to the contractor on a regular basis. This detailed report includes the place where the assessment took place and the facility where the treatment was received (if recommended). The summary portion of the report includes the following by pregnant women and women with children:

1. Total recommended for treatment
2. Recommended for Level I – Level 3
3. Members who went to treatment
4. Members who did not go to treatment
5. Members who went to a designated Women's facility.

The following are conclusions from an aggregate analysis of the report presented at the August 2013 Quality Committee:

- 7.70% of Women with Children admitted to SUD Treatment (Level 1 modality) utilize a Designated Women's Treatment Program.
- 27.9% of Women with Children admitted to Treatment (Level 2&3 modality) utilize a Designated Women's Treatment Program.
- 6.66% of Pregnant Women admitted to SUD Treatment (Level 1 modality) utilize a Designated Women's Treatment Program.
- 34.8% of Pregnant Women admitted to SUD Treatment (Level 2&3) utilize a Designated Women's Treatment Program.
- 23.3% of Pregnant Women who are recommended to Level 1 treatment do not attend.
- 24.2% of Pregnant Women who are recommended to Level 2 & 3 treatment do not attend.
- 22.0% of Women with Children who are recommended to Level 1 treatment do not attend.
- 23.6% of Women with Children who are recommended to Level 2 & 3 treatment do not attend.

In preliminary recommendations to Committee included continuing to trend the data and continuing provider education regarding the access standards in the coming months.

Language is included in the Provider Contracts that requires all clients be given a choice of three providers. A designated women's program must be included in the three choices if the individual is a priority client. Currently there is no way to ensure this occurs. The new data system that is being built will have the capability of measuring this requirement.

KDADS/BHS wants to support priority women participating in the designated women's programs to ensure their needs are fully met. In 2011 a study was conducted examining women's treatment and what makes it successful. Several emerging trends were discovered including women not engaging in treatment and short lengths of stay. This suggests that initial engagement is key to retention and engagement in treatment. The following recommendation was an example of the result of the study:

Improve gender specific treatment by conducting technical assistance in order to increase retention and improve quality of care.

With the reorganization of BHS, program staff may now have more time to focus on this area.

2. Increase admission into treatment within the required 14 day time frame or assure IVDU clients will be admitted 120 days from the time of the request and receive SAPT interim services.

A report from the contracted managed care entity includes two indicators-one comes from the assessment initial date of contact and date offered, the other is from the first treatment session post assessment comes from paid claims data. Data for IVDU individuals is collected from the KCPC initial contact and the first paid claim after the assessment but does not include the indicator for assessment offered. The KCPC data is given to the contractor on a regular basis

Two versions of the Access to Care Report, one is provided quarterly to show a monthly snapshot within the quarter, and one is trended by quarter for the fiscal year. Data is reported in aggregate to the Quality Committee and once approved posted on the contractors website for all providers in their network.

The following are indicators from the report:

- The baseline benchmark was set at 26.4%. This was an 18 month average (07/09 through 12/2010).
- 14 day admission First year target: 30.4% 120 day admission First Year target 75%
- 14 day admission Second year target: 33.4% 120 day admission Second year target: 80%

A review of the FY 2013 Access to Care report for IVDU clients indicated that 1,444 assessments that were completed between July 1, 2012 and June 30, 2013 recommended treatment for IVDU members. Of the 1,444 assessments, 1,087 individuals were admitted (75.3%) to treatment and 357 (24.7%) did not admit to SUD treatment.

A closer look at the data revealed that when network providers conduct the assessment, IVDU members admit to treatment within 14 days of initial contact at a higher rate compared to when a Regional Alcohol & Drug Assessment Center (RADAC) conducts the assessment and refers the member to a treatment provider. Specifically, when members are assessed by network providers they admitted to treatment within 14 days of first contact at a rate of 59.3%; whereas members assessed by RADACs admitted to treatment within 14 days of first contact at a rate of 17.6%.

It is noteworthy to mention that RADACs perform assessments on members in numerous locations, including members who might not be available to enter treatment within Federal access standards; 14 days from first contact.

Also during FY 2013, Interim Services (lower level of care) were provided to 16% of the IVDU members awaiting admission to treatment.

This data will be examined closely ensuring providers are meeting the 14 day State/Federal requirement for access to care and the 120 day Federal requirement. Additional data may be used from the KCPC and paid claims to analysis for compliance.

3. 100% compliance of all KDADS/BHS funded providers maintain policy and procedures for screening clients for TB risk assessments, referrals for TB screening when the results indicate further evaluations to include documentation of those results of screening tests and case-management if needed.

Data is collected to ensure compliance with this Federal regulation from the following sources:

- KDADS/BHS Funded Performance Reviews utilizing the KDADS/BHS Funded Provider Tool
- State of Kansas yearly KDADS/BHS Funded Report which is an analysis of the reports collected throughout the year.
- State of Kansas licensing /certification site visits which are conducted by BHS staff on an annual basis.

- State of Kansas yearly licensing/certification report which is an analysis of the reports collected throughout the year.

4. SUD Needs Assessment

SUD Treatment needs continue to be determined by the evaluation of treatment demand as collected from the AAPS integrated data system. This information system collects real time client level data from every funded provider receiving SAPT block grant funds. This data allows for a rich data set in which to evaluate trends over time and direct available funds where they are most needed. Because the client data is linked to provider billing on a fee for service annual allocation method, a high degree of accountability exists to ensure that the data is reliable.

BHS was able to utilize the statewide needs assessment completed in 2007 to assess treatment needs across the state. It enabled BHS to look at secondary data and assess the need for those persons who not captured in the current information system. The comprehensive needs assessment also provided synthetic estimates to help with strategic planning. The synthetic estimates are still utilized when attempting to determine gaps in services.

The State Quality Committee Cultural Competency Subcommittee met from March 2010 until December 2010. The Subcommittee's focus was to uncover any racial/ethnic disparities that may exist within the Kansas Medicaid and AAPS funded (combination of SAPT BG funds, state general funds, and state fee funds) substance use disorder treatment system, specifically as it related to the federally identified underserved populations. After reviewing multiple data sets from different sources, the Committee found that no substantial evidence of disparity had been reflected in the data sets brought to the Subcommittee. The Subcommittee was concluded and the Cultural Competency work folded into Prevention Cultural Competency initiatives at a systemic level.

Another report that is required of the contracted managed care organization allows us to monitor if members are being served in their home region, thus can help us identify service gaps. The AAPS Admissions Outside of Region Report is based on the member's home region. It looks at the total number of assessment conducted in each region, and then breaks down the data into four categories: 1) treated inside region, 2) treated outside region, 3) did not go to treatment, or 4) treatment not recommended.

BHS will continue to use data obtained through the State data collection system and reports submitted by the managed care entity to make decisions regarding the treatment system/services utilized by our clients. This data will also allow BHS to address the diverse needs of Kansans to include racial and ethnic minorities.

Prevention

During 2012 the statewide epidemiological profile that was originally published in 2006 was updated by the state's epidemiological core team. Data sources included in the updated profile include the following:

- **American Lung Association (ALA)** –Now in its second century, the ALA is the leading organization working to save lives by improving lung health and preventing lung disease through Education, Advocacy and Research. The ALA is a highly trusted organization, committed to transparency and accountability.
- **Behavior Risk Factor Surveillance System (BRFSS)** – The BRFSS is a random digit dialing (RDD) telephone survey. The CDC has developed the questionnaire to ensure compatibility across states. Core questions are asked annually each year in all states and states have the option of adding in additional supplemental questions concerning specific health behaviors and conditions.

- **Kansas Adult Tobacco Survey (ATS)** – The ATS is another RDD telephone survey that is used to measure population-based outcomes. The ATS has been conducted in Kansas during 2001-2002. The questionnaire is based upon CDC best practice questions, which allows for compatibility with other states and the BRFSS. The ATS provided in-depth questions concerning tobacco use, adult attitudes concerning smoking, as well as opinions concerning various aspects of tobacco control in Kansas.
- **Kansas Bureau of Investigation (KBI)** – Information from local and statewide law enforcement is reported to KBI. The information collected is on the number of offences reported to law enforcement as well as the number or arrests made. In some law enforcement agencies only summary information is report and not detailed individual accounts.
- **Kansas Communities That Care (KCTC)** -The KCTC is a school-based survey for students in grades 6, 8, 10, and 12 in Kansas. The KCTC is utilized to gather information concerning youth prevalence of various risk factors such as alcohol, tobacco, other drugs, gang involvement, and many others. In addition, the KCTC is utilized to gather information concerning individual and community risk and protective factors.
- **Kansas Department of Revenue Annual Report (KDR)**– The KDR annual report is used to gather information concerning the amount of taxes collected from the sales of alcohol, tobacco, and drug tax stamps.
- **Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics, Office of Health Assessment**—Data was provided from KDHE regarding deaths due to illicit drugs as underlying cause, specified by mortality due to external causes as unintentional drug poisoning and psychiatric causes based on psychiatric diagnosis.
- **Kansas Sentencing Commission (KSR)** – The KSR collects information from local judicial systems and compiles information for statewide analysis. The KSR is responsible for the SB123 initiative that collects information on individuals sentenced to intensive community supervision and treatment following initial arrest for possession/consumption charges related to illicit drugs. The KSR also monitors the number of individuals under supervision for a 4th or more Driving Under the Influence offence.
- **Kansas State Department of Education (KSDE)** – The KSDE data collection systems provide information on all school based offences. Information is collected on the nature of suspensions and expulsions, including if the offence is related to alcohol, tobacco, or other drugs.
- **Kansas Youth Tobacco Survey (YTS)** – The YTS is a school-based survey for students in grades 6-12 in Kansas. The YTS is utilized to gather information concerning youth prevalence of various tobacco products, youth attitudes concerning tobacco, as well as knowledge of programs designed for youth in the State of Kansas.
- **Kansas Vital Statistics (KVS)** – The KVS provide information on all births, pregnancies, marriages, divorces, and deaths in Kansas and among Kansas residents. Information is collected on many risk and protective factors surrounding the event as well as extensive demographic information. Information is available at the statewide and sub-state level.

- **Kansas Youth Risk Behavior Survey (YRBS)** – The YRBS is a school-based survey for students in grades 9-12 in Kansas. The YRBS is utilized to gather information concerning youth prevalence of various risk factors such as alcohol, tobacco, other drugs, physical activity, sexual activity, and many other.
- **Monitoring The Future (MTF)** – The MTF survey is an annual school-based survey of youth in grades 8, 10, and 12 nationally. The MTF survey is utilized to gather national trend information concerning drug use trend and patterns.
- **National Survey on Drug Use or Health (NSDUH)** – The NSDUH is an annual household survey of individuals aged 12 and older. The main foci of the survey are to obtain information concerning consumption patterns and dependence of alcohol, tobacco, and other illicit drugs. Over sampling occurs to provide statewide level estimates in addition to national estimates.
- **National Vital Statistics (NVS)** – The NVS provide information on all births, pregnancies, and deaths nationally. Information is collected on many risk and protective factors surrounding the event as well as extensive demographic information. Electronic reporting systems are currently being explored to increase data reliability and completeness as well as to provide a uniform data collection process.
- **Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)** – The SAMMEC system was designed and is maintained by the CDC. It is used to estimate the health outcomes attributable to tobacco, the number of deaths attributable to tobacco, as well as the financial burden of tobacco. Information is available for all states as well as at the national level. SAMMEC provides information on direct medical costs as well as indirect loss of productivity costs.
- **State of Kansas Synar report** – Kansas performs unannounced compliance checks on a random sample of all retailers and vendors of tobacco. Specifically these compliance checks are used to monitor the sales of tobacco to minors. Alcohol and Beverage Control (ABC) imposes fines upon individuals failing these checks. Results of the SYNAR report are used in the Kansas Substance Abuse Prevention and Treatment Block Grant.
- **Uniform Crime Report (UCR)** – The UCR is compiled by the Federal Bureau of Investigation (FBI) on criminal offences throughout the United States. The UCR provides data based upon agency, state, and national indexes of crime. Law enforcement agencies are required to submit monthly reports to the FBI. Electronic reporting systems are currently being implemented to increase data reliability and completeness.

Once the data was updated the epi core team engaged in a prioritization process that included scoring the data on the following criteria:

State/Community Readiness: Willingness

State/Community Readiness: Willingness is defined as the extent to which the State of Kansas general population and partner organizations considered the indicator to be a major public concern. This category represented the perceived impact the indicator has upon a community and their willingness to address the topic area. Possible questions to frame a rating included: Is there a large amount of public concern with this topic? Do most people in the state view this topic as something that needs to be addressed? Are there outside influences that may prevent a community from being willing to address the topic?

State/Community Readiness: Capacity

For the purpose of this scoring process, State/Community Readiness: Capacity was defined as the extent to which the State of Kansas is capable of addressing this topic now that funding has been made available. This category should represent the ability of the State of Kansas and communities to immediately begin work with minimal recruitment time. This category should also represent the extent to which there are evidence-based programs, policies, and practices specific to the issue in all domains that would allow communities to achieve change in the targeted outcome. Possible questions to frame this rating included: How many grassroots coalitions exist to address this topic? Do Statewide and local strategic plans exist for this particular topic? Do partners currently collaborate on other projects allowing a seamless transition into this focus area?

Political Will

For the purpose of this scoring process, Political Will was defined as the extent to which Statewide and Local policy makers consider the indicator to be major concern and are willing to address it through policy development. This category should represent the perceived impact the indicator has upon a community and the willingness of policy makers to support targeting this topic. Questions considered included: Would statewide or local policy makers support funding in this topic area? Would statewide or local policy makers encourage cooperation between partner organizations to address this topic? Would statewide or local policy makers be willing to create or strengthen policies that would impact this topic?

Feasibility: Resources

Feasibility: Resources was defined as the extent to which the proposed level of funding will make a population based impact on the consequences related to the indicator. This category should represent the ability to address the topic area in a meaningful way given the resources available for the project. Questions to frame a rating included: Given the resources available, is it possible to “move the needle” on this indicator? Would a larger investment be required to produce an impact? What is the cost of prevention per individual?

Feasibility: Time

Feasibility: Time was defined as given the timeline of 5 years the extent to which the indicator or intermediate variables leading to the indicator will change in the timeframe. This category should represent the ability to address the topic area in a meaningful way given the timeline available for the project. Possible questions to frame a rating included: Given the timeline available, is it possible to “move the needle” on this indicator? Would a longer timeline be required to see substantial changes in the indicator or intermediate predictors? Is it possible to correlate changes in the population with program activities given the timeline?

Changeability/Preventability/Malleability

Changeability/Preventability/Malleability was defined as the extent to which the indicator will shift as a direct result of substance abuse prevention efforts. This category should represent the population attributable risk associated with a condition as a result of substance abuse. Questions to frame a rating included: What portion of the indicator is a direct result of substance abuse? How many non-substance abuse factors influence the outcome of this topic? If substance abuse were completely eliminated, how would this impact the topic?

Severity

For the purpose of this scoring process, Severity was defined as the extent to which the indicator represents the ultimate negative outcome. This category should represent how damaging an indicator is upon the individual as well as upon the environment/community in which the individual interacts. Possible questions to frame a rating included: Is this the worst possible outcome that could happen as a result of substance abuse? Is this outcome an intermediate event that will lead to more serious outcomes in the future? What is the magnitude of the impact upon the individual and the environment/community in which the individual interacts?

Current Resources Addressing Topic

For the purpose of this scoring process, Current Resources Addressing Topic was defined as the extent to which other monetary and human resources are currently being allocated towards the topic in question. A high score in this category should represent limited or no resources addressing the topic whereas a low score in this category should represent a significant current investment in the topic. Questions to frame a rating include: How many government and private programs currently address this topic? Is there a gap between current resources and the need for resources in this particular topic? In relation to the impact of this topic, are there significant resources currently allocated?

Extent of Disparate Populations

For the purpose of this scoring process, Extent of Disparate Populations was defined as the degree to which the target population or subpopulations are more adversely impacted by this indicator than the general population. Examples include, but are not limited to: race/ethnic groups, pregnant women, youth, low socioeconomic status, access to health care, rural/urban, elderly population. Questions to frame a rating included: Are there subpopulations that require special programming or focus due to circumstance impacting the effect of the indicator? Is the population of interest more sensitive to this indicator than the general population? Does the population of interest account for the majority of the impact of the indicator?

As a result of this needs assessment process, the following prevention priorities were established:

1) Reduce Underage drinking

This will be measured by the reported past 30 day use as well as reported binge drinking on the KS Communities that Care Student Survey. The survey is given annually to students in 6, 8, 10, and 12th grade.

Our strategy is to increase the number of evidence-based strategies that directly impact influencing factors related to underage drinking.

It is expected that a reduction in the risk and increase in the protective factors will result in a reduction in underage drinking and tobacco use. Targeted statewide risk and protective factors for primary prevention are:

- Decrease in attitudes favorable toward substance use
- Decrease in peer's substance use
- Decrease in parental attitudes favorable toward substance use
- Decrease in academic failure
- Increase in perceived risk of harm
- Increase in social skills
- Decrease in poor family management

Collection and measuring of this performance measure comes from the Kansas Communities That Care Survey.

Decrease past 30-day alcohol use among students in grades 6, 8, 10, and 12 from a baseline of 25.63% in 2010 to 20% in 2014; **currently 20.86% in 2013, target 19.5% in 2015.**

Decrease binge drinking among students in grades 6, 8, 10, and 12 from a baseline of 13.77% in 2010 to 11.1% in 2014; **currently 10.61% in 2013, target 9.5% in 2015.**

2) Reduce Underage cigarette and smokeless tobacco use

To reduce underage cigarette and smokeless tobacco use defined as past 30-day cigarette and smokeless tobacco the strategy is to increase the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

It is expected that a reduction in the risk and increase in the protective factors will result in a reduction in underage drinking and tobacco use. Targeted statewide risk and protective factors for primary prevention are:

- Decrease in attitudes favorable toward substance use
- Decrease in peer's substance use
- Decrease in parental attitudes favorable toward substance use
- Decrease in academic failure
- Increase in perceived risk of harm
- Increase in social skills
- Decrease in poor family management

Collection and measuring of this performance measure comes from the Kansas Communities That Care Survey.

Decrease past 30-day cigarette use among students in grades 6, 8, 10, and 12 from a baseline of 9.79% in 2010 to 7.3% in 2014; **currently 6.55% in 2013, target 6.0% in 2015.**

Decrease past 30-day smokeless tobacco use among students in grades 6, 8, 10, and 12 from a baseline of 6.39% in 2010 to 5.9% in 2014; **currently 5.05% in 2013, target 4.75% in 2015.**

3) Reduce past 30 day marijuana use

The goal is to to reduce marijuana use among children and youth defined as past 30-day marijuana use among students in grades 6, 8, 10, and 12.

The strategy is to increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

It is expected that a reduction in the risk and increase in the protective factors will result in a reduction in marijuana use among children and youth. Targeted statewide risk and protective factors for primary prevention are:

- Decrease in attitudes favorable toward substance use
- Decrease in peer's substance use
- Decrease in parental attitudes favorable toward substance use
- Decrease in academic failure
- Increase in perceived risk of harm
- Increase in social skills
- Decrease in poor family management

Collection and measuring of this performance measure come from the Kansas Communities That Care Survey.

Decrease past 30-day marijuana use among students in grades 6, 8, 10, and 12 **from a baseline of 8.29% in 2013 to 8.0% in 2015.**

Identified Gaps

As a result of this assessment process gaps in data were identified.

Kansas does not have readily available data to examine the need of the young adult population, those in the age range of 18-21.

Additionally there is currently no behavioral health data integrated into our epidemiological profile. During the next fiscal year as a direct outcome of the receipt of an epi enhancement grant this data will be integrated into our profile.

Mental Health

Kansas has received a no-cost extension until March 1st, 2014 for the final year of our SAMHSA Data Infrastructure Grant (Kansas DIG) in order to produce the FY2013 Client Level Detail (CLD) file. As required by the DIG agreement, the Kansas CLD replaces the aggregate information historically provided through the Uniform Reporting System (URS) tables and submitted annually as a key component of the Mental Health Block Grant National Outcomes Measures Performance Indicators (NOMs).

With the relatively recent implementation of KanCare, this extension is necessary to allow time for compiling and analyzing encounter data from our KanCare Medicaid Managed Care Organizations (MCOs). The Kansas Dept. of Health and Environment (KDHE) oversees the KanCare contract and has been validating encounter information as it becomes available. Working with KDHE and KDADS staff, we have assembled the initial logic we will use to identify the Medicaid mental health consumer population from the broad spectrum of Medicaid services offered through KanCare. We are on schedule to complete the final DIG task as scheduled.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:

1

Priority Area:

SAPT BG funded pregnant women, and women with children

Priority Type:

SAT

Population(s):

PWWDC

Goal of the priority area:

Increase the number of pregnant women, and women with children admitted to designated women's treatment programs

Strategies to attain the goal:

Collect baseline data on the number of pregnant women and women with children assessed for treatment,

Collect baseline data on the number of pregnant women and women with children who are referred to treatment to include the specific modality of care,

Collect baseline data on the number of pregnant women and women with children who are admitted to SUD treatment,

Collect baseline data on the number of pregnant women and women with children who are admitted to a Designated Women's treatment programs,

Review and analyze data for percentage changes in admissions to designated women's treatment programs.

The comparison data will be shared at quality committees,

Provider contracts will continue to include requiring the inclusion of a designated women's program in the list of providers priority clients can choose from.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number of SAPTBG funded pregnant women and women with children served in DWP will increase by 2% each SFY (SFY2014/2015).

Baseline Measurement:

1575 Pregnant Women and Women with Children were admitted to SUD treatment in FY2014.

First-year target/outcome measurement:

1607 Pregnant Women and Women with Children to be admitted to a SUD Treatment Center.

Second-year target/outcome measurement:

1638 Pregnant Women and Women with Children to be admitted to SUD Treatment Centers.

Data Source:

Data collected from the KCPC data files and paid claims.

Description of Data:

Admission data

Data issues/caveats that affect outcome measures::

It is possible for some error in data due to user error.

Indicator #:

2

Indicator:

100% of the contracts will include language about requiring a referral to a DWP for priority population women.

Baseline Measurement:

Provider Contracts

First-year target/outcome measurement:

94 contracts include required language

Second-year target/outcome measurement:

94 contracts include required language

Data Source:

Verbal report from contracted managed care organization.

Description of Data:

Provider Contracts

Data issues/caveats that affect outcome measures::

None

Priority #:

2

Priority Area:

SAPTBG Funded IVDU clients

Priority Type:

SAT

Population(s):

IVDUs

Goal of the priority area:

Increase admission into treatment within the required 14 day time frame.

Strategies to attain the goal:

Communicate with all SUD treatment provider's the Federal requirements regarding IVDU. The communication will occur via electronically and verbally at the quarterly regional provider meetings.

Providers will enter the initial date of contact, assessment date and for all IVDU priority clients into the statewide data system. Paid claims data will be used to determine the first treatment post assessment.

The contracted managed care organization will provide reports to KDADS/BHS about IVDU client's access and admission rates.

BHS is implementing a new service code for Acute Detox. This new code is expected to target the IVDU population. BHS staff will review admission and discharge level data and look for trends.

New Strategy:

The current Access to Care report will be enhanced to include additional indicators, specifically IVDU admission to treatment within 120 days of first contact.

Kansas will target IVDU members assessed by RADACs that are referred to network providers to determine what portion of these members are actually available to enter treatment compared to those that are not available; i.e. in jail or other restrictive placement.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

IVDU clients are admitted to treatment within the required timeframe.

Baseline Measurement:

The initial baseline benchmark was set at 26.4%. This was an 18 month average for a 14 day admission rate. An initial baseline benchmark is approx. 70%. Data will be run by the ASO to determine an accurate baseline.

First-year target/outcome measurement:

14 day admission First year target: 30.4% 120 day admission First Year target 75%

Second-year target/outcome measurement:

14 day admission Second year target: 33.4% 120 day admission Second year target: 80%

Data Source:

Access to Care Report - There will be two versions of this report, one provided quarterly to show a monthly snapshot within the quarter, and one trended by quarter for the fiscal year. Data is reported in aggregate.

Interim services report

Description of Data:

A review of the FY 2013 Access to Care for IVDU member indicated that there were 1,444 assessments recommended treatment for IVDU members completed between July 1, 2012 and June 30, 2013. Of the 1,444 assessments, 1,087 admitted (75.3%) to treatment and 357 (24.7%) did not admit to SUD treatment.

A closer look at the data revealed that when network providers conduct the assessment, IVDU members admit to treatment within 14 days of initial contact at a higher rate compared to when a Regional Alcohol & Drug Assessment Center (RADAC) conducts the assessment and refers the member to a treatment provider. Specifically, when members are assessed by network providers they admitted to treatment within 14 days of first contact at a rate of 59.3%; whereas members assessed by RADACs admitted to treatment within 14 days of first contact at a rate of 17.6%.

It is noteworthy to mention that RADACs perform assessments on members in numerous locations, including members who might not be available to enter treatment within Federal access standards; 14 days from first contact.

Also during FY 2013, Interim Services (lower level of care) were provided to 16% of the IVDU members awaiting admission to treatment.

Data issues/caveats that affect outcome measures::

In the process of converting our current system to KDADS. IVDU clients who are assessed while incarcerated may influence the data.

Priority #:

3

Priority Area:

TB screening on all KDADS/BHS funded clients.

Priority Type:

SAT

Population(s):

TB

Goal of the priority area:

KDADS/BHS funded providers shall maintain policy and procedures for screening clients for TB risk assessments, referrals for TB screening when the results indicate further evaluations to include documentation of those results of screening tests and case-management if needed.

Strategies to attain the goal:

SAPTBG Funded Providers shall ensure Tuberculosis screening is provided to all persons entering a substance abuse treatment service.

KDADS/BHS Program Consultants will conduct on-site visits on all SAPTBG Funded Providers. The Program Consultants will review clinical files and policy and procedural manuals to ensure programs are meeting all SAPTBG Federal and contractual requirements.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

SUD Treatment Providers will abide by all SAPTBG Federal and contractual TB requirements.

Baseline Measurement:

83.8% of SAPTBG Funded Providers will meet all SAPTBG Federal and contractual TB Requirements.

First-year target/outcome measurement:

86.8 of all SAPTBG Funded Providers will meet all SAPTBG Federal and contractual TB requirements.

Second-year target/outcome measurement:

89.8% of SAPTBG Funded Providers will meet all SAPTBG Federal and State contractual requirements.

Data Source:

Biennial Trend Analysis of site visits

Description of Data:

KDADS/BHS SAPTBG Funded Quarterly and Annual Reports

KDADS/BHS SAPTBG State Performance Improvement Plan

Data issues/caveats that affect outcome measures::

Inter-rater reliability continues to be addressed to assure consistency and reliability among Program Consultants.

Indicator #:

2

Indicator:

KDADS/BHS Program Consultants will complete biennial on-site visits on all SAPTBG Funded providers to assure programs are meeting the SAPTBG TB requirements.

Baseline Measurement:

100% of all SAPTBG Funded Programs will receive an on-site program review.

First-year target/outcome measurement:

100% of all SAPTBG Funded Programs will receive an on-site program review.

Second-year target/outcome measurement:

100% of all SAPTBG Funded Programs will receive an on-site program review.

Data Source:

KDADS/BHS On-site Monitoring Tool

Biennial Trend Analysis of Site Visits

Description of Data:

KDADS/BHS SAPTBG Funded Quarterly and Annual Reports

KDADS/BHS SAPTBG State Performance Improvement Plan

Data issues/caveats that affect outcome measures::

Inter-rater reliability continues to be addressed to assure consistency and reliability among Program Consultants.

Priority #:

4

Priority Area:

Reduce underage drinking

Priority Type:

SAP

Population(s):

Other (universal and selective populations, including children and families of active duty and returned military))

Goal of the priority area:

Reduce past 30-day alcohol use among students in grades 6, 8, 10, and 12.

Strategies to attain the goal:

Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Decrease past 30-day alcohol use among students in grades 6, 8, 10, and 12 in Kansas.

Baseline Measurement:

20.86% (2013)

First-year target/outcome measurement:

20.0% (2014)

Second-year target/outcome measurement:

19.5% (2015)

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).

Priority #:

5

Priority Area:

Reduce underage drinking

Priority Type:

SAP

Population(s):

Other (Other (universal and selective populations, including children and families of active duty and returned military))

Goal of the priority area:

Reduce binge drinking among students in grades 6, 8, 10, and 12.

Strategies to attain the goal:

Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Decrease binge drinking among students in grades 6, 8, 10, and 12 in Kansas.

Baseline Measurement:

10.61% (2013)

First-year target/outcome measurement:

10.1% (2014)

Second-year target/outcome measurement:

9.5% (2015)

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).

Priority #:

6

Priority Area:

Reduce underage tobacco use

Priority Type:

SAP

Population(s):

Other (Other (universal and selective populations))

Goal of the priority area:

Reduce past 30-day cigarette use among students in grades 6, 8, 10, and 12.

Strategies to attain the goal:

Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Decrease past 30-day cigarette use among students in grades 6, 8, 10, and 12 in Kansas.

Baseline Measurement:

6.55% (2013)

First-year target/outcome measurement:

6.3% (2014)

Second-year target/outcome measurement:

6.0% (2015)

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).

