

Adult Continuum of Care Committee

Final Report



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Adult Continuum of Care Committee Description

At the request of the Secretary of the Kansas Department for Aging and Disability Services, a diverse group of stakeholders was convened to review the current behavioral health system and make recommendations for how to transform this system. The Adult Continuum of Care Committee was formed to build upon the work of the Governor's Mental Health Task Force and Hospital and Home Committee to review and make recommendations for transforming the behavioral health system to ensure an effective array of behavioral health services were available to promote recovery and community integration. This review included the current capacity of both state mental health hospitals as well as resources available in the communities.

The Adult Continuum of Care Committee met five times from May 21, 2015 through July 16, 2015. Staff from the Kansas Department for Aging and Disability Services facilitated the meetings and provided support to the committee. Through a series of facilitated discussions, the Adult Continuum of Care Committee examined the current behavioral health continuum of care, identified current resources, gaps, barriers, and opportunities for improvement. For the purposes of these facilitated discussions, the continuum of care system was split into the following categories; state mental health hospitals, community inpatient facilities, Nursing Facilities for Mental Health (NFMH), integrated care, community based housing, and community based services. The Adult Continuum of Care Committee was split off into smaller groups to discuss each category in detail. Each small group identified top barriers and recommendations in each category. A list of barriers and the identified opportunities are included as an appendix B. KDADS provided previous reports and data to the Adult Continuum of Care Committee to aid in their assessment of the continuum of care system and to aid in the development of the recommendations. It should be noted that the assessment of the continuum of care system and the corresponding recommendations were made during a limited number of meetings that were held in a short time period. With a more thorough review of the continuum of care system additional recommendations could be identified.

Executive Summary

Kansas has identified the need to move beyond a mental health system that is stretched beyond its ability to provide the right care at the right time in the right place for Kansas citizens since 2006. The health and safety of our citizens, families and communities are at risk in a system where we must desperately seek alternative placements in order to avoid unacceptable hospital census numbers.

Recovery and independence are best achieved through an array of psychiatric and SUD services and supports that provide quality care, individual choice, and treatment options that are specific to the needs of the individual. As the public mental health system struggles to meet the critical needs of increasing numbers of Kansans, we must address the available continuum of care now rather than later.

Why do we need a continuum? Providing the right care in the right setting at the right time enhances patient care and improves health outcomes for Kansans. It assures the effective use of resources and promotes individual recovery. It is this committee's unanimous assessment that the continuum in Kansas is insufficient to serve the needs of the population and makes it impossible for the state mental

health hospitals to reduce capacity or pursue a more specialized role than as a broad safety net setting. The 60 beds at Osawatomie State Hospital must come back into service as soon as the federally ordered renovations are complete.

While the current shortage of state mental health hospital beds has placed a significant strain on state hospitals, community hospitals, community mental health centers, and housing resources; it also presents an opportunity for Kansas to evaluate the strengths and weaknesses of our current adult continuum of care.

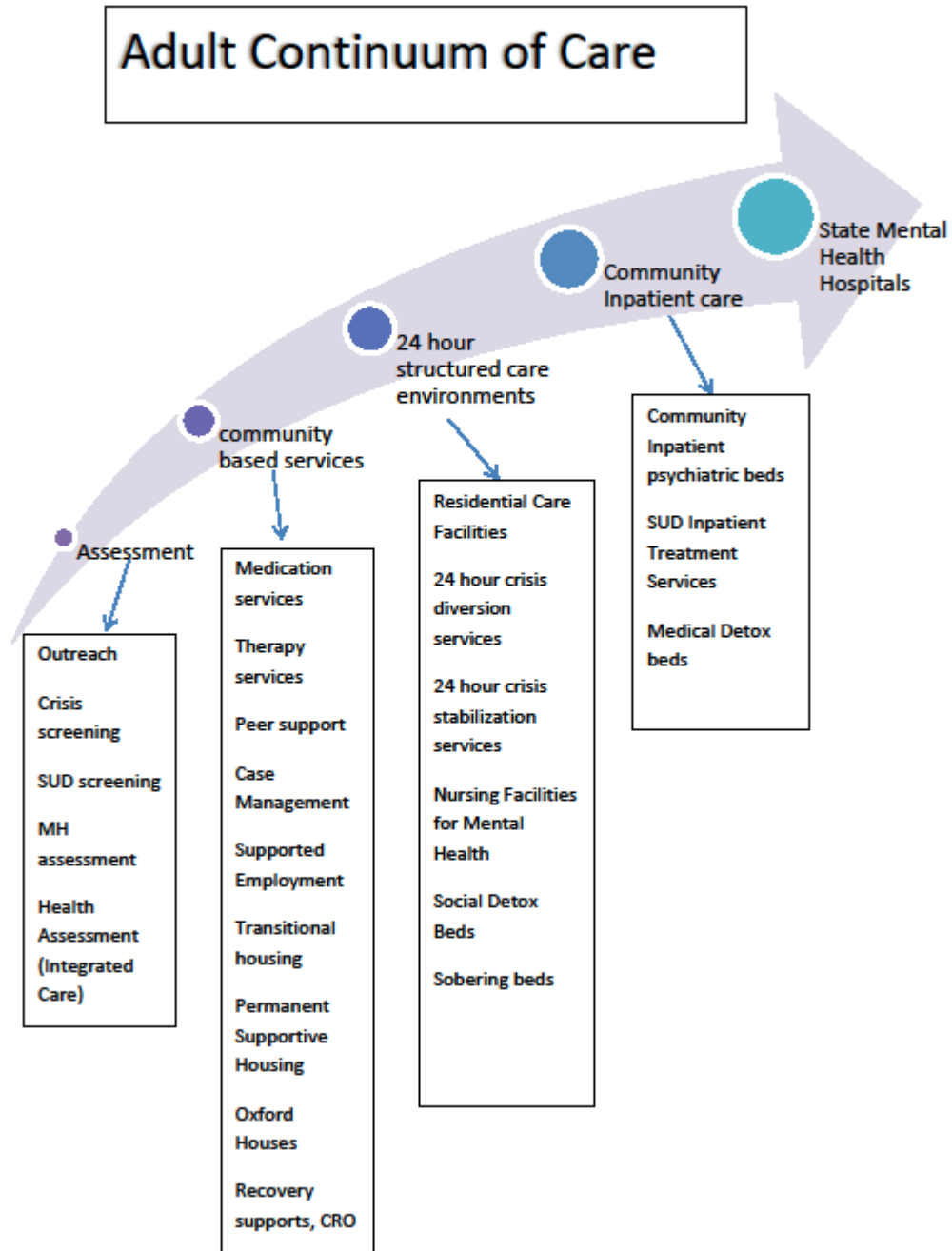
The committee endorses the report and recommendations of the Hospital and Home Core Team and asserts that the gaps in our continuum of care present a past, present and future barrier to achieving the Core Team goals for the state hospitals. One of those goals is for the state mental health hospitals to become more of a tertiary care hospital setting with a focus on treatment of chronic mental illness. The Hospital and Home Core Team also developed recommendations regarding screening and discharge processes. This committee did not attempt to repeat that work in the short time available, but hopes to build on that report with further recommendations focusing on the continuum.

To move our mental health system toward better health outcomes and the best chance of recovery for Kansans facing behavioral health issues, particularly chronic mental illness and chronic substance use disorders, we must bridge some of the gaps in our continuum of care. The State's innovation and investment in Rainbow Services Inc. (RSI) is an excellent step forward to strengthen at least one level of the continuum that has needed attention. The successes of RSI to date can be replicated in other communities if we can stimulate the partnerships and community support established there. But there is more work to be done to assure the sustainability of RSI, through funding, policy and statutory initiatives. The committee encourages the Department to lead those efforts and transfer lessons learned to invest in RSI model services in other Kansas communities.

In addition to recommending expansion of the RSI model to other communities, the committee recommends strategies to boost other levels of the continuum. When the continuum of care offers multiple levels of treatment addressing varied individual needs, such as those with chronic mental illness co-occurring with substance use disorders, developmental disabilities, and traumatic brain injuries, people are less likely to require referral to treatment at a state mental health hospital. Further, Kansas lacks appropriate treatment for transitional age youth, forensic, and geriatric populations, which are sometimes grouped together.

Within the body of this report, the committee has included a number of recommendations to strengthen the Adult Continuum of Care and recommends reconvening the committee periodically to monitor progress, revise the recommendations, and provide input regarding more specific circumstances.

Overview of adult continuum of care system



Adult Continuum of Care in Kansas:

Kansas' public behavioral health services are anchored by three groups of agencies – Community Mental Health Centers (CMHCs), Substance Use Disorder (SUD) providers and State Mental Health Hospitals (SMHHs), with publicly funded private community, inpatient, and residential mental health treatment providers and publicly funded mental health consumer and advocacy groups serving as part of the overall array of services. The social service system is made up of an array of critical services and supports, including state mental health hospitals. The role that each service fulfills affects the role of other services in the array.

CMHCs are responsible to provide effective and efficient community mental health services to persons with mental illness that result in an improved quality of life for those they serve, especially adults with a severe and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED). CMHCs provide community mental health services to all persons who need them without regard to their ability to pay. Community mental health services include: individual and group therapy, psychiatric medication prescribing and management, psychiatric rehabilitation, support services where the person needs them (e.g. in the home, in the family, in schools, in employment), coordination of all needed services, 24 hour seven day a week mental health crisis response, screening for individuals to determine the need for state and federally funded inpatient or residential psychiatric treatment, and liaison services to ensure effective, efficient, and person-centered transition into and out of the various mental health treatment settings. CMHCs also provide outreach to ensure Kansans with a mental illness know where to access mental health services and community education to inform the public regarding mental illness and the promise of recovery.

