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Comment	Response
1. The proposal appears to be silent on the revocation of an Outpatient Treatment Order - unless I missed it. Can we ask for information on revocations to be included in this?	KDADS will include OTO revocation language.
2. A.4. Re: Need for Nurse:Nurse and Doc:Doc call. When we call LSH, the triage nurse will ask "has the person been seen at a hospital in the last 24 hours" – if that answer is yes, they then require these calls. If the answer is no because the person is seen at CMHC or LEC, these calls do not need to take place. So, I do think it needs clearly stated that those calls are only required if client is being transferred to LSH from an ER or hospital unit	State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision.
3. B.7.c. re: EMTALA and hospital helping with transportation because that person is **their** patient. If someone is transferred from GC to Wichita due to a cardiac condition they cannot manage locally, they sure help that person get there so why wouldn't the hospital have the same responsibility in	State Hospitals are not obligated to make these arrangements.
II.A.5. There are many cases where it is clear from the beginning that community options are not appropriate due to the acuity and severity of the symptoms and safety of the patient and community. We would proceed immediately with moving towards state hospitalization.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission.
II.B.3. While we do our best to assess, it's not always straight forward in an emergency whether the behaviors are symptomatic as a direct result of a diagnosed mental illness or are substance induced. It is often the behavioral manifestation of intoxication or withdrawal that elicit behavioral problems than cannot be managed in the community.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission.
Also, to say that the individual must be able to benefit from the	State Hospitals independently decide on a case-by-case basis

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Comment	Response
active treatment is too subjective. II.B.5.d. It's not always easy to distinguish in an emergency, especially if early in the course of the illness, whether a person has a diagnoses which includes dementia or other neurocognitive disorder and will not benefit from active treatment. II.B.5.g Note: This section calls attention to a gap in the continuum of care. Where are Kansans who require specialized medical/nursing care services in addition to involuntary psychiatric services supposed to go? We're not commenting on the ability of OSH to provide this level of "the right care at the right place" but who *can* provide "the right care at the right place?" II.B.5.i. This seems inappropriate. A person with a primary diagnosis of BPD may very well require involuntary treatment due to the severity of their symptoms and harm to self or others. We understand that overuse of the state hospital by a particular patient with BPD might be a problem, but shouldn't that be addressed on a case by case basis rather than as a policy restriction against every patient with BPD? II.7.b. Within what timeframe will the state hospital psychiatrist review the screening instrument and make an independent assessment? Shouldn't this be stated as within 3 hours since this is emergency and CMHCs are held to that standard? II.8.c. The goal to provide the right care at the right time and the right place begs for the state to eliminate the waiting list concept.	when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals decides independently on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. Because each admission decision is on a case-by-case basis, a timeframe within which a State Hospital will make an admission decision is not consistent with the obligation to ensure that, without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission.
Please accept the following as my feedback regarding the Pre-admissions Process to the State Psychiatric Hospitals. Most of my	The current admission State Hospital triage process will continue.

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Comment	Response
questions address gaps in the continuum of care if the state hospital is not an option for certain individuals. Any clarification in the procedures to address these would be appreciated.	
Page 1, A-4. It says that a doc-to-doc or nurse-to-nurse “must take place unless the admitting state hospital determines it is not necessary”. But then on point 5, it states that screening can occur anywhere including in the community where there are not necessarily medical staff. If the screen occurs in a location other than a medical facility, what is the expectation? Are we to try and move someone from jail or a community setting to a medical facility so this phone call can occur? Under what circumstances or for what reasons would this be required?	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. This decision can only be made upon receipt of timely and accurate information and documentation from the QMHP.
The state hospital currently requires “medical clearance”, which is not referenced anywhere in this policy. Is this requirement being eliminated? Medical records, labs, etc… are difficult to obtain from the community. We have often asked what medical documents they need and often don’t get a clear answer. Can the document clarify this?	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. The conversation will include the discussion of the information and documentation necessary to facilitate an informed admission decision.
One concern is regarding “Persons presenting with an alcohol or substance abuse crisis, not obviously accompanied by a psychiatric crisis.” When our crisis clinicians are called to an ER or the county jail due to someone who appears psychotic, it is often difficult in the short term to know if it is a true psychotic episode or if it a SUD related episode. This is particularly true when the person is unknown to the mental health center. It seems that SUD is having to be ruled out prior to an agreement to admit, and I understand that on one hand. On the other hand, the current language is “sole diagnosis” of SUD. If the screener’s best	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision.

