

Adult Continuum of Care Task Force Update to the ACC Final Report of July 2015

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Priority Recommendations:

1. Immediately restore capacity for services at Osawatomie State Hospital by
 - a. Returning the hospital to 206 certified beds, ending the current waiting list and assuring system capacity to end the current moratorium,
 - b. Ensuring the availability of state hospital beds to address inpatient needs for voluntary admissions that cannot be fulfilled at the community level, and
 - o. Implementing quality improvements for state hospital staff and facilities, including long term planning.
2. Enhance the continuum of care and provide alternatives and support to state hospital treatment by
 - a. Developing additional diversion and crisis services at the community level,
 - b. Establishing residential codes for tiered community-based services, including intensive outpatient treatment (reference Missouri model),
 - c. Discontinuing the practice of Medicaid termination when individuals are hospitalized or incarcerated and implementing a suspended benefit status to ensure the timely reinstatement of benefits upon discharge,
 - d. Implementing the NFMH Work Group recommendations, and
 - e. Rejecting policies that result in the further erosion of behavioral health resources.
3. Improve the quality of care of consumers by
 - a. Expanding access to certified peer support specialists in hospital and community settings by reinstating availability of training,
 - b. Incentivizing professional training and accreditation,
 - c. Developing academic partnerships, including residencies and internships for clinical staff and
 - d. Assuring quality training for hospitals and community providers.

Task Force Description

At the request of the secretary of the Kansas Department for Aging and Disability Services, a diverse group of stakeholders was convened to continue the work of the Adult Continuum of Care Committee and to develop specific plans for the implementation of the recommendations from the 2015 ACC Report. The ACC Task Force serves under the auspices of the Governor's Behavioral Health Council (GBHSPC) in an advisory role to the Secretary of the Kansas Department for Aging and Disability Services (KDADS).

Interim Secretary Tim Keck and GBHSPC Chair Wes Cole asked the group to develop recommendations for

the near future and to consider the role of the state mental health hospitals. The Task Force met twice a month from July 26 to November 22 to develop the first update. The meetings were led by co-chairs Randy Callstrom, Wyandot, Inc., and Amy Campbell, Kansas Mental Health Coalition. The Kansas Department for Aging and Disability Services provided staff to facilitate the meetings.

Executive Summary

The ACC Task Force endorses the 2015 Report. These recommendations do not replace the recommendations of the 2015 Report and interested parties should read the full 2015 Report to provide context to this document.

The members of the ACC Task Force are discouraged at the continued erosion of the Kansas behavioral health continuum of care since the last report. While there have been positive developments, including Rainbow Services, Inc., and the creation of new crisis services in Wichita and Topeka, the overall system has degraded and cannot meet the statewide need.

Kansans who need treatment through the behavioral health system are currently all too often unable to get the help they need. Community resources are strained, affecting both mental health treatment and substance use disorders treatment.

The Osawatomie State Hospital moratorium is a crisis that must be ended and the Task Force supports restoring OSH to 206 beds. The 2015 Report recommended restoring 60 beds to Osawatomie State Hospital as soon as the federally ordered renovations are complete. In the months after that report was released, two major events occurred. First, due to the planned safety renovations and shortage of staff, KDADS initiated a moratorium on admissions. Second, CMS decertified Osawatomie State Hospital. Today, due to decertification and lack of staffing, Osawatomie continues to operate only 146 beds and continues under the moratorium. Until the gaps identified in our continuum of care have been addressed and community resources exist to serve Kansans who have serious mental illness and addictions, Kansas will be unable to implement any strategy for our state mental health hospitals that includes a data supported number of hospital beds.

Kansans who experience a mental health crisis need the care and treatment required to help stabilize them and allow them to return to the community. Of those who use our state hospitals, more than 70 percent do not have Medicaid or other forms of reimbursement, limiting their access to private hospital beds. All this underscores the need to support the state mental health hospital system as a safety net for those who experience a mental health crisis. Without that safety net, many of these individuals will become involved with law enforcement or be seen in emergency rooms, shifting the cost to other systems. Whether public or private, underfunded inpatient facilities are not safe for patients or staff and they do not produce lasting recovery for patients.

The moratorium on admissions means that people who are in crisis and at risk of harming themselves or others must wait for needed treatment. There are no voluntary admissions under the moratorium, so every case must go through the legal process for involuntary commitment. Kansas law enforcement organizations and community hospitals are on the front line of this crisis.