SUD treatment providers offer a range of 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. 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.

SMHHs provide inpatient psychiatric treatment to all persons approved for admission by a CMHC. Persons approved for admission by a CMHC are determined to be in need of inpatient care and are unable to be safely and effectively served in community settings or other inpatient or residential psychiatric treatment facilities. Individuals receive inpatient services until such time as the symptoms of their mental illness or co-occurring disorder are stabilized and they can be safely and effectively treated in a community setting. Because the state mental health hospitals are often considered the "placement of last resort," the role that mental health and other social services fulfill defines the role of the state mental health hospitals. As a result, in addition to providing inpatient psychiatric services, the state mental health hospitals are currently called on to provide broad social safety net services. Persons state mental health hospitals serve with these broad social safety net services are very vulnerable and/or a serious risk.

Summary of previous committees and reports

The Adult Continuum of Care Committee would like to acknowledge reports from previous workgroups and committees charged with assessing the behavioral health system and making recommendations on how to transform the system. The key findings and recommendations of these earlier reports are still significant today and have informed this report. The Adult Continuum of Care Committee's intent was to build on the work completed by these previous committees. The following provides a brief summary of the work completed by four of these committees.

Future of Kansas Mental Health Hospital Project Steering Committee Report December, 2003

The Secretary of SRS charged the Hospital Stakeholder Task Force to assess the guiding vision for public mental health services and the role of the hospitals in that vision. The committee reached agreement on recommendations through a consensus process and spent time framing the issues, conducting discussions, identifying data, and generating options and ideas around the role state hospitals do or could play in the mental health service system. Recommendations included

- The state mental health hospital resource, as part of the array of mental health services, is essential to meet critical needs of increasing number of Kansans in times of intense challenge, and to help them achieve timely and durable recovery, build resilience of children and support families.
- The role of the state mental health hospitals is changing, varies from one hospital to another, and reflects unique community and individual needs. Any additional decrease in state hospital services should occur with both a consensus plan developed with input by representatives of all stakeholders and prior or concurrent implementation of capacity building strategies to meet the needs of people accessing the impacted state hospitals.
- Community-based services and community psychiatric inpatient services must be supported to prevent further dissolution of resources for patients near their homes
- Work must continue to ensure that our state mental health hospitals are continuously effective and fully integrated parts of the Kansas Public Mental Health System.

Additional key findings from the Executive Summary:

- While admissions have dramatically increased and average daily census dramatically decreased, the state mental health hospitals have maintained a barely adequate supply of beds by working in effective collaboration with community mental health centers.
- There is no room presently for any further reduction in the service capacity of the state mental health hospitals.
- Two important issues currently facing the hospitals: customer-friendly steps to support treatment partnership for families of hospital patients, and the increasing number and complexity of forensic service needs for patients also involved in criminal prosecutions

Hospital and Home

The 2006 Interim Legislative Budget Committee Report expressed concern regarding increased state mental health hospital admissions resulting in chronic over census. As a result, the 2007 Legislature added supplemental funding to the state hospitals and asked that SRS and mental health stakeholders work together to address this issue. SRS responded by establishing the Hospital and Home Initiative to research and design a plan to implement an effective array of hospital and community services to better serve all Kansans with mental illness. The Hospital and Home Service Access Work Team recommended that the state mental health hospitals become tertiary mental health treatment facilities. The Service Access Work Team defined a tertiary care facility as one that provides longer and potentially more complex course of inpatient mental health treatment. The recommendation goes on to say that these facilities should only admit persons referred from a lower level of care or by a court for intensive specialized treatment. Achieving this recommendation requires that state mental health hospitals focus their resources on the treatment of mental illness and not on the broad safety net services which they are currently called upon to provide. Before the state mental health hospitals could be transformed to tertiary facilities, the following enhancements were recommended.

- Expanding regional private inpatient mental health treatment services;
- Re-visioning the role of NF/MHs;
- Requiring agencies that place individuals into state mental health hospitals to accept the person back to services once the person's acute mental health treatment has been successfully completed;
- Expanding housing options for persons with disabilities;
- Improving and expanding crisis services in community settings; and
- Improving the screening, assessment, and discharge process for state mental health hospitals.

The Hospital and Home Team also issued a report in May 2013 entitled Mercer Study Review and Recommendations for Alternative Use of Rainbow MHF.

- In FY13 KDADS contracted with Mercer to conduct an actuarial analysis of the hospital and community based services utilization. The Hospital and Home Team was charged with reviewing the report issued by Mercer and developing recommendations for reducing reliance on the state hospitals for public safety net services that could be provided elsewhere.
- The recommendations were specific to the development of alternative services at Rainbow Mental Health Facility, but have implications for future work and the development of similar services across the state.

Transformation Subcommittee of the Governor's Behavioral Health Services Planning Council:

The Transformation Subcommittee gathered information, recommended action steps, and actual actions taken to improve Kansas' Mental Health Services. The Subcommittee analyzed these efforts and identified recommended actions steps that are transformational. The Subcommittee examined the recommended transformational action steps to identify their commonalities and differences. The Subcommittee also analyzed what actions are actually being undertaken to transform Mental Health Services. Such actions may be statewide or regional in nature, systemic changes or pilot projects. The

Subcommittee developed recommendations regarding whether the transformational actions being undertaken are:

- Consistent throughout assessments and recommendations contained in the various reports;
- The highest priority items needing attention or if there are other higher priority items that should be undertaken;
- Blending resources to better achieve priority action steps; and
- Effective in improving the quality of people’s lives.

Governor’s Mental Health Task Force Report

In January 2013, Governor Sam Brownback declared the creation of a task force to study the mental health system of Kansas. The primary focus of this group was to examine ways to encourage intra-agency collaboration and coordination to better utilize resources for mental health programs for individuals and families and increase efficiencies. Furthermore, the group also examined key factors necessary for increasing community supports and capacity for those with mental illness or those with predisposition for developing mental illness. By 2014, the Task Force submitted a final report to Governor Brownback for consideration that included a number of recommendations in the following theme areas:

- Accountability for Outcomes and Effective Services
- Access to Effective Services and Supports
- Primary Behavioral Healthcare
- Effective Crisis Response, Prevention and Early Intervention
- Enhanced Community Involvement and Engagement

A copy of this report is available at: http://www.kdads.ks.gov/docs/default-source/CSP/CSP-Documents/bhs-documents/governor's-mental-health-task-force/governors_mental_health_task_force_report_041514.pdf?sfvrsn=6

Additional Information:

The Governors Behavioral Health Services Planning Council

The federal government mandates that all states have a mental health services planning and advisory council. The Governor’s Behavioral Health Services Planning Council fulfills that mandate for Kansas. The Council is made up of a cross section of mental health consumers, family members of mental health consumers, mental health service providers, state agency staff, and private citizens. The Council is actively involved in planning, implementing, monitoring, evaluating, and advising state government regarding Kansas’ mental health services.

The Council subcommittees submit annual reports and recommendations to the Secretary. These subcommittees are:

[Children’s Subcommittee](#)

[Housing and Homelessness Subcommittee](#)

[Justice Involved Youth and Adult Subcommittee](#)

[Rural and Frontier Subcommittee](#)

The Adult Continuum of Care Committee's Vision of a transformed continuum of care

Goal: The Hospital and Home Report calls for a developmental, multi-faceted approach to developing the service array regionally to better meet the needs of person with mental illness outside the state mental health hospitals. This would allow hospitals to focus on specialized inpatient psychiatric services consistent with tertiary care hospitals. *(see Hospital and Home Report in appendix C)*

Background information:

The two State Mental Health Hospitals; Larned State Hospital and Osawatomie State Hospital, have the capacity to serve an average daily census of 310 persons. However, due to construction, Osawatomie State Hospital was forced to reduce their beds to 146, which puts the statewide capacity at 250 persons. **OSH has a current capacity of 146 available beds to serve a population area of well over 1.5 million people.**

State Mental Health Hospitals have become a provider of last resort for people in need of behavioral health care and treatment in the state of Kansas, especially for people who are uninsured or underinsured. The State Mental Health Hospitals have been used as a place for people to be court committed if they are receiving involuntary care and treatment

The reduction of over 80 state hospital beds in the last 5 years has left a shortage of inpatient beds with an expectation that local communities fill the void. While programs such as Rainbow Service Inc. (RSI) Evergreen House in Emporia and the crisis stabilization programs in Topeka and Wichita have helped significantly, local inpatient psychiatric units have not been able to increase their capacity to meet the need. Particularly, those individuals deemed by the court as a danger to themselves or others and ordered to inpatient care, or those in need of inpatient substance abuse treatment, are unable to access the right level of care in a timely way. There are not adequate local inpatient beds for these two populations, and local facilities can screen out those who are deemed too violent or not a good fit for their milieu. These are the hardest to treat, and the shrinking resources at the State Mental Health Hospitals place them at the greatest risk. For those individuals without insurance, the State Hospital is often their only resource.

Due to the limited capacity at the state hospitals and lack of resources in the communities, there has been increasing pressure to discharge patients quickly to make room for more. Compounding this issue is a continuing challenge with staffing levels due to staff turnover, staff burnout and fatigue. There has

been a reported shortage of staff to cover all of the hours, resulting in staff working overtime. These staffing challenges impact the outcomes seen with the current system. Additionally, the overall scarcity of psychiatrists or medication prescribers in Kansas seems to be adding to the staffing woes in hospitals

Action Plan – Develop a multi-faceted approach to develop a regional service array to better meet the needs of persons with behavioral health disorders outside of the state mental health hospitals. This would allow the hospitals to focus on specialized inpatient psychiatric services consistent with tertiary care hospitals.