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Comment	Response
determination is that there is a co-occurring psychiatric disorder and SUD, and the person is at imminent risk of harm to themselves or others, there may be no other resources in local communities to keep them safe. It seems this is the role of the state hospital as the safety net. Persons requiring specialized medical/nursing care. I understand the limitations that the state hospital system has on providing medical care to individuals in a psychiatric crisis who are not medically stable or require medical treatment beyond the scope of the state psychiatric hospital. Are there other provisions that can be made for individuals that fall into this category? IE: Compensation for a community hospital that otherwise is not mandated to admit someone who does not have a pay source? If the state hospital is not an option for someone on dialysis, for example, and he/she is at eminent risk of harm, what options exist for emergency psychiatric inpatient treatment if that person does not have insurance or other resources? "Persons presenting with a primary diagnosis of borderline personality disorder, and whose presenting issues are a direct manifestation of that diagnosis." BPD is a SPMI diagnosis. And these individuals are certainly capable of being a danger to themselves or others. I understand the rationale, and it is not best practice to admit someone with BPD into a hospital. However, if someone is actively suicidal, and BPD is there diagnosis, I am concerned that they would not have alternatives for their safety and treatment.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. The care and treatment of a person before admission to a State Hospital and after discharge from a State Hospital is the responsibility and duty of the community. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. The conversation will include the discussion of the information and documentation necessary to facilitate an informed admission decision.
• We appreciate the statement of purpose for the policy. Would it be possible to include reference to all applicable	KDADS will include cites to relevant statutes.

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Comment	Response
laws that were considered in the policy?	
• Pre-Admission policy A1 specifies that the QMHP will provide an assessment of..."the immediate psychiatric and medical treatment needs of a person experiencing a psychiatric crisis." While QMHP staff are well trained in the ability to conduct a biopsychosocial assessment, we respectfully note that QMHP staff do not have the medical training required to conduct an assessment of medical treatment needs.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. The conversation will include the discussion of the information and documentation necessary to facilitate an informed admission decision.
• Pre-Admission policy A3 specifies that a crisis assessment is a "face-to-face appraisal." We would appreciate consideration of additional language here which specifies allowance of assessments performed via televideo. While ELC does not currently provide televideo assessments, we would like the freedom to manage this process in the modality that makes the most sense with regard to client needs, staffing patterns and value.	State Hospitals utilize tele-med technology.
• Pre-Admission policy A4 states that a "nurse-to-nurse and/or a doctor-to-doctor consult must take place unless the admitting state hospital determines it is not necessary." ELC would like clarification on the criteria that would drive this decision. We question the applicability of a medical consultation for most clients receiving a screen. Screens can occur at many different locations within the community, not always at a hospital location. And information obtained through the biopsychosocial assessment does not always suggest the need for medical consultation. Additionally, the possible requirement of having a medical consultation can increase the burden experienced by our local community hospitals, as well as result in additional service costs for our most vulnerable clients.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision.

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Comment	Response
• Pre-Admission policy A6 reads "...as opposed to those that can be attended to by community-based outpatient services." We suggest the addition here of language allowing for "outpatient and rehabilitation services" • Section B1 again references "nurse-to-nurse and doctor-to-doctor consults" that must be reviewed by hospital admitting staff. We respectfully request that this not be a requirement across the board as is does not seem applicable in every situation, and would appreciate clarification of the criteria which would trigger such a requirement. • Section B2a references the ability for voluntary admission to a state psychiatric hospital to be possible if certain criteria are met, including when "the head of the treatment facility determines such a person is in need..." Can you clarify the role of the person making this decision for the treatment facility (e.g. Superintendent, Medical Director, Psychiatrist on Duty, etc?) Also, how would adopting this draft policy play out under an admissions moratorium? • Section B2b(3) states with regard to admission based on property damage, "the harm must be of such a value and extent that the state's interest in protecting the property from such harm outweighs the person's interest in personal liberty..." Would it be possible to clarify what this means and how the determination between harm and liberty would be made? • Section B3 identifies that in order for approval of admission, an individual "must be able to benefit from, and participate in the active treatment provided by the hospital treatment staff." It would be helpful to further clarify this point. We are curious who makes this decision about the ability to benefit, and on what criteria is this	KDADS will not add the suggested language, which is more appropriate for an admission policy to a ICF/IID. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis when to initiate doctor-to-doctor consults to assist the Hospital in making an informed admission decision. The conversation will include the discussion of the information and documentation necessary to facilitate an informed admission decision, to include whether the person at that time will benefit from acute inpatient psychiatric treatment. The head of a State Hospital is the appointed Superintendent or their designee. The triage process will remain should the moratorium be removed. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis will consider all information provided to admission staff to ensure an informed admission decision is made.