Those who are involuntarily committed must wait for bed space to open up for their admission. Individuals are held in a variety of settings – placing community providers and law enforcement in the position of attempting to protect and care for them in surroundings that are not built for such situations and delaying the initiation of treatment. Local law enforcement officials confirm that under these circumstances, they have made the difficult decision to walk away from some cases where interventions might have been helpful, but simply can't be managed if it will require taking officers off the street.

The lack of capacity in community based mental health services and in the state hospital system exacerbates the mental health crisis of the individual through increased use of criminal charges for minor offenses to resolve immediate problems of disorder. This results in citizens being incarcerated that could be better served by mental health services. Incarceration in these situations needlessly compounds the person's ability to function in the community and places them in a setting where they are, at best, receiving minimal mental health services with diminished probability of stabilization.

While community mental health centers serve all Kansans regardless of their ability to pay. The depth in the array of treatments needed for many Kansans, especially those at risk, is not broadly available across Kansas communities.

The Secretary of the Kansas Department on Aging and Disability Services and Osawatomie State Hospital staff have energetically pursued CMS recertification for Osawatomie State Hospital and important improvements in training, staffing and treatment delivery at both state hospitals. The improvements accomplished to date are admirable but many challenges remain, including facility improvements and staffing goals. These problems have been exacerbated over many years, and they will not be fixed with any quick short-term strategies. The State's ability to address overall behavioral health treatment delivery for Kansans is limited while we struggle to deal with the immediate crisis.

The Task Force worked to develop recommendations to move Kansas beyond this crisis and to improve the overall continuum of care. Information was gathered from within the Task Force and outside our state system with the goal of addressing the larger issues of access to care and the role of the state hospitals. The 2015 Report identified multiple levels of our continuum of care that need attention (see page 6 of the 2015 Report). The Task Force examined the roles of Community Mental Health Centers (CMHCs), Substance Use Disorder (SUD) providers, Supported Housing and Nursing Facilities for Mental Health (NFMHs) today and the barriers that can prevent these agencies from providing the appropriate treatment at the appropriate time. The excellent programs that strive to transition people who have been discharged from the hospitals to the community are hampered by the lack of community housing options and Medicaid payment restrictions.

Kansas must, in the immediate future, implement regulations and funding strategies to incentivize the treatment and services necessary to fill the gaps of our continuum of care. Without access to the services necessary, people will continue to suffer the life threatening trauma of serious mental illness and addictions without the services that might prevent unnecessary incarceration or hospitalization. Without the resources for treatment at the right time and in the right setting, which include housing and employment support, we will continue to overuse more restrictive and expensive resources.

The Task Force is aware that KDADS has issued a Request for Proposals for privatization of Osawatomie State Hospital. The Task Force did not provide input to the RFP. In the absence of information regarding the proposals, the Task Force does not support private contracts for operating our state hospitals today, and priorities that need to be addressed in potential privatization contracts must be outlined for the Task Force to support a privatization recommendation.

Role of the State Mental Health Hospitals

The Task Force has reviewed prior task force and committee reports, and supports those recommendations. The Role of the State Hospitals has been molded for years by funding issues and rising census concerns, and less by long term planning or implementation of former advisory recommendations. The State Mental Health Hospitals are the safety net for Kansans who cannot be appropriately treated at the community level.

- The state hospital should function to ensure public safety for individuals who are a danger to

themselves or others.

- The state hospital should not be a default for all levels of care. Hospitalization should be utilized for intensive treatment only.
- The state hospital should not limit admissions to involuntary commitments only.
- The state hospital should not limit admissions based on the individual's payor source.
- The Task Force is very concerned about the potential inequities between certified and state licensed beds.
- The state hospital should provide individualized care, providing the appropriate settings for
 - Those who need acute crisis stabilization and
 - Those who need longer term stabilization and specialized treatment.
- Needs:
 - Need to evaluate availability of community resources for individuals before admitting to the state hospital,
 - Need to find stabilized funding for community level crisis care to maximize access at the community level,
 - Need to determine where there is the greatest demand for state hospital beds and ensure that privately contracted inpatient beds operate within the no eject, no reject policy,
 - Need to accumulate data to address the lack of appropriate services for individual with co-occurring disorders and specialized needs.

The Task Force is interested in tracking statistics from national sources, if available, that might inform an assessment of the number of beds that would be needed if Kansas were to improve its continuum of care and provide more housing, substance abuse and crisis care at the community level.

Data should be developed to analyze the needs of those individuals who are more difficult to treat at the community level. Some people are more challenged to maintain stabilization at the community level and can cycle through various placements without extended success. The Task Force heard reports that these individuals may be denied state hospital admission for their chronic illness, yet safe community resources are not readily accessible.