Priority #:

7

Priority Area:

Reduce underage tobacco use

Priority Type:

SAP

Population(s):

Other (Other (universal and selective populations))

Goal of the priority area:

Reduce past 30-day smokeless tobacco use among students in grades 6, 8, 10, and 12.

Strategies to attain the goal:

Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Decrease past 30-day smokeless tobacco among students in grades 6, 8, 10, and 12 in Kansas.

Baseline Measurement:

5.05% (2013)

First-year target/outcome measurement:

4.9% (2014)

Second-year target/outcome measurement:

4.75% (2015)

Data Source:

Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).

Priority #:

8

Priority Area:

Reduce underage marijuana use

Priority Type:

SAP

Population(s):

Other ((universal and selective populations))

Goal of the priority area:

Reduce past 30-day marijuana use among students in grades 6, 8, 10, and 12.

Strategies to attain the goal:

Increase in the implementation of direct or indirect services that support the implementation of evidence-based strategies that address state level priority outcome measures.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Decrease past 30-day marijuana among students in grades 6, 8, 10, and 12 in Kansas.

Baseline Measurement:

8.29% (2013)

First-year target/outcome measurement:

8.19% (2014)

Second-year target/outcome measurement:

8.1% (2015)

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

Based on the theory of change which underlies prevention science, the timeframe for achieving community-level effects on risk and protective factors is two to five years, and five or more years are required to observe

reductions in the prevalence and incidence of substance use. By increasing the number of evidence-based prevention programs being implemented, as well as increasing the rate of social norm change through environmental strategies, and narrowing the range of targeted substances and associated risk factors, it is anticipated that the rate of change in outcomes data can be increased (for example, one to three years for risk factor change, and three to five years for alcohol, tobacco, and substance prevalence change).

Priority #:

9

Priority Area:

The per capita number of adults with an SPMI served by the CMHC in the CMHC's catchment area.

Priority Type:

MHS

Population(s):

SMI

Goal of the priority area:

To increase the penetration rate for serving adults with an SPMI served by the CMHC in the CMHC's catchment area.

Strategies to attain the goal:

CMHC will provide active outreach and early identification for adults with an SPMI and provide necessary services.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

The number of adults with SPMI being served in each CMHC catchment area will increase.

Baseline Measurement:

SFY2012 Rate: 78.05

First-year target/outcome measurement:

SFY2013 80.00/80.22

Second-year target/outcome measurement:

SFY2014 81.00/

Data Source:

Automated Information Management System (AIMS)

Description of Data:

Data provided by 27 local Community Mental Health Centers (CMHC) Statewide data and reported through the Kansas Mental Health Information Management System

Data issues/caveats that affect outcome measures::

No major issues

Priority #:

10

Priority Area:

The per capita number of consumers with an SED served by the CMHC in the CMHC's catchment area.

Priority Type:

MHS

Population(s):

SED

Goal of the priority area:

To increase the penetration rate for serving youth with an SED served by the CMHC in the CMHC's catchment area.

Strategies to attain the goal:

CMHCs will provide active outreach and early identification for youth with an SED and provide necessary services.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

The number of youth with SED being served in each CMHC catchment area will increase.

Baseline Measurement:

SFY2012 Rate: 363.99

First-year target/outcome measurement:

SFY2013 370.00/384.53

Second-year target/outcome measurement:

SFY2014 385.00/

Data Source:

Automated Information Management System (AIMS)

Description of Data:

Data provided by 27 local Community Mental Health Centers (CMHC) Statewide data and reported through the Kansas Mental Health Information Management System

Data issues/caveats that affect outcome measures::

No major issues

Priority #:

11

Priority Area:

Decrease adult re-admissions to state mental health hospitals (SMHH)

Priority Type:

MHS

Population(s):

SMI

Goal of the priority area:

Adult SMHH hospital readmissions within 30 days will remain stable or decrease.

Strategies to attain the goal:

Current contracts with each of the CMHCs include this performance measure, which will be monitored quarterly. Behavioral Health staff meet monthly with State Mental Health Hospital Directors and Directors of the Community Mental Health Centers to discuss census issues and strategies to reduce hospital admissions.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

The percentage of adults readmitted to state mental health hospital within 30 days of discharge will remain stable or decrease during the fiscal year.

Baseline Measurement:

SFY2012 Percentage: 12.84%

First-year target/outcome measurement:

SFY2013 12.00%/11.84%

Second-year target/outcome measurement:

SFY2014 11.50%/

Data Source:

Statewide SMHH MRM database

Description of Data:

Client-level data from 3 distinct SMHH facilities provided to BHS in standardized MRM format and compiled for statewide reporting.

Data issues/caveats that affect outcome measures::

No major issues

Priority #:

12

Priority Area:

Decrease youth re-admissions to state hospital alternatives (SHA)

Priority Type:

MHS

Population(s):

SED

Goal of the priority area:

Youth SHA readmissions within 30 days will remain stable or decrease.

Strategies to attain the goal:

Current contracts with each of the CMHCs include this performance measure, which will be monitored quarterly.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

The percentage of youth readmitted to an SHA within 30 days of discharge will remain stable or decrease during the fiscal year.

Baseline Measurement:

SFY2012 Percentage: 3.44%

First-year target/outcome measurement:

SFY2013 3.33%/6.36%

Second-year target/outcome measurement:

SFY2014 3.33%/

Data Source:

Statewide SHA database

Description of Data:

Client-level admission/discharge data from SHA contractor operating 2 separate facilities with the state compiled for statewide reporting.

Data issues/caveats that affect outcome measures::

No major issues. The overall percentage of youth readmitted within 30 days during FY13 increased to an estimated 6.36% from 3.44% in FY12. The FY13 numbers represent 9 months of data. Final numbers for FY13 are not yet available.

Priority #:

13

Priority Area:

Evidence Based Practices

Priority Type:

SAP, SAT, MHP, MHS

Population(s):

Other (BHS staff)

Goal of the priority area:

Creating an internal infrastructure that is supportive of EBS/P implementation, evaluation and outcomes achievement.

Strategies to attain the goal:

Assessing the need,

Building staff capacity by adopting a formal definition,

Creating an action plan to adopt a BHS policy guideline,

Provider training and beginning to infuse this language into all grants and contracts consistently. Final result would be an implementation plan.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Implementation plan for EBS/P

Baseline Measurement:

Outcome measures include: baseline understanding of current EBS/P, development of internal strategic plan, revision to our vision and mission.

First-year target/outcome measurement:

N/A new project

Second-year target/outcome measurement:

N/A new project

Data Source:

Internal documents

Description of Data:

None at this time

Data issues/caveats that affect outcome measures::

Lack of resources to include: staffing, current staff's time, funding, staff buy-in, leadership buy-in

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	\$9,122,270		\$22,312,826	\$2,816,000	\$30,359,830	\$	\$
a. Pregnant Women and Women with Dependent Children*	\$2,081,929			\$	\$2,112,738	\$	\$
b. All Other	\$7,040,341		\$22,312,826	\$2,816,000	\$28,247,092	\$	\$
2. Substance Abuse Primary Prevention	\$2,856,608			\$142,962	\$1,672,362	\$	\$
3. Tuberculosis Services	\$			\$	\$	\$	\$
4. HIV Early Intervention Services	\$			\$	\$	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$70,481			\$97,022	\$1,988,796	\$	\$233,436
11. Total	\$12,049,359		\$22,312,826	\$3,055,984	\$34,020,988	\$	\$233,436

* Prevention other than primary prevention

footnote:

State Budgets for FY14 & 15 are estimated amounts. State funds for 1b is overstated and 1a is understated because data to separate Pregnant Women and Woment with Dependent Children is not available at this date.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2014

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$17,252,508	\$11,176,877	\$64,929,618	\$	\$
6. Other 24 Hour Care			\$50,517,702		\$81,916,554	\$	\$
7. Ambulatory/Community Non-24 Hour Care		\$3,107,075	\$209,364,676	\$20,179,400	\$199,382,196	\$52,308,584	\$
8. Mental Health Primary Prevention		\$	\$	\$	\$	\$	\$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		\$	\$	\$	\$	\$	\$
10. Administration (Excluding Program and Provider Level)		\$236,859	\$20,253,748	\$72,000	\$4,904,234	\$	\$
11. Total		\$3,343,934	\$297,388,634	\$31,428,277	\$351,132,602	\$52,308,584	\$

* Prevention other than primary prevention

footnote:

State Hospital (line 5) is estimated due to budget has not been finalized as of this date.

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$	\$
Specialized Outpatient Medical Services			\$	\$
Acute Primary Care			\$	\$
General Health Screens, Tests and Immunizations			\$	\$
Comprehensive Care Management			\$	\$
Care coordination and Health Promotion			\$	\$
Comprehensive Transitional Care			\$	\$
Individual and Family Support			\$	\$
Referral to Community Services Dissemination			\$	\$
Prevention (Including Promotion)			\$	\$
Screening, Brief Intervention and Referral to Treatment			\$	\$
Brief Motivational Interviews			\$	\$
Screening and Brief Intervention for Tobacco Cessation			\$	\$
Parent Training			\$	\$

Facilitated Referrals			\$	\$
Relapse Prevention/Wellness Recovery Support			\$	\$
Warm Line			\$	\$
Substance Abuse (Primary Prevention)			\$	\$
Classroom and/or small group sessions (Education)			\$	\$
Media campaigns (Information Dissemination)			\$	\$
Systematic Planning/Coalition and Community Team Building (Community Based Process)			\$	\$
Parenting and family management (Education)			\$	\$
Education programs for youth groups (Education)			\$	\$
Community Service Activities (Alternatives)			\$	\$
Student Assistance Programs (Problem Identification and Referral)			\$	\$
Employee Assistance programs (Problem Identification and Referral)			\$	\$
Community Team Building (Community Based Process)			\$	\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$	\$
Engagement Services			\$1,239,415	\$
Assessment	10405	10945.00	\$1,239,415	\$
Specialized Evaluations (Psychological and Neurological)	0	0.00	\$	\$
Service Planning (including crisis planning)	0	0.00	\$	\$
Consumer/Family Education	0	0.00	\$	\$
Outreach	0	0.00	\$	\$
Outpatient Services			\$3,146,022	\$396,795
Evidenced-based Therapies	9529	66802.00	\$977,066	\$132,265
Group Therapy	9761	415000.00	\$2,168,956	\$132,265
Family Therapy	5012	2035.00	\$	\$132,265
Multi-family Therapy	0	0.00	\$	\$
Consultation to Caregivers	0	0.00	\$	\$

Medication Services			\$	\$510,166
Medication Management	6418	8503.00	\$	\$510,166
Pharmacotherapy (including MAT)			\$	\$
Laboratory services			\$	\$
Community Support (Rehabilitative)			\$90,280	\$1,133,701
Parent/Caregiver Support	0	0.00	\$	\$
Skill Building (social, daily living, cognitive)	0	0.00	\$	\$
Case Management	14778	111510.00	\$90,280	\$1,133,701
Behavior Management	0	0.00	\$	\$
Supported Employment	0	0.00	\$	\$
Permanent Supported Housing	0	0.00	\$	\$
Recovery Housing	0	0.00	\$	\$
Therapeutic Mentoring	0	0.00	\$	\$
Traditional Healing Services	0	0.00	\$	\$
Recovery Supports			\$133,705	\$
Peer Support	824	19932.00	\$133,705	\$
Recovery Support Coaching	0	0.00	\$	\$
Recovery Support Center Services	0	0.00	\$	\$
Supports for Self-directed Care	0	0.00	\$	\$
Other Supports (Habilitative)			\$70,186	\$
Personal Care	0	0.00	\$	\$
Homemaker	0	0.00	\$	\$
Respite	0	0.00	\$	\$
Supported Education	0	0.00	\$	\$
Transportation	404	9659.00	\$70,186	\$
Assisted Living Services	0	0.00	\$	\$
Recreational Services	0	0.00	\$	\$
Trained Behavioral Health Interpreters	0	0.00	\$	\$
Interactive Communication Technology Devices	0	0.00	\$	\$
Intensive Support Services			\$1,896,223	\$

Substance Abuse Intensive Outpatient (IOP)	1315	19104.00	\$1,896,223	\$
Partial Hospital	0	0.00	\$	\$
Assertive Community Treatment	0	0.00	\$	\$
Intensive Home-based Services	0	0.00	\$	\$
Multi-systemic Therapy	0	0.00	\$	\$
Intensive Case Management	0	0.00	\$	\$
Out-of-Home Residential Services			\$23,232	\$
Children's Mental Health Residential Services	0	0.00	\$	\$
Crisis Residential/Stabilization	0	0.00	\$	\$
Clinically Managed 24 Hour Care (SA)	0	0.00	\$	\$
Clinically Managed Medium Intensity Care (SA)	0	0.00	\$	\$
Adult Mental Health Residential	0	0.00	\$	\$
Youth Substance Abuse Residential Services	54	1364.00	\$23,232	\$
Therapeutic Foster Care	0	0.00	\$	\$
Acute Intensive Services			\$	\$425,138
Mobile Crisis			\$	\$
Peer-based Crisis Services	5204	31191.00	\$	\$425,138
Urgent Care			\$	\$
23-hour Observation Bed			\$	\$
Medically Monitored Intensive Inpatient (SA)			\$	\$
24/7 Crisis Hotline Services			\$	\$
Other (please list)			\$7,009,147	\$
Overnight Boarding Children in a Women's Residential Treatment	115	380.00	\$75,989	\$
Telemedicine	319	1404.00	\$7,015	\$
Social Detoxification	1897	8020.00	\$816,055	\$
Reintegration	740	23280.00	\$1,581,277	\$
Adult Intermediate	1967	39287.00	\$4,528,811	\$

footnote:

Definitions:

Social Detoxification:

Social detoxification treatment is typically short term (less than 7 days) and provides 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal from other drugs. This modality of care provides services for those individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe enough to require 24-hour structure and support.

Reintegration Treatment:

Reintegration treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual back into the community. Individuals treated in a reintegration residential treatment setting typically experience problems with applying recovery skills, assuming personal responsibility, and/or problems with family, education or work.

Adult Intermediate Treatment:

Intermediate treatment provides a regimen of structured services in a 24-hour residential setting. They are housed in or affiliated with permanent facilities where individuals can reside safely. For the typical resident in an intermediate treatment program, the effects of the substance abuse on the individual's life are so significant, and the resulting level of impairment so great, that a less intensive modality of treatment is not feasible or effective.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$9,122,270	
2 . Substance Abuse Primary Prevention	\$2,856,608	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$70,481	
6. Total	\$12,049,359	

- * Prevention other than primary prevention
- ** HIV Early Intervention Services

footnote:



III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Strategy	IOM Target	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Information Dissemination	Universal	\$466,198	
	Selective	\$14,569	
	Indicated	\$4,856	
	Unspecified		
	Total	\$485,623	
Education	Universal	\$447,345	
	Selective	\$30,851	
	Indicated	\$35,993	
	Unspecified		
	Total	\$514,189	
Alternatives	Universal	\$83,984	
	Selective	\$1,714	
	Indicated		
	Unspecified		
	Total	\$85,698	
Problem Identification and Referral	Universal	\$26,281	
	Selective	\$571	
	Indicated	\$30,280	
	Unspecified		
	Total	\$57,132	
Community-Based Process	Universal	\$1,085,511	
	Selective	\$57,132	
	Indicated		
	Unspecified		
	Total	\$1,142,643	
Environmental	Universal	\$466,198	
	Selective	\$14,569	
	Indicated	\$4,856	
	Unspecified		
	Total	\$485,623	
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Other	Universal	\$65,989	
	Selective	\$19,711	
	Indicated		

	Unspecified	
Total		\$85,700
Total Prevention Expenditures		\$2,856,608
Total SABG Award*		\$12,049,359
Planned Primary Prevention Percentage		23.71 %

- *Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$2,456,600	
Universal Indirect	\$184,905	
Selective Indicated	\$139,117	
	\$75,986	
Column Total	\$2,856,608	
Total SABG Award*	\$12,049,359	
Planned Primary Prevention Percentage	23.71 %	

- *Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	☺
Tobacco	☺
Marijuana	☺
Prescription Drugs	☺
Cocaine	☺
Heroin	☺
Inhalants	☺
Methamphetamine	☺
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☺
Targeted Populations	
Students in College	☺
Military Families	☺
LGBTQ	☺
American Indians/Alaska Natives	☺
African American	☺
Hispanic	☺
Homeless	☺
Native Hawaiian/Other Pacific Islanders	☺
Asian	☺
Rural	☺
Underserved Racial and Ethnic Minorities	☺

footnote:

In Kansas our target population is primarily students in grades 6-12, with special focus on rural populations since much of our state is rural. As we progress into the next year our plan is to utilize our Epidemiological Profile including shared Behavioral Health indicators to assist in identifying target populations and areas of our state where specific targeted services can be deployed.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award			FY 2015 SA Block Grant Award				
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	56335.00			\$56,335				
2. Quality Assurance	8148.00			\$8,148				
3. Training (Post-Employment)	0.00							
4. Education (Pre-Employment)	0.00							
5. Program Development	0.00							
6. Research and Evaluation	13911.00			\$13,911				
7. Information Systems	11527.00			\$11,527				
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	\$89,921			\$89,921				

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$
MHA Planning Council Activities	\$
MHA Administration	\$ 236,859
MHA Data Collection/Reporting	\$
Enrollment and Provider Business Practices (3 percent of total award)	\$
MHA Activities Other Than Those Above	\$
Total Non-Direct Services	\$236859

Comments on Data:

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

Section C. Coverage for MH/SUD Services

The following Mental Health Services are currently covered by Medicaid:

- Assessment
- Specialized Evaluations (Psychological)
- Service Planning
- Individual evidence based therapies
- Group therapy
- Family therapy
- Medication management
- Parent/caregiver support
- Skill building (social, daily living, cognitive)
- Case management
- Behavior management
- Supported employment
- Peer support

The following SUD services are currently covered by Medicaid:

- Assessment
- Individual Outpatient
- Group Outpatient
- Case Management
- Peer Support
- Intensive Outpatient
- Intermediate (residential)
- Reintegration (residential)
- Sub-Acute Detoxification

The State Required Insurance Benefits for Behavioral Health are listed below:

- Mental Health Inpatient and Outpatient Services
- Substance Abuse Inpatient and Outpatient Services

The Kansas Insurance Commission is the beginning stages of planning for Health Care Reform. In reviewing the State's Required Benefits, it appears Mental Health and Substance Abuse Services will be included in the plans. Kansas Department for Aging and Disability Services/Behavioral Health Services staff are not currently included in these conversations.

Quality Assessment and Performance Improvement (QAPI) Program for Medicaid

Each of the KanCare health plans was required to submit a written Quality Assessment and Performance Improvement (QAPI) program plan to the State for approval. The QAPI plan detailed how each health plan will meet the quality program requirements set forth in the KanCare contracts. The QAPI program will evaluate how care is provided in the KanCare program, identify outliers to specific quality indicators, determine what needs to be accomplished to ensure high-quality care, and detail how improvements will be identified and documented.

As part of the QAPI program, each health plan must have a QAPI governing body that oversees the program, and a QAPI committee that includes stakeholders such as providers and consumers. The QAPI program must also include:

- Performance Improvement Projects;
- Submitting required performance measures;
- Detecting over- and under-utilization;
- Assessing the quality and appropriateness of care furnished to consumers; and
- Reporting on homelessness and employment.

The Kansas Department of Health and Environment (KDHE) has primary responsibility for the implementation, management, reporting, and monitoring of the programs under the KanCare 1115 Waiver. KDHE has established the KanCare Interagency Monitoring Team (IMT) as an important component of comprehensive oversight and monitoring. The IMT is a review and feedback body that will meet in work sessions quarterly, focusing on the monitoring and implementation of the State's Quality Improvement Strategy, consistent with the managed care contract and approved terms and conditions of the KanCare 1115 (a) Medicaid demonstration waiver. Representatives from Kansas Department for Aging and Disability Services/Behavioral Health Services are part of the IMT. These representatives took an active role in the development and approval of reports to be submitted by the MCO's.

As noted in the section on Parity-Kansas has no arbitrary limits on any publically funded SUD or MH treatment services. There is a full continuum/array of services for SUD and for MH treatment which clients can access once medical necessity is determined. KDADS/BHS requires our current contractor for SUD SAPT funded services and the Managed Care Organizations to utilize the Kansas Client Placement Criteria data system which includes ASAM II criteria to determine medical necessity and authorize SUD services. A clinical diagnostic assessment is conducted to determine eligibility for the MH target population and services are authorized according to individual need. All of these managed care contractors are required to disclose to anyone who requests it the criteria used for determining medical necessity.

KDADS/BHS does not have any contacts with the Insurance Commission to inquire or provide information to. If this is a requirement, we would need additional clarification and possibly technical assistance in this area.

The State of Kansas Insurance Commission is determining the Essential Benefits Package. Health Plans will be required to cover basic categories of healthcare including Behavioral Health Services.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

Section D. Affordable Insurance Exchange

SUD Treatment System

KDADS/BHS currently tracks through its integrated data system, the KCPC, the number of individuals accessing SUD treatment and the type of funding source being utilized. In the past, under the Pre-Paid Health Insurance Plan (Medicaid waiver) a geo access report was developed and monitored on a regular basis. No substantial growth rate was noted as a result of increased efforts by the State or providers to enroll individuals to receive Medicaid benefits. With the move to KanCare, a decision was made to not require this report.

KDADS/BHS and the ASO track and trend SAPT client's admissions in relation to the clients home regions. Data is stratified by clients' home region, including assessments, treatment inside and outside clients' home region, clients that did not go to referred treatment, and clients that were not referred to treatment.

The number of SAPT clients has continued to grow over the past 10 years without any increase in State or Federal funds. Kansas providers have continued to provide uncompensated care to individuals in need of SUD treatment, as noted below.

Uncompensated Care Totals:

Because the AAPS funds are capped and there are always more people that need service, than money available for that service to the indigent (those at 200% of FPL and KS Residents), providers deliver more care than what we can pay for – the totals for the past five years are:

FY 2009 - \$1,997,518.15

FY 2010 - \$1,259,294.67

FY 2011 - \$1,186,564.68

FY 2012 - \$ 1,127,899.74

FY 2013 - \$ 500,000

A separate report shows the admissions by county of residence of each AAPS funded client. This allows BHS staff to determine any gaps in services or need for additional services.

SUD treatment providers are required by contract to meet the following:

2.1 Eligibility Screening

The Provider shall use the AAPS funding source as the payor of last resort. To this end, Provider shall conduct eligibility screenings for all Members that present to their location to determine the

appropriate funding stream for the Member. Eligibility screenings shall include verification of possible funding through the Kansas Medical Assistance Program (KMAP) prior to admission and a minimum of monthly while the Member is in treatment. When appropriate, this shall include the facilitation of Medicaid enrollment activities, up to and including referral of a Member to a Department for Children and Family Office and/or a Medicaid enrollment entity.

As part of the eligibility determination, Provider shall obtain proper documentation on each Member for whom an eligibility screening is conducted and place it in the Member file. Documentation must confirm that the member's income and residency meet the most recent AAPS (Addiction And Prevention Services) eligibility guidelines. This section of the contract is meant to address deviations from the standard course of provider practice.

The following is policy, by which credentialed AAPS Funded providers are to abide, of the current contracted MCO who administers AAPS funding:

ValueOptions Kansas would like to take this opportunity to clarify the issue of Coordination of Benefits. There have been questions regarding the payment responsibility of VO KS after third party payors reimburse providers. Coordination of benefits is applicable to both Medicaid and Block Grant funding streams.

If primary insurance pays a higher rate than the Medicaid/Block Grant allowed amount VO KS will deny the claim with a reason code "no payment is due and VO KS has no responsibility".

If primary insurance pays at a lower rate than the Medicaid/Block Grant allowed amount, VO KS will pay the balance up to the Medicaid/Block Grant allowed amount. The explanation of benefits should be submitted to VO KS for coordination of benefits.

Provider must utilize existing network within the primary insurance. If benefits are available to member, provider must seek out reimbursement with primary insurance.

If benefits are exhausted or services are not covered, provider should submit explanation of benefits listing denial reason. ***Failure to provide complete and accurate information will result in denial of claims.***

If the service billed requires prior authorization, it is the responsibility of the provider to request a prior authorization from VO KS if any portion of the service may at any time be billed to VO KS. ***Failure to obtain prior authorization will result in denial of the claim.***

Block grant claims must be received by the 10th of the month following the date of service. Providers should submit claims to VO KS by the 10th of the following month to comply with claims processing guidelines. If other insurance is noted, provider will submit explanation of benefits (EOB) upon payment/denial and VO KS will then review claims impacted by third party liability (TPL).

Providers will need to review funding stream in KCPC and update information if member no longer has other insurance. The KCPC will be the

key indicator of TPL when AAPS/Possible other Health Insurance is designated.

It is expected that similar language will be added to ensure assistance to those needing help accessing the Insurance Marketplace.

The contractor for SUD treatment services (for AAPS funds) is required to submit claims data to a designated BHS staff person. This person matches this information against data obtained through our KCPC system which collects the number of units requested by the provider and approved by the ASO. This data is also matched against the MMIS system to ensure the clients were not eligible in the Medicaid system, while receiving services. If SAPT BG dollars were utilized the provider is expected to re-pay the SAPT monies paid.

All AAPS funded providers are required by their SAPT contract to be a Medicaid provider. BHS staff continues to encourage providers to explore electronic health records and to have adequate administrative support to maneuver billing systems of the 4 MCO's already in place. Staff explains this use of claims systems will continue to increase with the implementation of the health exchanges. Provider staff is savvy to the use of similar systems as a result of the implementation of managed care in Kansas in 2007. This move has increased providers understanding of the changing landscape of healthcare in the U.S.

Mental Health Services

In regards to the impact of ACA on mental health services, the following was information was given by the Medicaid agency: "Assuming moderate statewide population growth will continue, and using the CY2010 Medicaid/CHIP enrollment experience as a base, our best estimate if the State chooses not to expand Medicaid, is that the Medicaid/CHIP enrollment will increase by 20,563 in CY2014, ramping up to 41,538 (23,740 for Medicaid and 17,798 for CHIP) by CY2016, when the ACA is expected to be fully implemented. The increase in enrollment without expansion is assumed to occur due to outreach efforts under ACA implementation, regardless of expansion. This expected increase in enrollment for those who are currently eligible but not enrolled in the Medicaid/CHIP program is commonly referred to as the woodwork effect. The anticipated 10-year (CY2014-CY2023) State budget increase (state share only) for no expansion will be \$513.5M (\$455.5M for Medicaid and \$58.0M for CHIP)." (Aon Hewitt for KDHE)

It is in the financial interest of each CMHC to ensure client enrollment in Medicaid or other insurance programs. State and Block Grant resources are typically not sufficient to cover services to all uninsured clients. Payer source is tracked and monitored, for all CMHC clients, in AIMS.

Kansas is a SOAR state. Community Mental Health Centers (CMHCs) employ case managers trained in SOAR practices to assist the uninsured, who are receiving mental health services, with making application for social security benefits. CMHCs have not tracked block grant

expenditures until SFY13 when general service categories were identified. In SFY14, CMHCs are required to track service categories, specific dollar amounts per service and number of individuals served. Payer source is tracked for all CMHC clients in AIMS. It is through this database that changes in payer source can be monitored.

Medicaid Mental Health Providers – FFY 13

APRN (Advanced Practitioner Registered Nurse)	178
LCMFT (Licensed Clinical Marriage and Family Therapist)	132
LCP (Licensed Clinical Psychotherapist)	165
LP (Licensed Psychologist)	177
LPC (Licensed Professional Counselor)	129
LCPC (Licensed Clinical Professional Counselor)	94
LCSW (Licensed Clinical Social Worker)	3
LMFT (Licensed Marriage and Family Therapist)	116
LMLP (Licensed Masters Level Psychologist)	89
LMSW (Licensed Masters Social Worker)	551
LSCSW (Licensed Specialist Clinical Social Worker)	549
MD	237
PA (Physician's Assistant)	10
TLMFT (Temporary Licensed Marriage and Family Therapist)	11
TLMLP (Temporary Licensed Masters Level Psychologist)	41
TLMSW (Temporary Licensed Masters Social Worker)	9
TLP (Temporary Licensed Psychologist)	7
TLPC (Temporary Licensed Professional Counselor)	4
TOTAL MEDICAID PROVIDERS	2,502

There are a total of 27 CMHC's in Kansas.

Medicaid Substance Abuse Providers- FFY 13

AAPS funded providers (combination of SAPT, State general funds, and State fee funds)	164
Medicaid providers	98

All AAPS funded providers are required by their SAPT contract to be a Medicaid provider.

Medicaid Mental Health Providers – FFY 14 (Projected)

APRN (Advanced Practitioner Registered Nurse)	187
LCMFT (Licensed Clinical Marriage and Family Therapist)	137
LCP (Licensed Clinical Psychotherapist)	173
LP (Licensed Psychologist)	186
LPC (Licensed Professional Counselor)	135
LCPC (Licensed Clinical Professional Counselor)	99
LCSW (Licensed Clinical Social Worker)	3

LMFT (Licensed Marriage and Family Therapist)	122
LMLP (Licensed Masters Level Psychologist)	93
LMSW (Licensed Masters Social Worker)	551
LSCSW (Licensed Specialist Clinical Social Worker)	579
MD	249
PA (Physician's Assistant)	11
TLMFT (Temporary Licensed Marriage and Family Therapist)	12
TLMLP (Temporary Licensed Masters Level Psychologist)	43
TLMSW (Temporary Licensed Masters Social Worker)	9
TLP (Temporary Licensed Psychologist)	7
TLPC (Temporary Licensed Professional Counselor)	4
TOTAL MEDICAID PROVIDERS	2,600

There are a total of 27 CMHC's in Kansas.