An adequate number of state hospital beds to serve as the safety net for those at greatest risk is essential. The Hospital and Home Report addresses this issue extremely well and outlines specific steps to help assess the number of beds needed. This is a complex issue, and the determining factors cannot solely be financial. The risk is too great.

A continuum of care for behavioral health care must include treatment facilities for those individuals who experience the most severe, complex illnesses that cannot be adequately treated, stabilized, and rehabilitated in a lower level of care. An inadequate safety net jeopardizes the well-being of those individuals, puts communities at risk, and places an undue burden on local resources including law enforcement.

The state mental health hospitals should forge better integration with other systems of care such as CMHCs, NFMH, RSI and similar facilities, community providers to ensure that diversion occurs whenever possible or appropriate and that discharge plans begin on the first day the patient enters the hospital. Solid discharge plans and sufficient resources for the people to return to in their communities would cut down on the revolving door cycle that some patients find themselves trapped in.

Before a final recommendation on the “right” number of available state hospital beds can be given, the gaps in care at lower levels of intensity and in the community must be addressed and additional community based housing resources must be developed. It is not completely known how many of the people that currently end up in a state hospital would not have ended up there had there been more robust resources available in their local communities.

Any reduction of beds, of any number, is not recommended. Local communities must first have the resources to provide timely and excellent care for those who would have otherwise been hospitalized at the State Mental Health Hospital.

The committee did not receive any research that would support the recommendations for a specific number of state mental health hospital beds to serve the Kansas population, but the research should be engaged. A comparative analysis of supportive data was not available during these Committee meetings.

List of Recommendations

Inpatient Care Recommendations

- Restore 60 beds at Osawatomie State Hospital into service as soon as the federally ordered renovations are complete
- Explore barriers for collaboration for rehabilitative services with NFMHS, Consumer Run Organizations, Community Mental Health Centers
- Create more residential care facilities that replicate the Evergreen House model (Emporia) and provide intensive supportive services for patients discharging from the state mental health hospitals.
- Decide on the role of the Nursing Facilities for Mental Health (NFMH)
- Conduct an NFMH population survey
- Evaluate if the NFMHs are appropriately licensed
- Reevaluate the services provided in the NFMH more frequently
- Explore the feasibility of having the MCOs provide oversight with the NFMHs
- Evaluate the transportation needs of the patients utilizing the local crisis stabilization centers and develop funding mechanism for secure transport and/or law enforcement agencies to cover the costs of transportation.
- Create more regional crisis stabilization /diversion programs that replicate the RSI model
- Conduct community town hall meetings, forums, surveys to build relationships with law enforcement, court system, community mental health centers, NFMHS, emergency rooms / medical providers
- Further develop the collaboration between systems and agencies
- Continuing to periodically assess and improving screening and discharge tools.
- Expand Mental Health First Aid to include the court system and judges.
- Expand the use of persons with lived experience so that there is a mechanism to connect patients to other consumers in the community
- Support the development of community based / local resources
- Develop alternatives at the local level for involuntary inpatient treatment

Community Based Services Recommendations:

- Convene community coalitions to strengthen partnerships (regional, judicial)
- Develop needs assessment based on factors that are most likely to provide for appropriate placements in lieu of placement at a state mental health hospital
- Any barriers for promoting consumer choice for behavioral health services needs to be addressed.
- Expand certified peer support services across Kansas
- At a minimum maintain current level of funding and resources. Further reductions would be harmful to the behavioral health system

- Develop a lead housing agency. This agency could provide technical assistance to local communities in developing housing alternatives including assistance in how to leverage HUD funding, develop 811 projects, master lease units, and develop supported housing programs. A lead housing agency could also manage a flex funds to help keep people in their housing similar to HPRP.
- Explore alternative billing codes for supported housing services , such as a per diem for daily contact and 24/7 support. Create flexible funding opportunities to allow communities to tailor programs to meet the community’s needs. Examples include the development of Tiny houses or shipping container housing alternatives. Leverage State General Funding with federal and local funding sources.
- Offer Mental Health First Aid Training to housing providers, including public housing authorities, supported housing programs and landlords
- Increase the availability of substance abuse reintegration beds throughout Kansas

Workforce Development /Policy / Funding Recommendations

- Bring stakeholders together to develop consensus to endorse amendment or revocation of the Federal IMD Exclusion rule. It is strongly recommended the State submit comment and coordinate with stakeholders to do the same
- Pursue solutions for serving the uninsured, such as exploring one or models of Medicaid Expansion. Such model should consider the impact on access to behavioral health services. Facilitate a detailed review of the reimbursement rates to enhance our ability to achieve priorities of access to a continuum of care and workforce development
- Create standard process to identify and pursue federal funds where such funding will enhance patient care and improve health outcomes through an effective continuum of care.
- Engage community stakeholders for the development of sustainable funding for additional behavioral health and housing options through long-term partnerships for federal, state, local and private funding commitments. (Law enforcement, judiciary, local governments, community hospitals, elected officials, providers, consumers and family members) These partnerships must set goals and outcomes to achieve over time
- Increase the number of residencies at the University of Kansas Medical School Psychiatric Program and engage the residents in work at the State Mental Health Hospitals and other behavioral health treatment settings
- Promote and expand cross training for student nurses by adding psychiatric inpatient experience, additions, treatment experience, and other behavioral health treatment settings.
- Promote and expand cross trainings for mental health and addictions professionals through specialized education programs at the universities and community colleges pre and post-graduation
- Promote and expand training and employment of peer specialists and peer mentors.
- Licensed Mental Health Technicians (LMHT) should receive proper educational training and be appropriate utilized within their established scope of practice

- Encourage the use of telemedicine and gather information on current and past utilization of telemedicine for areas of improvement from professional, consumer and family members

Recommendations

I. Inpatient Care recommendations

A. Local Crisis Stabilization Centers

Background: Rainbow Services Inc (RSI) offers sobering services, 24 hour crisis observation, and 10 day crisis stabilization services to Johnson and Wyandotte County residents, and recently have admitted residents from other counties. Critical to the success of RSI is the availability of psychiatric services and medication management. Similar services are available in Topeka and Wichita.

Residential Care Facilities provide short-term and long-term residential services to adults with mental illness in several regions across the state. In some regions there are supervised housing programs.

Gaps / Barriers: These services are not accessible to all communities in the catchment areas for the state mental health hospitals. Transportation is a critical barrier to accessing care at the Crisis Stabilization Centers, and funding for transportation is a high need.

Sustainable funding is a critical need for these services. The ability to accept the uninsured is essential, and without adequate state and local funding to underwrite the costs, these programs will be at risk.

Not enough of these facilities exist to meet the housing demands of adults with mental illness, particularly those at risk of, or residing in, the State's mental health hospitals.

There is a need for additional structured care environments (licensed as a residential care facility) that provide a residential facility for patients discharging from the state mental health hospital with high psychiatric needs. These structured care living environments are an essential part of the continuum and provide a resource for patients discharging from the state mental health hospitals. These structured care living environments are an essential component of the array of housing in Kansas. This type of facilities is not available in most communities.

Action Plan:

- Restore 60 beds at Osawatome State Hospital into service as soon as the federally ordered renovations are complete
- Explore barriers for collaboration for rehabilitative services with NFMHS, Consumer Run Organizations, Community Mental Health Centers
- Evaluate the transportation needs of the patients utilizing the local crisis stabilization centers and develop funding mechanism for secure transport and/or law enforcement agencies to cover the costs of transportation.

- Create more residential care facilities that replicate the Evergreen House model in Emporia and provide intensive supportive services for patients discharging from the state mental health hospitals. This type of residential care facility provides a short term structured environment for patients discharging from the state mental health hospitals. Developing these structured care facilities that provide a resource for people discharging from the state hospital we will help right size the state hospitals.
- Create more regional crisis stabilization /diversion programs that replicate the RSI model. KDADS help facilitate collaboration between systems and agencies to braid funding and develop sustainability plans for these crisis stabilization programs.
- **KDADS should conduct community town hall meetings, forums, surveys to build relationships with law enforcement, court system, community mental health centers, NFMHS, emergency rooms / medical providers**
- Further develop the collaboration between systems and agencies.
- If Crisis Stabilization Centers are to be part of the state safety net system, the State must provide ongoing funding for these services. Without state funding, programs would be dependent on local governments and private funders to serve the uninsured, and sustaining the necessary array of services to prevent the need for a higher of level care or even the sustainability of these programs at all would be precarious at best. A safety net system of the state hospital and crisis stabilization programs is a delicate balancing act. If one component is lost, the ripple effect would be an overburdened system inadequately equipped to absorb the mental health needs of the most vulnerable, highest risk population. And, unless the state supports crisis stabilization centers, the entire safety net system would be jeopardized if even one program shut down to due lack of funding
- Continuing to periodically assess and improving screening and discharge tools.
- Expand Mental Health First Aid to include the court system and judges.
- Expand the use of persons with lived experience so that there is a mechanism to connect patients to other consumers in the community
- Support the development of community based / local resources.
- Develop alternatives at the local level for involuntary inpatient treatment.

B. Nursing Facilities for Mental Health (NFMH)

Background: The NFMH model is unique to Kansas. The NFMH provides residential and other care for those individuals experiencing severe mental illness, have co-morbid physical health disabilities, or require assistance to meet their basic daily activities. Originally, NFMHS were created to resolve placement for people with mental illness being served in nursing facilities, which is in conflict with CMS rules for nursing homes (no more than 50% with primary diagnosis of Mental Illness). Intent was to rehabilitate and return to the community. They are currently licensed as nursing homes. People must have PASAR and Level II screening to be placed in an NFMH. Due to the Medicaid IMD Exclusion Rule, a patient's stay at a NFMH is not covered under Medicaid, it is paid for by the state general fund. Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster

is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds.