The Behavioral Health Continuum of Care

The 2015 Report stated: *"At a minimum, maintain current level of funding and resources. Further reductions would be harmful to the behavioral health system."* (See page 12.)

The current crisis in the Kansas behavioral health system has been magnified by the Kansas financial picture. When Osawatomie State Hospital lost its Medicare certification, Kansas began losing nearly \$1 million per month in Medicare and Disproportionate Share funding from the federal government. Kansas cut reimbursement rates to community providers by four percent, the health homes program ended and the process for Medicaid inpatient screening changed, all with a negative impact on community based providers. Recently, KDADS cancelled the University of Kansas contract supporting evidence based programs and reduced the Wichita State University contract supporting consumer programs. Both University played a pivotal role in the training of community based services staff.

Pages 14 to 26 of the 2015 ACC Report describe recommendations to close many of the gaps in our continuum of care. The current Task Force urges the Department to collaborate with policymakers and the Kansas Department of Health and Environment to take action now to strengthen the continuum of care. Specifically:

- Policies and funding must be crafted to incentivize the services we know are effective at the community level. Funding models should align incentives with desired outcomes.
- The State should consider reinstating grant funding to support crisis stabilization units and services for uninsured and difficult to serve populations.

- The Task Force reviewed information regarding emergency observation and treatment legislative proposals. If constructive compromise can be reached within the Judicial Council to protect the rights of individuals, while opening the opportunity for involuntary treatment at the community level, it could help individual access treatment more quickly and immediately engage local resources.
- The Task Force received testimony from Dr. Richard N. Gowdy, PhD, Director, Division of Behavioral Health, Missouri Dept. of Mental Health and Brent McGinty, President/CEO, Missouri Coalition for Behavioral Health Care. Missouri faces its own challenges in providing a full continuum of care, but the tiered reimbursement structure for community programs could provide the stable funding needed for residential programs and intensive outpatient services. These programs do not exist in most of our Kansas communities, and the programs we have are at risk. There was a great deal of discussion within the Task Force regarding the sustainability of these programs as they attempt to serve a population that is often uninsured or underinsured. Medicaid reimbursement policies in Kansas are not designed for 24 hour care and monitoring.

The State and payor systems should be committed to ensuring needed resources to support recovery in the community are available. A cycle of repeat hospitalizations and/or multiple incarcerations is a reality for far too many Kansans. This devastating cycle hurts individuals, families, and our communities. It goes without saying that it is absolutely a poor use of public resources.

- The Task Force commends the new contract with Valeo Behavioral Health Center transition bed project. It is a positive step to retain behavioral health beds in the Topeka community and should provide lessons for establishing similar efforts in other communities.
- More programs designed to support individuals who are discharged from hospitalization would improve the lives of those who struggle to be independent in community settings. Kansas needs flexible funding opportunities and regulatory licensing to support these programs.
- Supported Housing is a fundamental stabilizing component for individuals “at risk” of hospitalization or incarceration or moving out of secured settings to community based services. A plan should be created to provide supported housing programs where individuals do not have access to such programs. (Appendix E of the 2015 Report for the Transitional Care Services Needs Assessment.)
- The Task Force emphasizes the need for substance abuse reintegration beds throughout Kansas, as well as options for medical and social detox. Recommendations for bolstering community programs apply to both traditional mental health treatment and substance abuse disorder treatment. Testimony was presented to the Task Force providing evidence of the positive outcomes that occur when addictions screening is an integrated part of hospital discharge planning.
- The agency should advocate for the use of the Problem Gambling and Addictions Fund for delivering substance abuse treatment.

Access to medication management is often key to successful discharge and living in the community. The cost of medication management is high and it is a growing challenge to hire and retain the clinical professionals needed to provide these services.

- The cost of medication management is high and it is a growing challenge to hire and retain the clinical professionals needed to provide these services. Funding must support access to medication management.
- Hospitals should collaborate with representatives of the managed care organizations, CMHCs and NFMHs to review the state hospital formularies and the impact for individuals’ transition to community programs and long term stabilization.
- Programs should facilitate opportunities for primary care providers to manage medications for individuals with simple regimens. Medication management alternatives within primary care for individuals with stable medication regimens could benefit people who do not need regular

psychiatric care or live in rural or frontier areas.

- The Task Force received information about Project ECHO which offers education and assistance for primary care providers hesitant to take on medication management for individuals with mental illness. This program could benefit Kansas health professionals and patients.

