

Kansas

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 03/03/2016 4.48.21 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 878195098

Expiration Date

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

Agency Name Kansas Department for Aging and Disability Services

Organizational Unit Behavioral Health Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

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

First Name Stacy

Last Name Chamberlain

Agency Name Kansas Department for Aging and Disability Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

Telephone 785-296-0649

Fax 785-296-0256

Email Address Stacy.Chamberlain@kdads.ks.gov

State CMHS DUNS Number

Number 878195098

Expiration Date

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

Agency Name Kansas Department for Aging and Disability Services

Organizational Unit Behavioral Health Services

Mailing Address 503 S. Kansas Ave.

City Topeka

Zip Code 66603

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

First Name Ted

Last Name Jester

Agency Name Kansas Department for Aging and Disability Services

Mailing Address 503 S. Kansas

City Topeka

Zip Code 66603

Telephone 785-296-0141

Fax 785-296-6495

Email Address Ted.Jester@kdads.ks.gov

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

From 7/1/2014

To 6/30/2015

IV. Date Submitted

Submission Date 9/1/2015 5:37:32 PM

Revision Date 3/3/2016 4:47:23 PM

V. Contact Person Responsible for Application Submission

First Name Stacy

Last Name Chamberlain

Telephone 785-296-0649

Fax 785-296-0256

Email Address Stacy.Chamberlain@kdads.ks.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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Fiscal Year 2016

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: William C. Rein

Signature of CEO or Designee¹: William C. Rein, J.D.

Title: Commissioner

Date Signed: 08/24/2015

mm/dd/yyyy

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

Behavioral Health Services Commission
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404



Phone: (785) 296-3471
Fax: (785) 296-0256
wwwmail@kdads.ks.gov
www.kdads.ks.gov

Kari M. Bruffett, Secretary
Bill Rein, Commissioner

Sam Brownback, Governor

June 4, 2015

Virginia Simmons, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke cherry Road, Room 7-1109
Rockville, Maryland 20850

Dear Ms. Simmons:

This is written to inform you of a change in leadership for Behavioral Health Services. With this change and the authority granted to me by Governor Brownback, I hereby delegate responsibility of the Substance Abuse Prevention and Treatment (SAPT) and Mental Health (MH) Block Grants to William Rein, the new Commissioner for Behavioral Health Services. This authority allows him to sign funding agreements and certifications, provide assurances of compliance to the Secretary of Health and Human Services, and to perform similar acts relevant to the administration of the SAPT and MH Block Grants until such time as this delegation of authority is rescinded.

Mr. Rein can be reached by phone at 785-368-7228 or by email at Bill.Rein@kdads.ks.gov. His mailing address is 503 S. Kansas Ave. Topeka, Kansas 66603.

Sincerely,

A handwritten signature in black ink, appearing to read "Kari M. Bruffett".

Kari Bruffett
Secretary for Aging and Disability Services

CC: Gilbert Rose, SAMHSA
Ernest Fields, SAMHSA

Behavioral Health Services Commission
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404



Phone: (785) 296-3471
Fax: (785) 296-0256
wwwmail@kdads.ks.gov
www.kdads.ks.gov

Kari M. Bruffett, Secretary
Bill Rein, Commissioner

Sam Brownback, Governor

August 24, 2015

Gilbert Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

RE: Delegation of Single State Authority for Kansas

Dear Mr. Rose:

On behalf of Kansas Department for Aging and Disability Services (KDADS), I am writing to inform you that from this date on, the Single State Authority on Substance Use Disorders for the State of Kansas shall be the Director of Addiction Services within the agency's Behavioral Health Services Commission.

The Director may be reached by phone at 785-296-0649 or by mail 503 S. Kansas Ave. Topeka, Kansas 66603.

Should you have any questions regarding this delegation, please do not hesitate to contact me directly at 785-368-7228 or Bill.Rein@kdads.ks.gov.

Sincerely,

A handwritten signature in black ink that reads "William Rein".

William Rein
Commissioner for Behavioral Health Services

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

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Section 1953	Continuation of Certain Programs	42 USC § 300x-63
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (a)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Willaim Rein

Signature of CEO or Designee¹: _____

Title: Commissioner for Behavioral Health Services

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
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www.kansas.gov

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: William C. Rein

Signature of CEO or Designee¹: William C. Rein, J.D.