Medicaid Substance Abuse Providers- FFY 14 (Projected)

AAPS funded providers (combination of SAPT, State general funds, and State fee funds)	169
Medicaid providers	101

All AAPS funded providers are required by their SAPT contract to be a Medicaid provider. There was an estimated increase of 3.8% in Medicaid providers from FFY13 to FFY14. A 3.0% increase was used for SA Providers.

Medicaid Mental Health Providers – FFY 15 (Projected)

APRN (Advanced Practitioner Registered Nurse)	191
LCMFT (Licensed Clinical Marriage and Family Therapist)	140
LCP (Licensed Clinical Psychotherapist)	176
LP (Licensed Psychologist)	190
LPC (Licensed Professional Counselor)	138
LCPC (Licensed Clinical Professional Counselor)	101
LCSW (Licensed Clinical Social Worker)	3
LMFT (Licensed Marriage and Family Therapist)	124
LMLP (Licensed Masters Level Psychologist)	95
LMSW (Licensed Masters Social Worker)	562
LSCSW (Licensed Specialist Clinical Social Worker)	591
MD	254
PA (Physician's Assistant)	11
TLMFT (Temporary Licensed Marriage and Family Therapist)	12
TLMLP (Temporary Licensed Masters Level Psychologist)	44
TLMSW (Temporary Licensed Masters Social Worker)	9
TLP (Temporary Licensed Psychologist)	8
TLPC (Temporary Licensed Professional Counselor)	4
TOTAL MEDICAID PROVIDERS	2,653

There are a total of 27 CMHC's in Kansas.

Medicaid Substance Abuse Providers- FFY 15 (Projected)

AAPS funded providers (combination of SAPT, State general funds, and State fee funds)	172
Medicaid providers	103

All AAPS funded providers are required by their SAPT contract to be a Medicaid provider. There was an estimated increase of 2.0% in Medicaid providers from FFY13 to FFY14. A 2.0% increase was used for SA Providers as well.

Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 13. Please provide the assumptions and methodology used to develop the estimate.

SUD:

Estimated number of uninsured individuals served under the SAPT BG during CY 2013= 10,674

Methodology: This number was based on a review of admissions in SFY 2013. It includes all SUD clients who were interviewed with the KCPC and for which an ASAM level of care was recommended (does not include clients who were not recommended for treatment). These clients did not have insurance and had a poverty level less than 138%.

Methodology: This number was based on a review of treatment admission in 2011 and 2012. It includes all SUD clients who were interviewed with the KCPC and for which an ASAM level of care was recommended (does not include clients who were not recommended for treatment). These clients did not have insurance and had a poverty level less than 138%.

Assumptions:

- Admission has slowed with the implementation of managed care in 2007.
- Admission has also been impacted by the reduction of State General funds and Fee funds used for SUD treatment.
- This estimate assumes that Kansas will choose not expand Medicaid under the Affordable Care Act (ACA).

MH:

Estimated number of uninsured individuals served under the MHBG during CY2013 = 35,580

Methodology: An estimate of the number of uninsured individuals served in the public mental health system was determined by counting the annual number served during the previous 3 fiscal years, based on the individual's payment source. These actual totals established the trend line used to forecast an estimated number of uninsured over the current (2013) and successive (2014 and 2015) calendar years.

Assumptions:

- Based on census estimates for 2011 and 2012, Kansas will experience an annual population growth rate of 0.5%. This rate will continue through 2015.
- The percentage of the entire population eligible for Medicaid/CHIP will grow at the same rate as the overall population (0.5% annually) assuming no changes to the poverty-based and medical condition based eligibility rules.
- This estimate assumes that Kansas will choose not expand Medicaid under the Affordable Care Act (ACA).

Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY2014 and CY2015. Please provide the assumptions and methodology used to develop the estimate.

SUD:

Estimated number of uninsured individuals served under the SAPTBG during CY2014 = 10,461

Estimated number of uninsured individuals served under the SAPTBG during CY2015 = 10,251

Methodology: This determination was made based on the growing decline of admissions to publically funded treatment. Estimated number of uninsured individuals assumes a 2.0% decrease in members served due to continued reduced funding.

Assumptions:

- Admission has slowed with the implementation of managed care in 2007.
- Admission has also been impacted by the reduction of State General funds and Fee funds used for SUD treatment. It is anticipated this number will be further reduced with the reduction in Federal funding.
- This estimate assumes that Kansas will choose not expand Medicaid under the Affordable Care Act (ACA).

MH:

Estimated number of uninsured individuals served under the MHBG during CY2014 = 35,758

Estimated number of uninsured individuals served under the MHBG during CY2015 = 35,937

Methodology: An estimate of the number of uninsured individuals served in the public mental health system was determined by counting the annual number served during the previous 3 fiscal years, based on the individual's payment source. These actual totals established the trendline used to forecast an estimated number of uninsured over the current (2013) and successive (2014 and 2015) calendar years.

Assumptions:

- Based on census estimates for 2011 and 2012, Kansas will experience an annual population growth rate of 0.5%. This rate will continue through 2015.
- The percentage of the entire population eligible for Medicaid/CHIP will grow at the same rate as the overall population (0.5% annually) assuming no changes to the poverty-based and medical condition based eligibility rules.
- This estimate assumes that Kansas will choose not expand Medicaid under the Affordable Care Act (ACA).

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

Section E. Program Integrity

KDADS/Behavioral Health Services has a program integrity/quality assurance plan in place for monitoring the contracted Administrative Service Organization (ASO) that oversees and authorizes SUD treatment services funded with SAPT BG funds. A staff person is designated to oversee this contract to ensure the contract requirements are being met.

BHS/Prevention does not have one specific staff person that is responsible for the agency's program integrity activities, however all BHS/Prevention staff are responsible for holding grantees accountable and ensure they are meeting the requirements of their grants.

BHS/Prevention heavily monitors grantee budgets to ensure that funds are being used in the manner intended. Grantees submit a budget and narrative at the beginning of the fiscal year, BHS/Prevention staff review and approve or request revisions to each line item within the budget. Prior written approval is required for revisions throughout the year of 10 percent or more of the grantees approved budget for any line item. Any change in Personnel and Indirect Costs requires written approval from BHS/Prevention staff.

BHS/Prevention Grantees monthly expenditures are reported based on the line item budget and a supplemental narrative providing an overview of expense is also required and reviewed. On a quarterly basis grantees provide fiscal documentation (receipts, facilities breakdown by program, travel logs, etc.) with their expenditure reports. If discrepancies are found at any time, contact is made with the grantee for additional information or denial of a specific expense.

BHS/Prevention grantees report monthly on our Online Documentation and Support System (ODSS) and entries are reviewed by BHS staff on a monthly basis and the contractor for our ODSS system completes inter-rater reliability scoring on a monthly basis. Grantee work plans are also updated and reviewed on a monthly basis. All Prevention KDADS grantees are required to complete an annual independent audit. Audits are submitted to KDADS Department of Audits to ensure providers are meeting general accounting practices and are financially viable.

Community Mental Health Quality Improvement Field Staff (CMHQIFS) will monitor MHBG fund expenditures at each of their Community Mental Health Centers (CMHCs) to ensure that Block Grant funds are used in accordance with the four priority categories. CMHCs are the public safety net and are the exclusive providers of Medicaid rehabilitation services to targeted populations in addition to outpatient therapy and medication management. Block Grant and state funds enable provision of comparable services to clients who are uninsured/underinsured. Priority 2 is addressed through member manuals created and distributed by the three Medicaid managed care organizations in Kansas. Priorities 1, 3 and 4 are addressed in licensing requirements for the CMHCs which are monitored on a continuous basis throughout the 2 year licensing cycle by the CMHQIFS.

CMHQIFS will be responsible for monitoring the appropriate use of Block Grant funds according to each CMHCs identified area of use for the funds. A detailed description of how each CMHC will use the funds will be included in the annual Participating Community Mental Health Center Contract which is effective July 1 through June 30. This description will include the anticipated number of uninsured/underinsured clients who will benefit, the number of service hours (if applicable), and how expenditures will be tracked. CMHCs will submit quarterly reports to the CMHQIFS for monitoring.

Block Grant funds have been distributed through the Participating Community Mental Health Center Contract for many years and CMHCs are accustomed to the quarterly disbursement format. The state assists CMHCs in adopting practices that promote compliance with program requirements, including quality and safety standards through contract provisions and licensing standards.

The Community Medication Support Program is monitored each month by a state staff that reviews and approves the budget expenses. The information provided by Prescription Network is allows the state to run utilization reports by individual mental health center. We can track month dollars spent and the number of persons served each month with the medication assistance program.

The State ensures that Block Grant funds and State dollars are used for to pay for the uninsured population as well as individuals not covered by Medicaid because there is policy indicates that in order to receive services the person meets the following criteria:

Income 200% or less than the current federal poverty level, AND lack medical insurance covering the above specified medication(s), AND been denied acceptance into an indigent drug program. List the indigent drug programs that denied acceptance:

OR

Eligible for Medicaid but currently on Spend down: Start Date and End Date

This criterion is also listed on the application form to get approved for assistance. If the criteria are not met then the claims do not get allowed.

Budget reviews are conducted by the Director of Behavioral Health on a regular basis. This review is completed to determine the appropriate funds are expended for prevention, SUD treatment, mental health services, support services, and administration. This is conducted in conjunction with other pertinent individuals including the Budget Director and assigned Fiscal staff.

The contractor for SUD treatment services is required to submit claims data to a designated person. This person matches this information against data obtained through our KCPC system which collects the number of units requested by the provider and approved by the ASO. This

data is also matched against the MMIS system to ensure the clients were not eligible in the Medicaid system, while receiving services. If SAPT BG dollars were utilized the provider is expected to re-pay the SAPT monies paid.

KDADS/Behavioral Health Management staff meets regularly to review a document entitled Sources and Uses. This document includes all grants and contracts funded by State and Federal funds and overseen by KDADS. This meeting allows managers to give updates and request any changes resulting from budget cuts, funds shifting, and grant/contract changes. Fiscal staff provides guidance and maintain the document to ensure compliance tied to any funding streams.

For SUD treatment services, the contracted ASO is required to submit weekly, semi-monthly or monthly reports that include an accumulator (providers allocations and utilization), claims payment (to providers) timeliness and accuracy, weekly claims report, check register, and independent audited financial statements. KDADS staff is assigned to monitor compliance with the reports to ensure the report was received by the due date, the correct methodology is used, and the benchmark, if applicable, was met. KDADS staff is assigned to monitor for compliance and report any discrepancies to the staff assigned to oversee the contract. Monthly meetings are held internally with the assigned staff as well as monthly meetings with staff from the ASO. Pertinent issues are discussed at these meetings and any joint decisions are made concerning the ASO or the provider network.

KDADS requires that all funded SUD treatment providers to utilize the integrated data base, the Kansas Client Placement Criteria (KCPC). This tool includes ASAM II criteria and determines the appropriate level of care and medical necessity. It also collects the required data elements for SAMHSA (TEDS and NOMS). A fee for service is in place and providers must request units of service through the KCPC system. The request is then reviewed by the ASO. Services must be authorized by the ASO and a claim submitted through their claims system. Encounter data is collected through the KCPC and the ASO's claim system and matched to ensure all claims paid are authorized. KDADS staff and staff from the ASO partner to complete chart reviews to ensure documentation is in place for each service authorized and paid. Performance, gathered from the onsite reviews and Licensing visits conducted by KDADS, staff and utilization are factors when determining allocations for the next year.

The contracted ASO for SUD treatment services is required to provide their annual independent audit. KDADS staff reviews this to ensure financial stability within their corporate organization. Requirements are included in SUD treatment provider's contract with the ASO to submit an A-133 audit, if applicable, or a limited scope audit. These audits are to be submitted to KDADS Department of Audits to ensure providers are meeting general accounting practices and are financially viable.

KDADS staff in conjunction with the staff of the ASO for SUD treatment services reviews the contract language to ensure all federal requirements are included. The ASO's fiscal staff

develops several formulas to distribute funds available. These formulas include any funding decreases or increases, utilization, and performance issues. KDADS management staff and the ASO then meet to discuss the methodology to be applied. Special considerations and gaps in service are also considered when making the allocations. Rates for each type of service have been set and are reviewed occasionally to determine if any changes need to be made.

KDADS staff conducts onsite reviews for program monitoring using a protocol to identify compliance with the ASO, for SUD treatment services, contract and Federal SAPT BG requirements. No fiscal reviews are currently conducted onsite and would not be unless indicated.

KDADS has several policies and practices in place to ensure the correct funding source is utilized for SUD treatment services. A policy is in place to determine income eligibility for SUD services. This policy requires providers to request documentation from clients proving their income. If the client has no income, KDADS requires letters from other sources confirming their lack of income. This income information is then entered into the KCPC which calculates whether the client is eligible for BG funded services. Providers receiving SAPT funds for SUD clients must determine whether the client is eligible for Medicaid services by checking the State website or the designated/contracted MCO's (Medicaid) website. If the person is not currently eligible for Medicaid but is not employed, the providers are required to refer them or help them make contact with the local office to apply for benefits.

KDADS staff has begun discussions about how the BG dollars will be managed in the future. Kansas has been able to implement a rich array of SUD treatment and support services for which rates are set for both the BG and Medicaid. There are also support services covered only by the BG-support services which include transportation and interpretation services, overnight boarding for children in residential treatment with their mothers, and social detox. It is expected that we will further expand ROSC throughout the State to ensure individuals are supported in their recovery.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

Section F. Use of Evidence in Purchasing Decisions

Behavioral Health Services/Substance Use Disorders (BHS/SUD) does not have a designated staff person who is responsible for tracking and disseminating information regarding evidence-based practices or promising approaches. When the BHS/SUD division becomes aware of learning opportunities for evidence based practices or promising approaches, the information is electronically forwarded to all SUD providers within the State of Kansas.

To support integration of mental health and substance use disorders, Behavioral Health Services will be integrating efforts of SUD providers in the Unified Training Advisory Group (UTAG). Historically, UTAG has been charged with providing recommendations and information to inform BHS on training policy and increasing communication between stakeholders to improve training for mental health service providers. This Advisory Group is supportive of providing EBP models into trainings of direct service staff statewide. Engaging SUD providers will ensure training curriculum for Medicaid service providers in Kansas will meet the needs of Kansans with co-occurring disorders.

KDADS/BHS contracts with the University of Kansas (KU) to provide on-site training and consultation to CMHCs as they start-up any of the three EBPs. These EBP's can be billed at an enhanced Medicaid rate. The KU staff also conducts annual on-site fidelity reviews in order to certify CMHC staff to bill at enhanced rates. Community Mental Health Quality Improvement Field Staff participate in fidelity reviews and review the resulting report for approval. Certifications are sent by KU to BHS central office then disseminated to the three MCOs and the CMHC executive director. KU staff is also involved in capacity building for other EBPs and promising practices like dialectical behavioral therapy. Kansas State University is contracted to provide training to child therapists in promising practices for in-home family therapy.

All BHS/Prevention staff members make it a priority to track and disseminate information regarding evidence-based or promising practices to providers and other partners.

BHS/SUD does not use information and/or data about evidence-based or promising practices in our purchasing and/or policy decisions. BHS/SUD does not have contract language or policy which requires providers to implement EBPs. Some providers are voluntarily implementing EBPs, typically Cognitive Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET), yet there is no systematic implementation of these EBPs. BHS/SUD would be interested in building capacity around EBP's and the appropriate implementation within SUD treatment providers.

An initiative rubric included an item identifying the number of EBPs each CMHC is implementing. A score was attached. This was one of the criteria used to select CMHCs to be the "hub" in 5-7 designated regions throughout the state. Hub CMHCs will receive a portion of \$5 million earmarked for the Governor's Mental Health initiative.

BHS/Prevention has set guidelines for our grantees in selecting evidence-based or promising practices. Prior to the selection of a program, prevention providers must complete an assessment to determine community need, build the capacity of the community to take action on the needs

and create a comprehensive plan to address those needs. When selecting prevention programs for the communities comprehensive plan the programs must meet the following guidelines and be approved by BHS/Prevention prior to the purchase. Communities must provide documentation to BHS/Prevention that demonstrates the selected program meets the Kansas Criteria for Evidence-Based Prevention Strategy selection. We find that this process is very important and useful in selecting programs for communities within our state as well building the capacity of our partners and stakeholders to make data informed decisions.

Kansas Criteria for Evidence-Based Prevention Strategy Selection –

Included in a federal list or registry of evidence-based intervention strategies

OR

Reported in a peer-reviewed journal to have produced positive results

OR

Documented as effective based on all three of the following guidelines: The intervention is based on a solid theory or theoretical perspective that has validated research;

AND

The intervention is supported by a documented body of knowledge – a converging of empirical evidence of effectiveness – generated from similar or related interventions that indicate effectiveness;

AND

The intervention is judged by a consensus of informed experts to be effective based on their combined knowledge of theory and their research and practice experience. “Informed experts” may include key community leaders and elders or other respected leaders within indigenous cultures.

In March of 2013, BHS/SUD in collaboration with the Mid America ATTC offered a one day Best Practices in Adolescent Treatment training. The State marketed the training to adolescent treatment providers who were considered to be innovators and early adopters. The training was an interactive workshop which allowed adolescent SUD providers to identify evidence based practices, become more familiar with instructional manuals for the implantation of EBPs and the opportunity to examine issues related to adopting innovative practices in community settings.

BHS/Prevention uses information regarding evidence based practices to educate stakeholders and providers to ensure that quality services are being provided in communities based on need.

KDADS/BHS staff educated the Managed Care Organizations about practices that receive an enhanced Medicaid rate, fidelity reviews and certification process. Future state contract requirements for CMHCs include a provision to make at least two EBPs available statewide.

BHS/SUD staff is not currently providing any formal education to the State Medicaid agency about purchasing services based on evidence based practices. However, the MH staff has done so through meetings with the MCOs. Enhanced rates for Medicaid services are available for certain EBPs within CMHCs demonstrating high fidelity.

BHS/SUD is currently working on a survey to determine the readiness of SUD providers to move towards a pay for performance model. It is hoped to use the information obtained in the

survey to implement this model. This survey will include questions on: business models, staffing plans, use of EBP's with fidelity, quality improvement plan, continuum of services, ROSC, etc.

BHS/MH purchases specific tasks in the agencies contract with Kansas State University that focus on EBP implementation, fidelity reviews and certification.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

Section G. Quality

Since the data elements included in the Health Barometer are not yet available it is difficult to provide information regarding the additional measures. However, KDADS/BHS is involved in the following initiatives which we believe will help improve behavioral health and related outcomes. Once implemented, we will collect data, analyze trends, and make any policy changes needed to improve these services.

KanCare was launched in January 2013 to administer Kansas Medicaid. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare health plans are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and United Healthcare Community Plan of Kansas (United). As part of KanCare, Behavioral Health Services has had the opportunity for the expansion of additional Medicaid health codes.

Kansas is currently in the process of creating MMIS policy for SBIRT, specifically CPT 99408, H0049 and H0050. Kansas will be able to collect numerous data sets to determine the utilization of SBIRT. Those data sets are at both a practitioner and consumer level. It is anticipated the MMIS Policy will be finalized no later than November 2013.

Kansas is contracting with Wichita State University for the collection of a master list of approved SBIRT Medicaid practitioners. This list will afford Kansas the opportunity of knowing how many SBIRT Practitioners, those practitioners' occupations and their communities of practice. As SBIRT grows, Kansas will be able target outreach efforts thoughtfully to expand capacity. The three managed care organizations will be able to query encounter data. The described data sets will allow the State of Kansas to look at utilization levels and assist in strategic planning for upcoming years.

Kansas will be implementing a Health Home model targeted for the SMI population beginning in January 2014. In July 2014, a second target population will be added and will include people with diabetes. The six core service areas will be integral to model #2, involving a team of health professionals. The KanCare Health Home model will be flexible to accommodate the large rural areas and allow for continuing relationships between community providers in order to improve the health of those participating. Health Homes will be designed to ensure:

- Critical information is shared among providers and with consumers
- Consumers have the tools needed to help manage chronic conditions
- Necessary screenings and tests occur timely
- Unnecessary emergency room visits and hospital stays are avoided
- Community and social supports are in place to help maintain health

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

Section H. Trauma

Behavioral Health Services / Substance Use Disorder (BHS/SUD) focus does not have specific policies directing substance use disorder treatment providers to screen SAPT clients for personal histories of trauma. Every SAPT funded client receives an assessment utilizing the Kansas Client Placement Criteria (KCPC). The KCPC serves as the placement and tracking system for evaluation, placement, service requests for all SAPT funded clients. As part of the KCPC assessment, every individual is asked if they have been a victim or perpetrator of physical, emotional and sexual abuse. Although the KCPC is not a trauma-informed screening tool, it does provide the best snapshot at this time regarding history of trauma for SAPT funded clients within the State of Kansas.

BHS/Mental Health (MH) does not have policy that directs Community Mental Health Centers (CMHC) to screen clients for a personal history of trauma. CMHC's have an assessment process which mental health clinicians use when interviewing individuals. As part of the assessment there is a history component that asks individual if they have been a victim or perpetrator of physical, emotional and/or sexual abuse. Our Psychiatric Residential Treatment Facilities (PRTF) have been providing training in the state on trauma informed care through workshops and have sponsored a workshop as well.

BHS/SUD does not have specific policies mandating all SAPT funded SUD treatment providers connect individuals who self-report histories of trauma to trauma focused therapy.

BHS/MH at this time does not have policies which promote the provision of trauma-informed care. The Governor's Mental Health Services Planning Council Task Force (now the Behavioral Health Services Planning Council) mentioned below may find this as a goal in their efforts to inform and educate systems across the state.

BHS/SUD does not have specific policies which promote the provision of trauma-informed care for substance use disorder treatment providers. BHS/SUD does have contractual requirements for the Designated Women's Facilities to arrange for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse and parenting. The Designated Women's treatment facilities are the only SAPT Funded programs contractually responsible for therapeutic interventions to include appropriate referrals for issues related to unhealthy relationships to include sexual, physical and emotional abuse.

BHS/MH at this time does not have policies which promote the provision of trauma-informed care. The Governor's Behavioral Health Services Planning Council Task Force mentioned below may find this as a goal in their efforts to inform and educate systems across the state.

BHS/SUD does not mandate the provision of evidence-based trauma specific interventions for SAPT funded clients over a life span. In March of 2013, the State of Kansas completed an on-line survey with SAPT funded clients asking questions about the provision of evidence-based trauma specific interventions and found unreliable responses. Such responses serve as an indicator to BHS/SUD the needs to build capacity within SUD treatment providers regarding the use of evidence based trauma specific interventions related to trauma over a lifespan.

BHS contracts with Wichita State University/Center for Community Support and Research (CCSR) to provide Training and Consultation on Emerging Practice throughout the fiscal year. CCSR provides training and consultation on emerging practices in human services which includes Trauma-Informed Care to Certified Peer Specialists and Trauma-Informed Clinical Supervision Training to supervisors which includes six to eight team coaching sessions for four teams.

BHS in fiscal year 2014 is contracting with Kansas State University to provide training to service providers on an EBP Trauma Informed Care (TIC) which will include field mentoring/coaching to clinicians providing direct services to youth and families.

The Governors Behavioral Health Services Planning Council (GBHSPC) has requested that a Trauma Informed Care Task Force be developed. This task force membership includes stakeholders from the GBHSPC subcommittees and facilitation is provided through CCSR. The purpose is to focus on Trauma Informed Care by informing and educating Mental Health and Substance Use service communities. Their commitment to the continuation of outreach efforts by organizations throughout Kansas will be to act as an entity to create a Trauma Informed Care culture crossing the spectrum of services. The task force has presently developed a charter, reviewed national research and is gathering data on what agencies and other entities are presently supporting Trauma Informed Care in the state.

BHS/SUD partnered with the Mid America Addiction Technology Transfer Center in March 2012 to sponsor a Women and Substance Use Disorder conference. The conference featured Claudia Black who spoke to issues related to trauma and supporting family recovery. This one-day workshop was designed to familiarize behavioral health care providers, child welfare providers, home visitation and other social service professionals with information on the complex issues involved in women's substance use and recovery. The role of trauma and shame, and the impact on families was a primary theme of the learning event.

BHS staff is included on a committee in the largest urban area that strives to address pregnant women that are using substances. This committee sponsors a large multi-discipline training each year with different topics that impact the care of these individuals. Examples of some of the

presentations include: sex trafficking, methadone treatment and pregnant women, FASD, success stories, etc. BHS will recommend that trauma be addressed in the 2014 training.

BHS/MH has a contract with Wichita State University/Center for Community Support and Research (CCSR) to provide Training and Consultation on Emerging Practice throughout the fiscal year. CCSR provides training and consultation on emerging practices in human services which includes Trauma-Informed Care to Certified Peer Specialists and Trauma-Informed Clinical Supervision Training which includes six to eight team coaching sessions for four teams.

BHS/MH will be adding an additional task under a contract with Kansas State University to provide training to clinical staff under the direction of Dr. Bruce Perry and the Child Trauma Academy.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

Section I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

Kansas has chosen to either partner with the Federal government or let the Federal government create an exchange in Kansas without State input. We have no further information at this time regarding the exchange.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

K.S.A. 22-3302 sets forth legislation for individuals charged with a misdemeanor or felony may be ordered for an evaluation to determine if they are competent to stand trial. Per 22-3302, courts may order a competency evaluation be performed at an institution, or in jail or on pretrial release by a mental health center or other psychological or psychiatric clinic.

In Kansas, approximately 20% of evaluations are performed at Larned State Security Program (LSSP), a state security hospital that serves the entire state as a secure setting for criminal forensic patients during evaluation and treatment, and non-forensic patients with severe behavioral problems who may be transferred from other hospitals.

In lieu of evaluation at LSSP, evaluations performed under K.S.A. 22-3301 by a community mental health center are reimbursed at a rate of \$315 per evaluation by Behavioral Health Services. In FY12, 345 evaluations were performed by CMHCs in Kansas. Evaluations performed by private psychiatric or other psychiatric clinics are not reimbursed by BHS.

Because of costs associated with evaluation and long waiting lists at LSSP, community-based strategies have been deployed to reduce the wait for admission to Larned State Security Program (LSSP) and to reduce the number of people with mental illnesses entering the criminal justice system. Community-based strategies include development of mental health courts, jail diversion, increased number of trained competency evaluators to expand utilization of community-based forensic evaluation, improving efficiencies in evaluation policies and procedures, and close collaboration with referring agencies.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

Data tells us that significant numbers of individuals, both youth and adult, living with serious mental illness experience encounters with law enforcement agencies and end up in the criminal justice system where the recognition and treatment of mental illness is not the primary mission. In FY12, 38% of the KDOC inmate population is mentally ill, and 10% of this number is severely and persistently mentally ill. Since 2006, the mentally ill population has increased by 126%. KDOC mental health facilities are consistently full and have waiting lists for inmate placement.

Increased costs to corrections, local jails, Medicaid and the public mental health system are often attributed to repeated detentions, hospitalizations, extended waiting periods for admission to

Learned State Security Program (LSSP) for evaluation or competency treatment, and access to appropriate services while incarcerated, and reentry.

To address issues and problems facing Kansans with mental illness in or at risk of entering the criminal justice system, Behavioral Health Services has led efforts of the Justice Involved Youth and Adult Subcommittee under the Governor's Mental Health Services Planning Council (GMHSPC) to examine pertinent issues in Kansas as they pertain to the forensic population with mental illness by prioritizing goals and activities around transforming policies, programs, and funding that address jail diversion, access to timely and appropriate services while incarcerated, and reentry to reduce recidivism for individuals with mental illness. This group is a strong collaborative of representatives from the Behavioral Health Services, Kansas Department of Corrections, National Alliance for Mental Illness (NAMI) of Kansas, law enforcement, judges, prosecutors, and consumers to discuss various issues in depth, identify key issues to address, and establish specific tasks and recommendations at a public policy level.

In addition to this work, Behavioral Health Services has partnered with the Kansas Department of Corrections since 2001 to provide care coordination services for 3rd and sequential DUI offenders as established in K.S.A. 1867. This service is provided through the two Regional Alcohol and Drug Assessment Centers contracted by BHS. This service provides recovery support for 12 months for offenders in a cooperative effort with treatment providers, probation and parole services, and other community partners. Funding is established for this service through State fee funds. Currently, Five hundred fifty (550) offenders receive this service.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Kansas has Care Coordination programs related to the 3rd time DUI program as well as other care coordination provided through grants with Heartland Regional Alcohol and Drug Assessment Center. These serve persons with co-occurring disorders that have a history of legal issues, failed SUD treatment, and frequent commitments to state hospitals. These individuals receive services to assist in accessing housing, and community resources that will build capacity for recovery in the individual and in the community.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Behavioral Health Services has recognized the need for cross-training for behavioral health providers and law enforcement and other criminal justice officials to understand how to successfully work with persons with mental illness and co-occurring disorders in ways that address the mental illness through needed treatment and prevent unnecessary incarceration. Funds are budgeted each year to purchase cross-training contractual services through a formal Request for Proposal process. For a modest sum of \$13,000 per year, in Fiscal Year 2012 this service supported a collaborative of the Kansas Law Enforcement Training Center (KLETC), Kansas police and sheriff's departments, community mental health centers and consumer run organizations to successfully provide 5 police trainings to 93 Kansas law enforcement and criminal justice personnel.