Since the NFMH is licensed under the same rules as nursing homes, they are unable to provide rehabilitation services. Furthermore, CMHCs are unable to bill for any rehabilitative services that they could potentially provide to an individual residing in an NFMH until 120 days before discharge.

CMHCs have a QMHP do continued stay screenings yearly to assess whether the person still needs that level of care. The number of beds available in the NFMH facilities in Kansas has decreased over the last few years.

Barriers / gaps: There is inadequate access to Nursing Homes For Mental Health leaving many patients in the state mental health hospital who cannot otherwise be served in the community. Rehabilitative services are meant to be included the NFMH payment, which restricts the CMHC from serving the consumers in a NFMH due to the IMD exclusion rule. The system becomes fragmented and consumers rarely return to lower levels of care.

Due to the inadequate reimbursement rates paid the NFMHS, they are not able to provide adequate training and compensation for their staff.

Due to the institutional setting of the NFMHS, the individual has limited freedom and limited choices about basic life activities that others may take for granted such as what and when to eat, what to do for recreation, who to share living space with, who to spend time with, work, education, or other factors that might help a person feel motivated towards recovery. Over time, the environment in an NFMH fosters dependence and people become afraid to be discharged because they may be aware that they've lost skills and/or feel unable to make healthy choices for themselves.

There is a lack of ongoing, active behavioral health care treatment in these facilities. This results in very few residents being discharged to a lesser level of care and their recovery options limited.

Action Plan:

- NFMHs – The OSH safety construction project compelled by CMS requires OSH to operate through the summer with 60 beds out of service. The crisis presents an opportunity for KDADS to survey the current population at Kansas Nursing Facilities for Mental Health for a snapshot at a time when the need for such residential care is very high. The survey should identify specialized needs including: addictions, traumatic brain injury or developmental disabilities, forensic history, and age range.
- Develop a task force specifically to evaluate the NFMH system and make recommendations. This task force should decide on the role of the NFMH and evaluate if the NFMHS are appropriately licensed. If advantageous, the NFMH task force should explore the feasibility of changing the licensing regulations for the NFMHs since they have a different population from a regular nursing home to allow for more rehabilitative services to be provided.

- Explore barriers for collaboration for rehabilitative services with NFMHS, Consumer Run Organizations, and Community Mental Health Centers. The NFMH task force should explore how to remove barriers to allow for CMHC staff to bill for providing services in the NFMHs and build relationships with people, teach them skills and how to make decisions and choices, and help them to improve over time.
- KDADS should encourage the extensive use of certified peer specialists who are specially trained to work with NFMH populations and provide information about recovery, share lived experiences, talk about coping skills and learning to make good decisions, assist with WRAP planning, and generally give the residents there hope and a sense of possibility for their future beyond living out the rest of their years in an institution.
- The services provided at the NFMH should be reevaluated more frequently. One possible solution is for the MCOS to provide oversight with the NFMH.

C. Community Inpatient Psychiatric Beds:

Short-term, acute psychiatric hospitals provide access to adults with mental illness in several regions of the state. CMHCs have crisis intervention/diversion programs of various kinds and intensities across the state.

This resource is provided through private entities ranging from the local community medical center to dedicated psychiatric hospital units. Length of stay is typically 4-5 days and is intended for those who are actively suicidal/homicidal or severely psychotic.

Gaps / Barriers: There is disparity across the state for access to IP psych beds. This is due to many factors which include: inability to attract and maintain psychiatrists, keep beds available due to fluctuating census and keeping staff. The process of admission has been under revision since CMS has identified the screening process presents a barrier to these services and does not support parity. Involuntary admissions are typically not accepted at the private hospitals due to their inability to manage the level of care needed and they often cannot serve special populations (IDD). Communication across systems has relied on the screening process and there is often a breakdown in communication and handing off of the member/client when transitioning from one level of service to another.

In spite of increased demand, local inpatient psychiatric units have closed in some regions of the state due to cost overruns. These units provided immediate alternatives to placement in a state mental health hospital. With this alternative asset diminished, the state hospitals become the default placement, as do local county and municipal jails. The capacity of CMHCs to provide crisis intervention and diversion services varies across the state. Transportation to hospitals, an ongoing concern even in an ideal public mental health system, is now at a crisis level, usually falling on law enforcement

Action Plan:

- Continue to periodically assess and improve screening and discharge tools.
- Increase the reimbursement rate and pay for beds to support smaller community hospitals in expanding psychiatric units.

- Work with KU Medical Center to expand their support of the rural community hospitals.
- Expand the use of persons with lived experience so that there is a mechanism to connect patients to other consumers in the community.
- Continue the open lines of communication between the hospitals, CMHCs and MCOs so that services flow across the systems and members are handed off smoothly. Insure there is a mechanism in place to support this communication when the screening process is changed.
- Support the development of community based / local resources targeted to patients discharging from the institutions.
- Expand Mental Health First Aid to include the court system and judges.

II. *Community Based Services Recommendations*

A. Community Based Housing

Background: Housing and Urban Development provides funding for Section 8 and other housing subsidies.

Many local Community Mental Health Centers provide supported housing services using appropriate outpatient mental health Medicaid codes.

Supported housing services are a big need in most communities. Helping people maintain stable housing would cut down on state hospital admissions.

Gaps / Barriers: While some housing resources exist for people with severe mental illness, communities lack affordable housing, and too many are homeless or precariously housed. As a result, the mental health needs of consumers are exacerbated by the chronic stress of homelessness and inadequate housing. People who are homeless are at greater risk of law enforcement contact leading to an increase in the jail census of people experiencing mental illness. As a result, there are a greater number of people ordered for involuntary inpatient and outpatient treatment. But, because they are homeless, they are harder to treat and often harder to find. Some people with severe mental illness have difficulty living independently and meeting their own daily living activities, abuse alcohol or drugs, and need frequent support. Too often, the result is an admission to the state hospital.

Action Plan

- Develop a lead housing agency. This agency could provide technical assistance to local communities in developing housing alternatives including assistance in how to leverage HUD funding, develop 811 projects, master lease units, and develop supported housing programs. A lead housing agency could also manage a flex funds to help keep people in their housing similar to HPRP.
- Explore alternative billing codes for supported housing services, such as a per diem for daily contact and 24/7 support. Create flexible funding opportunities to allow communities to tailor programs to meet the community's needs. Examples include the development of Tiny houses or

shipping container housing alternatives. Leverage State General Funding with federal and local funding sources.

- Offer Mental Health First Aid Training to housing providers, including public housing authorities, supported housing programs and landlords.

B. Community Based Behavioral Health Services

Background:

Supportive services within the community to prevent hospitalization improve functioning and maintain stabilization following an inpatient treatment episode

Currently, the continuum of care includes community mental health centers, other mental health and SUD treatment providers in the community, psych wards in local hospitals, RSI and other facilities that exist to intervene in crises and divert state hospitalizations and provide appropriate mental health services and treatment for substance use disorders.

What is available in the community or region varies widely around the state. Many of the above listed resources are few or minimal, not available everywhere. Levels and types of services provided differ among the various CMHCs. Some of this is due to varying needs and levels of resources in the individual communities. Preliminary research appears to indicate that the presence of evidenced based practices, i.e. Strengths Model of Case management and IPS Supported Employment Services may be an indicator that leads to a decrease in hospitalization. However, some CMHCs are not able to implement evidenced based practices due to financial barriers.

Some CMHCs have been hit hard with budget cuts and financial problems have reduced the availability and comprehensiveness of many community services of all types including hospitals, clinics, CMHCs, SUD treatment facilities, emergency departments and so forth.

Gaps / barriers: Due to underfunding, the capacity of any given community or region to provide an array of services for their citizens' behavioral health needs at a local level is less than it has been, creating more pressure on the state hospital system to be the final safety net for many people.

Inpatient psychiatric units in local community hospitals are becoming far scarcer than once was the case. There are many reasons for this. Two that were mentioned in our small groups are the shortage of psychiatrists and financial constraints; they lose a lot of money.

People with a primary mental illness or substance use disorder are burdening local emergency departments, leaving them with less capacity to serve people with medical emergencies

Uninsured people may utilize a large amount community behavioral health services that go unreimbursed, causing local hospitals to lose money, particularly on psych services, CMHCs to have to do more with less, and the availability of SUD treatment continues to diminish.

When funds are tight, some CMHCs perceive disincentives to provide evidence based care and treatment.

Caseload sizes at many CMHCs are too high to provide adequate services and support to the people who need more intensive care and/or crisis intervention.

Not enough resources exist in communities at present that might serve to divert people in crisis from state hospitals. These could include CMHC provided case management, attendant care or peer support services that are available outside regular office hours, peer support services offered by consumer run organizations, peer run respite homes, RSI type crisis facilities, sobering beds or “social detox” being more widely available, and local inpatient psych units.

There is a lack of capacity for special populations which include Substance Use, I/DD, TBI and transitional age youth (18-24). Criteria for programs are vague and need clarification. There are limitations for funding sources as well as availability of providers.

Action Plan:

- Build a more robust array of services in the community. Conduct needs assessments for each region of the state and make a plan to plug the holes that exist in each community’s system. Identify where people are falling through the cracks.
- Convene community coalitions to strengthen local and or regional partnerships to include the judicial system.
- Develop needs assessment based on factors that are most likely provide for appropriate placements in lieu of placement at a state mental health hospital.
- **Maintain current level of funding and resources. Further reductions would be harmful to the behavioral health system.**
- Any barriers for promoting consumer choice for behavioral health services needs to be addressed.
- Expand the use of certified peer support services across Kansas.
- Evidence based practices should be reimbursed at an enhanced billing rate or other financial incentives provided. The focus should always be on helping people get better, never on stabilize, maintain, or protect. Recovery will look like different things for different service recipients but nearly everyone can improve their quality of life in some way with the right types of supports and services in place. Incentivize all Evidence Based Practices that support maintaining individuals in the community, i.e. Strength Based Case Management.
- It’s important to recognize that no matter how enhanced the billing rate may be, the CMHCs won’t get anything out of billing the uninsured for the most part. This is also true for psych hospitals, peer run crisis homes, RSI like facilities, and other crisis/diversion type services.
- Pursue solutions for serving the uninsured, such as exploring one or more models of Medicaid Expansion. Such model should consider the impact on access to behavioral health services. Kansas also needs to go after other potential sources of funds by applying for grants.