Title: Commissioner

Date Signed: 08/24/2015

mm/dd/yyyy

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

Behavioral Health Services Commission
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404



Phone: (785) 296-3471
Fax: (785) 296-0256
wwwmail@kdads.ks.gov
www.kdads.ks.gov

Kari M. Bruffett, Secretary
Bill Rein, Commissioner

Sam Brownback, Governor

June 4, 2015

Virginia Simmons, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke cherry Road, Room 7-1109
Rockville, Maryland 20850

Dear Ms. Simmons:

This is written to inform you of a change in leadership for Behavioral Health Services. With this change and the authority granted to me by Governor Brownback, I hereby delegate responsibility of the Substance Abuse Prevention and Treatment (SAPT) and Mental Health (MH) Block Grants to William Rein, the new Commissioner for Behavioral Health Services. This authority allows him to sign funding agreements and certifications, provide assurances of compliance to the Secretary of Health and Human Services, and to perform similar acts relevant to the administration of the SAPT and MH Block Grants until such time as this delegation of authority is rescinded.

Mr. Rein can be reached by phone at 785-368-7228 or by email at Bill.Rein@kdads.ks.gov. His mailing address is 503 S. Kansas Ave. Topeka, Kansas 66603.

Sincerely,

A handwritten signature in black ink, appearing to read "Kari M. Bruffett".

Kari Bruffett
Secretary for Aging and Disability Services

CC: Gilbert Rose, SAMHSA
Ernest Fields, SAMHSA

Behavioral Health Services Commission
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404



Phone: (785) 296-3471
Fax: (785) 296-0256
wwwmail@kdads.ks.gov
www.kdads.ks.gov

Kari M. Bruffett, Secretary
Bill Rein, Commissioner

Sam Brownback, Governor

August 24, 2015

Gilbert Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

RE: Delegation of Single State Authority for Kansas

Dear Mr. Rose:

On behalf of Kansas Department for Aging and Disability Services (KDADS), I am writing to inform you that from this date on, the Single State Authority on Substance Use Disorders for the State of Kansas shall be the Director of Addiction Services within the agency's Behavioral Health Services Commission.

The Director may be reached by phone at 785-296-0649 or by mail 503 S. Kansas Ave. Topeka, Kansas 66603.

Should you have any questions regarding this delegation, please do not hesitate to contact me directly at 785-368-7228 or Bill.Rein@kdads.ks.gov.

Sincerely,

A handwritten signature in black ink that reads "William Rein".

William Rein
Commissioner for Behavioral Health Services

State Information

Disclosure of Lobbying Activities

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

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

Name	<input type="text" value="Stacy Chamberlain"/>
Title	<input type="text" value="Director of Addiction Services"/>
Organization	<input type="text" value="KDADS/Behavioral Health Services"/>

Signature: _____ Date: _____

Footnotes:

This form is N/A to our State.

Planning Steps

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

Narrative Question:

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

Footnotes:

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

Agency Reorganization

In July of 2012, Disability and Behavioral Health Services was moved under the Kansas Department for Aging and Disability Services/Community Services and Programs. Social and Rehabilitation Services also changed its name to the Department for Children and Family Services. With this move, Mental Health and Addiction and Prevention Services became integrated into a newly formed division named Behavioral Health Services (BHS). BHS was a part of the Community Services and Programs Commission which also encompassed the Home and Community Based Services (HCBS) Waiver programs. In June of 2015, the agency made a decision to separate the two divisions within the Community Services and Programs Commission; Behavioral Health Services and HCBS (waiver services) were separated. Behavioral Health Services became its own Commission at that time under one Commissioner. This will allow the new Commissioner to focus entirely on Behavioral Health and build the program needed to manage all the behavioral health needs of the State. The two State Hospitals that provide psychiatric care for those individuals experiencing acute mental health crisis's was also moved under this new commission.

When the split of commissions occurred, the single Director who had been named to provide oversight of the new division of behavioral health was displaced and the new Commissioner began to work to create a new organization with a Director who will act as the Single State Authority (SSA) for Addiction Services, and a Director who will act as the State Mental Health Authority (SMHA). There will also be a Director for Behavioral Health Prevention and Promotion Services and a Director of Operations and Hospital Integration. It is hoped with this change the teams will be more cohesive and better prepared to work on program specific areas.

The Commission continues to work towards identifying areas in which it can create integration. This will include semi-monthly meetings to work on projects together, streamlining the licensure system and reviewing the draft of the Strategic plan for areas in which we can create unity in the work we do. An Integration Committee has been formed which includes staff identified as subject matter experts (SME) and field staff to review Commission priorities and the Strategic plan. The Committee has identified language that can be changed to support integration. It is hoped the new Commission will continue to find areas in which to move towards integrated projects and thus more integrated care for the individuals we serve.