This training includes general information on major mental illnesses (bi-polar, schizophrenia, major depression, and other psychosis) and how these mental illnesses express themselves, especially during crisis; issues of mental illness and stigma within the criminal justice system; state and local resources for mental health and substance abuse services; commonly prescribed psychotropic medications; current jail diversion initiatives in the state, and communication and de-escalation skills for intervening with a person in a mental health crisis.

In addition to these efforts funded by Behavioral Health Services, numerous agencies in Kansas have had the foresight to make an investment in Crisis Intervention Teams (CIT) to deescalate crises and to divert individuals into mental health treatment services. Over the past few years, there has been steady growth in the training of law enforcement personnel at all levels through seven 40-hour training events offered to 217 officers through the Kansas Law Enforcement Training Center. Pursuant to a House concurrent Resolution 5032 adopted by the Kansas House and Senate in 2012, the legislature recognized the outstanding leadership of CIT programs and CIT as a model of best practice for law enforcement intervention with persons who have a mental illness. Furthermore, the legislature encouraged law enforcement agencies to lead the effort in partnership, with community mental health centers and local advocacy organizations representing individuals living with mental illness and their family members to establish local and regional CIT programs. Currently, seven Kansas communities have established CIT programs, with a statewide CIT Leadership Group convening monthly to support expansion of CIT efforts across the state.

Peer mentoring planning discussions have been held with KDOC to develop an infrastructure for peer support services provided to reentry candidates. Discussions have also been held regarding the concepts of implementation of a recovery model to enhance the current public safety model in reentry programs and the training of corrections workers in the stages of change.

KDOC parole and Community Corrections officers, as well as Court Services officers, have participated in Person Centered Case Management trainings.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

Section J. Parity

Kansas has no arbitrary limits on any publically funded SUD or MH treatment services. There is a full continuum/array of services for SUD and for MH treatment which clients can access once medical necessity is determined. KDADS/BHS requires our current contractor for SUD SAPT funded services and the Managed Care Organizations to utilize the Kansas Client Placement Criteria data system which includes ASAM II criteria to determine medical necessity and authorize SUD services. A clinical diagnostic assessment is conducted to determine eligibility for the MH target population and services are authorized according to individual need. All of these managed care contractors are required to disclose to anyone who requests it the criteria used for determining medical necessity.

KDADS/BHS does not have any contacts with the Insurance Commission to inquire or provide information to. If this is a requirement, we would need additional clarification and possibly technical assistance in this area.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

Section K. Primary and Behavioral Health Care Integration Activities

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. The State of Kansas, in a joint partnership between the Kansas Department for Aging and Disability Services (KDADS) and the Kansas Department of Health and Environment – Division of Health Care Finance (KDHE-DCF) is engaged in the process of creating a Medicaid state plan amendment to create Health Homes for Medicaid recipients. This initiative is currently the only effort being coordinated by the state to integrate primary and behavioral health care.

Two groups are working on the Health Homes initiative. The first is an interagency project team with staff from KDADS, KDHE-DCF, representatives from the three KanCare managed care organizations, Amerigroup, United HealthCare, and Sunflower State Health Plan, and interested stakeholders. The primary goal of this group is to define the various aspects of the Kansas Health Home model. There are six subgroups within the interagency group working on health home service definitions, selection of target groups, definition of health home quality measures, utilization of the KanCare Health Homes webpage, definition of a Health Homes payment structure, stakeholder involvement, and outlining of provider qualifications. The project team meets weekly to coordinate efforts of the subgroups, and the subgroups meet on differing schedules, usually at least twice monthly.

The second group working on the Health Homes initiative is the Health Homes Focus Group, which is comprised of over 60 interested stakeholders. The Health Homes Focus Group meets bi-monthly and provides additional assistance in the design of the Kansas Health Homes model.

The Kansas Association for the Medically Underserved (KAMU), is incorporated as a 501(C)(3) nonprofit corporation and serves as the state's primary care organization. KAMU is an active participant in the Health Homes Focus Group and is coordinating grants for primary care organizations to work towards integration with behavioral health providers. The Sunflower Foundation, another 501(C)(3) nonprofit corporation has provided grants for twelve primary care/behavioral health care provider partnerships in Kansas and is also an active participant in the Health Homes Focus Group.

The following requirements are included in the regulations for the licensure of all SUD treatment facilities in the State. Programs are required to have policy and implement that policy. Compliance is monitored at the program's annual on site visit.

A licensee shall develop policy for use of tobacco products at the facility to include the following:

1. For programs providing services to adults, tobacco use is prohibited inside the facility and may be permitted outside in a designated area, and
2. For programs providing services to minors, tobacco use is prohibited on the premises by minors.

Kansas is in the process of revising the current Standards for the licensure of SUD treatment facilities. These revisions will include a requirement that all licensed SUD programs provide nicotine cessation reference materials to each client entering treatment at that facility.

Kansas does not currently fund for the treatment for nicotine dependence. Only alcohol and the other drugs reported to TEDS are allowed as diagnosis for SAPT BG funded services. There is no current plan to include this as a funded service. Some treatment providers in the State do include when conducting treatment planning with clients. This is allowable.

In the Kansas Client Placement Criteria tool (KCPC-all clients are assessed using this tool), client tobacco use is currently addressed and will continue to be addressed. The questions ask about use in the past 30 days, either smoked or non-smoked, and age of first use. This allows providers to address tobacco use in a treatment plan if appropriate. In addition, all SUD providers are required to complete a section in the KCPC (described in question 4) on the client's physical health. If an outstanding problem is identified, the provider is required to either address or make a referral to the appropriate medical agency.

Although many Community Mental Health Centers across the state have policies that prohibit tobacco use on their grounds, there is no organized effort from the state at this time to require facilities and grounds to be tobacco free. Similarly, many Community Mental Health Centers are screening, referring, and/or treating tobacco use, especially those in various stages of integrating behavioral health care and primary care, but there is no organized effort from the state in this regard. Many Community Mental Health Centers have smoking cessation support groups and those centers that employ nurses may screen and refer for heart disease, hypertension, and high cholesterol, but the state has not taken steps to make these efforts mandatory at this time.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

Section L. Health Disparities

SUD Treatment

The State of Kansas utilizes the AAPS Integrated Data System in which the Kansas Client Placement Criteria (KCPC) is housed as the primary client placement and tracking system for Behavioral Health Services/Substance Use Disorders (BHS/SUD) clients. It allows for the collection of evaluation data, placement data, service requests and authorizations for all SAPT funded clients. Additionally, the KCPC serves as the data warehouse for all client demographic assessment information and corresponding treatment episodes. Specifically, the KCPC collects the following data sets:

- Race
- Age
- Ethnicity
- Gender
- Clients primary language
- Primary language spoken in family
- Visually impaired
- English not the primary language
- Deaf hard of hearing
- Physical learning disabilities
- Other concerns

The State of Kansas does not collect data regarding sexual preference, explicitly lesbian, gay, bisexual, and transgender (LGBTQ). The State recognizes the need for additional fields to be added to our existing data collection system, therefore KDADS will be requesting a service request to enhance the system for the addition of questions related to sexual preference into the KCPC system.

Regarding service provider questions, BHS collects information about the SUD treatment provider's ability to provide specialized services to specific subpopulations through the licensing application. The provider initial and renewal application requires providers to indicate if they provide specialized services to the following populations:

- Adolescents
- Adult Men
- Seniors
- Women with Children
- Adult Women
- Pregnant Post-Partum Women
- Co-Occurring
- HIV/AIDS
- Hearing Impaired
- Native American
- Gay/Lesbian
- Criminal Justice
- Charitable Choice / Faith Based

This information is maintained in the Integrated Data System. KDADS continues to refine the state regulations by adding specific requirements to providers who indicate the capacity to treat special populations. For example, if a provider indicates they provide treatment to adolescents, they are expected to meet additional state regulations. Those regulations include but are not limited to background checks for child abuse, developmentally appropriate treatment, and education requirements for counselors regarding adolescent developmental needs. KDADS has plans to expand licensure requirements for additional subpopulations i.e. Women's specialized services.

Other data captured in the Data System includes the SUD provider's capability to provide SUD treatment services in languages other than English. SUD providers can indicate any of the following:

Spanish
Korean
Vietnamese
American Sign Language
Other

KDADS currently does not have an identified work plan that addresses disparity or increasing access to treatment for vulnerable subpopulations. BHS/SUD does recognize the value of such plan. KDADS/BHS is currently entertaining the idea of creating a plan that would analyze bi-annual and annual disparity data. The data collection would include reviewing multiple subpopulations by completing data queries and drilling down data sets by multiple factors such as age, race, drug of choice, multiple treatment episodes etc... The data will be collated and reviewed for patterns, trends and/or markers that will assist the state in creating comprehensive work plans which are data driven. Data could be shared at quarterly provider meetings to update providers who attend and provide services to SAPT funded clients.

The State of Kansas has minimum standards of care for SUD treatment programs in Kansas which are contained in Standards for Licensure/Certification of Alcohol and Other Drug Abuse Treatment Programs (as authorized by KSA 39-708c and 65-4016). Several of the Kansas standards are centered on the expectation of providing linguistically appropriate services in clinical settings. The state will continue to reinforce state regulations that address disparity. Specifically:

R03 – 501 B – A licensee shall make available at the program, and at other licensed or certified location, materials that which mandates programs be transparent about the ability to provide culturally competent, linguistically appropriate services in brochures, websites or other advertisements.

R03-602 C – A licensee shall ensure that written permission for release of a client record or information,

- a. Before a client record or information is release or disclosed
- b. Is obtained in a language understood by the individual signing the written permission

R03-603 B-15 – A licensee shall ensure that a client record contains the following:

- a. The clinical file must maintain documentation of assistance provided to a client who does not speak English.
- b. Assistance provided to a client who has a physical or other disability and,

Other projects include KDADS partnering with Kansas Department for Health and Environment (KDHE) to develop a Task Group for individuals diagnosed with a HCV. The purpose of the HCV Task Group is to increase the capacity of providers/agencies to offer viral hepatitis and related services within KDADS/BHS licensed substance abuse (SA) treatment centers and methadone clinics. The HCV Task Group will increase provider/agency competence through the review of provider assessments and guidance on the development of capacity building activities.

The HCV Task Group is to be comprised of the KDHE Viral Hepatitis Prevention Coordinator (VHPC), one representative from KDADS/BHS, one representative from each Kansas provider region, and 2-4 representatives from regional methadone clinics. The HCV Task Group will meet on a quarterly basis, to include one in-person meeting and three conference calls. The KDHE, VHPC will coordinate the logistics for all quarterly meetings.

Possible barriers include making changes to the Data System. This is at times difficult due to shrinking resources and reliance on another Department (IT). KDADS will request technical changes to the KCPC by making some fields' mandatory and adding questions regarding the client's sexual preference.

Another barrier is the residency and eligibility policy in place for SAPT funded services. This policy requires providers to obtain proof of State residency and US citizenship. BHS has added numerous forms of verification but it does prohibit anyone who is not a legal resident from obtaining services funded with SAPT monies.

The State of Kansas will utilize the KCPC to measure and track disparities within Kansas. The State completes quarterly data reports that are shared and discussed with SAPT funded treatment providers. Providers do have the ability to request additional data as it pertains to the populations they serve. As trends are identified, KDADS will create strategies to address and reduce disparity within the State. Additionally, KDADS will continue to work with ValueOptions of Kansas, the Administrative Service Organization contracted to administer the SAPT treatment funds, to monitor provider performance. ValueOptions of Kansas is expected to complete quarterly and annual performance reports to include access to care, provider satisfaction surveys, utilization and other reports which will assist the State of Kansas in identifying and reducing disparities.

Prevention

The reduction of disparities among individuals served by SAPT Block Grant-related funding, as well as through other efforts and initiatives, remains a priority in Kansas. Although many of the small, rural communities throughout Kansas view themselves as racially and ethnically homogeneous, recent efforts have focused on assisting coalitions and prevention partnerships in understanding a broader definition of diversity, enhancing their understanding and strategic planning to maximize access and inclusivity,

and developing their ability to recognize and address disparities that may exist among a wide range of subpopulations.

In order to improve information management, tracking, and monitoring, methods will be identified and put into place to allow for program and participant level data collection in communities in which evidence-based prevention strategies are being implemented with SAPT Block Grant funds. This will entail weaving additional data fields into existing program and participant level evaluation tools to collect information about participant characteristics (e.g., race, ethnicity, gender, LGBTQ, and age), and primary languages spoken at home (and provided via prevention services). In addition, communities will be provided access to the evaluation team to allow for tailoring evaluation measures at the program or participant level to tailor additional indicators and data collected to respond to subpopulations and locally-identified disparities and issues.

As part of the SPF community assessment process and key informant interviews, prevention coalitions will be required to determine the language needs prevalent in local communities, and develop action plans for all proposed evidence-based strategies as well as information dissemination and resource distribution that address the diversity of language needs, as well as literacy rates, in the community. This will entail stronger collaborative, partnership, and mobilization efforts, and offer the added benefit of greater stakeholder involvement and participation in prevention efforts by outreach to respond to this need. Statewide media campaign materials will be similarly designed and adapted to language-specific, and cultural-specific, needs.

Kansas will develop a state-specific prevention plan to direct local-level prevention efforts in order to address and over time, reduce disparities in access, service use, and outcomes for identified subpopulations across the State, which are disparity-vulnerable. This will entail a multi-tiered assessment and planning approach first at the state-level, to begin the process of identifying potential disparity-vulnerable subpopulations, determining resources already in place that may be under-utilized, and exploring approaches for enhancing access to services and appropriate messaging, information, and resource dissemination that can be translated to the community level. In addition, state-level training and technical assistance would be of benefit in learning more about how disparities typically manifest in rural and frontier communities, and best practices in addressing needs among disparity-vulnerable subpopulations.

SAPT Block Grant funds will be used to support this process of addressing, monitoring, and tracking access and utilization of prevention services in Kansas among identified subpopulations through several primary methods: inclusion of optional enhanced demographic self-reported information on both student survey and participant-level evaluation instruments with the option of choosing to disclose or not disclose personal information of this nature left to the discretion of the individual, aggregation of data at multiple levels (e.g., county, regional, or state level) as appropriate to determine baseline levels of access and ability to serve specific subpopulations, and provision of parameters for assessment and data collection to explore disparities and potential disparities utilizing subject matter expertise within the State Epidemiological Outcomes Workgroup.

Mental Health

The Automated Management Information System (AIMS) is a succession of processes that result in a comprehensive data set comprised of 85 data fields that reflect demographic, client status, and encounter data for the mental health consumers served by local Community Mental Health Centers (CMHCs) in Kansas. The State has used data generated through the AIMS since September 2002 in federal and state quality improvement reports and to monitor CMHCs' Mental Health Reform Contracts.

The following demographics are collected to identify sub-populations: date of birth (age), race, ethnicity and gender. Access is measured for all served by collecting and comparing initial contact date with first scheduled appointment date; and admission date (when the case is opened) with next service offered. Service data is reported for all clients served who are in the target populations (SPMI adults and SED children). The following elements relate to collection of outcome data reported monthly: ADULTS - total number of psychiatric hospitalizations during the reporting period, current educational status, current residential arrangement (from a list of choices), current vocational status (from a list of choices), total number of arrests; total number of arrests, number of convicted felonies – both against property and person, number of convicted misdemeanors; CHILDREN/YOUTH –school attendance (from a list of choices), average academic performance, grade level, current residential setting (from a list of choices), total number of NEW foster care placements, utilization of hospital/PRTFs, total number of arrests, number of adjudicated felonies, for both property and person, number of adjudicated misdemeanors, law enforcement contact, total competence, problem, internalizing/externalizing. In addition, numbers served are compared with the general population to measure penetration for both adults and children/youth.

Community Mental Health Center licensing requirements address disparity issues as follows:

K.A.R. 30-60-15

Access; identification; information.

(a) Each center shall make every reasonable effort to overcome any barriers that consumers may have to receiving services, including the following:

- (1) Physical disabilities;
- (2) disabilities specifically resulting from any mental illness;
- (3) language or other communication barriers;
- (4) barriers associated with cultural, social, ethnic, and religious factors; and
- (5) barriers associated with economic issues, including a consumer's access to public transportation, child care needs, and the demands of the consumer's employer.

(b) Each center shall make the following information generally known to or easily discoverable by the public:

- (1) The address and location of the center;
- (2) the center's usual office hours;
- (3) the center's telephone number, including any telephone number that should be called in an emergency; and

(4) the types of services provided by the center or its contractors, or by any affiliated center or affiliate with which the center has an affiliation agreement. Each center shall make an effort to advertise the center's services, the services of any affiliated center or affiliate with which the center has an affiliation agreement, and the availability of those services, at locations where consumers are likely to be found.

(c) If a center is physically located within a multi-use or multipurpose building, the center shall insure that the center can be found within that building by having posted, both outside and inside of the building, signs or other directory information sufficient to assist consumers to locate the center.

(d) Each center shall make available at the center, and at other appropriate locations, materials that provide information about the following:

- (1) A description of the center and the services that the center or its contractors provide;
- (2) a description of any affiliated center or affiliate with which the center has an affiliation agreement and the services that each provides;
- (3) the rights of consumers;
- (4) the center's policy on fees and adjustments to those fees; and
- (5) the ways to contact the center for services.

(e) The materials specified in subsection (d) shall be designed to be comprehensible to persons with only a limited education.

(f) All center stationery used to communicate with the public and any preprinted materials prepared for use in communicating with consumers shall have printed on that stationery and those materials the center's name, address, and telephone number, including any telephone number that should be called in an emergency.

Revision Section L. Health Disparities

In July 2012 Addiction and Prevention Services integrated with Mental Health and was also merged into the Kansas Department of Aging resulting in the creation of KDADS (Kansas Department for Aging and Disability Services). As a result of the integration with Aging, new technology became available for developing a replacement data system. The Information Technology section of KDADS has begun working with program staff to develop the replacement for the AAPS Integrated Data System using Oracle APEX framework.

KDADS recognizes the need to collect specific data regarding sexual preference. KDADS is updating the substance use disorder assessment tool and will include a question to identify the sexual orientation of the individual. The following language/definitions will also be included:

- Heterosexual
- Gay - A man who self-identifies as having an emotional, sexual, and/or relational attraction to other men. Note: The term gay may be used by some women who prefer it over the term lesbian.
- Lesbian - A woman who self-identifies as having an emotional, sexual, and/or relational attraction to other women.
- Transgender - A person whose gender identity and/or expression is different from that typically associated with their assigned sex at birth. Note: The term transgender has been used to describe a number of gender minorities including, but not limited to, transsexuals, cross-dressers, androgynous people, gender queers, and gender non-conforming people. "Trans" is shorthand for "transgender."
- Bi-Sexual - A person who self-identifies as having an emotional, sexual, and/or relational attraction to men and women.
- Questioning- an individual who may be unsure and still exploring their sexuality and, concerned about applying a social label to themselves for various reasons.
- Coming Out - A person who self-identifies as having an emotional, sexual, and/or relational attraction to men and women.

Once the new tool has been implemented, KDADS will be able to collect baseline regarding the sexual preference of individuals entering substance use disorder treatment. Sexual preference data will allow KDADS the opportunity to analyze data to include disparity issues, engagement rates and retention data. It will also enable the providers to meet any special needs of these clients.

Work continues on the new system and it is hoped it will be tested, individuals trained, and fully implemented by the Fall of 2014.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

Section M. Recovery

Indicators/Measures

1. Yes. Kansas supports the SAMHSA working definition of “recovery” from mental disorders and substance use disorders as defined from the Recovery Supports Strategic Initiative, that definition being “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”. Kansas agrees with the four identified dimensions that support a life of recovery: Health, Home, Purpose, and Community. Kansas also supports the 10 identified Guiding Principles of Recovery, and includes the understanding and support of these principles in the training curriculum for the certification of Peer Mentors and the certification of Person Centered Case Managers. KDADS/Behavioral Health Services (BHS) has also established formal policy that states all future funding opportunities will prioritize a Recovery Oriented Systems of Care (ROSC) delivery design.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system? Yes

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Yes

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

The state approved training Curriculum for peer Mentor certification includes recognition and competency development of cultural and ethnic related needs in delivery of services. Peer mentors and case managers delivering care coordination services through a MOU between KDADS and DCF/EES for TANF cash recipients identified with SUD related barriers are receiving training in trauma informed service delivery. Care coordinators and peer mentors providing recovery support services for persons convicted of a third of sequential DUI as established under state statute through a MOU with KDOC are also receiving Trauma informed training. Currently KDADS has a workgroup, supported through the Kansas Veterans Initiative and the SAMHSA Veterans Policy Academy, that has been developing infrastructure and policy for certification of veteran peer to peer mentoring for persons that are accessing the public treatment system for Behavioral Health needs.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes. Training sessions have been held for SUD treatment, Prevention, Mental health, and corrections workforces regarding ROSC and person centered /strength based case management. Over the past years Kansas has provided presentations at annual providers meetings on the ROSC model. In the past year training was held with the statewide regional Prevention Center staff to provide understanding of ROSC development in the community and preventions role in building recovery capacity in the community would fit within the scope of work and practice of the Regional Prevention Centers. Currently two community pilots are in progress, both in urban areas, to introduce the development of ROSC in those communities. Community colleges and universities that provide the curriculum for addictions counseling have been encouraged to include ROSC as part of the course work.

7. Does the state have an accreditation program, certification program, or standards for peer-run services? Yes Kansas has had a certification process for peer mentors since 2011. The certification is a two tiered structure with set numbers of required training hours. The first level is a Kansas Certified Peer Mentor in Training. With this level a peer may work up to 20 contact hours a week with a high level of supervision. The second level of certification is a Kansas Certified Peer Mentor. With this level of certification the mentor can have up to 30 contact hours per week with reduced supervision. Peer mentor services are reimbursable under licensed treatment programs.

Kansas also has a certification program for peer mentors in mental health. All Community Mental Health Centers are required to provide the service. Training programs for peers in mental health are provided through contracts with Kansas University and with Wichita State University

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

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Kansas also has a certification program for peer mentors in mental health. All Community Mental Health Centers are required to provide the service.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery

organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

Kansas has a strong track record in valuing and encouraging the participation of youth and adults with substance use disorder (SUD) and mental health services in the planning, development, and evaluation of behavioral health services, and in broader systemic and policy development.

Behavioral Health Services has invested significant financial resources to purchase services to ensure consumer voice is infused within the infrastructure of the behavioral health service system. Services include:

- Recovery oriented services delivered by a network of 20 consumer run organizations (CROs) that are consumer operated and consumer governed 501(c)(3) organizations across the state that provide recovery oriented services to adults with severe and persistent mental illness.
- A network of 67 self-run, self-supported addiction recovery houses for men and for women, and women with children that provide housing and rehabilitative support.
- Statewide peer-to-peer empowerment services focused on consumer leadership and development and trauma informed care within Consumer Run Organizations (CROs) in Kansas to promote recovery for adult mental health consumers. Work includes:
 - Leadership for Empowerment designed to help consumers become active leaders in the consumer movement and/or community.
 - Leadership in Action designed to provide consumers with leadership skills to become active leaders in their CRO, the consumer movement and/or in the community.
 - A statewide Recovery Conference that brings together practical approaches and research outcomes that foster a strong consumer leadership network via presentations, discussions, and workshops.
 - Trauma Informed Care trainings to CROs to infuse the TIC guiding principles into organizational practices and procedures.
- Education, support and referral services for children with serious emotional disturbance (SED) and their family members.
- Youth led peer to peer recovery supports to youth (ages 12 to 18) with a serious emotional disturbance (SED) with the support and guidance of their primary caregiver(s), especially mothers and fathers.
- Training and certification of Certified Peer Specialists employed by community mental health centers across the state.

- Consumers as Providers Training Program that teaches consumers of mental health services the skills and knowledge on the provision of mental health services in order to work in the mental health or human service field as a consumer provider.
- Education, support and referral services for adults with mental illness and their family members.
- Training of Parent Support direct service staff in a promising practice model to provide peer-to-peer service to parents/guardians of children with an SED diagnosis.

The role of consumer child and family support to the children's mental health system has increased dramatically over the past few years. To address this need, BHS has incorporated a Consumer Affairs Specialist on staff for children & families. This position supports core values in coordinating with consumers to achieve statewide consumer driven mental health services, gather local and statewide consumer feedback to inform the policy development process for and disseminate information regarding policies back to consumer networks, and to administer, disperse and monitor funding sources which support children and family services across the state.

In past years, a Consumer Affairs Specialist for adult support has been funded by Behavioral Health Services and employed within the SMHA. This position has contributed to the improvement of mental health services' responsiveness to consumers' needs through the inclusion of consumers' perspectives across all aspects of the mental health services' planning, delivery and evaluation. Due to funding limitations, the position has not been funded the past two years. In Fiscal Year 2014, BHS has identified a priority of bringing consumer voice back to Behavioral Health Services in public policy, strategic planning and capacity building.

At a policy level, the Behavioral Health Services Planning Council (BHSPC) is made up of a cross-section of mental health and substance use disorder consumers, family members of mental health and SUD consumers, mental health and SUD providers, state allies, and private citizens. The BHSPC is actively involved in the planning, implementation, monitoring, evaluation and advising of the Governor of Kansas regarding Kansas' behavioral health service system. Recognized within the BHSPC are subcommittees which support consumer and family voice statewide (Children, Aging, Suicide, Forensics, Vocational Rehabilitation, and Rural & Frontier).

In 2011, BHS conducted an annual survey to ask consumers who participate in community mental health services their perception of how mental health treatment has improved their quality of life. A sample of adults with SPMI who had received either Community Psychiatric Supportive Treatment or Psychosocial Rehabilitation within 60 days of the date the sample was selected was surveyed. Quality measures were designed to determine if consumers are experiencing recovery, if they feel safe, healthy, and successful and in control of their lives - all of which are significant to the mission of BHS. The purpose of the report is to garner feedback that can be used at the state, local, and provider level to improve the quality of behavioral health service system services in Kansas.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

Kansas has many behavioral health sponsored meetings that engage consumers and their family members developing and implementing behavioral health services in Kansas. BHS provides funding to support these efforts and is looking for opportunities to increase this support.

For several years, BHS has purchased services to provide peer-to-peer empowerment through a wide array of leadership development such as a Leadership Academy, Leadership in Action, and the annual statewide Recovery Conference, attracting over 500 consumers annually. Each venue provides an opportunity for consumers to engage in leadership opportunities to become active at the state and local level to inform the behavioral health service system. A formal report from these events is presented to BHS Executive Leadership annually in April with recommendations for system improvements.

Additional supports include quarterly outreach meetings of 20 Consumer run Organizations. These supports are purchased through a contract that provides a venue for CRO Executive Directors to share information about promising and best practices, Member engagement, strategic planning for continuous improvement of recovery supports in Kansas, and professional development.

Services also include family and youth led peer to peer supports and services that provide a venue to engage families and youth in leadership opportunities at a state, local and individual level. This work has evolved into five (5) community youth leadership sites in various areas across the state that provide an array of services including mutual support, leadership opportunities, community services, information and resources and growth to youth and families.

Meetings of the BHSPC and its' Subcommittees provide a venue for consumer engagement in issues and needs regarding the behavioral health service system. The BHSPC conducts quarterly public meetings, with Subcommittee meetings held monthly or bi-monthly to focus on topics such as employment, housing and homelessness, suicide prevention, justice involvement, trauma informed care, aging and children's issues, rural and frontier, and consumer affairs.

A Hospital and Home Initiative was charged with providing advice and direction in developing a plan that identifies the necessary components of a comprehensive array of mental health services including inpatient treatment. The Initiative engages a core team consisting of a cross section of consumers, family members, advocates, and state agency staff, all of which are coordinated with the Behavioral health Service's Planning Council (BHSPC) and have become a part of the block grant 3-year action plan. The Core Team has started developing outcome measures that will help determine whether or not the implementation of these action steps has a positive impact on the lives of persons with mental illness. The following three overarching outcomes have been identified:

- Consumers will experience minimal disruption in their lives by maintaining their homes, occupation, financial stability and personal relationships,
- Consumers experience satisfaction with themselves, their world, and their dreams/aspirations, and

- Consumers experience recovery and live safe, healthy, successful, self-determined lives in their communities.