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Comment	Response
determination made?	
• Section B5d suggests the restriction from admission of any person presenting with diagnoses including dementia or other neurocognitive disorder. Clarification would be helpful with regard to whether or not such admission would be possible for an individual presenting with these diagnoses, but who are also a clear danger to themselves or someone else. ELC has concerns with regard to alternative continuum of care options for individuals with neurocognitive disorders meeting criteria for involuntary psychiatric admission.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis will consider all information provided to admission staff to ensure an informed admission decision is made, to include whether the person at that time will benefit from acute inpatient psychiatric treatment.
• Section B5e suggests restriction from admission for those individuals presenting with substance use disorder that is "not obviously accompanied by a psychiatric crisis." What is meant by "obviously" in this context? Also, ELC notes that during a brief crisis contact it is often difficult to fully distinguish the contribution that substance use has to the presenting dangerousness - or what alternatives exist for those individuals who are intoxicated and also of danger to themselves or someone else. We note that wonderful progress has occurred in the state of Kansas over the past several years with regard to recognition of the importance of integrated healthcare in achieving important clinical outcomes as well as cost savings. The distinction between substance use disorder and psychiatric illness does not seem in keeping with the State's direction regarding integrated care.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis will consider all information provided to admission staff to ensure an informed admission decision is made, to include whether the to include whether the person at that time will benefit from acute inpatient psychiatric treatment.
• Section B5f references restriction of admission for "Persons exhibiting extreme sexual acting out which is harmful to self or others and is not related to psychiatric symptoms." Further clarification on specific situations of this nature would be helpful.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis

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Comment	Response
• Section B5h prohibits admission for individuals with diagnoses primarily related to "conduct disorder, antisocial personality disorder or traits of antisocial personality disorder." ELC was aware of some previous restrictions along these lines, but wonder if "traits of antisocial personality disorder" is a new criteria. This seems somewhat broad and potentially overly restrictive as "traits" are typically indications of something that might be present, but do not comprise a formal diagnosis. • Section B5h also indicates restriction of admission for persons "presenting with a primary diagnosis of borderline personality disorder and whose presenting issues are a direct manifestation of that diagnosis." Could clarification be provided regarding from what law this requirement stems? While ELC recognizes and works hard to avoid hospitalization for persons experiencing borderline personality disorder, we also note that at times the symptoms of this disorder result in extremely dangerous behaviors which warrant involuntary hospitalization criteria. • Section B6b states that when determining whether an admission is voluntary or involuntary, a QMHP must "exhaust all community hospital options within the state before referring to a state hospital." While ELC recognizes the importance of preserving our state hospital resources and strives continuously to be good stewards in the process, the need to contact every hospital across the State is very time consuming. During this time, clients in need tend to escalate and become more aggressive or disruptive. Additionally, it is not feasible for clients to work with admission options across the wide State of Kansas. Many clients ELC encounters in crisis are living	consider information provided to admission staff to ensure an informed admission decision is made. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis consider all information provided to admission staff to ensure an informed admission decision is made, to include whether the person at that time will benefit from acute inpatient psychiatric treatment. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis consider all information provided to admission staff to ensure an informed admission decision is made, to include whether the person at that time will benefit from acute inpatient psychiatric treatment. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission, which includes the assurance that it can be demonstrated that all community services have been exhausted. State Hospitals independently decide on a case-by-case basis all information provided to admission staff to ensure an informed admission decision is made. A person's income level or societal status are not determining factors for admission into any treatment facility.

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well below the poverty level, lack transportation and have poor social supports that would render distant travel impossible.	
• Section B6c references the need for the QMHP to "be prepared for a consult with medical staff." Further clarification on this process, including anticipated questions, would be helpful to the preparation process. • Section B7aii states the QMHP should assist the admissions office "...in any other way..." We respectfully ask for the addition of the term "reasonable way."	It is expected that when a QMHP is recommending admission to a State Hospital they are prepared to engage in a conversation with admission staff to assist admission staff on a case-by-case basis to ensure an informed admission decision is made, and that the person meets the statutory criteria for admission.
• Section B7aiii states the need for the QMHP to help a client to collect documentation and information they will need in order to be admitted. Clarification on required documentation and information would be helpful in facilitating this for the state hospital.	The key source of information is the QMHP. It is expected that the QMHP has considered all available community resources before recommending admission to a State Hospital. Therefore, the QMHP must have documentation to support their recommendation.
• Section B7c references the need for the QMHP to make "reasonable efforts to coordinate secure transportation for the person..." This section goes on to specify that the QMHP should work to make the transportation as least restrictive as possible, utilizing family, case mangers..." Clarification would be helpful regarding the use of the term "secure transport" in conjunction with "least restrictive." We recognize and agree with the importance of limiting the resource drain to our local law enforcement partners with regard to crisis management. However, ELC's understanding is that secure transportation is limited in nature, and includes options such as law enforcement, ambulance and/or available secure transportation companies. If this is the desired direction of KDADS, we respectfully request direction with regard to how secure transportation will be	The State Hospitals do not arrange transportation of a person for purposes of determining if they meet the statutory criteria for admission. Transportation should be considered a community resource and the decision made on a local level.