- If there is cost savings that results from diverting state hospital admissions that needs to be plugged back into the center or facility that diverted the hospitalization. If there's not a financial incentive to CMHCs to divert state hospital admissions to a local resource—there needs to be.
- CMHC services need to be flexible and change with the needs of the individual. ACT may be too costly to implement in its purest form in many communities. But the features of ACT such as lower caseload sizes for case managers working with high intensity needs individuals (10:1 is the recommended ratio for ACT), availability of services outside normal business hours, and the use of a multidisciplinary team who work together to provide the level and type of support an individual needs could be incorporated into traditional strengths model case management for certain segments of the CMHCs clientele.
- Evaluate communities and regions around the state to determine the best locations for a series of RSI like facilities. Customize each facility to the needs of the local community and build on knowledge that is being gained from experience as RSI continues to refine the services they provide.
- Explore the outcome data available for peer run respite homes. Have they been shown to reduce hospital usage or produce better outcomes for the people who go to them? If the outcome data looks favorable, explore having one or more such homes.
- Explore how to allow CROs to have CPS on staff who can bill Medicaid for their services to make these homes, as well as other services provided within the CRO a sustainable option for people who would rather be served in that type of setting.
- Improve peer support services around the state by providing clear job descriptions and roles for peers in evidence based practice settings. Provide training and support for individuals who supervise peer support workers, recommend that these supervisors be CPSs also.
- Provide Mental Health First Aid training to all first responders

C. Emergency Observation and Treatment

Current status: People on Outpatient Treatment Orders (OTO) who are in violation of their court order are picked up by the Sheriff's office and transported to the State Hospital.

In addition, people who are in psychiatric crisis and meet state statute criteria for involuntary commitment are typically transported to OSH—especially when they are either too ill or combative to be treated in other psychiatric facilities. OSH is the safety net for involuntary commitments

Barriers: State statute does not allow someone on a pick up order to be brought to a facility other than the State Hospital. While many may require that level of care, others may simply need to be evaluated and re-engaged in treatment including initiation of their medication.

In addition, many individuals in psychiatric crisis can be stabilized in a short period of time (within 72 hours). If our stabilization centers were equipped to take involuntary commitments (secure room, injectable medications, ability to hold a patient), we could stabilize the crisis in their home community, facilitate linkage back to community based services, while also reducing law enforcement resources with transports to OSH.

Action Plan:

- Facilities such as a Crisis Stabilization Center or other local inpatient psychiatric facility may often be a better alternative for those in violation of their OTO, or who otherwise meet criteria for involuntary commitment. A change in statute would give the court, law enforcement, and local treatment providers flexibility in intervening with the right level of care for those needing involuntary treatment. This would require Crisis Stabilization Centers and inpatient psychiatric units to be equipped to accept an involuntary patient.

D. Integrated Care

Background: Health Homes were developed to integrate behavioral health with medical care as a whole person approach to wellness. They were designed to address all needs of the individual with coordination happening among all the providers, whether they were co-located or not.

Gaps - There are barriers to the handoff of health information as perceived by the provider community. There is a lack of looking at creative options for providing services such as telemedicine and providers who understand the holistic approach to care based on lack of understanding the need to this type of approach as well as the stigma around MH/SUD among the public and providers. Issues among providers across waiver services, such as mental health and IDD. Lack of generalists to cross over into psychiatric.

Action Plan

- Continue to support the Health Home project beyond the initial phase of two years to determine its efficacy.
- Use model practices that support integrated care and provide incentives to follow those models through increased reimbursement.
- Actively recruit medical providers from KU to follow the integration model.

III. Workforce Development / Policy and Funding Recommendations

A. Policy Recommendations

Adult Continuum of Care Implementation Committee

Gaps / Barriers / Problem Statement: The Hospital to Home report (2008) and the Governor's Mental Health Task Force Report (2014) - as well as previous committee's work - all made important recommendations to improve the mental health system in Kansas. The Hospital to Home Committee identified the potential crisis in State Hospital beds in 2008 and identified solutions to prevent such a crisis. However, like many such reports, little action followed.

Action plan:

- The Adult Continuum of Care Committee, like the Hospital To Home Committee, has identified many steps to improve the quality of care and prevent higher levels of costly care, but action

must now be taken. **It is the recommendation of this committee that the Secretary empower the Adult Continuum of Care committee to continue meeting on a regular basis to oversee the implementation of these recommendations.** This committee consists of a diverse membership that can help identify and eliminate system barriers as they arise. KDADS should continue to engage the committee members whom were not able to attend the previous meetings due to scheduling conflicts. . Adjustments are always necessary, and this group would be responsible to evaluate and make new recommendations as needed.

B. Funding Issues:

Current Status: Community Mental Health Centers receive less than half of the State funding provided for serving the uninsured in 2007.

Barriers / Gaps: An underfunded system is challenged to meet the basic needs of people with severe mental illness, let alone develop evidenced based practices, enhance existing services, or create needed alternatives of care.

Low Medicaid rates and limited state and federal grant dollars have left this level of care under-funded at a time when demand is high, particularly demand from un-insured and under-insured individuals. Persons who are addicted to substances have a greater chance of being hospitalized for psychiatric care. The availability of this level of care has decreased. State mental health hospitals become the safety net for persons who should be more appropriately treated in re-integration substance abuse settings

Committee work groups have identified multiple barriers to filling the gaps that weaken the overall ability of community based services to provide the right care in the right setting at the right time. Serving the uninsured is not optional, and it is very expensive when it occurs in the wrong setting. Statewide, more than half of the patients served by our system are uninsured – more, if you include the correctional system. The 1990 mental health reform act established state mental health grants to offset the cost of serving the uninsured at community mental health centers. The grant program was reduced from \$31 million to \$10.9 million between 2007 and 2010 due to the recession. Similar reductions were experienced in addictions treatment and community corrections programs that serve the uninsured. The Affordable Care Act reduces Disproportionate Share to Hospitals (DSH) funds that support serving the uninsured. While the funds available to serve the uninsured are decreasing, the number of uninsured served in the system has grown.

Therefore, the problem of serving the uninsured is one of the significant funding barriers reducing access to some services and threatening the sustainability of current programs, including all levels of the continuum – from state hospitals and community hospitals to housing resources and outpatient programs. A few of the other funding barriers discussed by the committee include insufficient reimbursement rates for services from Medicaid, Medicare and private insurance, the federal IMD exclusion rule, stagnant federal grant funding for housing programs, reduced DSH payments to support the state mental health hospitals and community hospitals, and others.

It is clear that the State of Kansas must implement additional funding options if we are to achieve a more complete continuum of care for persons with mental illness and substance use disorders. The following recommendations are a starting point and not intended to be limiting.

A. Staffing / Workforce Development:

Workforce Development

Current: Kansas experiences the same gaps in workforce as other states. They occur at every level of the behavioral health continuum, sometimes even when funding and reimbursement are available. Shortages are keenly felt in the rural and frontier regions, but qualified professionals can also be scarce in more populated areas. One example is Lawrence, where the inability to retain qualified psychiatrists contributed to the closure of the Lawrence Memorial Hospital 15 bed psychiatric unit in 2004. Community mental health centers are operating with as few as half the number of psychiatric care providers who are able to prescribe medications and monitor patients. The State Mental Health Hospitals have numerous open staffing positions, sometimes leading to unacceptable levels of overtime and strain on the current workforce.

Gaps / Barriers: Shortages of qualified workers, recruitment and retention of staff and an aging workforce and the lack of workers in rural/frontier areas are a significant problem. What are the reasons? Inadequate compensation, minimal behavioral health treatment training within nursing and medical programs, and the misperceptions and prejudice surrounding mental and substance use disorders are deterrents to new professionals entering the field. The workforce shortage itself can make employment unpleasant, with excessive demands placed on those who are working in the field today. Additionally, individual caseloads have increased in nearly every setting. This shortage has an impact on both access and quality of care.

Information excerpted from the SAMHSA [Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues](#) from January 24, 2013 linked here:

<http://store.samhsa.gov/shin/content//PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>

The Institute of Medicine (IOM; 2006) chronicles efforts beginning as early as the 1970s that attempt to deal with some of the workforce issues regarding mental and substance use disorders, but notes that most have not been sustained long enough or been comprehensive enough to remedy the problems. Shortages of qualified workers, recruitment and retention of staff and an aging workforce have long been cited as problems. Lack of workers in rural/frontier areas and the need for a workforce more reflective of the racial and ethnic composition of the U.S. population create additional barriers to accessing care for many. Recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering or remaining in the field. In addition, the misperceptions and prejudice surrounding mental and substance use disorders and those who experience them are imputed to those who work in the field.

Of additional concern, a new IOM report (2012) notes that the current workforce is unprepared to meet the mental and substance use disorder treatment needs of the rapidly growing population of older adults. The IOM report's data indicate that 5.6 to 8 million older adults, about one in five,

have one or more mental health and substance use conditions which compound the care they need. However, there is a dearth of mental health or substance abuse practitioners who are trained to deal with this population.