In addition to the above, Behavioral Health Services also works with Community Mental Health Centers (CMHC) by providing “Case In Point” facilitation. Case Conference: Case-in-Point was designed by the Cambridge Leadership Associates Adaptive Leadership Case Consultation Model. It supports seeing a situation/case in a fundamentally different way by allowing for free brainstorming without constraint; there are no bad ideas, nor are there avenues closed to exploration. What often happens is that as themes develop the group will begin to gravitate towards one or two ideas about looking at the case that are new or were tried in the past but might need to be looked at again. Adaptive Challenge: The adaptive challenge is figuring out a systemic solution to providing treatment and community supports to keep individuals out of inpatient settings and in community settings. The state has incorporated this program with adults leaving the state hospital and is in process of incorporating with CMHC for youth and families. Behavioral Health facilitates regularly meetings with Department for Children & Families, Community Support Services (Autism Waiver Program and Developmental Disabilities Waiver Program) and Juvenile Justice Authority. These meetings are designed to support communication, collaboration and education of each other’s departments. Discussion involves new programs, youth cases, issues and concerns. Each department is then able to educate and support their provider staff with information and ideas shared from these meetings.

Behavioral Health is also working closely with Department for Children & Families (DCF) with a newly developed program; Permanency Roundtables “Breaking Barriers, Building Futures”. Permanency Roundtables are structured, professional case consultations that are strictly designed to support DCF case managers and supervisors in pursuing a relentless focus on permanency for every child in foster care. Mental Health has participated in these efforts by providing mental health consultation, resources and support. This program is designed to support key factors to expedite safe legal permanency and lifelong connections for youth in foster care for the longest periods of time (e.g., reunification, adoption and legal guardianship);

- Develop a realistic, concrete and action oriented plan for each child to achieve or improve their permanency outcome;
- Stimulate thinking and learning about pathways to permanency for children languishing in foster care;
- Identify and address barriers to permanency through creative thinking, professional staff development, policy change, resource development, and the engagement of system partners;
- Identify systematic barriers that lengthen children’s time in foster care without achieving legal permanency;
- Promote staff and organizational values of legal permanency and lifelong connections to caring adults for every youth in care.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

The Kansas Citizens Committee which serves as an advisory committee to the Secretary has stakeholder representation from around the state. These individuals gather information from persons in the community which they then share with the committee and may include in recommendations to the Secretary. The structural change of the Governors Mental Health Services Planning Council to become the Governors Behavioral Health Services Planning Council (GBHSPC) adds the following new positions: two persons in long term recovery from SUD, a family member of a person experiencing SUD, a peer mentor of persons with SUD, a provider of SUD services and a provider of prevention services. This provides direct impact to the Governors and Secretaries offices on recommendations, and concerns that effect policy related to SUD services in Kansas. The TANF Solutions program for care coordination of persons receiving TANF that have SUD related issues and person receiving services under the 3rd and sequential DUI program are present for all Multi-disciplinary meetings. Family members and support persons may attend those meetings. The care coordinators work with the participants and their family members and support persons in establishing recovery capacity.

The GMHSPC and its six subcommittees all have individual and family participation. Each subcommittee values the individual and family perspective and voice. May need to add more here or admit. And should we add some component of the CRO's

Shared Decision Making (Journeys Program) is based on Emerging Best Practices in adult behavioral Healthcare. Journey's is a program designed to support shared decision making and collaboration among families and providers regarding psychiatric medication. Behavioral Health has contracted with the University of Kansas to implement this program with youth in two of our states Psychiatric Residential Treatment Facilities (PRTF). The Department for Children & Families has placed this program in their state plan to support the decrease in psychotropic medications and improved understanding of medications for youth, parents, case managers and foster care families.

Youth Leaders in Kansas (YLinK)

Behavioral Health contracts with Wichita State University (WSU) to promote support of the YLinK program statewide. The YLinK program is an innovative peer-to-peer support and leadership program promoting the opportunity for youth to develop personal and community leadership and advocacy skills, which includes the leadership and ownership of their individual youth site program, self-advocacy skills and peer-to-peer support with the support and guidance from parents, both fathers and mothers, ages 12 to 18 with a severe emotional disturbance (SED). The program is youth-driven where youth participants have the primary responsibility for program activities, and parents serve in an advisory capacity; in an encouraging rather than directive style. Parents participate in a supportive role during semi-monthly meetings that focus on youth identifying qualities of leadership and developing an action plan through participation in group-selected activities.

Professional parent-to-parent support providers (Parent Support & Training Service) from the Community Mental Health Center deliver administrative oversight and facilitation to parent

caregivers and youth. This experience is often new for parents and youth who may struggle in their relationship because of issues related to the youth's emotional disturbance. Parents are vulnerable to falling victim to courtesy stigma – focusing primarily on their youths' deficits and challenges and losing sight of the positive qualities and potential their children possess. The parent-to-parent support providers associated with YLinK assist parents to reframe issues in a positive manner to support the increased independence and self-responsibility of their youth. Youth gain a voice in their own treatment and recovery and then go on to mentor their peers. The groups select and carry out projects at local, state, and national levels that contribute to community education on mental illness; anti-stigma; acceptance and inclusion of youth living with SED in family, school, and community settings; basic pre-employment skills development; effective transition to adulthood; and positive communication in family life.

Data gathered from surveys completed by both youth and their parents reveal that the relationship between youth and parents have improved, the youths advocacy and leadership skills have increased, they have improved their social skills, developed peer friendships, gained the knowledge to support them in finding a job and/or continuing with their education. These outcomes can only be accomplished through the dedication and enthusiasm of the youth and their family. Examples: social skills, peer interaction, working on relationships with parents and others, self-regulation (to be able to stay focused during meetings) appropriate ways to express feelings and emotion.

Behavioral Health this fiscal year has contracted with WSU to begin gathering data and research to support the process of a possible EBP. Below is the abstract from beginning findings which they submitted for the Society for Community Research and Action conference being held in Miami in June 2013. "Unintended empowerment: The consequence of using qualitative research methods with marginalized youth"

This roundtable will focus on discussion of the "unintended empowerment" that may result from qualitative research, whether participatory or not, with marginalized youth. The presenters will provide brief descriptions of two qualitative research projects: one related to youth leadership activities for youth with mental illness and the other involving young survivors of human trafficking/sexual exploitation. In the project with youth leadership groups, results of focus groups conducted with youth participants were used in combination with a presentation of Hart's Ladder of Youth Participation (1992) to help the youth take charge of processes typically led by adults. The project with survivors of human trafficking/sexual exploitation (HT/SE) involved interviews focused on their perceptions of their own resiliency and ability to escape HT/SE. These projects began as traditional efforts to gather data to increase knowledge and inform practice but, through reflecting their own words back to the youth, became empowering and helped youth gain insight and healing. The primary focus of this session will be on discussion amongst participants and presenters regarding similar experiences, efforts to capitalize on unintended empowerment, and ethical considerations in conducting qualitative research with marginalized youth.

Behavioral Health recognizes that Wraparound is a team-based planning process and service delivery model intended to provide coordinated, holistic, family-driven care to meet the complex needs of youth who are involved with multiple systems, at risk of placement in institutional settings, and/or experiencing serious emotional or behavioral difficulties. Wraparound provides an “on the ground” mechanism for ensuring that core system of care values will guide planning and produce individualized, family-driven and youth-guided support that is community based and culturally competent. This is an essential service provided to the child and family at each CMHC across our state.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

KDADS/BHS provides Peer Mentoring Certification Training and Person Centered Case Management certification training at no cost to the participant. Funding is provided to the Friends of Recovery Association for promotion of recovery community functions which are organized by Oxford House members and Alumni members. Funding is also provided to support a statewide Oxford House member’s summit based on the design of the Oxford House World Conference each year. Funding is provided to Oxford House members to hold a state women’s workshop each year. Consumer run organizations in Mental Health are supported through funding of Wichita State University Center for Community Support & Research (CCSR) and through the Kansas Consumer Advocacy Council (CAC). Support is provided to fund the CAC annual recovery conference. Funding was provided to support the development of the Washburn University Recovery College development by sending student and faculty representation to Texas Tech University for introduction and training to their Recovery College support program. Funding is provided to support Kansas chapter of NAMI.

Housing

1. What are your state’s plans to address housing needs of persons so that they are not served in settings more restrictive than necessary?

As part of the Governor’s Mental Health Initiative (GMHI), Kansas is replicating Tennessee’s Creating Homes Initiative. Beginning July 1, 2013, Community Mental Health Centers (CMHC) will be required to employ staff or subcontract with an organization who has expert staff who will build a grassroots collaborative effort aimed at maximizing funding opportunities that would expand and enhance safe, decent, affordable housing for people with mental illness and/or co-occurring disorders and is consistent with their needs and choice. Potential housing options created as part of the GMHI may include transitional housing, partially supervised permanent housing, tenant-based permanent housing and home ownership.

In addition to the GMHI, Kansas operates programs that assist persons with Severe Persistent Mental Illness (SPMI) and Serious Emotional Disturbance (SED) who are 18-22 obtain or maintain housing. One is called the Supportive Housing Fund Program (SHF). The SHF program provides temporary financial support to eligible individuals to obtain and maintain housing in the least restrictive environment possible. The goal of the program is to provide adults who have SPMI or transition aged youth who have SED the financial help and support they need to stay housed and live more independent, healthy, productive, and fulfilling lives.

Community Mental Health Centers and other organizations in Kansas that provide community based mental health services to SHF's target populations utilize the Supported Housing Fund Program to pay vendors such as landlords, utility companies, department stores, and other businesses or individuals for housing or household items. In 2012, there were 1,615 payments that community based mental health service providers made to vendors at an average \$359.32 per payment.

The other program is the Interim Housing Program. The Interim Housing program provides immediate housing for persons living in the community but who are homeless or for persons who are homeless who are leaving a state hospital, Nursing Facility for Mental Health or any other state funded institution or system of care setting. The goal of Interim Housing Grant is for CMHCs to provide immediate housing, instead of discharging individuals to homeless shelters, and then assisting participants to rapidly obtain permanent housing. In 2013, Kansas had 10 grantees that provided IH assistance to approximately 60 people.

2. What your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Kansas has incorporated consumer choice into all decisions related to housing. As part of the Supported Housing Program, each SHF participant is required to complete a housing stability plan. This plan addresses the consumer's current living status and current income. The consumer and case manager work to develop a stability plan that helps the consumer develop a budget for new housing options or to maintain current housing. Each CMHC employs a Housing Specialist who works with local landlords and local public housing authorities to increase safe, decent and affordable housing options. Case managers then work with the consumer to find housing that is affordable and fits the needs of the consumer.

KDADS has incorporated the housing stability plan into the GMHI and will be considered as part of contract negotiations.

Kansas supports the development, support, and oversight of the revolving loan fund for Oxford Houses in Kansas through a grant to Friends of Recovery Association (FORA). They have been involved in the support of Oxford House in Kansas for over 15 years. Currently they support 67 houses in Kansas and continue to seek new properties for new house expansion. The grant funding also includes support and development of the alumni association of past Oxford members, for the promotion of recovery community activities by the chapters, peer to peer services to Oxford members, and promotion of ROSC in communities.

Behavioral Health Services (BHS) has traditionally provided funding to support a statewide network of 21 Consumer Run Organizations (CROs) to promote recovery through peer recovery supports to consumers or former consumers of mental health services, especially people with severe and persistent mental illness (SPMI). CROs must be legally incorporated consumer operated and consumer governed entities. BHS provides the fiscal and administrative oversight of these 21 contracts. Additionally, BHS has leveraged resources through contracts with the Kansas Consumer Advisory Council (CAC), Wichita State Center for Community Support & Research (CCSR) to provide technical assistance, capacity building and succession planning, leadership development, training and support to grow and support this infrastructure.

Currently a workgroup is focused on development of Peer to Peer services for Veterans and those involved in military services post 9/11 that will be in the public funded treatment system. KDADS/BHS SUD has policy that states that funding preference be given to programs that have a ROSC focus.

BHS has provided startup and training funding to Washburn University to establish a “Recovery College” student initiative.

BHS staff is currently working with Wichita State University to establish a certification for Peer Mentors specializing in Co-occurring Disorders.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

Section N. 1 Prevention

1. In order to identify state-level targeted outcomes and areas of focus, an intensive assessment and prioritization process was conducted over the course of SFY 12-13, beginning with the updating and enhancement of the state epidemiological profile by the State Epidemiological Outcomes Workgroup (SEOW). First created in 2006 as a precursor assessment resource prior to the award of SPF-SIG funding, the state profile details the patterns of consumption and associated consequences for alcohol, tobacco, and other drug use across Kansas. Following the updating of the Epi Profile, members of the SEOW, in conjunction with prevention staff representing Behavioral Health Services, participated in a prioritization process of prevalence and consumption data, informed by the levels of extant supplemental consequence data, utilizing tangible and intangible criteria that included trend, magnitude, comparison, capacity, resources, readiness, and social and political will. The results of this prioritization process were the selection of two statewide prevention outcomes: 1) prevention and reduction of underage drinking, defined as both past 30-day alcohol use among children and youth, and 2) prevention and reduction of past 30-day marijuana use among children and youth, in communities demonstrating elevated rates of consumption and problematic trends in usage. Targeted risk and protective factors will be determined at the local level, as the result of community assessments implemented as part of the SPF process.

The integration of behavioral health across the continuum of services including substance abuse prevention, treatment, and recovery, and mental health services, will be initiated through identification of key indicators - that is, risk and protective factors - that are associated with either mental health, substance abuse, or other key behavioral health outcomes. Once identified, the Kansas State Epidemiological Outcomes Workgroup (SEOW) will be tasked with establishing parameters for data collection and inclusion in the state epidemiological profile, as well as with collection of extant indicators. In addition, for those indicators that are deemed priority measures but do not have an existing or reliable data source, a gaps analysis will be completed to determine means by which this data can be acquired in the future, through partnership and collaborative efforts, or other capacity development strategies associated with behavioral health, as needed. To further enhance the ability to use this data in a comprehensive state-level assessment process, the indicators will be cross-walked with current Kansas Communities That Care risk and protective factor data, as well as archival measures.

Following the acquisition of data across the behavioral health spectrum and inclusion in the epidemiological profile, this data will be analyzed and prioritized to allow for the selection of key outcome targets that could be reasonably shared across behavioral health services. This will create an opportunity for exploring means by which providers, and deliverables supported through Substance Abuse Prevention and Treatment Block Grant funding, can be infused into the assessment practices at the local level (via providers) and enable collaborative local-level assessment and planning such that communities select and target those shared risk and protective factors for behavioral health that can be addressed through the implementation of both

environmental and individual-level evidence-based strategies, in order to achieve specified individual and population-level outcomes.

2. While a specific menu of prevention services will not be provided to communities for implementation, communities will be guided through the SPF process to ensure that evidence-based prevention strategies are selected and implemented that: are tailored to 2-5 specific risk and protective factors targeted at the local level as the result of comprehensive assessment, include multiple primary and secondary environmental and individual approaches, include a mix of bolstering protective factors while reducing risk factors, are implemented with high fidelity while responsive to the need for culturally-responsive adaptations, are inclusive of multiple community domains and sectors, and address effectiveness gaps.

These statewide priorities drive the selection of eligible outcomes targets at the community level; following local-level assessment and utilization of the SPF process, communities will identify problematic risk and protective factors to address these state and local outcomes, and implement a comprehensive array of tailored evidence-based strategies that include information dissemination to increase mobilization, readiness, and awareness, education for skill building, knowledge development, and behavior change, alternative activities (consistent with increasing protective factors and inclusive of the Social Development Strategy), problem identification and referral to allow selected and indicated target populations to access gradations in intensity of services and supports, community-based processes to support adoption of EBS policy and practice change, and environmental approaches that are sustainable and offer the benefit of population-level impacts.

In addition to comprehensive plans developed at the local level that are broad-based and inclusive of multiple core strategies with EBS infused throughout, a statewide Teen Thinking media campaign will continue to be utilized and enhanced to support targeted information dissemination as it relates to underage drinking prevention efforts first initiated during the Kansas SPF-SIG. With all SAPT Block Grant funding awarded to communities, emphasis will remain, however, on the selection and implementation of environmental strategies to maximize saturation and scope of reach, and long-term sustainable impacts on a population-level scale.

Methods used to ensure non-duplication of SAPT Block Grant resources to fund primary prevention services not funded through other means will be twofold. First, fiscal requirements for monies allocated to communities for the implementation of evidence-based prevention strategies will be contingent upon non-duplication of funding, with strict parameters detailed in the binding notices of grant award issued. Secondly, community strategic plans will require state-level review and approval prior to the disbursement of implementation funding, and as part of the review and approval process, any strategy identified as one that is enhancing an existing evidence-based strategy will be required demonstrate proof of non-duplication of funding.

3. Kansas will build capacity within both the provider network (comprised of grantees and contractors) and workforce, as well as the capacity of community coalitions and prevention partnerships on an on-going basis, and in response to multiple assessments of capacity development needs to ensure ability to deliver and engage in high-quality, effective, local-level prevention work that impacts individuals, families, youth, and the social environment, optimally across a wide range of behavioral health focus areas. Employing technology and innovative practices to support both distance learning (i.e., synchronous and asynchronous) and collective learning, workforce development efforts will be focused on timely, application and retention-focused learning to enhance cost-effectiveness and utilization.

Education methods will include self-guided learning and content chunking, and innovative delivery techniques supplementing traditional instructional methods and design with complementary podcasts, self-assessments, real practice, and reflection and application opportunities that will be self-paced and web-based. Topics focused on key learning needs will include, but not be limited to: introductory and advanced facilitation skills, elements of the Strategic Prevention Framework and the Communities that Care model, leadership and adaptive challenges, effective coaching and capacity development, environmental strategies, collection and use of epidemiological data, and incorporation of behavioral health indicators into community level planning and large-scale prevention efforts. In addition, five core teams comprised of subject matter experts corresponding to each step of the SPF will also contribute significantly to learning and workforce development, in terms of both training, technical assistance to peers in the provider network and community-based coalitions, as well as resource development to support SPF utilization at the local level and the development of capacity for engaging in effective, outcomes-focused, prevention efforts.

4. Kansas will collect outcome data related to funded prevention strategies, and this information will be used to support evaluation and mid-course corrections and enhancements at the local level. Specifically, outcome indicators to be collected include prevalence for past 30-day use of alcohol and marijuana, and binge drinking, among children and youth (as reported on the annual Kansas Communities that Care Student Survey - KCTC), indicators for the nine influencing factors identified as having strong association with underage drinking, and risk and protective factor scales scores and indicators prioritized by K-SPF target communities to allow for strategy level evaluation, in addition to program and participant level data collection as feasible for evidence-based prevention strategies implemented in target communities with SAPT Block Grant resources.

In addition to data collection for prevalence outcomes at the state and local level, and targeted risk and protective factors at the community level, community coalitions and prevention training and technical assistance providers will continue to be required to document key services and systems changes taking place throughout the state on the Online Documentation and Support System (ODSS). This includes documentation of new or modified community changes, services provided, community actions, planning products, developmental activities, resources generated,

and media coverage. Coupled with outcome data collected through archival indicators and KCTC student survey data, this documentation of systems changes and services provided tell the story of community mobilization and engagement, coalition infrastructure development, capacity and readiness enhancement, service delivery, and the adoption of new or enhanced programs, policies, and practices for prevention across the state.

Data will be aggregated and utilized in annual sense-making and reflection sessions with providers and community coalitions receiving SAPT Block Grant funding, in an effort to bolster accountability, track and celebrate progress achieving short, intermediate, and long-term outcomes, and provide valuable information for enhancing strategy implementation, be it in terms of fidelity, need for adaptations based on cultural considerations for disparity-vulnerable subpopulations or other contextual variables, and improving saturation, dosage, duration, intensity, and delivery.

5. Through leveraging resources and providing parameters for expectations and service delivery to ensure that target communities are implementing the Strategic Prevention Framework, the State's budget for prevention utilizing SAPT Block Grant funds is increasingly supportive of effective, outcomes-focused, community-level prevention efforts. In the previous fiscal year implicit changes to the prevention infrastructure were put into place with the sole purpose of intentionally infusing the SPF framework into all prevention efforts in our state; this initiative, the Kansas Strategic Prevention Framework, or K-SPF effort will be enhanced during FFY14. However, a need for enhancing this fiscal support for the K-SPF remains, and will be continuously addressed over the course of SFY 2014-2015.

At present, support for the implementation of evidence-based environmental strategies at the regional level has been accomplished by identifying set-aside funding amounts for the ten Regional Prevention Centers throughout the state, at a minimum amount of \$20,000 per region. This is a pilot initiative for Kansas, and a significant growth and learning opportunity, as historically Kansas has used SAPT Block Grant funds exclusively to support a data and information management system for assessment and evaluation, and centers for the provision of community-level training and technical assistance, with no requirements or provisions for the implementation of evidence-based prevention strategies. Based on the results of recent stakeholder assessments, it was established that while the first three steps of the SPF are often completed at the community level, the lack of monetary resources is a significant barrier to implementation, evaluation, and ultimately, sustainment.

To redress this issue, beginning in SFY 14 and increasing in scale in SFY 15, Kansas will fund target community-level implementation of evidence-based strategies upon successful completion of the assessment, capacity and planning steps of the Strategic Prevention Framework. Scaling up in SFY 15, an anticipated 40% of Regional Prevention Center funding will be redirected to support community-level implementation of evidence-based prevention strategies – again, contingent upon fidelity completion of the first three steps of the SPF. However, aside from a

sheer monetary standpoint, Kansas has traditionally used SAPT Block Grant funding to provide a system of data and information management, RADAR services, and a network of prevention training and technical assistance providers available to serve all counties across the state in the adoption and utilization of best practices, evidence-based strategies, and the Strategic Prevention Framework.

6. How much of the SAPTBG set-aside goes to the state, versus community organizations?

With regard to the SAPT Block Grant set-aside for prevention, approximately 24% of the total award is dedicated to prevention. Of that set aside, nearly half of the funds are spent on state level supports for prevention; this includes our statewide CTC survey which serves as the primary source of outcomes data, online documentation support system for capturing community level changes associated with community level funding, and also supports our RADAR center and provision of workforce development efforts for the prevention professionals and coalition leaders in our state. The remaining funds are currently allocated to the community level, to a network of ten Regional Prevention Centers whose primary role is to support the infusion and utilization of the SPF framework in targeted communities across our state. At present, a minimum of \$20,000 in each of ten regions is earmarked for community-level implementation of evidence-based strategies, with this amount slated to increase in SFY 2014, and increase more dramatically in SFY 2015 as we make more changes to the prevention infrastructure with the aim of funding more directly, local level implementation of evidence-based prevention strategies.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

There is no set amount of the prevention set-aside funds required to support a specific strategy, or set of evidence-based practices and environmental strategies uniformly across the state, there is however, an expectation that an array of evidence-based strategies and environmental approaches be tailored to an individual target community or service region. This is a pilot initiative put into place during SFY 2013, in which Regional Prevention Centers, part of the Kansas prevention infrastructure and recipients of SAPT Block Grant funding in order to provide training and technical assistance to communities to implement the Strategic Prevention Framework, earmark a portion of the budget as Direct Impact Dollars, which can only be used to support the implementation of evidence-based prevention strategies within their defined service areas. Examples of the evidence-based strategies that are being implemented at the community or regional level include saturation patrols, retailer compliance checks, Project Sticker Shock, MADD Power of Parents, increased law enforcement patrols of high-risk areas for underage drinking, and increase enforcement of social hosting laws. Beginning in SFY 2014, communities that have completed the assessment, capacity development, and strategic planning steps of the K-SPF will be eligible to receive funding to support the implementation of a comprehensive set of evidence-based strategies and environmental approaches tailored to impact prioritized local prevalence outcomes and targeted risk and protective factors.

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

Section N. 2 Prevention

The integration of behavioral health across the continuum of services including substance abuse prevention, treatment, and recovery, and mental health services, will be initiated through identification of key indicators - that is, risk and protective factors - that are associated with either mental health, substance abuse, or other key behavioral health outcomes. Once identified, the Kansas State Epidemiological Outcomes Workgroup (SEOW) will be tasked with establishing parameters for data collection and inclusion in the state epidemiological profile, as well as with collection of extant indicators. In addition, for those indicators that are deemed priority measures but do not have an existing or reliable data source, a gaps analysis will be completed to determine means by which this data can be acquired in the future, through partnership and collaborative efforts, or other capacity development strategies associated with behavioral health, as needed. To further enhance the ability to use this data in a comprehensive state-level assessment process, the indicators, as well as the ACE's - the Adverse Childhood Experiences indicators that are predictive of a wide range of behavioral health needs and issues - will be cross-walked with current Kansas Communities That Care risk and protective factor data, as well as archival measures. Compiling and aggregating this data on shared risk and protective factors that are predictive of a wide range of health and wellness issues for children, young people, adults, and families will be the first step in finding common ground, shared outcomes, and mechanisms for truly comprehensive and multi-issue strategic planning that can be later accomplished at the community level through provider-level systems changes and shifts in practice. This process will also lay the foundation for establishing a Kansas epidemiological profile for behavioral health, and expand the scope of the original profile from its roots in prevention and into the areas of substance abuse intervention, treatment, recover, and mental health.

Following the acquisition of data across the behavioral health spectrum and inclusion in the epidemiological profile, this data will be analyzed and prioritized to allow for the selection of key outcome targets that could be reasonably shared across behavioral health services. This will create an opportunity for exploring means by which providers, and deliverables supported through Substance Abuse Prevention and Treatment Block Grant funding, can be infused into the assessment practices at the local level (via providers) and enable collaborative local-level assessment and planning such that communities select and target those shared risk and protective factors for behavioral health that can be addressed through the implementation of both environmental and individual-level evidence-based strategies, in order to achieve specified individual and population-level outcomes. In order to engage in this prioritization process, it will first be necessary for KDADS BHS to engage in foundation development, mobilization, and other groundwork. These key activities include, but are not limited to, development of a Prevention Advisory Committee that is invested in addressing and enhancing efforts to address behavioral health needs, creation of an internal BHS workgroup with accompanying guidance and charter, recruitment across behavioral health divisions, de-siloing of data collection and

information sharing within appropriate parameters of aggregation to ensure confidentiality, facilitation of focus groups to prioritize data and identify feasible, achievable, shared outcomes, creation of guiding principles of behavioral health services, and development of a shared logic model with outcomes specified for behavioral health. Additional data regarding needs, issues, and challenges associated with behavioral health, and the concomitant community-level strategies and systems level changes necessary to address these needs among the universal population, as well as targeted and indicated populations, those at highest risk, those actively in treatment, and those in recovery, will be solicited through data collection methods and structured facilitation to better inform state-level decision making and gaps analysis.

Once targets are identified; integrated efforts will be made to assess the current level of mental health promotion and EBS activities, including those related to suicide prevention, currently being implemented in our state. Additional activities will involve research and compilation of resources and information related to evidence-based strategies, programs, and best practices in the disciplines of prevention, treatment, and mental health, to better ensure infusion and adoption of research-based approaches by both SAPT Block Grant supported grantees, contractors, and service providers, as well as for aiding communities and local coalitions or partnerships in strategic planning that includes outcome targets for shared, high priority, risk and protective factors for behavioral health, and the concomitant implementation of associated and aligned tested, effective approaches.

Through these processes and activities facilitated and undertaken by KDADS BHS, a structure, process, and multi-tiered (i.e., state, provider, regional, and/or community level) system will be devised and put into action to better be able to coordinate and measure those efforts in a strategic way, including creating intentional and robust enhancements within the current prevention network that has primarily focused on SUD prevention—this will allow us to effectively and efficiently utilize the 5% set aside to achieve outcomes.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

Section O. Children/Adolescents BHS

KDADS/Behavioral Health Services (BHS) SUD treatment providers are required to comply with the regulations-Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs. Within these Standards are the following requirements for any SUD treatment provider who provides adolescent treatment:

R03-715. Supplemental Requirements for Adolescent Services

- A. A licensee providing services to adolescents shall comply with the following standards:
1. Conduct and document that background checks for all employees to include the Kansas SRS Child Abuse and Neglect Central Registry. This must be obtained for all personnel providing direct services to children and adolescents according to K.S.A. 65-516. An employee or volunteer identified as a prohibited individual pursuant to K.S.A. 65-516 is prohibited from providing services to or caring for children or adolescents.
 2. Counseling groups for children and adolescents must be specifically designed to meet their developmental and treatment needs. If adolescent clients participate in groups that include adult clients, documentation in the client file must include:
 - a. clinical justification for placement in the group,
 - b. a description of how the adolescents developmental and treatment needs can be met within the group.
 3. If residential services are provided, the program must make arrangements for the continuity of the client's academic education that are appropriate to the developmental needs of the child or adolescent served and meet applicable federal, state, and local requirements.
 4. If residential services are provided, children and adolescents must be assigned sleeping quarters and bathroom facilities separate from adults and members of the opposite sex.
 5. The organization must develop policies and procedures that address:
 - a. Providing physical activities and recreation appropriate to the developmental needs of children and adolescents.
 - b. Providing counseling and education for the family members of children or adolescents served in the program.
 - c. Providing staff training to enhance staff understanding of child and adolescent development and substance abuse.
 - d. Methods of disciplining children and adolescents.

One SUD treatment provider, Dream, provides summer camps for children. These camps have been held since the summer of 1990. Their goal is to reach the children of chemically addicted families through summer camp programs developed specifically to meet their needs. Excellent evaluation results of Dream camps have been collected illustrating improvement for the children attending camps in all areas of knowledge concerning chemical addiction, coping skills and goal-setting as well as significant improvement in levels of self-esteem.

BHS staff is working with NASADAD to review and approve Guidelines/Best Practices for Youth SUD Treatment. It is expected once these are complete and approved by SAMHSA that BHS will make revisions to the Standards to incorporate more requirements for the treatment of youth identified with SUD problems to ensure quality services.