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Additionally, we respectfully suggest the addition in policy of the following responsibilities for state hospital staff:

1. required timeframes for response by state hospital staff with regard to the need for additional information as well as decision-making regarding the admission decision. ELC notes that there are often very long delays in this response (sometimes over 24 hours), and the increased time from the delays typically results in a significant exacerbation of client symptoms, increased frustration for community partners including law enforcment, and additional drain on limited community resources.
2. written notification to the CMHC Executive Director regarding any denials in hospital admission, including the reasons for denial. This information would be extremely helpful in allowing for additional staff training and hopefully improvement in staff's ability to provide screening assessments which are in line with KDADS's expectations

Finally, ELC notes that the previous Screeners Manual contained training instructions that went beyond this scope of this draft policy focused on clarification of laws. Can clarification be provided on whether this policy will completely replace the previous training manual and/or how that information will be incorporated for our screeners?

Thank you again for the opportunity to share this feedback.</td><td>State Hospitals' triage and admission process' are dependent on receiving timely and accurate information from our community partners. It is expected that QMHPs will appreciate the deliberative admission process.

State Hospitals independently decide on a case-by-case basis all information provided to admission staff to ensure an informed admission decision is made.

KDADS no longer relies on the previous "Screeners Manual" as a tool to be used for the admission of a person to a State Hospital.

Training of a QMHP is the responsibility of the CMHC.

The KDADS guidance document sets out the agency's expectations regarding admission to a State Hospital and prepares the QMHPs for what information and documentation will be</td></tr>
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Comment	Response
Please don't hesitate to let me know if you have questions or would like additional information.	required to facilitate a State Hospital's admission decision.
Labette Center would like to provide this feedback on the proposed Admission policy to State Psychiatric Hospitals. In the "Pre-Admission" section of "Policy and Procedure" (II A) it states in A(4) that a nurse-to-nurse consultation or a doctor-to-doctor consultation "must take place unless the admitting state hospital determines it is not necessary." Many screens occur at non-medical settings. Requiring a medical examination or clearance in instances where there is no indication of medical distress or substance intoxication can cause further delay in admission, and often results in uncompensated care provided by Emergency Departments. Rather than require such clearance, unless determined to not be necessary by the State Psychiatric Hospital, we would propose that such an exam be requested only in those instances when there is specific reason to believe medical care and clearance is required for the specific individual. We would also call out that an individual can refuse such medical examination, even if they are in police protective custody. In section IIB, paragraph 3 contains the statement "the individual must be able to benefit from, and participate in the active treatment provided by the hospital treatment staff." We would recommend the development of a protocol, collaborative in nature between the State Psychiatric Hospital and the screening CMHC that can make such a determination on a case by case basis when this appears to be an issue, with an appeal process should there be disagreement between the State Psychiatric Hospital and the screening CMHC.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis will consider all information provided to admission staff to ensure an informed admission decision is made, and ensure that the person will benefit from acute inpatient psychiatric treatment. The care and treatment act does not provide for an appeal process. Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission.

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Comment	Response
We note on page 11, the first paragraph (i) designates a new diagnosis for exclusion from admission, that diagnosis being Borderline Personality Disorder. We would recommend that the conditions that exclude a person from care in a State Psychiatric Hospital not be expanded beyond those in existing state statute. We also recommend the development and implementation of an appeal process in those instances where an admission is denied by a State Psychiatric Hospital that can be quickly accessed by the screening CMHC that has determined the denied individual does meet criteria for admission. We thank you for the opportunity to provide this feedback.	Without exception, a person cannot be admitted to a State Hospital without satisfying the statutory criteria for admission. State Hospitals independently decide on a case-by-case basis will consider all information provided to admission staff to ensure an informed admission decision is made, and ensure that the person will benefit from acute inpatient psychiatric treatment. The care and treatment act does not provide for an appeal process.

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