Pre-service education and continuing education and training of the workforce have been found wanting, as evidenced by the long delays in adoption of evidence-based practices, under-utilization of technology, and lack of skills in critical thinking (SAMHSA, 2007). These education and training deficiencies are even more problematic with the increasing integration of primary care and mental or substance use disorder treatment, and the focus on improving quality of care and outcomes. As noted by the IOM (2003), all health care personnel, including behavioral health clinicians, should be trained “to deliver patient centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics.”

The Kansas Department for Aging and Disability Services should explore current staffing needs, compensation of staff compared to other staff working in similar positions elsewhere, ways to support staff to prevent burn out and fatigue, provide additional training to staff.

Expand the availability of psychiatric residencies across Kansas, particularly in State Mental Health Hospitals. Provide incentives for newly trained psychiatrists to practice at the state hospitals such as scholarships, stipends, or student debt forgiveness, similar to what is offered for doctors who will practice medicine in rural settings. This should be done for CMHCS because they, too, have a severe shortage of prescribing physicians and in some areas, a great deal of turnover among prescribers.

Use technology such as telemedicine to maximize the availability of the psychiatrists we currently have available.

Action plan

- Bring stakeholders together to develop consensus to endorse amendment or revocation of the Federal IMD Exclusion rule. It is strongly recommended the State submit comment and coordinate with stakeholders to do the same
- Pursue solutions for serving the uninsured, such as exploring one or models of Medicaid Expansion. Such model should consider the impact on access to behavioral health services.
- Facilitate a detailed review of the reimbursement rates to enhance our ability to achieve priorities of access to a continuum of care and workforce development
- Create standard process to identify and pursue federal funds where such funding will enhance patient care and improve health outcomes through an effective continuum of care.
- Engage community stakeholders for the development of sustainable funding for additional behavioral health and housing options through long-term partnerships for federal, state, local and private funding commitments. (Law enforcement, judiciary, local governments, community hospitals, elected officials, providers, consumers and family members) These partnerships must set goals and outcomes to achieve over time

- Increase the number of residencies at the University of Kansas Medical School Psychiatric Program and engage the residents in work at the State Mental Health Hospitals and other behavioral health treatment settings
- Promote and expand cross training for student nurses by adding psychiatric inpatient experience, additions, treatment experience, and other behavioral health treatment settings.
- Promote and expand cross trainings for mental health and addictions professionals through specialized education programs at the universities and community colleges pre and post-graduation
- Promote and expand training and employment of peer specialists and peer mentors.
- Licensed Mental Health Technicians (LMHT) should receive proper educational training and be appropriately utilized within their established scope of practice
- Encourage the use of telemedicine and gather information on current and past utilization of telemedicine for areas of improvement from professional, consumer and family members

Conclusion

The Adult Continuum of Care Committee applauds the Secretary's efforts to transform the continuum of care for behavioral health services in Kansas. In particular, the committee commends KDADS for allocating the resources necessary to redesign and fund Rainbow Services, Inc. Furthermore, the committee commends KDADS for providing the resources necessary for the new crisis stabilization units in Emporia (Evergreen House) and Wichita.

It is this committee's belief that, even with these programs, the continuum in Kansas is insufficient to adequately meet the needs of the population. The Committee endorses the recommendation of the Hospital and Home Team calling for a developmental, multi-faceted approach to developing the service array regionally to better meet the needs of persons with mental illness outside of the state mental health hospitals. It should be noted that the recommendations and this report was developed over a short period of time. Additional recommendations could be realized and developed if this committee is allowed to continue to meet.

Appendix A: Adult Continuum of Care Committee Charter

Purpose: The Adult Continuum of Care Committee will build upon the work of the Governor’s Mental Health Task Force to review and make recommendations for transforming the behavioral health system. The Kansas behavioral health system is comprised of mental health, substance use disorders, prevention services, and problem gambling.

Timeline: Work will begin May 2015 and be completed by July 2015. Recommendations from this group will be presented to KDADS leadership by July 24, 2015.

Goal: The Adult Continuum of Care Committee will review the current system for providing behavioral health services. This review will include the current capacity of both state mental health hospitals as well as resources available in the communities. This committee will make recommendations to ensure an effective array of behavioral health services and supports to promote recovery and community integration.

Tasks:

- Review relevant recommendations from previous mental health and substance use disorder initiatives
- Review the current role of the State Mental Health Hospitals (Osawatomie State Hospital and Larned State Hospital)
- Make recommendations about the future role of the State Mental Health Hospitals within the behavioral health system
- Review current resources available in the communities for diversion and as a step down from the hospitals
- Identify gaps in housing and services (mental health, prevention, substance use disorder treatment services, etc) in the communities and make recommendations on what is needed
- Identify other gaps in the community’ services and make recommendations for what is needed
- Assess and make recommendations on how multiple systems of care can collaborate to better serve individuals with complex needs

Membership:

- Association of Counties - **Randall Allen, Executive Director**
- Behavioral Health Services Planning Council –**Wes Cole, Chair**
- Community Hospital - **Maggie Rassette, Via Christy Hospital Manhattan**
- Community Mental Health Center –
 - **Randy Callstrom, Wyandot Center**
 - **Bill Persinger, MHC of ECK**
- Persons with Lived Experience- -
 - **Beth Oswald**
- DCF – Adult Protective Services – **Leslie Hale, DCF - Prevention and Protection Services**

- Emergency Medicine – **Ryan Jacobson, MD, EMS System Medical Director, Johnson County**
- Governor’s MH Task Force representative –**Becky Gray, Director of Housing and Community Development at City of Pittsburg**
- Home and Community Based Waiver Services staff– **Ashley Kurtz**
- Hospital / Psychiatry –
 - **Karen Shumate, Lawrence Memorial Hospital**
 - **SallyAnne Schneider, Stormont Vail Hospital**
 - **Dr. Vishal Adma, Medical Director, KVC**
- Judge –
 - **Judge Kathleen Lynch**
 - **Judge Bradley Ambrosier, 26th Judicial District**
- KanCare Managed Care Organizations –
 - **Gena Hyatt and Joe Schlageck – Amerigroup**
 - **Sandra Berg – Sunflower**
 - **Sandy Hashman and Lisa Gravelle – United**
 - **Gerald Snell - United**
- Kansas Consumer Advisory Committee (CAC)
- Kansas Department of Corrections —
 - **Margie Phelps**
 - **Sarah Barnhart**
- Kansas Department for Health and Environment - **Fran Seymour-Hunter**
- Kansas Housing Resources Corporation — **Al Dorsey**
- Law Enforcement Officer -CIT trained – **Bill Cochran**
- Legislators –
 - **Representative Will Carpenter**
 - **Representative Kathy Wolfe Moore**
 - **Senator Forrest Knox**
- Mental Health Coalition – **Amy Campbell**
- Sheriff’s Association – **Jeff Herrig, President**
- State Mental Health Hospital –
 - **John Worley – Osawatomie State Hospital**
 - **Jessie Fox – Larned State Hospital**
- Substance Use Disorder Providers -
 - **Doug Johnson, Mirror Inc**
 - **Dulcinea Rakestraw, Preferred Family Health**

Invited Guests:

Dan Peters, KU Hospital; Deb Stern, KHA; Adele Ducharme

Facilitator(s): The Adult Continuum of Care Committee will be facilitated by KDADS staff;

- Doug Wallace, Housing & Homeless Specialist
- Carla Drescher, Director of Behavioral Health Services

Appendix B: Gaps / Suggested opportunities for improvement that were generated during facilitated roundtable discussions

I. State Mental Health Hospital

Barriers:

- Lack of clear role for SMHH
- Staffing levels
- People not being appropriately transitioned back to the community
- Lack of funding to support discharge
- Transportation to and from the hospital
- IMD Exclusion rule is a barrier in Kansas
- SMHH have to cover more due to lack of resources

Opportunities:

1. Improve staffing and increase services at SMHH
2. Utilize community based transportation resources
3. Create more RSI like facilities and increase diversion resources
4. State should look at diversion models used by other states; such as Minnesota, Missouri and New Jersey
5. Evaluate the IMD Exclusion rule in Kansas
6. Support hospitals as safety net

II. NFMH

Barriers:

- Not rehabilitative
- Funding does not allow for transition plans
- People are “stuck” in NFMH due to lack of alternative housing
- Role of NFMH is not clear
- IMD Exclusion rule may be challenge

Opportunities:

1. Redefine role of NFMHS
2. Review data to see what type of residents are currently using NFMH
3. Reach out to other states to see what they use instead of NFMH
4. Open codes for CMHC services to be provided in the NFMH
5. Increase supported housing options
6. Coordinated mental health services
7. Support rehab and transition planning

III. Community Inpatient Psych beds

Barriers:

- Hand off between systems and transitioning people back to the hospital
- Not enough RSI facilities in Kansas
- Not enough psych providers
- Can't mix voluntary patients with involuntary patients. Need separation of units
- Private hospitals can refuse involuntary admissions
- Inability to serve special needs populations

Opportunities:

1. Importance of case management and discharge planning
2. Need for more peer support and peer specialists
3. Need to create more RSI type facilities
4. Increase public and provide partnerships
5. Need more funding to expand diversion resources
6. Early interventions and education
7. Drop in Centers

IV. Integrated care

Barriers:

- Handoff between systems
- Formularies for medications
- Shortage of providers to have seamless services
- Lack of telemed/telepsych options
- Statutes that “tie our hands” with providing integrated care
- Stigma among providers and public

Opportunities:

1. Focus on policy and funding that promote integrated care
2. Any cost savings from programs need to go back into programs
3. Replicate the Southeast Kansas model of a one stop shop – model of collaboration
4. Incorporate SUD services – add more sobering beds
5. State funded 1-800 number for curbside consultation
6. Support Health Homes
7. Increase communication across medical and behavioral health providers