BHS staff has met with staff from JJA to begin to discuss the need of SUD treatment for adolescents confined in youth correctional facilities. JJA plans to obtain licensure for SUD treatment for at least one of their facilities to provide these needed services. It is hoped that a similar conversation can take place regarding those youth in JJA custody who reside in the community.

As part of the SPF-PFS II initiative through funding awarded by SAMHSA, Kansas will revitalize the Advisory Council previously established as part of the requirements for the SPF-SIG. This will enable the opportunity to engage other state and regional level stakeholders in dialogue regarding behavioral health needs of children and youth, and ways to contribute via comprehensive prevention planning and services made available at the community level. Examples of these partners and stakeholders include the Kansas Department of Health and Environment, Department of Children and Families, Department of Education, Department of Corrections, Juvenile Justice Authority, Aging and Disabilities Services, the Kansas Board of Regents, and the Kansas Highway Patrol. This group will be tasked with examining behavioral health data sets made available by the State Epidemiological Outcomes Workgroup (SEOW), and subsequently recommending strategies to enhance or facilitate universal, selected, and indicated prevention strategies for children and youth to address shared outcomes, and methods of fostering collaboration at the local level. In a related fashion, all communities receiving SAPT Block Grant resources for prevention service are currently, and will continue to be, required to maintain coalition membership representative of the 12 community sectors, in order to ensure local stakeholder support for prevention planning and implementation of multi-faceted strategic plans that are inclusive of environmental strategies and individual strategies across the continuum care to address behavioral health needs by impacting shared, predictive, risk and protective factors targeted as part of the SPF assessment process.

The Department for Children and Families (DCF) has primary responsibility for the public mental health and substance abuse treatment systems and key components of those systems are community based managed care programs that include Medicaid funded services for youth in the child welfare/ foster care system. The access, quality, performance management and oversight criteria for those programs all apply equally to these youth and are monitored extensively by DCF staff. Oversight of those programs is shared collaboratively between DCF and Kansas Department of Health and Environment.

DCF requested support and collaboration from Kansas Department for Aging and Disability Services (KDADS) & KDHE in assisting them in the development of a State Plan to decrease the prevalence of psychotropic medication prescriptions among children in out-of-home (OOH)

placement within the Kansas foster care system. From a University of Kansas study and the statutory mandates required of states DCF, KDADS and KDHE have joined together to work collaboratively to support the decrease in prevalence of prescribing medications to out-of-home placement foster care youth across the state. The purpose of this advisory team is to collaborate with other prescribing child services system. KDADS supported DCF efforts by writing a work plan that they have implemented into their state plan.

KDADS also facilitates quarterly meetings with DCF and Juvenile Justice Authority (JJA) department staff to provide a collaborative effort in supporting each other with information of each other's system process, policies and procedures; updates on new or existing programs; discussion around youth cases etc. This has been very beneficial not only for the state department staff, but we are then able to take some of this information on to our providers/staff which in return is showing outcomes of direct service providers/staff beginning to communicate and collaborate with each other in their own communities. This is a big plus for children and families when system work closer together is supporting the youth and family with their needs and resources; many creative ideas/resources and treatment plans have come from this work.

KDADS has developed and facilitates an Advisory Work Group. The group's intention is to provide continued mental health quality of care for children in DCF Out-of-Home and JJA Placement. The members of the group are not only state department staff but include Community Mental Health Centers (CMHC) Community Based Services Directors, foster care contractors, Managed Care Organization and JJA and court representatives. Purpose of the group: Kansas provides an array of community based mental health services statewide for children and adolescents. Community based services are designed to benefit the child/adolescent in their home, school and community. Community based services are effective in supporting both the child and the family and decreasing the need for institutional care. Collaboration among other child services systems which a child may be involved in is essential to the wellbeing of the child. This group will look at increasing continued quality of care and responsive mental health services for children in DCF Out-of-Home and JJA placement. This group has developed and implemented a Universal Referral Packet which all Community Mental Health Centers, foster care contractors and JJA provider staff have approved and are now using. CMHC have provide a list of liaison contacts and information to foster care and JJA staff, JJA and foster care providers have developed liaisons in their arena and have provided that information to CMHC staff. This has supported a simple and effective way to make sure that information and communication are going to the staff who can implement the needed services.

Kansas Permanency Roundtables (PRT) - "*BREAKING BARRIERS, BUILDING FUTURES*" is a program that DCF has implemented which supports their efforts in gaining permanency for all youth in state custody. PRT models what "true collaboration" and "system integration" should look like. This brings a team together from many systems to support the case workers efforts in gaining permanency for a child. It is the opportunity to brainstorm without blame of one system or the other at fault; very well facilitated. Many different resources and action plans come from

these PRT’s to support staff working for the best interest of the child. KDADS staff provides support at these PRT by being the Mental Health Specialist on the team.

SUD treatment providers are not currently required to provide evidence based approaches in treatment services provided to youth. With the integration of SUD and MH to Behavioral Health Services, it is hoped that staff can begin to examine how this can be accomplished.

The Kansas Prevention infrastructure will provide training in evidence-based prevention strategies (EBS) to children/adolescents and their families through two primary processes: training and technical assistance provided to local coalitions and prevention partnerships to support the SPF process and the creation of local strategic plans inclusive of EBS, and follow-up access to resource to ensure training of trainers/implementers for high-fidelity delivery of services and programs. Secondly, Kansas will require that communities receiving SAPT Block Grant funds develop comprehensive plans that engage a wide range of stakeholders across behavioral health-related organizations and service providers, to ensure that strategic plans reflect and allow for delivery of services across the continuum of care (i.e., universal, selected, and indicated), allow for collaboration and referral for at-risk children and youth and their families to reduce the challenge of individuals “slipping through the cracks,” and provide evidence-based strategies that impact shared outcomes across shared risk and protective factors for both prevention and behavioral health overall. While this process will be iterative and incremental, as it reflects a policy and systems-level shift in allocations of SAPT Block Grant funding for prevention, preliminary efforts are already underway, and as the State Epidemiological Outcomes Workgroup acquires greater access to behavioral health data, this information can be better infused into local level assessment and planning efforts.

Below is a chart which shows the practices that Kansas is implementing to provide training on EBP in the mental health and recovery services for children and families.

Emerging, Promising and Evidenced Based Practices in Kansas

Training Provided or in Process –provided to CMHC staff	Practice	State Trainers	Description
Home Based Family Therapy	EBP-Functional Family Therapy & Multi-Systemic Therapy (widely known and well established EBP nationally)	K-State has developed a training with components of both practices-offered during each FY to clinicians who do in-home family therapy	Functional Family Therapy has been applied to work with families with a youth who is at risk for delinquency, violent behaviors and drug use. Multisystem therapy has guided work with youth exhibiting antisocial behaviors and substance abuse. Four components of HBFT: <ul style="list-style-type: none"> • Family Issues • Therapeutic Skills

			<ul style="list-style-type: none"> • Therapists Self-Care • Supervision <p>HBFT also provides ongoing mentoring/coaching and numerous continuing education credits that focus on ethical issues and DSM information that is unique to HBFT providers.</p>
Positive Behavioral Supports	Nationally - EBP	KU – different levels of support and training are now being offered to CMHC	PBS is a set of tools and processes for organizing the physical, educational, biomedical and logistical supports needed to achieve basic lifestyle goals for individuals while reducing problem behaviors that pose barriers to these goals.
Parent Support Training	Based on Emerging Best Practice in children’s mental health systems of care.	KU Children’s Research Team – Currently conducting a multi-site study to build stronger evidence that high fidelity to the PST Practice Protocol results in increased home stability for youth who experience SED.	The PST Practice Protocol a research based, Kansas developed model of family engagement for Community-Based Children’s Mental Health Treatment Teams.
Training Provided or in Process –provided to CMHC staff	Practice	State Trainers	Description
Wraparound	Promising Practice & Best Practice with high fidelity (some states classify as EBP with use of full fidelity system); NWI model under review by SAMSHA for National Registry of Evidence-Based Programs & Practices	KU Children’s Research Team – 1 to 2 pilot site will be developed in this FY to help support the development of a Wraparound Curriculum to be used for the required state training for Wraparound Facilitators	Wraparound is a team-based planning process and service delivery model intended to provide coordinated, holistic, family-driven care to meet the complex needs of youth who are involved with multiple systems, at risk of placement in institutional settings, and/or experiencing serious emotional or behavioral difficulties. Wraparound provides an “on the ground” mechanism for ensuring that core system of care

			values will guide planning and produce individualized, family-driven and youth-guided support that is community based and culturally competent.
Family Care Treatment	Based on EBP Oregon Social Learning Center's Multidimensional Treatment Foster Care	KU Life Span Institute at Parsons	Family Care Treatment provides parents of children with challenging behavior with behavioral assessment, individualized behavioral strategies and in-home direct instruction on treatment implementation.
Shared Decision Making (Journey's Program)	Based on Emerging Best Practices in adult behavioral healthcare	KU Children's Research Team	Journey's is a program designed to support shared decision making and collaboration among families and providers regarding psychiatric medication.
Strengths Based Case Management	Based on Emerging Practice in adult behavioral healthcare	KU Adult/Children Research Teams will begin work on development and implementation of strengths-based case management training curriculum and field mentoring/coaching criteria to CBS case management providers.	Strengths Model is both a philosophy of practice and a set of tools and methods designed to enhance recovery.
Training Provided or in Process –provided to CMHC staff	Practice	State Trainers	Description
Trauma Informed Care	Incorporate an EBP (FY 14)	K-State in the coming FY will begin working on providing an EBP in this area for training clinicians.	New Program in development (FY14)

For SUD treatment services, the contracted ASO is required to submit weekly, semi-monthly or monthly reports that include an accumulator (providers allocations and utilization), claims payment (to providers) timeliness and accuracy, weekly claims report, check register, and independent audited financial statements. BHS staff is able to track utilization and length of stay

from data collected from the KCPC (AAPS integrated data system) and claims data of youth in the SUD treatment programs. Other data is also collected and reviewed on a regular basis. This includes gender, age, co-occurring, drug of choice, and race. This data is distributed to providers at quarterly provider meetings.

Population-level prevention outcomes related to prevalence outcomes and risk/protective factor outcomes will be tracked utilizing epidemiological indicators and Kansas Communities That Care (KCTC) student survey data. In those communities implementing individual prevention strategies (in addition to environmental approaches), evaluation plans at the local level will require the collection and submission of program and participant level data using a unique identifier code that protects the confidentiality of individuals taking part in the program or services. In combination, this will allow for outcomes-based evaluation of short-term indicators (e.g., participant level data, program level data, process evaluation indicators, fidelity implementation indicators, systems-change, service provision, and community prevention development indicators), as well as intermediate indicators (e.g., shifts in prioritized local risk and protective factors), and long-term indicators (e.g., prevention prevalence outcomes and improvements in behavioral health indices).

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

Section P. Tribal Consultation

There are four federally recognized tribes in Kansas. All four are located in the Northeastern part of the State.

Iowa Tribe of Kansas and Nebraska

Kickapoo Tribe of Kansas

Prairie Band and Potawatomi Nation

Sac and Fox Nation

In 2012 there was a major reorganization of State agencies which included Kansas Behavioral Health and Disability Services moving to the newly formed Kansas Department for Aging and Disability Services. The Division of Community Services and Programs was also formed at this time and the integration of Mental Health and Addiction and Prevention Services occurred under this Division. With the major changes that have occurred at not only the State level but the ongoing changes at the Federal level, no actions have taken place to obtain tribal consultation. Behavioral Health Services has made minimal contact with the Tribal Nations and has some interaction at the service level. Tribal Consultation at the official level has not taken place. Technical assistance was requested in the 2011/2013 SAPT BG application and the need was discussed with the Federal project officer.

Kansas needs education and direction in this area to ensure we are meeting Federal rules and regulations. We are again requesting Technical Assistance from SAMHSA in this area.

Section P. Tribal Consultation Revision

BHS staff spoke with Laura Howard, SAMHSA Regional Representative, regarding Tribal Consultation. The following outlines a tentative plan to move this initiative forward:

1. Contact the Tribal Technical Advisory Group to inquire about regular attendance at this meeting. This group focuses on Medicaid and the new KanCare Medicaid initiative in Kansas.
2. Contact Chris Howe, the Governor's Tribal Liaison, requesting help planning an annual meeting. This meeting would include upper level KDADS and/or BHS staff and representatives from each tribe. The meeting might be held in June and July. Ms. Howard suggested the following as a beginning agenda:
 - *Brief overview of the behavioral health system and the block grant.
 - *Data presentation
 - *Discussion of tribal behavioral health issues
 - *Next steps and opportunities for collaboration
3. Meet with BHS management team to discuss the possibility of including tribal representation on the Governor's Behavioral Health Planning Council and/or the Kansas Citizens Committee.
4. Ms. Howard will provide more information about the Federal Tribal Technical Assistance Center. This information will be passed on to the tribal representatives.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Section Q. Data and Information Technology

Update of state's progress since the FY 2012/2013 Block Grant application:

The most significant changes occurring since our previous SABG and MHBG applications have been associated with the continuing integration of SUD Treatment and MH Service units into a single Behavioral Health Services Division. While alignment to date has focused primarily on the administrative functions at the state level and key functions and responsibilities of BHS staff are currently being reviewed to support this objective, it has opened the way to establishing mechanisms for the development of a unified and cohesive behavioral health data reporting system. For the purposes of this section of our first combined application, we will detail the progress made within each distinct system on objectives outlined in our separately filed 2012/13 SABG and MHBG Behavioral Health Assessment and Plans.

SUD Treatment

The current AAPS system (KCPC) is designed and written in FoxPro, which is an end-of-life software tool. FoxPro is scheduled to be phased out by Microsoft in the year 2015. When this occurs the agency will no longer have Microsoft updates/support for the AAPS Integrated Data System. Additionally support staff for upgrades and maintenance has been severely reduced which puts current processing at risk.

The workflows and business requirements for AAPS and licensing for the divisions of DBHS (now BHS) have been documented in preparation of future conversion.

In July 2012 AAPS was integrated both with Mental Health and then into the Department of Aging. With this move, the Kansas Department for Aging and Disability Services (KDADS) was formed. As a result of the integration with Aging, new technology became available for developing a replacement system. The Information Technology section of KDADS has begun working with program staff to develop the replacement for the AAPS Integrated Data System using Oracle APEX framework.

The new AAPS system will be written and integrated with two existing proven web based applications. It will include a licensing maintenance, certification and survey system and an assessment and Plan of Care system. These systems provide many of the functional attributes identified in the business requirements which include real time processing, role-based security, and ad hoc reporting as well as the items listed above.

The scope of the project is to convert the KCPC and Facility Maintenance systems which will include the existing functionality and provide additional enhancements based on functionality in the already existing systems. A future proposed enhancement will be an interface between the providers and the KDADS system.

A majority of the SUD treatment providers in the State have already begun to adopt systems for electronic health records. The Standards for the Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs are currently under revision and include language that will ensure they are using systems they protect client's privacy. This revision includes the following language regarding Electronic Health Records and has been shared with providers who are in the process of purchasing a system:

R03-503. Electronic Health Records

A. If the licensee utilizes an electronic health record they shall develop, implement, and comply with policies that protect the privacy and security of the electronic health record by:

1. Identifying who is responsible for the backup of data, what data will be backed up, when backup of data will occur, and how the back up of data happens,
2. Defining/describing the type of encryption used for data traversing the Internet.
3. Monitoring and auditing electronic transmission of data,
4. Designating a staff person to monitor and audit electronic transmission of data,
5. Defining what specific information can be viewed and entered by every staff member with access to the data,
6. Addressing client approval to share data via the electronic health record,
7. Addressing a process for submitting corrections to the electronic health record,
8. Allowing for notification to clients in the case of a data release or security breach which exposes client data, and
9. Addressing a tracking/monitoring process and periodic review of the electronic health record access.

B. If the licensee utilizes electronic signature pads, they shall develop, implement, and comply with policies for the use of the electronic signature pads. The policy shall include:

A procedure for:

1. Assuring that each individual client shall sign the signature pad each time his/her signature is used.
 2. Verifying the identification of the person making the signature,
 3. Assuring the signature is under the sole control of the person using it, and
- Affirming the signature is linked to the data in such a manner that if the

data is changed, the signature is invalidated.

4. A statement to indicate the signer's approval of the information contained in the document.

BHS/SUD staff develops and implements all policy regarding SAPT and Medicaid substance use disorders treatment. As a result all Medicaid SUD providers are required to use the current AAPS data system. Included in the data system are modalities of care and other billable services that if approved, each provider is eligible to use for reimbursement. Clients are associated with funding sources and the contracted managed care entity ensures the proper reimbursement mechanism is used for each client served. No barriers have been identified as Kansas already utilizes an encounter based system.

We would like to explore the possibilities for the development of a better unique client identifier. The current system utilizes an algorithm utilizing the first and last name and birthdate. The current data system also develops a unique treatment episode identifier. We would like to explore other possible solutions for a unique treatment episode identifier. We continue to explore how the data system will work at the most efficient level for the clients and the treatment programs, but still be in compliance with 42 CFR, part 2.

Mental Health

Description of plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data

Participation in the Mental Health Client-Level Data Pilot Project provided Kansas the opportunity to be at the forefront of this new SAMHSA Mental Health Initiative. Working with SAMSHA's technical contractor, the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI), Kansas received critical technical assistance for the assembly and analysis of the Kansas public mental health client-level data file. Federal reporting of Mental Health information historically produced in aggregate form through the Unified Reporting System is now assembled and provided at the client level.

List and briefly describe all unique information technology systems maintained and/or utilized by the state agency

To enhance our capacity to provide unique client-level data for all individuals served within the Kansas public mental health system, BHS maintains several information management systems. The Automated Information Management System (AIMS) is the primary decision support tool for planning and quality improvement at the state level. Client-level admission, assessment, and discharge information is collect on all individuals receiving public mental health services, regardless of insurance type or payment source. Information on the type, frequency and duration

of mental health services provided by the CMHC is collected at the client-level for individuals in our targeted population. This at-risk population includes adults with a severe and persistent mental illness (SPMI) who are enrolled in community support services and children and youth with a serious emotional disturbance (SED) enrolled in community-based services.

In addition, BHS has established viable connectivity with a variety of unique information management systems that enhance and inform the decision-making process at all levels of our public mental health system. Information about each of these systems is outlined below.

State Mental Health Hospitals (SMHH)

One of the key systems used in conjunction with the AIMS is the statewide inpatient hospital database. Each of the three state-operated mental health hospitals in Kansas provides BHS with a monthly file containing data in a standardized format. These separate files are combined to provide statewide reporting, expanding our capacity for tracking and reporting of the mental health population.

State Alternatives to Mental Health Hospitals for Youth

Since 2006, BHS has provided an alternative to state-operated inpatient mental health treatment for youth under age 18 through a contract with KVC Health Systems, Inc. KVC inpatient facilities provide BHS with client-level data in a standardized format that is merged with AIMS and adult (SMHH) data, expanding our capacity for tracking and reporting of the mental health population of youth receiving state-contracted inpatient treatment.

State Mental Health Managed Care System:

From July, 2007 to December, 2012, Kansas provided a Medicaid Managed Care Plan for outpatient mental health services. During this time, BHS received regular monthly extracts of Medicaid claims information, greatly enhancing our ability to monitor and track expenditures and forecast trends in the Medicaid Managed Care population. As a claims processing system, the Mental Health Managed Care data collects and stores unique provider identification required for submitting claims for Medicaid services. In addition, this provides the ability to aggregate services and other information by unique provider. The Mental Health Managed Care system provides client-level data in the form of encounters and claims that include information on individual date of service, type of service, service quantity, and identity of individual provider. On January 1st, 2013, Kansas implemented a section 1115(a) Medicaid demonstration project called KanCare. From a systems development stand-point, BHS continues to be intricately involved in the design and implementation of this large-scale project, ensuring noticeable and effective representation for the individuals served through the Kansas public mental health system.

Additional Administrative Data Systems utilized by BHS

BHS has established or pending agreements with various state agencies and contractors for the exchange of client level data for distinct populations that provides critical information to our shared decision-making process, including:

Information about children and youth during treatment at all state-licensed Psychiatric Residential Treatment Facilities (PRTF).

Results from all Inpatient Screening Assessments performed by our Community Mental Health Centers, including determinations, type and frequency.

Detailed assessments of individuals residing in Kansas Nursing Homes for Mental Health (NFMH).

Information about children with mental health needs who have been placed in state custody and removed from their family home.

Provide information regarding current efforts to assist providers with developing and using EHRs

As part of the current Kansas Data Infrastructure Grant (DIG), BHS has initiated processes designed to improve our current IT system. The primary focus of this effort is to address issues related to data interoperability. Although BHS does not have funding to create a statewide health information exchange, over the past several years, we have assisted 24 of the 27 CMHCs in transitioning to shared data systems. This consolidation of vendor services has allowed the CMHCs to maintain consistency, implement timely system modifications, and reduce costs. This has positioned them for standardized development of Electronic Health Records. The remaining centers operate within a county-structured system or maintain a proprietary system.

Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment

To track and report MHBG expenditures by service through an encounter/claims based approach would require extensive modifications to the CMHCs' claims systems and the AIMS. Given severe limitations placed on the state's mental health budget over the past several years, such changes would not be feasible without considerable support from state and federal governments to support this effort.

Although the AIMS system collects information about the client's specific insurance coverage associated with the mental health services they have received, CMHCs in Kansas have not historically been required to provide AIMS with detail of the separate funding streams they utilizes to pay for distinct mental health services for individuals not covered by Medicaid or other government or private insurance.

To provide this information for Kansas 2013 MH Block Grant Table 5 MHBG Expenditures By Service, BHS required each CMHC to identify and report on the area(s) within their organizations in which Block Grant funds were expended. For SFY2014, each CMHC is required to provide additional information to further identify the number of individuals and services purchased by Block Grant funds. Specifically, for each service purchased with MHBG funds during FY2014, the CMHC will report the anticipated number of uninsured/underinsured clients who will benefit, number of service hours (if applicable) and how expenditures are tracked. CMHCs will submit quarterly reports to the BHS Community Mental Health Quality Improvement Field Staff for monitoring.

Identify the specific technical assistance needs the state may have regarding data and information technology

BHS is in the process of developing solutions for the following priority areas identified in our current Kansas DIG grant:

Establishment of a client identifier for AIMS that remains viable across service delivery systems

Implementation of an efficient process for a systematic closure of inactive client records in the AIMS system

Provide a secure, readily accessible web-based system that allows the Community Mental Health Centers (CMHC) to share appropriate client level information

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Section R. Quality Improvement Plan

KDADS is still in the process of integrating the Mental Health unit and Substance Use Disorders unit into Behavioral Health Services. Attached is our first draft of the Kansas Behavioral Health Comprehensive Quality Improvement Plan. It includes the following:

SUD Treatment

Standards of Care/Licensure:

By Statute all programs providing substance use disorder treatment must be licensed by KDADS/BHS. KDADS/BHS has regulations in place “Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs.” The minimum standards of care for substance use disorder treatment programs in Kansas are contained in Standards for Licensure/Certification of Alcohol and Other Drug Abuse Treatment Programs (as authorized by KSA 39-708c and 65-4016). The minimum standards include requirements for Program Management; Clinical Program Staffing; Quality Improvement Systems; Accessibility, Environment and Transportation; General Program Standards; Alcohol and Other Drug Treatment Services; Licensure/Certification.

KDADS/BHS monitors providers at on-site visits. The frequencies of the visits are based on provider performance. Programs that have no major deficiencies for two years in a row may be eligible for up to a three year license. Currently, approximately less than 20% of Kansas providers receive a three year license. If any deficiencies are noted during a site visit, providers are required to submit a corrective action plan within 30 days and have all deficiencies corrected/implemented within 90 days. KDADS/BHS has policies and protocols which outline the licensure/certification and the corrective action plan processes. Additionally, KDADS/BHS collects and compiles all site visits data, including deficiencies, for the purpose of trending, reporting purposes, and continuous quality improvement. The data reports are shared at quarterly provider meetings and KDADS/BHS staff in order to improve inter-rater reliability. This process supports a continuous internal and external quality improvement process.

KDADS/BHS plans to make revisions to the standards to include requirements for the licensure of addiction counselors, Women’s specialized services, criminal background checks for staff, Electronic Health Records, and electronic counseling (telemedicine).

Documentation:

Standards of Care

Policy and Procedures

Monitoring tool and reports

Corrective Action forms

SAPT BG Monitoring:

KDADS/BHS contracts with ValueOptions of Kansas (VO/KS), who is an Administrative Service Organization, for the oversight and administration of SAPT BG funds used for treatment services. KDADS/BHS requires VO/KS to include all of the SAPT BG requirements in the provider agreements. KDADS/BHS has protocol and a monitoring tool that is used in conjunction with a tool utilized for the licensure of the treatment programs. KDADS/BHS staff

is currently conducting SAPT BG monitoring site visits for FY2013. If a program has any SAPT BG deficiency, the program is required to complete a Performance Improvement Plan. The Performance Improvement Plans are monitored by VO/KS to ensure compliance and implementation. KDADS/BHS collects and compiles all deficiencies from the SAPT BG site visits for the purpose of trending, reporting, and continuous quality improvement. Training and technical assistance will be provided as needed to any provider identified. KDADS completes these on-site monitoring visits with all SAPT BG funded providers every other year. The alternate year BHS develops a State quality improvement plan and technical strategies. The quality improvement plan addresses corrections that BHS, the treatment program, or the ASO needs to take in order to improve compliance to the federal regulations. These are implemented and corrections made prior to the compliance visits in the next year.

Documentation:

Policy and Protocol

Monitoring tool

Performance Improvement Plan

Fiscal Monitoring:

KDADS/BHS has two levels of fiscal monitoring; one for the administrative care organization and the other with the SUD providers.

KDADS/BHS requires the inclusion of language in the Administrative Service Organization contracts with providers regarding the submission of fiscal audits to KDADS/BHS.

KDADS/BHS requires any non-federal entity that expends \$500,000 or more in a year of Federal awards must have a program specific audit conducted for that year in accordance with the provisions of OMB Circular A-133. In addition to the requirements of the A-133 audit, the provider may be required to conduct a separate limited scope engagement with an agreed upon procedure. These additional procedures will be designated in the terms and conditions of the award.

For entities that do not fall under the audit requirements (expend less than \$500,000 in a year in Federal awards or State awards or expend more than \$500,000 in State awards) the provider shall have a limited scope engagement with agreed-upon procedures and/or be subject to internal monitoring performed by KDADS/BHS staff determined at the time of the negotiation of the award.

The contracted ASO for SUD treatment services is required to submit claims data to a designated BHS staff person. This person matches this information against data obtained through our KCPC system which collects the number of units requested by the provider and approved by the ASO. This data is also matched against the MMIS system to ensure the clients were not eligible in the Medicaid system, while receiving services. If SAPT BG dollars were utilized the provider is expected to re-pay the monies paid.

Documentation:

Policy

Contract Language

Reports

Monitoring of the Administrative Care Organization:

KDADS/BHS has multiple quality improvement processes in place to measure, evaluate and provide oversight on the Administrative Services Organization, ValueOptions of Kansas.

The contracted ASO is required to submit weekly, semi-monthly or monthly reports that include an accumulator (providers allocations and utilization), claims payment (to providers) timeliness and accuracy, weekly claims report, check register, and independent audited financial statements. KDADS staff is assigned to monitor compliance with the reports to ensure the report was received by the due date, the correct methodology is used, and the benchmark, if applicable, was met. KDADS staff is assigned to monitor for compliance and report any discrepancies to the staff assigned to oversee the contract. Monthly meetings are held internally with the assigned staff. Pertinent issues are discussed at these meetings and any joint decisions are made concerning the ASO or the provider network.

The Administrative Service Organization, ValueOptions of Kansas, and KDADS/BHS staff meets monthly for business meetings. The purpose of the meeting is to discuss ongoing business issues associated with the management and monitoring of the program. Topics include reporting and accountability concerning member or provider issues; claims processing or payment issues; or any contractual, system, clinical, financial, coordination, training, or other issues associated with programs. ValueOptions of Kansas takes minutes for the purpose of reference and shared decision making. Additionally, KDADS has a monthly internal contract meeting which discusses any “hot topics”, areas of concern, provider performance issues and performance improvement.

Documentation:

Monitoring Work plan for Performance Measures
Reports
Meeting notes

Quality Improvement Monitoring Work plan for Performance Measures:

KDADS/BHS requires the Administrative Care Organization (ValueOptions of Kansas) to submit the following reports:

- Appointment Access (Referral timeframes) Quarterly and Annually
- Problem Gambling Access to Care Quarterly and Annually
- SAPT Waitlist Report Quarterly and Annually
- AAPS Admissions Outside of Region (Block Grant Access) Quarterly and Annually
- Designated Women’s Facilities Quarterly and Annually
- Interim Services Report Quarterly and Annually
- Out of State Placement Quarterly and Annually
- Higher Levels of Care Utilization Report Quarterly and Annually
- Lower levels of Care Utilization Report Quarterly and Annually
- Over and Under Utilization Report (Average Length of Stay) Quarterly and Annually
- Grievance Report Annual

- Appeals Report Semi Annual, Annual
- Adverse Incident Report Semi Annual, Annual
- Claims Payment Timelines & Accuracy Report Monthly
- Provider Satisfaction Survey Annual
- Provider Report Card Annual

Documentation:

Monitoring Work plan for Performance Measures Reports

Quality Committee of Kansas:

KDADS/BHS has implemented a state SUD quality committee. The Quality Committee consists of State staff, providers (including quality directors representing large and small providers across the state), and a consumer. The committee is overseen by the Clinical Services Coordinator, is data driven and reviews and makes recommendations on reports prepared by state staff and the administrative care organization. The Quality Committee may request additional data reports or more in-depth reviews of SUD topics which may be of interest to the committee. KDADS/BHS is responsible for sharing reports generated by the Administrative Care Organization for review, gathering feedback, and identifying possible performance improvement projects.