Staff Structure

The following describes our current staff structure and their responsibilities:

The Director of Addiction Services and assigned staff (one administrative specialist, one program consultant assigned to the management of block grant priorities and 5 program consultants located in the field) hold licensed substance use disorder treatment programs accountable for licensing regulations. This is done by licensing site visits with each of the licensed programs throughout Kansas. During these visits clinical files are reviewed for compliance, a review of policies and procedures is completed, as well as an inspection of the physical location. Based on those visits corrective action plans are implemented to ensure

quality of care and compliance. Through this same process of site visits, programs that receive Block Grant funds are also monitored on site. This occurs every other year and includes review of clinical files and program policies and procedures. These reports are then forwarded to the Contracted Management organization for any needed follow up. These staff are all assigned areas of interest such as training, adolescent treatment, criminal justice and quality. A new Quality position for Problem Gambling Treatment has been added to this team. This position will work on developing and implementing a quality program to monitor certified problem gambling providers to ensure quality services are being provided to individuals who are in need of these services. This team will also be working to integrate problem gambling into the SUD regulations for licensing, creating a consistent monitoring process for all providers who provide services for those individuals in need of Addiction Treatment Services. The Problem Gambling Coordinator also manages the linkage of the continuum of care for problem gamblers including, outreach, outpatient care, and inpatient care in the development and management of resources for consumers requiring any level of care. A Behavioral Health nurse is also on this team. This position helps review the methadone clinics, medication areas in all residential SUD treatment programs, and any critical incidents regarding medications. The position also works with the PRTF staff listed below. There are plans to add another field position and another position in central office to help manage the various projects assigned.

The Director of Prevention and Promotion Services has 5 dedicated staff; Behavioral Health Prevention Consultants. Three FTE manage all of the SUD prevention services as well as mental health promotion initiatives including suicide prevention. This includes the management of two discretionary grants from SAMHSA. Two FTE are dedicated to working to build awareness and provide education around problem gambling risks and concerns. This team provides management and oversight to all aspects of the SAPTBG prevention set aside. Kansas dedicates approximately 24% of the total SAPTBG to the prevention infrastructure which consists of training and technical assistance providers and evaluation and logistics contractors. The prevention team ensures that the providers are accountable for implementing effective community level prevention initiatives that utilize the Strategic Prevention Framework (SPF) to achieve established outcomes. This team also partners with other state agencies to ensure our state is compliant with all aspects of the federal Synar Regulations and partners with other staff to integrate prevention to all behavioral health services.

The Director who will act as the State Mental Health Authority (SMHA) has five Community Quality Improvement staff and one supervisor that hold community mental health centers (CMHCs) accountable for licensing regulations and contract outcomes. This is done by:

1. reviewing policy and procedures;
2. interviewing consumers, family members, board members and staff;
3. addressing, tracking and trending complaints;
4. investigating reports of adverse incidents;
5. observing and evaluating CMHC services and delivery; and,
6. gathering and analyzing outcome data, and requiring CMHCs to appropriately, timely and successfully correct poor performance and failure to meet outcome standards.

The above supervisor also supervises three Facility Quality Improvement staff who oversee 9 Psychiatric Residential Treatment Facilities (PRTFs), the 25 Residential Care Facilities (RCFs),

and the 5 free standing Private Psychiatric Hospitals (PPH) accountable to basic requirements of health and safety, licensing regulations, and active treatment standards for participating in Medicaid funding. This is done by completing routine and special surveys, investigating reports of adverse incidents, and ensuring the facilities appropriately, timely and successfully address adverse incidents and correct substandard care and treatment.

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

Another position is designated to develop and implement policies and programs for inpatient, residential, and community treatment for adult mental health. This position gathers and analyzes data to influence improvement in outcomes for consumers and to uphold Olmstead compliance. They develop and provide oversight for contracts with agencies providing community treatment.

One position is dedicated to monitor the Medicaid Managed Care contract for compliance in the following areas: data, quality assurance, established standards for evaluation of Managed Care Contractual obligations. They identify non-compliance issues of the Managed Care contract and works with contractor to develop and implement corrective action plans. The position monitors, reviews, and provides feedback on activities of corrective action plans for the Managed Care contractors. They review and provided feedback and approval on Managed Care Contractors policy and procedures, provider notices and other contractual documents. They review all relevant reports from Managed Care Contractor on performance activities. They monitor data deficiencies during an established time frame. This position conducts onsite and desk review on relevant data, trends and Managed Care contractual requirements.