V. Community Based Services

Barriers:

- Lack of capacity for special populations
- Lack of capacity for SUD and CBS – licensing structure, credentialing process, and getting reimbursed

- Lack of services for transition aged youth
- High caseloads
- Insurance limits
- Lack of funding for CMHCS – limits availability of services
- Confusing criteria for programs

Opportunities:

1. Explore one or models of Medicaid expansion, focusing on overcoming or minimizing barriers for uninsured Kansans with behavioral health needs.
2. Reward innovation and the use of evidenced based programs
3. Workforce development – residency program in MH and SUD community programs
4. Have adequate reimbursement / funding for community based services
5. State needs adequate staffing to be able to take advantage of federal grants
6. Need to open codes so to allow non CMHCS to provide the services
7. More support for transportation

VI. Community Based Housing

Barriers:

- Lack of housing options or poor quality housing
- Lack of services connected to housing options
- Rigid requirements for housing
- No housing options for transitioned age youth
- Quality of housing in rural areas
- Shortage of funding for housing

Opportunities:

1. Develop a lead housing agency
2. Provide an array of services in housing
3. CMHC catchment areas shouldn't limit care
4. Need funding to be flexible enough to allow for communities to tailor programs to meet the community's needs
5. Create more 24 hour structured care environments and other housing options
6. Develop expertise of housing resources
7. Allocate state resources so that can pull down federal funds

Appendix C: SYNOPSIS: THE CURRENT ROLE OF THE STATE HOSPITAL, VISIONS FOR THE FUTURE

October 19, 2008

Summary: The social service system is made up of an array of critical services and supports, including state mental health hospitals. The role that each service fulfills affects the role of other services in the array. Because the state mental health hospitals are often considered the “placement of last resort,” the role that mental health and other social services fulfill defines the role of the state mental health hospitals. As a result, in addition to providing inpatient psychiatric services, the state mental health hospitals are currently called on to provide broad social safety net services. Persons state mental health hospitals serve with these broad social safety net services are very vulnerable and/or a serious risk. The Hospital and Home Initiative work plan calls for taking a developmental, multi-faceted approach to developing the service array to better meet these person’s needs outside the state mental health hospitals. This will gradually allow the state mental health hospitals to focus more resources on specialized inpatient psychiatric services thereby moving them closer to fulfilling the Hospital and Home Initiative recommendation that they become tertiary care facilities.

Background: In 2006, a legislative Interim Subcommittee expressed concern regarding increased state mental health hospital admissions resulting in chronic over census. The Interim Subcommittee asked that SRS and mental health stakeholders work together to address this issue. SRS responded by establishing the Hospital and Home Initiative to research and design a plan to implement an effective array of hospital and community services to better serve all Kansans with mental illness. The Hospital and Home Core Team engaged a large number of key stakeholders in Work Teams to develop a comprehensive list of recommendations. The Work Teams were asked to, “Outline the role(s) of state hospitals in all recommended actions.” All three reports included references to the role of the state mental health hospitals; however, consensus was not reached on how to best transition to a new role for state mental health hospitals.

Current Role: The three state mental health hospitals currently have the capacity to serve an average daily census of 325 persons in their general psychiatric services programs¹. According to state law, with few exceptions, a qualified mental health professional employed by a community mental health center (CMHC) must determine that a person is mentally ill and, because of the person's mental illness, is likely to cause harm to self or others before the person can be admitted to a state mental health hospital. As a matter of policy Kansas state mental health hospitals accept everyone approved for admission by a CMHC, even when the hospital is above its budgeted capacity.

The Hospital and Home Initiative Core Team reviewed admission data for the state mental health hospitals. The data revealed significant variability in state mental health hospital admission rates

¹ This does not include the State Security Hospital or the Sexual Predator Treatment Program or KVC STAR for children.

from various areas across the state. The data suggests that this variability may be occurring for one or more of the following reasons:

- Variability in how individual screeners determine danger to self or others;
- Variability in the availability of regional inpatient mental health treatment services;
- Variability in the rates of homelessness;
- Variability in the amount and type of available mental health services in different areas of the state;
- Variability in how CMHCs serve persons in crisis whom they have not previously served; and
- Variability in the amount and type of available services and supports for persons with other complex needs such as mental retardation, traumatic brain injury, elderly with difficult behavior challenges, substance abuse, etc.

These variations have resulted in the state mental health hospitals serving persons with a wide variety of needs beyond just their mental illness. The wide variety of needs has required the state mental health hospitals to, in part, provide broad social safety net services. In addition to providing inpatient mental health treatment, state mental health hospitals are currently called on to serve persons:

- Who could be effectively served in local, private inpatient settings if they were available;
- Experiencing severe maladaptive behaviors not directly related to mental illness such as persons who are frail elderly, persons with a developmental disability, persons with a traumatic brain injury, etc.;
- Needing primarily inpatient substance abuse treatment;
- Who would be served in community based services if they were from other areas of the state; and
- Who, due primarily to being homeless or precariously housed, are not effectively served in the community.

Recommendation: The Hospital and Home Service Access Work Team has recommended that the state mental health hospitals become tertiary mental health treatment facilities. The Service Access Work Team defined a tertiary care facility as one that provides longer and potentially more complex course of inpatient mental health treatment. Tertiary care facilities have professional staff composed of mental health specialists who are actively engaged in relevant research and who bring the most advanced science to their clinical practice. The recommendation goes on to say that these facilities should only admit persons referred from a lower level of care or by a court for intensive specialized treatment. Achieving this recommendation requires that state mental health hospitals focus their resources on the treatment of mental illness and not on the broad safety net services which they are currently called upon to provide.

Next Steps: The Hospital and Home Core Team has preliminarily selected the Work Team recommendations that should be implemented first and is overseeing the implementation of those recommendations. Many of those recommendations, when implemented, will help reduce the need for state mental health hospitals to provide broad safety net services allowing them to evolve

toward the role recommended by the Service Access Work Team. The Work Team recommendations selected to implement first include:

- Expanding regional private inpatient mental health treatment services;
- Re-visioning the role of NF/MHs;
- Requiring agencies that place individuals into state mental health hospitals to accept the person back to services once the person's acute mental health treatment has been successfully completed;
- Expanding housing options for persons with disabilities;
- Improving and expanding crisis services in community settings; and
- Improving the screening, assessment, and discharge process for state mental health hospitals.

Additional efforts are being made that, while not Hospital and Home Initiative recommendations, will support this process. For example, the Association of Community Mental Health Centers of Kansas and InterHab, the developmental disabilities providers association, have undertaken the "Building Bridges" project to improve community services to persons with a developmental disability and mental illness. And KHS is focusing on ensuring persons diverted from state mental health hospital admission or being discharged from a state mental health hospital receive adequate, timely services.

Appendix D: Medicaid IMD Exclusion Rule

INSTITUTIONS FOR MENTAL DISEASES (IMD) INFORMATION SHEET

An Institution for Mental Disease (IMD) is defined at 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)]. Effective July 5, 2000, HCFA granted Arizona expenditure authority to provide limited services to Title XIX persons age 21 through 64 in IMDs. Based on current ADHS/OBHL licensing language, facilities which meet the definition of an IMD are licensed Level I facilities with more than 16 total treatment beds. General acute care hospitals with psychiatric units *are not* considered IMDs.

Settings/Provider Types:

- Level I Psychiatric Hospital (provider type 71)
- Level I Residential Treatment Center with more than 16 beds (provider types B1 and B3)
- Level I Sub-acute facility with more than 16 beds (provider type B6)
- Medicare certified nursing facility with more than 16 beds and more than 50% of patients are primarily treated for mental disorders (provider type 22)

Service Limitations:

A Title XIX member who is 21 years through 64 years old may receive services in an IMD for up to 30 days per admission and 60 days per contract year (July 1 – June 30). A member whose stay exceeds 30 days per admission/60 days per contract year may lose Title XIX eligibility. IMD agencies must provide written notification to a Title XIX member at admission that their AHCCCS eligibility will end if they remain in an IMD longer than 30 days per admission or 60 days annually. An AHCCCS member (21-64 years) who exceeds 30 inpatient days in an IMD is considered to be in an ineligible setting and is not entitled to receive any Medicaid service, either inside or outside of the facility, while remaining as a resident.

Reimbursement Limitations/Provider Requirements :

- The Arizona State Hospital must report all admissions of Title XIX or Title XXI members to AHCCCS Member Services (fax: 602-253-4807 or telephone: 602-417-4063).
- IMDs, other than the Arizona State Hospital, are required to notify AHCCCS Member Services (fax: 602-253-4807 or telephone: 602-417-4063) only when a Title XIX member age 21 through 64 years old has been a resident/inpatient for 30 consecutive days and provide the following information:
 - *Provider* Identification Number and telephone number
 - *Recipient's* name, date of birth, AHCCCS Identification Number *and* Social Security Number
 - Date of admission

AHCCCS eligibility for a member whose admission has been reported as exceeding 30 days will be 'suspended' for the remainder of the admission. IMD Providers are required to notify AHCCCS Division of Members Services (DMS) when the member is discharged so that eligibility can be restored. This limited tracking of member admissions/discharges will not function to collect cumulative utilization. Contractors and providers should be aware that due to claims and encounter lags, they cannot rely on timely tracking of utilization at the state agency level (AHCCCS and ADHS/DBHS) and are therefore encouraged to solicit utilization information from client history,

medical records and other measures as appropriate. Facilities other than the Arizona State Hospital should *not* report admissions of members who are less than 21 years old or age 65 and older to AHCCCS but may be required to report such admissions to RBHAs or ALTCS Contractors. ALTCS Contractors and ADHS or designee must monitor 2 members age 21 through 64 cumulative utilization and report to DMS when a member reaches 60 cumulative days.