Documentation:

Policy and Charter
Aggregate Analysis

Mental Health

Psychiatric Residential Treatment Facilities (PRTFs):

PRTFs provide out of home residential psychiatric treatment to children and adolescents whose mental health needs cannot be effectively and safely met in a community setting. These programs are intended to provide active treatment in a structured therapeutic environment for children and youth with significant functional impairments resulting from an identified mental health diagnosis, substance use diagnosis, sexual abuse disorders, and/or mental health diagnosis with co-occurring disorder (i.e., substance related disorders, intellectual/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues).

Documentation:

Standards
Interpretative Guidelines

Private Psychiatric Hospitals (PPHs):

PPHs are “free-standing” community hospitals that provide only acute inpatient psychiatric services.

Documentation:

Guidelines

Residential Care Facilities (RCFs):

RCFs provide housing and needed supports to persons with serious and persistent mental illness that cannot find their own housing and who need staff support to live successfully in the community. KDADS licenses RCFs, but does not provide them any direct financial support. However, due to a serious incident occurring in a facility that refused to be licensed, the legislature changed the statute requiring more facilities to be licensed. KDADS is currently writing regulations to comply with this statute change.

Facilities Quality Improvement Field Staff:

Three Facility Quality Improvement staff, one supervisor, and one Mental Health Nurse hold the 14 Psychiatric Residential Treatment Facilities (PRTFs), the 25 Residential Care Facilities (RCFs), and the three 3 free standing Private Psychiatric Hospitals (PPHs) accountable to basic requirements of health and safety, licensing regulations, and active treatment standards for participating in Medicaid funding. This is done by completing routine and special surveys, investigating critical incidents and serious occurrences, and ensuring the facilities appropriately, timely and successfully address critical incidents and correct substandard care and treatment. The adverse incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices. Providers report all adverse incidents involving individuals receiving services by agencies licensed or funded by KDADS online through the Adverse Incident Report (AIR) web portal within 24 hours of becoming aware of the incident. These reports are assigned to a Facility Quality Improvement Field Staff and are investigated. As a result of the investigation, a prevention plan or performance improvement plan may be required of the provider. All incidents are tracked and trended and each provider has baseline outcome measures to continuously decrease the number and/or type of critical incidents and serious occurrences.

Other outcome measures include length of stays (LOS), restraints and seclusions, family engagement in treatment, recidivism, and quality of life.

Community Mental Health Centers enter into a contract with Behavioral Health Services annually. Performance measures and the process for implementing a performance improvement plan are defined. The following is an excerpt from the SFY13 contract:

Outcome Measures: The CMHC will provide community mental health services to the consumers in the priority target population in a manner that achieves quality outcomes. The following outcomes are the key performance measures of this contract:

- a. The percentage of consumers with an SPMI who improve their vocational status within the reporting period. The CMHC will be assigned a score based on the vocational status of each individual with an SPMI receiving a CSS service within the last 90 days, who can be considered in the workforce. See Attachment 1 for assignment of point values, CSS service code list, determination of service requirement and explanation of vocational statuses considered for this performance measure.

Numerator: Total points achieved by CMHC based on the vocational status of each individual with an SPMI who has received a CSS service within the last 90 days.

Denominator: Total number of individuals with an SPMI receiving a CSS service within the last 90 days, who can be considered in the workforce multiplied by 6 (highest point value possible)

Data Source: AIMS system/Client Status Reports (CSR)

Reported: Monthly by established catchment areas

- b. The percentage of youth with an SED who improve their residential status within the reporting period. The CMHC will be assigned a score based on the residential status of each youth who have received Community Based Services (CBS) within the last 90 days. See Attachment 2 for assignment of point values, CBS service code list, determination of service requirement and explanation of residential statuses considered for this performance measure.

Numerator: Total points achieved by CMHC receiving at least one CBS service within the last 90 days based on the residential status of each youth with an SED.

Denominator: Total number of youth with an SED receiving a CBS service within the last 90 days multiplied by 5 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR)

Reported: Monthly by established catchment area

- c. Percent of screening determinations by the same responsible CMHC resulting in readmissions of adults, age 18 and over, to any SMHH, private psychiatric hospital, local acute psychiatric unit, occurring within 30 days of previous discharge.

Numerator: Number of adults discharged from SMHH, private psychiatric hospital, local acute psychiatric unit with a subsequent readmission occurring within 30 days.

Denominator: Total number of Adult discharges from SMHH, private psychiatric hospital, or local acute psychiatric services occurring within 30 days of reporting period.

Data Source: Inpatient Screening Database (IPS)

Reported: Monthly by responsible CMHC reported in IPS

- d. Percent of screening determinations by the same responsible CMHC resulting in readmissions of youth, age 17 and under, to any SMHH alternative, private psychiatric hospital, local acute psychiatric unit, or PRTF, within 30 and 90 days of previous discharge.

Numerator: Number of youth discharged from SMHH alternative, private psychiatric hospital, local acute psychiatric unit, or PRTF with a subsequent readmission within 30 or 90 days.

Denominator: Total number of Youth discharges from SMHH alternative, private psychiatric hospital, local acute psychiatric unit, or PRTF occurring within 30 or 90 days of reporting period.

Data Source: Inpatient Screening Database (IPS)

Reported: Monthly by responsible CMHC reported in IPS

- 1) Performance Expectations: The CMHC is expected to improve its performance on the outcome measures listed above. Performance improvement planning will be initiated based upon the trend specific to the CMHC for each outcome. Discussion and further study will result if the trend for a given outcome begins to move in a negative direction. A performance improvement plan may be initiated at any time upon agreement between KDADS and the CMHC, but will be developed in the event of a negative trend that persists for 3 consecutive months.

The CMHC will use recognized performance improvement methods to develop and implement a performance improvement plan to improve its performance on the identified outcome(s).

If the CMHC believes that improving performance on the outcome(s) is beyond its control, the CMHC may, within 15 days submit a written request to be exempted from developing and implementing a performance improvement plan. The request will include data to substantiate the reason(s) for requesting the exemption. KDADS will evaluate the request and notify the CMHC in writing within 15 days of receiving the request whether or not the exemption request justified.

KDADS will share available outcomes and trend lines with the CMHC monthly. Mental Health Field Staff will monitor performance and enter into a performance improvement planning process with the CMHC as indicated.

- 2) Data will continue to be collected and reported for the following outcome measures and monitored by the grantee.
 - a. The percentage of consumers with an SPMI who live independently. The CMHC will report the percentage of consumers with an SPMI who are living independently.

Numerator: Number of consumers with an SPMI that have received CSS services in the last six months who are living independently.

Denominator: Total number of consumers with an SPMI that have received CSS services in the last six months.

Data Source: AIMS system (CSR)

Reported: Quarterly by established catchment areas

- b. The percentage of youth with an SED receiving CBS who attend school regularly. The CMHC will report the percentage of youth with an SED received CBS services who are attending school regularly.

Numerator: Number of youth with an SED that have received CBS services within the last six months who are attending school with less than 5 unexcused absences.

Denominator: Total number of youth with an SED that have received CBS services within the last six months.

Data Source: AIMS system (CSR)

Reported: Twice per year by established catchment areas

- c. The per capita number of consumers with an SPMI the CMHC serves.

Numerator: Number of unduplicated consumers with an SPMI that have received CSS services within the last 90 days.

Denominator: Number of persons living in the CMHC catchment area in the adult age range.

Data Source: AIMS system

Reported: Quarterly

- d. The per capita number of youth with an SED the CMHC serves.

Numerator: Number of unduplicated youth with an SED that have received CBS services within the last 90 days.

Denominator: Number of persons living in the CMHC catchment area in the youth age range.

Data Source: AIMS system

Reported: Quarterly

Documentation:

Data reports

Performance Improvement Plans

SUD Prevention

Behavioral Health Services (BHS) Prevention monitors SABG funds on both a fiscal and programmatic level for compliance, effectiveness and timely submission.

BHS/Prevention staff review grantee and contractor invoices and supplemental narratives on a monthly basis. On a quarterly basis grantees are required to submit back up documentation with their invoice to ensure that spending is meeting the grants requirements. Prior to payment all reporting for the month must be submitted or payment will be held. Invoices are reviewed for any abnormal spending and signed off for payment.

The University of Kansas Work Group on Community Health and Development (KU Workgroup) maintains an Online Documentation and Support System (ODSS) where grantees and contractors document actions and accomplishments. By reporting these actions and accomplishments BHS staff is able to monitor and evaluate the progress on implementing

prevention goals and outcomes. These actions and accomplishments are reviewed and scored for reliability on a monthly basis by the KU Workgroup.

BHS Prevention conducts virtual bi-monthly coaching sessions with grantees and contractors. The purpose of the sessions are to provide clarity and guidance concerning deliverables, reporting and progress implementing proposed services and activities. During the sessions, monthly reports are reviewed for accuracy and clarity if needed and any issues pertaining to the documentation of actions and accomplishments reported on the ODSS are reviewed.

Documentation:

Prevention Report and Deliverable Tracking Form

BHS Adverse Incident Reporting

In December 2013, KDADS merged Mental Health, Substance Use Disorder and Community Supports and Programs adverse incident reports into one combined fluid notification, reporting and documentation web based system. KDADS staff developed an agreed upon list of adverse incident definitions and the necessary reporting structure for providers. Next, a database was built to capture all adverse incidents for all licensed and/or certified providers in order to track and trend all adverse incidents. Providers were notified electronically of the new KDADS Community Services and Programs Adverse Incident Protocol and advised of the expectation to follow the new reporting system. The web based reporting system allows for a seamless process of notifying both managed care organizations, administrative care organizations and KDADS field staff about the ongoing status of adverse incidents. The agreed upon definitions are as follows:

1. Preventable death- Any death that occurs as a direct result of the actions (or lack thereof) of any CSP provider that can be reasonably confirmed by the providers or upon medical examination
2. Physical abuse - Any allegation of intentionally or recklessly causing physical harm to a consumer by any other person, while receiving a CSP service.
3. Inappropriate sexual contact - Any allegation of intentional touching of a sexual nature, of any consumer, who does not give consent or is incapable of resisting or declining consent due to mental deficiency, or disease, or fear of retribution or hardship. In addition:
 - a. Consumers receiving services in any KDADS CSP licensed or certified program who are under the age of 18 years of age cannot give consent
 - b. Any allegation of intentional touching of a sexual nature, by a provider, towards a consumer is inappropriate sexual contact
4. Misuse of medications - The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.
5. Psychological abuse - A threat or menacing conduct directed toward an individual that result in or might reasonably be expected to cause emotional distress, mental distress or fear to an individual.

6. Neglect - The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
7. Suicide - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
8. Suicide attempt - A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
9. Serious injury – An unexpected occurrence involving the significant impairment of the physical condition of a consumer. Serious injury specifically includes loss of limb or function.
10. Elopement – The unplanned departure from an inpatient unit or facility where a consumer leaves without prior notification or permission or staff escort.
11. High profile event - Any situation which is likely to result in negative media coverage or involvement of the Kansas Legislators or complaints to the Governor's office.
12. Natural disaster – Any closure or evacuation of a facility due to fire, storm damage or mechanical system failure that may result in major expenditures or work stoppage or any significant event affecting consumers.

An adverse incident is reported if the event occurred while the individual was participating in a KDADS CSP paid service or on any premises owned or operated by a provider or facility licensed by KDADS. Each incident is reported using the KDADS Adverse Incident Report (A.I.R) web based tool at www.aging.ks.gov within 24 hours of the provider becoming aware of the occurrence of the adverse incident.

All reportable adverse incidents are documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports may be reviewed jointly by the KDADS designated quality manager and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS CSP policies and procedures (note procedures may be slightly different depending on provider type).

Documentation:
Policy

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

Section S. Suicide Prevention

With community collaboration and a multi-faceted approach, the Suicide Prevention Subcommittee (SPS) of the Governor's Behavioral Health Services Planning Council (GBHSPC) promotes efforts to create a suicide-free Kansas where quality mental health services are available, trusted, and used when needed, without stigma.

The SPS strongly believes the essential elements for reducing suicide behaviors in Kansas is through 1) informed public policy, 2) education and awareness, 3) promoting access to care and service capacity, and 4) development of a comprehensive state plan based on data-driven strategies as a call for action. Public policy efforts must be centered on facilitating data driven strategies to inform planning and implementation of programs and services. Education and awareness activities shall continue to provide a foundation for conversations to occur at the state and local level to change the way the public talks about suicide and suicide prevention, as well as creating a statewide resource center to promote access to care and build service capacity at the state and local level. Finally, a comprehensive Suicide Prevention State Plan infusing strategies from the National Strategy for Suicide Prevention is needed with clearly defined goals and objectives to pave the way for reducing suicide deaths in Kansas.

As a guide for action, the SPS has begun focusing efforts on the review and update of the 2006 Suicide Prevention Plan to align with the National Strategy for Suicide Prevention. Planning activities are currently underway with a completion date set for May 2014 (please see attached timeline of planning activities).”

Month	Planning Activities	Responsible Party/Entity
April - May 2013	Establish Composition of Leadership Group for Update of Kansas Suicide Prevention Plan	GBHSPC Suicide Prevention Subcommittee (SPS) ad hoc committee including Chair Bill Art & KDADS staff Kelly Potter
June 2013	Review of current Kansas Suicide Prevention plan: Where are we now? <ul style="list-style-type: none"> ● Finalize SPS Charter ● Review SPS Mission ● Review SPS Vision Statement ● Define Values and/or guiding principles ● Review current Kansas Suicide Prevention Plan and Plans from other States ● Review September 2012 National Strategy for Suicide Prevention (NSSP) http://actionallianceforsuicideprevention.org/NSSP ● Gather additional input from SPS members during monthly meeting 	Leadership Group
July 2013	Framing the Issue <ul style="list-style-type: none"> ● Review available census data ● Review available data on suicide deaths and attempts of Kansans ● Review available national data on suicide deaths, and SAMHSA's most current estimates on suicide behaviors by percentage of population ● Review Best Practices Registry http://www.sprc.org/bpr ● Review goals of NSSP ● Prioritize broad suicide prevention goals for Kansas ● Gather additional input from SPS members during monthly meeting ● Gather Constituent Feedback during Kansas Youth Suicide Prevention Summit on July 30-31 in Hays 	Leadership Group
August - October 2013	Draft Roadmap / Strategic Plan Develop Priorities: <ul style="list-style-type: none"> ● Short term goals/objectives/action plans/indicators ● Gather additional input from SPS members & Suicide Prevention Coalitions during monthly meetings 	Leadership Group
November 2013	Draft Plan Review by Suicide Prevention Subcommittee	Leadership Group

December 2013	Finalize working plan for January - June 2014, including <ul style="list-style-type: none"> ● acknowledgement of constituents ● one page summary of highlights 	Suicide Prevention Subcommittee
January 2014	Present Draft Action Plan to GBHSPC	Leadership Group
February - April 2014	Regional Public Forums for additional input <ul style="list-style-type: none"> ● Gather additional input from SPS members during monthly meetings 	Leadership Group
May 2014	Finalize Plan <ul style="list-style-type: none"> ● Gather additional input from SPS members during monthly meetings 	Leadership Group
June 2014	SPS adopts plan and begins monitoring monthly progress	Leadership Group & Suicide Prevention Subcommittee
June 2014	Present Plan to GBHSPC & Secretary's of KDADS & KDHE	Suicide Prevention Subcommittee Co-Chairs
July - December 2014	Implementation of State Plan & Legislative Support SPS continues monitoring monthly progress	GBHSPC Executive Committee & Leadership Group
January - May 2015	To the Legislature SPS continues monitoring monthly progress	GBHSPC Executive Committee & Leadership Group

Mission: To bring Kansans of diverse backgrounds, government and private agencies, health care providers and funders together to share information about suicide attempts and deaths in Kansas, about evidence-based and promising practices that are employed in the state or nationally, and to stimulate and support the adoption of new initiatives where needed to recognize and reduce suicide risk, attempts, and deaths of Kansans.

Vision: To create a suicide-free Kansas, where quality mental health services are available, trusted, and used when needed, without stigma.

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

Section T. Use of Technology

Kansas will be implementing a Health Home model targeted for the SMI population beginning in January 2014. In July 2014, a second target population will be added and will include people with diabetes. The six core service areas, including “use of HIT to link services,” will be integral to model #2, involving a team of health professionals. The KanCare Health Home model will be flexible to accommodate the large rural areas and allow for continuing relationships between community providers in order to improve the health of those participating. Health Homes will be designed to ensure:

- Critical information is shared among providers and with consumers
- Consumers have the tools needed to help manage chronic conditions
- Necessary screenings and tests occur timely
- Unnecessary emergency room visits and hospital stays are avoided
- Community and social supports are in place to help maintain health

KDADS/BHS will have access to data from this initiative and will help evaluate the effectiveness of this model.

Linkage between the Medicaid claims system and AIMS, the state’s outpatient mental health information system, will provide a core dataset for compiling and measuring outcomes designed to evaluate the effectiveness of the KanCare Health Home model at both the provider and individual client level. Specific pay-for-performance incentives for successfully implementing and promoting Health Homes in Kansas have been incorporated into contractual agreements with each of the KanCare Managed Care Organizations.

SUD Treatment

KanCare was launched in January 2013 to administer Kansas Medicaid. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare health plans are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and United Healthcare Community Plan of Kansas (United). As part of KanCare, Behavioral Health Services has had the opportunity for the expansion of additional Medicaid health codes.

Kansas is currently in the process of creating MMIS policy for SBIRT, specifically CPT 99408, H0049 and H0050. Kansas will be able to collect numerous data sets to determine the utilization of SBIRT. Those data sets are at both a practitioner and consumer level. It is anticipated the MMIS Policy will be finalized no later than November 2013.

Kansas is contracting with Wichita State University for the collection of a master list of approved SBIRT Medicaid practitioners. This list will afford Kansas the opportunity of knowing how many SBIRT Practitioners, those practitioners' occupations and their communities of practice. As SBIRT grows, Kansas will be able target outreach efforts thoughtfully to expand capacity. The three managed care organizations will be able to query encounter data. The described data sets will allow the State of Kansas to look at utilization levels and assist in strategic planning for upcoming years.

KDADS/BHS activated telemedicine codes that could be used with all outpatient services, with the exception of Intensive Outpatient. In 2010, AAPS and other stakeholders worked to develop a strategic plan for telemedicine expansion. Primary education about the use of technology was provided to build capacity for tele-health in the future. However, providers have continued to use this service primarily for assessments. No funding was assigned to this project.

The current KDADS/BHS SUD system (KCPC) is designed and written in FoxPro, which is an end-of-life software tool. FoxPro is scheduled to be phased out by Microsoft in the year 2015. When this occurs the agency will no longer have Microsoft updates/support for the AAPS (SUD) Integrated Data System. Additionally support staff for upgrades and maintenance has been severely reduced which puts current processing at risk.

The workflows and business requirements for AAPS and licensing for the divisions of DBHS (now BHS) have been documented in preparation of future conversion.

In July 2012 AAPS was integrated both with Mental Health and then into the Department of Aging. With this move, the Kansas Department for Aging and Disability Services (KDADS) was formed. As a result of the integration with Aging, new technology became available for developing a replacement system. The Information Technology section of KDADS has begun working with program staff to develop the replacement for the AAPS Integrated Data System using Oracle APEX framework. KDADS/BHS has also formed a stakeholder workgroup that consists of providers, representatives from each MCO, BHS clinical staff, and IT staff.

The new AAPS system will be written and integrated with two existing proven web based applications. It will include a licensing maintenance, certification and survey system and an assessment and Plan of Care system. These systems provide many of the functional attributes identified in the business requirements which include real time processing, role-based security, and ad hoc reporting as well as the items listed above.

The scope of the project is to convert the KCPC and Facility Maintenance systems which will include the existing functionality and provide additional enhancements based on functionality in the already existing systems. A future proposed enhancement will be an interface between the providers and the KDADS system.

KDADS requires that all funded SUD treatment providers to utilize the integrated data base, the Kansas Client Placement Criteria (KCPC). This tool includes ASAM II criteria and determines the appropriate level of care and medical necessity. It also collects the required data elements for SAMHSA (TEDS and NOMS). A fee for service is in place and providers must request units of

service through the KCPC system. The request is then reviewed by the ASO. Services must be authorized by the ASO and a claim submitted through their claims system. Encounter data is collected through the KCPC and the ASO's claim system and matched to ensure all claims paid are authorized. KDADS staff and staff from the ASO partner to complete chart reviews to ensure documentation is in place for each service authorized and paid. Performance, gathered from the onsite reviews and Licensing visits conducted by KDADS, staff and utilization are factors when determining allocations for the next year.

KDADS/BHS contracts with an Administrative Service Organization for SUD treatment services. The contracted ASO is required to submit weekly, semi-monthly or monthly reports that include an accumulator (providers allocations and utilization), claims payment (to providers) timeliness and accuracy, weekly claims report, check register, and independent audited financial statements. KDADS staff is assigned to monitor compliance with the reports to ensure the report was received by the due date, the correct methodology is used, and the benchmark, if applicable, was met. KDADS staff is assigned to monitor for compliance and report any discrepancies to the staff assigned to oversee the contract. The data is reviewed, analyzed, and for some reports an aggregate analysis is developed to present at the quarterly Quality Committee. Monthly meetings are held internally with the assigned staff as well as monthly meetings with staff from the ASO. Pertinent issues are discussed at these meetings and any joint decisions are made concerning the ASO or the provider network.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

Section U. Technical Assistance Needs

1. In 2012 there was a major reorganization of State agencies which included Kansas Behavioral Health and Disability Services moving to the newly formed Kansas Department for Aging and Disability Services. The Division of Community Services and Programs was also formed at this time and the integration of Mental Health and Addiction and Prevention Services occurred under this Division. With the major changes that have occurred at not only the State level but the ongoing changes at the Federal level, no actions have taken place to obtain tribal consultation. Behavioral Health Services has made minimal contact with the Tribal Nations and has some interaction at the service level. Tribal Consultation at the official level has not taken place. Technical assistance was requested in the 2011/2013 SAPT BG application and the need was discussed with the Federal project officer.

Kansas needs education and direction in this area to ensure we are meeting Federal rules and regulations. We are again requesting Technical Assistance from SAMHSA in this area and plan to submit this in the TA system.

2. KDADS/BHS is the process of converting our current integrated data system into our new agencies software. We would like to explore the possibilities for the development of a better unique client identifier. The current system utilizes an algorithm utilizing the first and last name and birthdate. The current data system also develops a unique treatment episode identifier. We would like to explore other possible solutions for a unique treatment episode identifier. We continue to explore how the data system will work at the most efficient level for the clients and the treatment programs, and still be in compliance with 42 CFR, part 2. In our workgroup discussions, several areas have been identified that could be in violation of this regulation. We need technical assistance in this area to ensure compliance with Federal regulations. We have already touched base with the assigned Federal project officer and plan to submit this in the TA system.

Technical Assistance (TA) Request Form (PRINTABLE VIEW)

All fields with an asterisk (*) are required to save the form.
 All fields with a pound sign (#) are required to submit the form.

Request Source: KS	Request ID Number: 4185	Request Date: 11/27/2013	Current Status of Request: NA
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Brief History	
Date request first submitted to SPO:	Date Division Director first submitted request to COR:
Date SPO first submitted request to Team Leader:	Date COR submitted request to contractor:
Date Team Leader first submitted request to Branch Chief:	Date request last returned to State:
Date Branch Chief first submitted request to Division Director:	

Section I. Requestor Information

*Center:

Name: Stacy Chamberlain

Title: State Employee BHS Quality Manager

Organization: Kansas Department of Aging and Disability Services Behavioral Health Services

Address: 503 S. Kansas Avenue

City, State, Zip: Topeka, KS 66603

Phone (ext.): 785-296-0649

E-mail Address: STACY.CHAMBERLAIN@KDADS.KS.GOV

State Director Information:

Name: Angela Hagen

Title: State Director

Organization: Kansas Department of Social and Rehabilitation Services Division of Disability and Behavioral Health Services

Address: Docking State Building 915 SW Harrison, 9th Floor South

City, State, Zip: Kansas, KS 66612-1570

Phone (ext.): 785-296-3471

E-mail Address: Angela.Hagen@kdads.ks.gov

*Contact Person Information:

Please select contact person for this request:

State Director Requestor Other

Request Based On (check all that apply):

- Technical review findings/compliance/monitoring visit/recommendations
- Systems development need(s)
- Performance or National Outcome Measures/SAMHSA priorities
- Other (please specify)
- Project officer request/recommendations
- State or grantee initiated request / State or grantee identified service need
- State response to potential/existing court order

*Brief Description: Also, provide a brief description (no more than 200-characters) of the nature of this TA.

You have 33 characters remaining.

KDADS/BHS is requesting TA to review changes being made to the current Inegrated Data System to ensure 42 CFR and other Federal regulations and requirements are met.

Section II. Request Information

#Issue(s) to be Addressed: In a paragraph or two, briefly describe the nature of the issue(s) or problem(s) for which TA is needed.

You have 2122 characters remaining.

The current AAPS system (KCPC) is designed and written in FoxPro, which is an end-of-life software tool. FoxPro is scheduled to be phased out by Microsoft in the year 2015. When this occurs the agency will no longer have Microsoft updates/support for the AAPS Integrated Data System. Additionally support staff for upgrades and maintenance has been severely reduced which puts current processing at risk. Previously, in preparation for this project, IT staff and business members attended several demonstrations of COTS (commercial off- the-shelf) packages. The group also looked at the possibility of in-house development or continuing with the current system without the support from Microsoft. The workflows and business requirements for AAPS and licensing for the divisions of DBHS (now BHS) were documented at this time. With the move to the new agency, KDADS, new technology is now available for developing a replacement system. The Information Technology section of KDADS has begun working with program staff to develop the replacement for the AAPS Integrated Data System using Oracle APEX framework. The new AAPS system will be written and integrated with two existing proven web based applications, KOTA and KAMIS. KOTA is a licensing maintenance, certification and survey system and KAMIS an assessment and Plan of Care system. These systems provide many of the functional attributes identified in the business requirements which include real time processing, role-based security, and adhoc reporting as well as the items listed above. The scope of the project is to convert the KCPC and Facility Maintenance systems which will include the existing functionality and provide additional enhancements based on functionality already existing in KOTA and KAMIS. A future proposed enhancement will be an interface between the providers and the KDADS system.

#Short-term Goals: Describe short-term outcomes you expect the TA to produce.

You have 4000 characters remaining.

1. To review proposed system changes 2. To ensure changes are meeting all Federal rules and regulations

#Long-term Goals: Describe long-term outcomes you expect the TA to produce.

You have 4000 characters remaining.

1. Training is provided to all users 2. New system is implemented

#Followup Actions: Describe the followup activities the State will undertake to ensure the successful implementation of the TA and sustainability of this effort.

You have 3863 characters remaining.

Acceptance and User Testing, training for all Users including State staff and providers, Coordination between State IT and program staff

*Full Description of the TA: Please provide a description(no more than 4000-characters) of the nature and type of assistance you are requesting.

You have 3463 characters remaining.

KDADS/BHS needs consultants to come onsite to review the product (data collection system) to ensure it is meeting all Federal regulations i.e. 42 CFR and HIPPA. An agency system is being developed to convert data from the current system which meets all regulations and data collection requirements. BHS needs to ensure before full implementation that proposed changes will not negatively impact Federal requirements for tracking and reporting data. We also have questions about requirements for record retention versus archiving data.

Type of Assistance Requested (check all that apply to this request):

- We need one or more consultant(s) to come to our State to review an organization, program, or system of care.
- We need one or more consultant(s) to come to our State to provide onsite consultation.
- We need one or more consultant(s) to come to our State to deliver a training, present at a conference, and/or conduct/facilitate a meeting.
- We need one or more consultant(s) to come to our State to develop and/or review a product, such as a set of guidelines, policies and procedures, a compendium, or a curriculum.
- We need one or more consultant(s) to provide telephonic consultation and/or review a product, such as a set of guidelines, policies and procedures, a compendium, or a curriculum, that does not require the consultant(s) to visit our State.
- We need SAMHSA support to help us plan and/or manage one or more training(s), conference(s), and/or meeting(s).
- We need help with a literature search.
- Other (please specify):

Audience for the TA: If applicable, describe the proposed target audience for this TA, including how many participants you expect to be involved in any onsite activities.

You have 1932 characters remaining.

State staff and stakeholder workgroup (approximately 20 individuals)

Organization to Receive the TA: Describe the specific organizations(s) or type(s) of organization(s) you expect to participate in onsite activities.