Workforce issues have challenged inpatient and outpatient programs across the state. In many communities, there is a shortage of qualified behavioral health workforce, while in others, the inability to provide competitive pay leads qualified people to work in other fields.

- Behavioral health providers must be able to offer competitive pay in ensure qualified individuals are not lost to other medical, hospital, or commercial positions.
- Quality training and accreditation programs attract and retain good employees and should be supported by State initiatives.
- The University of Kansas Psychiatry program could be incorporated into state loan repayment options through statute.
- Expanding psychiatric residency programs into state hospitals and CMHCs could aid with Kansas retention of graduates.
- Similar academic partnerships should be reinstated to benefit nurses, psychologists, and social workers where possible.
- There could be opportunities to address telehealth barriers that prohibit psychiatrists from working in state due to distance requirements or licensing reciprocity.
- KDADS needs to move quickly to replace the training and certification services that were formerly provided by the university contracts.

Kansas would benefit from the development of a long term strategic plan for the Behavioral Health Continuum of Care. In the meantime, we are aware that funding and staffing challenges throughout the system and within KDADS can make system-wide initiatives very difficult.

Nursing Facilities for Mental Health

The role of the Nursing Facilities for Mental Health has changed over the decades, and there is an increase in the use of these facilities for state hospital discharge plans. The 2015 ACC Report recommended convening the NFMH Work Group. The current NFMH Work Group has identified a number of important strategies that should be implemented. (See 2015 ACC Report pages 15-17.)

- Emphasize the training manuals and processes which would encourage:
 - Implementation of strengths-based screening process
 - Collaboration between NFMHs and CMHCs, especially in securing case managers
 - Discharge planning beginning on day of admission
 - Appropriate placement of individuals based on criteria
 - Discharge recommendations for individuals no longer meeting criteria
- Provide support for client skill building programs that have been removed due to nursing home regulations
- Update licensing structure to allow for necessary rehabilitative services and inclusion within continuum of care
- Incentivize moving individuals out of facilities, with discharge rates, job programs, medication management processes, and therapy appointments
- Improve reimbursement for services, especially for collaborative programs with CMHCs
- Enhance training for mental health screeners and provide consistent training for NFMH staff providing mental health care
- Provide processes to facilitate working relationships and information sharing among NFMHs and CMHCs.

Privatization of State Mental Health Hospitals

Task Force members discussed potential benefits and challenges for privatization of state hospitals in Kansas. The Task Force did not provide input to the RFP. In the absence of information regarding the proposals, the Task Force does not support private contracts for operating our state hospitals today, and priorities that need to be addressed in potential privatization contracts must be outlined for the Task Force to openly support a privatization recommendation.

- The Task Force members are generally not supportive of the idea to privatize the state hospitals through contracts with for-profit entities. (Agency employees have withheld comment.)
- History shows that privatization can harm people and providers when contracting the lowest bidder fails to meet the needs of program participants and/or there are unintended consequences within and beyond the scope of the contracts. Such harm can extend to existing programs and services, further constricting the continuum of care. Other states have seen privatized hospital beds decertified or worse, patients and employees harmed because privatization cannot resolve the problems of understaffing and underfunding.
- Some members believe that the state mental health hospitals are an example of a needed function of state government that is best operated by the State itself. This is similar to the federal determination that federal prisons are best operated by the government.
- State and national examples illustrate privatization efforts that have succeeded and failed.
- Kansas has established public-private non-profit partnerships such as the OSH diversion beds at KVC and State Hospital Alternative children's hospital services with KVC that have been successful. The partnerships with Via Christi and Prairie View to provide inpatient treatment were also good for individuals and families, especially in central Kansas.
- Privatization could offer operational resources, more modern electronic medical records systems, and staffing to better equip the state hospitals.
- Privatization of the state hospital that is not Medicare certified would not be worthwhile.
- Privatization of other services rather than inpatient treatment could be explored.
- Privatization should not reduce the number of state mental health hospital beds.
- Privatization should provide transparency and access to patient data and cumulative data.
- Privatization would need to include close state oversight and strong outcomes requirements.
- Privatization could be more likely to succeed if implemented to serve target populations that require specialized treatment.
- Privatization will not succeed if the primary objective is to reduce expenditures.
- It is not clear how stakeholders, consumers and families provide input to the proposal process.

Next Steps

The ACC Task Force looks forward to meeting in 2017 to further explore resources and collect information and data that could be useful as Kansas works to improve behavioral health care. The members request the opportunity to meet again with the Secretary to discuss the proposals for hospital privatization and ongoing changes at the state mental health hospitals and within the continuum.