Kids Care:

The federal IMD regulations do not apply to Title XXI (KidsCare) members; the 30/60 IMD limitations are not applicable to this population. Admission/discharge notification is *not* reported to AHCCCS Administration. AHCCCS KidsCare members can be admitted to an IMD if they are *already* eligible for Title XXI. However, federal regulations prohibit application or redetermination for Title XXI while a resident of an IMD. Provider types which identify IMD status of Residential Treatment Centers have therefore been established: provider types B1 and B3 **are** IMDs; provider types 78 and B2 **are not** IMDs for KidsCare redetermination purposes only. KidsCare members in IMDs will be evaluated for Title XIX eligibility at the end of their KidsCare eligibility period.

Appendix E: Transitional Care Services Needs Assessment 2015

The data resources used for this report were collected from 26 community mental health centers (CMHCs) in September 2014. In this report, Section I describes the details in relation to the availability of housing options, eligibility, target population, and other key elements of the program; Section II presents the availability of services in any of housing options, how timely the services are, and other key elements of the services.

Section I: Housing										
1. <u>What currently exists (The number of individuals for whom each option is available)?</u>	Not Available		1-5		6-10		11-15		Over 15	
	#	%	#	%	#	%	#	%	#	%
Interim housing	16	61.54	2	7.69	5	19.23	1	3.85	2	7.69
Structured care environments	19	73.08	1	3.85	2	7.69	0	0.00	4	15.38
Vouchers for hotels	9	34.62	12	46.15	1	3.85	1	3.85	3	11.54
Transitional housing beds	16	61.54	1	3.85	6	23.08	1	3.85	2	7.69
Rapid re-housing*	18	72.00	0	0.00	2	8.00	0	0.00	5	20.00
Professional resource family care	12	46.15	10	38.46	0	0.00	0	0.00	4	15.38
Short-term respite care	4	15.38	9	34.62	3	11.54	2	7.69	8	30.77
		Yes		No						
Other housing options?*	#	%	#	%						
	7	28.00	18	72.00						
<i>Note: * The response from one agency is missing</i>										
		Yes		No						
2. <u>Present capacity is adequate?</u>	#	%	#	%						
	6	23.08	20	76.92						
		1-5		6-10		11-15		Over 15		
	#	%	#	%	#	%	#	%		
If not adequate, how many additional beds could be used	3	15.00	10	50.00	4	20.00	3	15.00		

3. <u>Population to whom options*** are available (check all that apply)</u>	Medicaid Only		Self-pay		Adults		Children		Singles		Families		Persons with SUD	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Interim housing	8	30.77	8	30.77	11	42.31	2**	7.69	8	30.77	2	7.69	8	30.77
Structured care environments	5	19.23	3	11.54	5	19.23	0	0.00	2	7.69	0	0.00	3	11.54
Vouchers for hotels	8	30.77	9	34.62	14	53.85	3	11.54	10	38.46	11	42.31	6	23.08
Transitional housing beds	7	26.92	5	19.23	9	34.62	1	3.85	5	19.23	1	3.85	4	15.38
Rapid rehousing	6	23.08	5	19.23	8	30.77	4	15.38	6	23.08	5	19.23	2	7.69
Professional resource family care	8	30.77	1	3.85	0	0.00	13	50.00	0	0.00	1	3.85	0	0.00
Short-term respite care	14	53.85	3	11.54	1	3.85	20	76.92	0	0.00	0	0.00	0	0.00
			Yes		No									
	#	%	#	%										
Others	4	15.38	22	84.62										

Note: **The two CMHCs have interim housing open to children only when they are with their family members.

***A glossary of housing options is provided in the Appendix.

4. <u>Are any of the above options CMHC owned/operated or run by other programs? Please specify.</u>	Yes		No	
	#	%	#	%
	15	57.69	11	42.31

5. <u>Does your center use a local shelter as a transition option?</u>	Yes		No					
	#	%	#	%				
	15	57.69	11	42.31				
			1-5		6-10		11-15	Over 15
	#	%	#	%	#	%	#	%
If yes, how many times is the shelter used per year?	2	13.33	1	6.67	2	13.33	10	66.67

	Yes		No	
	#	%	#	%
6. <u>Is there a clinical need required to access the options?</u>	16	61.54	10	38.46

	SMI/SPMI/SED		Homeless		Discharged from hospitalization		Other criteria	
	#	%	#	%	#	%	#	%
If yes, specify*	8	30.77	3	11.54	2	7.69	2	7.69

Note: * The response from one agency is missing

	Yes		No	
	#	%	#	%
7. <u>Do you employ a housing specialist?*</u>	18	72.00	7	28.00

Note: * The response from one agency is missing

	Full-time (%)		Half-time (%)		Quarter-time (%)		No allocation (%)	
	#	%	#	%	#	%	#	%
If yes, are they	12	66.67	1	5.56	1	5.56	4	22.22

Section II: Services

8. <u>What services are available in any of housing options listed in Q1 &3?</u>	24/7		12 hrs/day		8 hrs/day		4 hrs/day		<4 hrs/day		Not Available	
	#	%	#	%	#	%	#	%	#	%	#	%

Attendant care*	12	48.00	5	20.00	3	12.00	1	4.00	3	12.00	1	4.00
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	1-3 hrs		3-6 hrs (%)		6-9 hrs (%)		Over 9 hrs (%)		Not Available (%)	
	#	%	#	%	#	%	#	%	#	%
Peer support***	5	20.83	5	20.83	4	16.67	2	8.33	8	33.33
CPST***	13	54.17	4	16.67	3	12.50	2	8.33	2	8.33
Parent support	9	39.13	4	17.39	2	8.70	0	0.00	11	42.31

Note: * The response from one agency is missing
 *** The responses from two agencies are missing

9. <u>How soon after discharge is service typically available?</u>	Within 1 hour		Same day		2-3 days		4-7 days		Over 7 days		Not Available	
	#	%	#	%	#	%	#	%	#	%	#	%
Attendant care*	2	8.00	16	64.00	5	20.00	2	8.00	0	0.00	0	0.00
Peer support*	0	0.00	11	44.00	5	20.00	5	20.00	0	0.00	4	16.00
CPST*	1	4.00	18	72.00	2	8.00	3	12.00	1	4.00	0	0.00
Parent support***	0	0.00	12	52.17	3	13.04	5	21.74	2	8.70	1	4.35
Therapy*	0	0.00	14	56.00	4	16.00	5	20.00	2	8.00	0	0.00

Note: *The response from one agency is missing
 *** The response from three agencies are missing;

10. <u>Which service is immediately available?</u>	Yes		No	
	#	%	#	%
Attendant care*	17	68.00	8	32.00
Peer support*	10	40.00	15	60.00
CPST*	20	80.00	5	20.00
Parent support*	10	40.00	15	60.00
Therapy*	16	64.00	9	36.00

Other 12 48.00 14 52.00

Note: * The response from one agency is missing.

	Yes		No							
	#	%	#	%	#	%	#	%	#	%
11. <u>Are Med-drops available?*</u>	17	65.38	9	34.62						
	Once daily		2-3x/day		Weekly		Other		All options	
	#	%	#	%	#	%	#	%	#	%
If yes, how often*	3	18.75	8	50.00	1	6.25	2	12.50	2	12.50
	One week		Two weeks		1 month		Over a month		As needed	
	#	%	#	%	#	%	#	%	#	%
If yes, how long*	2	12.50	0	0.00	0	0.00	9	56.25	5	31.25

Note: * The response from one agency is missing

12. <u>When transition options - housing and services- are not available, what are the barriers to making them available?</u>	Yes		No	
	#	%	#	%
Professional Resource Family Care*	1	4.00	24	96.00
Funding	21	84.00	5	20.00
Capacity*	6	24.00	19	76.00
Resource not in the community	10	40.00	16	64.00
Resources for clients with criminal Records	2	8.00	24	96.00
City resistance*	1	4.00	24	96.00

Note: * The response from one agency is missing

13. <u>If resources were unlimited, what transition options would your center develop in both housing and services? Please be specific. ****</u>	Yes		No	
	#	%	#	%

Crisis stabilization beds or respite care for children	10	38.46	16	61.54
Parent support services	5	19.23	21	80.77
Peer support	5	19.23	21	80.77
Crisis beds for adults	7	26.92	19	73.08
Crisis intervention services	7	26.92	19	73.08
Interim housing/other short-term housing	10	38.46	16	61.54

*Note: ***** Listed are only the options five or more CMHCs identified.

Appendix I.

The Glossary of Housing Option Terms

Emergency Shelter – Any facility whose primary purpose is to provide temporary shelter for the homeless in general or for specific populations of the homeless.

Interim Housing – Short-term (up to six months) project-based housing that provides immediate community-based housing for persons who are homeless or who are homeless and being discharged from inpatient or residential mental health or substance use treatment facility (e.g., a state psychiatric hospital (SPH), nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program.

Structured Care Living Environment – Short-term residential facility providing a safe, structured environment for individuals with high psychiatric needs. Services are available 24 hours per day and are offered according to clinical need. The facility can be owned or leased by the CMHC or owned by a community organization. Length of stay in the facility is short term and is no more than 6 months.

Housing Vouchers – Short-term financial assistance used to temporarily place an individual or family in a hotel following discharge from an institution.

Transitional Housing Beds – Short-term housing beds coupled with supportive services. Short term stays can be defined as residing in the beds for up to 6 months; 6 months – 1 year, or 1-2 years.

Rapid-Rehousing – Programs to assist individuals and families who are homeless move as quickly as possible into permanent housing and achieve stability in that housing through a combination of short term rental assistance and supportive services.

Housing Placement Services – Services to help people find permanent housing after discharge from the transitional housing option.