You have 1934 characters remaining.

KDADS/BHS program staff, KDADS IT staff, treatment providers, MCOs

Resources for the TA: To complete this TA, check the type of support you are requesting from SAMHSA, and indicate if the State or another source will help support this TA. Selecting "Other" indicates that TA-related costs will be covered by training/conference participants or by other organizations. If "Other" is selected, please specify the source of the support in the space provided.

Resources for the TA

Category	SAMHSA	State	Other
Consultant fees	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other consultant expenses (travel, lodging, meals, etc.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel expenses for individuals other than consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lodging expenses for individuals other than consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registration fee for individuals (other than consultants) to attend a conference or meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reproduction of materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparation, mailing, and processing of registration materials for meetings, conferences, or trainings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facility rental costs (e.g., hotel meeting room)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Audiovisual equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refreshment breaks or meals at training events, conferences, or meetings	N/A**	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Per SAMHSA contracting requirements, SAMHSA contracts are not allowed to cover the cost of refreshment breaks or meals at events.

Section III. Consultant Information

Consultant Expertise: What type of consultant expertise do you think will be needed to carry out the TA?

You have 1890 characters remaining.

Knowledge of Federal regulations, any new regulations that may impact SUD treatment (ACA), IT system knowledge

Consultant Suggestions:

Check if you identified any possible consultant(s) who have the type of expertise you need for this TA.

If so, please provide as much information as you can about your suggested consultant(s).

You have 2000 characters remaining.

[Use this link for CEDB instructions.](#)

Consultant Information

Section IV. Event Information

Date, Location, and Participant Information: If there is a specific event or set of events (trainings, conferences, meetings, etc.) for which you need support, please indicate any of the following information you have: the event's date/time frame, location, and total number of participants and number of participants for whom you are seeking SAMHSA support.

Event

Section V. Final Comments

Please elaborate on any of your responses and/or provide any other general comments that would help SAMHSA and its TA contractor process or manage this TA.

You have 3781 characters remaining.

KDADS/BHS moved to a new State agency last year and so all data including MH and DD is eventually being converted to the new agencies system. Having this TA will help facilitate future conversations as we move forward.

Update on TAs

Data System 01/17/14

KDADS staff met with SAMHSA staff via phone on 1/2/14 to discuss the development and implementation of the new data system. KDADS staff gave an overview of the new system and how it would work. Several questions were posed to SAMHSA staff who stated they would check with other staff and follow up with KDADS. SAMHSA has responded and BHS staff will take this information to discuss with the stakeholder workgroup. The projected implementation date of the new system is 10/1/14.

Tribal Consultation 01/24/14

After a conversation with Laura Howard, Regional SAMHSA representative, a decision was made not to submit a technical assistance request to SAMHSA. Laura agreed to meet with KDADS/BHS staff and provide guidance on this topic. The first meeting is scheduled for January 29th. Laura has already sent several documents to be reviewed prior to the meeting. A larger meeting with BHS staff will take place once the information is discussed and a draft implementation plan has been developed.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

June 25, 2013

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Mr. Rose:

Juvenile Services is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the single State authority for mental health and substance use disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency. We are involved and currently partner with KDADS/BHS on the following:

- Community-Based juvenile offender population issues
- Provision of behavioral health services is a preventive strategy to keep youth out of the juvenile justice system
- Member of Governor's Behavioral Health Planning Council
- Systems Collaboration Meetings

We understand the importance of addressing behavioral health prevention treatment and recovery and are committed to continue our support to ensure individuals seeking services for behavioral health issues are provided quality care.

Sincerely,



Randy Bowman
Director of Community-Based Services

RB/kar

Prevention and Protection Services
915 SW Harrison St., Suite 530-E
Topeka, KS 66612



Phone: (785) 296-4653
Fax: (785) 368-8159
www.dcf.ks.gov

Phyllis Gilmore, Secretary

Sam Brownback, Governor

June 19, 2013

To whom it may concern:

Department for Children & Families is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS on the following projects:

- Systems Collaboration Team
- Discharge Planning
- Screening Planning
- Kansas Permanency Roundtables
- Psychotropic Medication Advisory Group

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,

A handwritten signature in black ink, appearing to read "T. McQuin". The signature is fluid and cursive, extending across the width of the page.

Teresa McQuin, Interim Director
Prevention and Protection Services

TM:br

Strong Families Make A Strong Kansas

Economic and Employment Services
915 SW Harrison St., Suite 580-W
Topeka, KS 66612



Phone: (785) 296-3349
Fax: (785) 296-6960
www.dcf.ks.gov

Phyllis Gilmore, Secretary

Sam Brownback, Governor

June 28, 2013

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose:

Kansas Department for Children and Families/Economic Employment Services (DCF/EES) is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders (SUD) Services.

This agency works in collaboration and partnership with KDADS/BHS and is willing to participate and support the priorities of this agency regarding SUD. Currently, DCF/EES is involved through partnership with KDADS/BHS as follows:

- Interagency Agreement for *Solutions Recovery Care Coordination (SRCC) services* to provide assessment and referrals for mandatory adult recipients of Temporary Assistance to Needy Families (TANF) Work Programs. The purpose in providing SRCC services is to assist TANF recipients with SUD through intensive case management with the goal to obtain and retain gainful employment.

Again, DCF supports and understands the importance for TANF recipients to receive quality care for SUD services for prevention, treatment and recovery in order to obtain and retain gainful employment.

Sincerely,

A handwritten signature in black ink, appearing to read "Jaime Rogers".

Jaime Rogers
EES Director

JR/sh

Strong Families Make A Strong Kansas

Rehabilitation Services
915 SW Harrison St., 8th Floor West
Topeka, KS 66612



Phone: (785) 368-7471
Fax: (785) 368-7467
TDD: (785) 368-7478
www.dcf.ks.gov

Phyllis Gilmore, Secretary

Sam Brownback, Governor

June 17, 2013

Michael Donnelly
Department for Children and Families/Vocational Rehabilitation Services
915 SW Harrison, DSOB, 8th Floor
Topeka, Kansas
66612

To whom it may concern:

Vocational Rehabilitation Services is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS in providing supported employment services, particularly the evidence-based practice, Individual Placement and Support, to individuals with severe and persistent mental illness.

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,

A handwritten signature in black ink that reads "Michael Donnelly". The signature is fluid and cursive.

Michael Donnelly
Director
Rehabilitation Services

Strong Families Make A Strong Kansas



Landon State Office Building
900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov/hcf/

Robert Moser, MD, Secretary
Kari Bruffett, Director

Sam Brownback, Governor

July 15, 2013

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose:

The Kansas Department of Health and Environment/Division of Health Care Finance (the Medicaid Single State Authority), is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) in their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration with KDADS/BHS staff and supports the priorities of this agency as it interfaces with the Medicaid program.

This collaboration is demonstrated through several means. A KDHE/DHCF staff member is a member of the Governor's Behavioral Health Services Planning Council. Additionally, we are involved and currently partner with KDADS/BHS on several projects including the Psychotropic Medication Advisory Group.

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continuing this support to ensure individuals seeking services for SUD/MH issues are provided appropriate care.

Sincerely,

Susan Mosier, MD, MBA, FACS
Director of Medicaid Services
LSOB, 900 SW Jackson Street, Suite 900
Topeka, Kansas 66612
785-296-3512



Landon State Office Building
900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov/hcf/

Robert Moser, MD, Secretary

Sam Brownback, Governor

June 18, 2013

Gilbert P. Rose, R.N., M.P.H.
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose:

On behalf of the Kansas Department of Health and Environment – Division of Health Care Finance, I write this letter in support of the Kansas Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS on several substantive projects, including:

- Comprehensive Medicaid managed care program, called KanCare, which was launched on 1.1.13. This program includes nearly all Medicaid services in Kansas, and specifically includes all mental health and substance use disorder services which are administered by KDADS/BHS. As we developed that program, launched it, and now are operating it, we have worked closely with our partners at KDADS/BHS to ensure that their policies and program goals – including prominently those of prevention, treatment and recovery – are incorporated into and reflected in the outcomes of the KanCare program. This includes significant and prominent elements of the SUD/MH programs serving as key components of unique pay for performance measurements, through which up to 5% of MCO payments are withheld unless and until performance targets are met.
- An upcoming new feature of the KanCare program, in the development of which we are working closely with KDADS/BHS staff and their program stakeholders, involves the launching of health homes. In the initial use of that service option, we anticipate that members with serious mental illness will be the first focus of the supports that model achieves, whereby the needs of those members across all service types and settings, with sharp focus on prevention, early intervention, access and recovery, will receive enhanced care management and access support. We are very excited about our partnership with KDADS/BHS on this new and promising service option, and intend to build on successes they have achieved in the administration of their programs and the partnerships they have built with their provider groups, associations and other stakeholders to achieve maximum benefit for these members.

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,

A handwritten signature in black ink, appearing to read "Kari M. Bruffett". The signature is fluid and cursive, with a large, stylized initial "K" and "B".

Kari Bruffett
Director
Division of Health Care Finance
Kansas Department of Health and Environment

Curtis State Office Building
1090 SW Jackson St., Suite 540
Topeka, KS 66612-1367



Phone: 785-296-0461
Fax: 785-368-6388
www.kdheks.gov

Robert Moser, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

June 17, 2013

To Whom It May Concern:

The Kansas Department of Health and Environment, Viral Hepatitis Prevention Program is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS on the following project:

- HCV Advisory Group

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,

Dominique Saunders

Viral Hepatitis Prevention Coordinator | Public Health Educator
Kansas Department of Health and Environment
Bureau of Disease Control and Prevention, STI/HIV Section
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274

June 20, 2013

To whom it may concern:

The Kansas Department of Health and Environment Tuberculosis Control and Prevention Program is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS on the following project:

- Ensuring compliance with SAPT BG regulations for TB control

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,



Phil Griffin. BBA, CPM
Bureau of Disease Control and Prevention Deputy Director
Kansas Tuberculosis Controller

Landon State Office Building
900 SW Jackson, 4th Floor
Topeka, KS 66612



Phone: (785) 296-3317
Fax: (785) 296-0014
Email: kdocpub@doc.ks.gov
www.doc.ks.gov

Ray Roberts, Secretary

Sam Brownback, Governor

June 18, 2013

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose:

The Kansas Department of Corrections is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency. Within our incarcerated inmate population, over 38% are mentally ill and 66% are substance abusers. Of the 66% of the population that are substance abusers, 33% are confirmed addicts of their substance abuse. Therefore, I know only too well the challenges that are faced with this group of individuals.

At this time, we are involved and partner with KDADS/BHS on the following projects:

- Treatment and supervision for DUI offenders
- Justice Reinvestment Initiative work groups

Given the challenges we face within our agency and the overall Kansas public safety community with this specific population, we understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided comprehensive quality care.

Sincerely,

Ray Roberts
Secretary of Corrections

June 17, 2013

Kansas Department of Revenue
Alcoholic Beverage Control
Docking State Office Building
915 SW Harrison
Topeka, KS 66625

To whom it may concern:

Kansas Department of Revenue/Alcoholic Beverage Control is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS in efforts to reduce tobacco consumption by youth and maintain compliance rates for Synar.

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,



Mike Padilla
Chief of Enforcement

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

Section W. State Behavioral Health Advisory Council

Under State statute the Kansas Citizens Committee (KCC) serves as advisory committee to the Secretary of KDADS on issues of substance use disorders (SUD) and prevention. The group makes a formal presentation to the Secretary each year on the state of services and the recommendations as to needs. In the past year the group made recommendations through a White Paper regarding workforce needs in the state especially in the rural and frontier areas. Recommendations also include the expansion of ROSC development and the usage of Peer Mentoring services, and co-occurring services

The State also meets regularly with the Kansas Association of Addictions Professionals (KAAP) the trade association for addiction in Kansas. Input and recommendations are taken in to account. Legislative issues related to SUD and prevention services are reported and mutual support of needs is addressed.

The State also meets regularly with Value Options who is the managed care organization contracted by KDADS to oversee treatment services through the public funding system including SAPT BG funds. These meetings include a review of capacity needs, quality, fiscal, and, clinical concerns.

The Governors Mental Health Services Planning Council (GMHSPC) was changed by statute in the current legislative session to be known as the Governors Behavioral Health Planning Council (GBHSPC). The KCC has been charged to function as a subcommittee of the newly formed GBHSPC but maintains its autonomy as the KCC. The chair of the KCC is a member of the executive council for the GBHSPC.

Webinar sessions with and surveys to stakeholders were provided to gather information regarding needs to be addressed in the combined SUD/MH Block Grant application. The application was posted for public comment and review for a period of 2 weeks prior to submission.

The Governors Mental Health Services Planning Council (GMHSPC) was changed by statute in this legislative session to be known as the Governors Behavioral Health Planning Council (GBHSPC). The following new positions were added to the council: two Substance treatment providers, one Prevention professional, one family member of a person experiencing SUD, two persons in long term recovery from SUD, one person that serves as a Peer mentor for persons experiencing SUD.

Members are actively recruited to make application to the Governor to ensure diversity in membership.

The following is a description of the Councils duties:

DUTIES OF THE COUNCIL

- A. To serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, persons affected by substance use disorders, and other individuals with mental illness or emotional problems.
- B. Confer, advise, and consult with the Secretary of KDADS with respect to the policies governing the management and operation of all state psychiatric hospitals and facilities, community-based mental health services, and substance use disorder treatment and prevention services
- C. Monitor, review, and evaluate, not less than once a year, the allocation and adequacy of mental health services and substance use disorders within the state.
- D. Perform such other planning, reviewing, and evaluating of mental health and substance use disorder services in this state, as may be requested by the Secretary of KDADS or as may be prescribed by law.
- E. Consult with and advise the governor, from time to time, with reference to the management, conduct, and operations of state psychiatric hospitals, community mental health and substance use disorder programs.
- F. A member or members of the Governor's Behavioral Health Services Planning Council, at least once each year, shall visit each state psychiatric hospital and shall visit other providers of community-based mental health and substance use disorder services for the purpose of inspecting the state psychiatric hospitals, mental health centers, or the facility of other such providers of community-based mental health and substance use disorder services, including consumer residence, with their permission. Such visits shall be made at such times and in such manner as the council determines at a regular meeting.
- G. The Governor's Behavioral Health Services Planning Council shall make annual reports to the Governor and members of the Legislature and may make such recommendations as it deems advisable for appropriate legislation.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Jane Adams	Others (Not State employees or providers)	Keys for networking	3926 E Hwy 40 Topeka, KS 66607 PH: 785-233-8732	jadams@keys.org
Denise Baynham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5757 Rowland Kansas City, KS 66104 PH: 913-689-8192	baynhamdenise@yahoo.com
Aaron Bennett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Family Networking Project/NAMI	2436 S Mosley Wichita, KS PH: 316-263-0442	sherri@mmasck.org
Cheri Bledsoe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	SIDE	2004 N 65th Kansas City, KS 66109 PH: 913-787-3507	cheriebledsoe@sbcglobal.net
Roxanne Bollin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		109 N Hospital Drive Paola, KS 66071 PH: 913-731-1158	rbollin@ymail.com
Kathryn Byrnes	Family Members of Individuals in Recovery (to include family members of adults with SMI)		8007 West 99th Terrace Overland Park, KS 66212 PH: 913-206-0543	katherine.byrnes@yahoo.com
Rick Cagan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Executive Director, NAMI KY	Post Office Box 675 Topeka, KS 66601 PH: 785-233-0755	rcagan@nami.org
Wes Cole	Others (Not State employees or providers)		937 Walnut Osawatomie, KS 66064 PH: 913-755-3655	scole@micoks.net
Al Dorsey	Leading State Experts	Kansas Housing Corporation	1000 SW Jackson Topeka, KS PH: 785-296-2262	adorsey@kshousingcorp.org
Brad Luthe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1224 Cramer Wichita, KS 67212 PH: 316-300-9214	sherri@mmasck.org
Kathy McNett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1201 Morton Great Bend, KS 67530 PH: 620-639-1722	imokrightnow@yahoo.com
Rhonda Moreland	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 362, 211 Sante Fe Waverly, KS 66871 PH: 620-412-3772	moreland.rhonda@yahoo.com
Gary Parker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Advisory Council	1150 S Frankin Ave Suite 36 Colby, KS 67701 PH: 785-432-0412	kansascac@sbcglobal.net
Sue Schuster	State Employees	Kansas Department for Aging and Disability Services	503 S Kansas Ave Topeka, KS 66603 PH: 785-291-3090	sue.schuster@aging.ks.gov

Walter Hill	Providers	High Plains Mental Health Center	208 E 7th Street Hays, KS 67601 PH: 785-628-2871	walt@hpmhc.com
Scott Jackson	Providers	Spring River mental Health and Wellness Inc	201 W Walnut Columbus, KS 66725 PH: 620-429-1680	sjackosn@srmhw.org
Michael Leeson	Providers	Kansas Health Solutions	534 S Kansas Ave Ste 510 Topeka, KS 66603 PH: 785-291-9100	michaell@khs-ks.org
Jo Lowe	Family Members of Individuals in Recovery (to include family members of adults with SMI)		504 E Broad Street Colony, KS 66015 PH: 785-383-8988	jg1221@yahoo.com
Fran Seymour-Hunter	State Employees	Kansas Health and Environment	900 SW Jackson ste 900 Topeka, KS 66612 PH: 785-296-2212	fseymorehunter@kdheks.gov
Peg Spencer	State Employees	social and rehabilitative services	915 SE Harrison Topeka, KS 66612 PH: 785-368-8214	peg.spencer@srs.ks.gov
Angela Hagen	State Employees	Kansas Department for Aging and Disability Services	530 South Kansas Avenue Topeka, KS 66612 PH: 785-296-3471 FAX: 785-296-0256	angela.hagen@kdads.ks.gov
Brad Burke	State Employees	Juvenile Justice Authority	714 SW Jackson Suite 300 Topeka, KS 66603 PH: 785-296-4213	bburke@jja.ks.gov
Lee Flamik	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1104 East Florence Rush Center, KS 67575	flamik@gbta.net
Susan Gile	State Employees	DHS/Division of Child and Family Services	915 SW Harrison Suite 5S Topeka, KS 66612 PH: 785-296-5254	susan.gile@srs.ks.gov
Catherine Ramshaw	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1421 SW Hodges Topeka, KS 66614 PH: 785-478-0739	cramshaw1989@yahoo.com
Viola Riggins	State Employees	Kansas Department of Corrections	900 SW Jackson 4th Floor Topeka, KS 66612 PH: 785-296-0460	violar@doc.ks.gov
Charles Bartlett	State Employees	Kansas Department for Aging and Disability Services	503 S. Kansas Topeka, KS 66603 PH: 785-296-6807 FAX: 785-296-7275	Charles.Bartlett@kdads.ks.gov

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	27	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	15	55.56%
State Employees	8	
Providers	3	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="1"/>	
Total State Employees & Providers	12	44.44%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

Section X. Enrollment and provider business practices, including Billing Systems

Kansas is an active SOAR state. All Community Mental Health Centers (CMHC) have trained their staff to assist with benefits application and follow-up (outreach and enrollment) to assure enrollment for individuals served by the CMHC who initially have no source of payment for service. Training programs have been offered annually at various locations around the state in order to accommodate turnover. CMHCs see this as an essential program and are invested in its continuation. All CMHCs have the capability to bill multiple carriers in addition to the three managed care organizations (MCOs) included in the Medicaid program. All have collection agencies with which they work to collect on delinquent accounts. Regulations and other laws require risk management and corporate compliance programs in order for CMHCs to be licensed. In addition, for over a year, CMHCs have been positioning themselves to become partners with our three MCOs to become Health Homes for the SMI population, beginning in January 2014. In doing so they have developed the ability to coordinate benefits among multiple funding sources and have adopted health information technology to meet meaningful use standards.

KDADS/BHS contracts with an Administrative Service Organization, ValueOptions of Kansas, for the administration of the SAPT BG funded treatment services. In order to ensure providers are billing the appropriate funding streams, the following language is included in the SUD treatment provider's contracts with ValueOptions. This language will be expanded to include providers assisting clients to connect with the insurance marketplaces.

2.1 Eligibility Screening

The following contract language seeks to ensure appropriate eligibility screening and protection of limited SAPT BG funds. "The Provider shall use the AAPS funding source as the payor of last resort. To this end, Provider shall conduct eligibility screenings for all Members that present to their location to determine the appropriate funding stream for the Member. Eligibility screenings shall include verification of possible funding through the Kansas Medical Assistance Program (KMAP) prior to admission and a minimum of weekly while the Member is in treatment. When appropriate, this shall include the facilitation of Medicaid enrollment activities, up to and including referral of a Member to a Department for Children and Family Services office and/or a Medicaid enrollment entity.

As part of the eligibility determination, Provider shall obtain proper documentation on each Member for whom an eligibility screening is conducted and place it in the Member file. Documentation must confirm that the member's income and residency meet the most recent KDADS/BHS eligibility guidelines." This section of the contract is meant to address deviations from the standard course of provider practice.

SUD treatment services in the State of Kansas have been fee for service for almost 20 years. The treatment providers have been required to use the KDADS/BHS SUD Integrated Data System. This system includes the following components: facility information system, client information system, data collection for TEDS and NOMS, facility licensing system, grant system, treatment billing system, and State billing payment system. When the system was implemented providers were required to change business practices-moving from a grant system in which there was

minimal accountability, to fee for service where they did not receive payment unless services were authorized and then provided.

In 2007, all SUD treatment services were folded under managed care as a result of the implementation of a 1915 B waiver for Medicaid services. Providers were still required to use the State data system and were now additionally required to use ValueOption's claims system instead of the State billing system. With these changes the majority of SUD providers implemented their own Electronic Health Record and become more technologically savvy. Included in the ValueOptions contract is the requirement to coordinate benefits among multiple funding sources. Since July 1, 2007, ValueOptions has coordinated over \$400,000 of benefits with other insurance carriers, with an estimated savings of more than \$234,000 to the block grant program.

In January 2013, the Kansas Medicaid system again underwent a change, and an 1115 waiver was obtained from CMS. All Medicaid services were contracted to three managed care organizations (MCOs) contracted to provide Medicaid services. In addition to billing with the multiple managed care organizations, all publically funded SUD providers have the capability to bill multiple insurance carriers.

In addition, some SUD treatment providers have begun partnering with medical practices, FQHC's, and other primary health care providers to identify and treat individuals who present with substance abuse issues. Through this process they have developed the ability to coordinate benefits among multiple funding sources and have adopted health information technology to meet meaningful use standards. These providers have also been integral in the discussions regarding SBIRT and Health Homes.

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IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Section Y. Comment on State Plan

Feedback Process for the 2014/2015 Combined MH and SAPT Block Grant Application

Providing opportunities for acquiring and integrating feedback into the combined Substance Abuse Prevention and Treatment and Mental Health Block Grant has been in progress throughout the last several months. Our approach to integrating feedback was two pronged; Reports of the Governor's Behavioral Health Services Planning Council (GBHSPC) sub-committees were reviewed and a content analysis was conducted to help identify common or consistent themes, additionally, a series of three webinars interactive webinars were offered to all BHS stakeholders, consumers, and vendors.

Content analysis was completed by reviewing sub-committee reports, developing a set of the most common themes, elements or key words presented, conducting a frequency count of the number of times the themes, concepts or elements occurred, and in conclusion summarizing the results. That summary is included below.

Summary

An analysis of the emergent themes and elements from the Behavioral Health Planning Council's subcommittees' reports was conducted to determine the key observations and identified needs. The most common findings across the subcommittees included (in order of frequency):

- ***workforce and provider needs*** (e.g., consistency in services, standardized training, increased capacity, increased staffing)
- ***need for tools, training and subject matter expertise***
- ***need for increased collaboration, partnership, integration, and service and supports wraparound across systems and providers to ensure continuity of care***
- ***the importance of stakeholder involvement***
- ***inclusivity and broad-based multi-sector participation***
- ***need for increased or enhanced availability and accessibility of services***
- ***need for the increased utilization and adoption of best practices***
- ***promising approaches, model programs, and evidence-based strategies***
- ***the importance of community-driven and community-based efforts***
- ***funding and resource acquisition***

- *activities centering around increasing awareness, promotion of issues and information dissemination*
- *need for ongoing research*
- *need for data collection, utilization and gaps analysis*

In addition to the content analysis, opportunities to glean further stakeholder, consumer, and vendor feedback were provided by hosting three virtual reflection and feedback sessions. A Summary of that process is outlined below.

Behavioral Health Providers/Stakeholders Reflection and Feedback Session 1:

Providers and consumers across prevention, treatment, and mental health were invited to participate in a feedback and reflection session designed to identify gaps in services and behavioral health needs for consideration for BHS strategic planning and SAPTBG development. Representatives of providers and consumers across the state and from prevention, treatment, and mental health were in attendance during a 90 minute web-based reflection session. This session provided a structured feedback opportunity, during which a facilitated discussion took place, and responses were collected and compiled as close to verbatim as possible in response to reflection questions that included:

1. *What are we doing well that must be sustained?*
2. *What are the primary needs to be addressed by BHS?*
3. *Where do people fall through the cracks?*
4. *What gaps exist in services or supports?*
5. *What one thing would make the biggest difference in serving the needs of our target populations?*

The responses to these reflection questions were compiled, and a three-stage content analysis process was conducted to identify key themes and concepts, and the frequency of these themes and concepts across responses.

Stakeholder Feedback and Reflection Session 2:

A follow-up reflection session was facilitated to provide consumers and providers the opportunity to offer their perspective in response to the themes and elements identified through the content analysis. New participants who had not been in attendance at the first reflection session were invited to share their additional thoughts and responses to each of the reflection questions, and the frequency count and key emergent themes were presented for elaboration and

additional feedback from consumers and providers. These themes can be found in the document titled "March 29th Stakeholder Brainstorming Session Summary."

Reflection and Summary Session Three:

Additional responses and supplemental comments were integrated into the content analysis, and a final summary of key concepts, ideas, and themes for each discussion question was presented during a final web-based reflection session for consumers and providers. During this session, each of the key themes and concepts in response to each question were presented, and participants were given the opportunity to vote for which issues or elements were of highest priority or importance. The results of this group voting and prioritization process were aggregated, and resulted in the summary document titled "BHS Strategic Planning Reflection and Theming - April 12, 2013."

While these reflection sessions were facilitated with consumers and providers, an **internal BHS planning and reflection process was also facilitated**. With implications and considerations from that process woven into the key concepts and needs identified by consumers and providers.

An additional analysis of data to inform BHS-related needs was conducted with data obtained from a **content analysis of mental health subcommittee reports**. This information, obtained in narrative format, was assessed for key themes, concepts, and issues using an identical three-stage content analysis process. These themes and frequency count are detailed in the document titled "Subcommittee Reports Content Analysis Summary," which was provided to BHS on August 21, 2013.

In summary, across all three processes, both external and internal to BHS, a number of key elements emerged as consistent areas of need. When practical and feasible, those elements were woven into the FFY 2014 Substance Abuse Prevention and Treatment Block Grant Proposal, the themes that were identified included the following:

Access to a Full Continuum of Care

- With special focus on the uninsured or those not covered by Medicaid—and non-congruent services
- Continuum should be from prevention, intervention, treatment to recovery and peer services, including strong evaluation and data collection
- Licensing flexibility to allow for further integration with primary health
- Emphasis should be placed on dual diagnosis and co-morbidity

Evidence-Based Strategies (Programs)

- Move from capacity building (training) to implementation
- Higher reimbursement rates for EBS/P Implementation
- Inclusion of EBS/P criteria in grants and contract language
- Data collection and outcomes achievement
- Emphasis on fidelity

Reimbursement Rate Challenges

- Need to consider reimbursement for selective and indicated prevention
- Need to reimburse for family and support services
- Need to enhance/improve Problem Gambling reimbursement system

Special Populations

- Native American
- Veterans/Military
- Rural Challenges
- Adoption of Urban/Rural Definition
- Hispanic Population

Follow-up planning that integrated results from internal BHS planning and prioritization with the outcome of the facilitated discussion with stakeholders pointed to the need to include a priority around evidence-based strategies/programs for the SAPT Block Grant, specifically in terms of creating an internal infrastructure that is supportive of EBS/P implementation, and evaluation and outcomes achievement. This would subsume four goals focused on: assessing need, building staff capacity by adopting a formal definition, creating an action plan to adopt a BHS policy guideline, and infusion of this language into all grants and contracts consistently, which may be supplemented by provider training, culminating in a BHS implementation plan. Outcome measures would include: baseline understanding of current EBS/P, development of internal strategic plan, revision to the BHS vision and mission statements as feasible and necessary to reflect these priorities. Other themes that aren't being utilized as extensively in the block grant for the current year will be carried forward and utilized as BHS continues to create a strategic plan to guide our work in the coming months.

Feedback/Comment on Narratives

KDADS/BHS also provided another opportunity for the review and feedback on the information to be submitted in the narratives of the combined application. BHS posted the 2014/2015 Combined SAPT and MH BG application and the narratives written by BHS on the BHS website for public comment prior to uploading into BGAS. The feedback was reviewed and there no changes to make to the narratives prior to submission. There were several questions asked about tasks BHS included. Stakeholders will be included in the processes as we move forward. Once the application is approved it will be posted on the BHS website for public review.