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

The Children's Inpatient Manager plans, organizes, directs, manages and administers the Kansas' PRTF and state hospital alternatives for children. They research, develop and maintain state and federal Medicaid and licensing standards in cooperation with Behavioral Health Quality Assurance. They oversee and maintain federal reporting. They direct and implement research

regarding PRTFs and state hospital alternatives. This position utilizes the research results in the developing efficient and effective policies, procedures, and standards. They maintain and report accurate information about PRTFs and state hospital alternatives. They plan, organize, lead, and coordinate PRTF provider meetings. This position formulates proposed solutions to problems related to the proper and appropriate utilization of PRTF's. They ensure the solutions improve the positive outcomes and quality of life of children receiving these services. This position proficiently writes and prepares miscellaneous reports by researching, analyzing and compiling data from various sources to support children's behavioral health programs.

The new Director of Operations and Hospital Integration has one Project Coordinator who works across the state to develop a system of recovery support. The Coordinator promotes Recovery Oriented Systems of Care throughout the state. This includes the support of Oxford Houses, development of Peer Mentors and Person Centered Case Management, and development of the Kansas Voices and Faces of Recovery group. Two positions dedicated to recovery efforts Adult and Children and family are supervised by the project coordinator. The Project Coordinator also has developed partnerships with the Kansas Department of Corrections and Department for Children and Families (DCF)-Economic and Employment Supports to provide treatment and case management for individuals they serve such as those with third or subsequent DUIs or families receiving Temporary Aid to Needy Families (TANF). This position provides oversight of the grants supporting Consumer Run Organizations in the state, serves as liaison for the Governors Behavioral Health Services Planning Council, and for the Kansas Citizens Committee on Alcohol and other Drug Abuse. This position also works closely with stakeholder groups such as adult and juvenile corrections, law enforcement, consumers, community mental health centers (CMHCs), Governor's Behavioral Health Services Planning Council's Justice Involved Youth and Adult Subcommittee, and the courts.

The Adult Inpatient Manager sits under the new Director of Operations and Hospital Integration and oversees eleven Nursing Facilities for Mental Health (NFMH) in the state. In addition this individual reviews and approves continued stay screens on all 640 individuals in the NFMH annually. This position also administers and monitors two contracts with private psychiatric hospitals to provide inpatient psychiatric treatment to individuals when the state hospitals are at capacity. The adult inpatient manager also administers and monitors a contract that helps individuals with no other payment source access atypical antipsychotics. Another major responsibility of the adult inpatient systems manager is to administer and monitor a contract for Intensive Case Management services that is provided to individuals with co-occurring mental health and Substance Use Disorder issues. They also serve as a liaison to state mental health hospitals (SMHH) and children's state hospital alternative programs and assists with difficult to discharge cases.

Provider/Service Structure and Prevention Infrastructure

The Medicaid structure remains the same as explained in the last application. The following is a repeat overview of this system:

KanCare is the program through which the State of Kansas administers Medicaid. Launched in January, 2013, KanCare is delivering whole-person, integrated care to more than 360,000

consumers across the state. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare health plans are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (United).

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the State of Kansas. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as operates the state hospitals and institutions.

Each Medicaid consumer is assigned to one of the KanCare health plans. Consumers in KanCare receive all the same services provided under the previous Medicaid delivery system, plus additional services. The inclusion of services provided through the Home and Community Based Services waiver for consumers with intellectual or developmental disabilities (I/DD) became part of KanCare in February 2014. In addition to the services that were available to Medicaid consumers prior to 2013, the three health plans offer new services to their members, such as preventative dental care for adults, heart/lung transplants and bariatric surgery. Consumers have the option during open enrollment season once a year to change to a different KanCare health plan if they prefer to do so. Open season corresponds with the anniversary month of enrollment in the program.

All pre-2013 Medicaid services are now provided through the KanCare health plans. These include physical health services such as doctor appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care. All the services offered through the State's Home and Community Based Services waivers are part of KanCare. The HealthWave and HealthConnect Kansas programs have ended, and all of those services are now provided through the KanCare health plans.

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

On July 1, 2014 Health Homes for people with serious mental illness were implemented as Kansas believes that they are a critical core component of the positive health outcomes expected from KanCare

The comprehensive and intensive coordination of care provided by Health Homes will result in positive outcomes for KanCare members who experience chronic conditions such as SMI or diabetes. These are KanCare members who need more concentrated care coordination than most.

Health Homes will ensure that:

- Critical information is shared among providers and with Health Home consumers
- Members have the tools they to manage their chronic conditions
- Critical screenings and tests are performed regularly and on time
- Unnecessary emergency room visits and hospital stays are avoided
- Community and social supports are in place to help Health Home consumers stay healthy

SUD Treatment Providers

Beginning in 2007, KDADS/BHS (formerly AAPS) contracted with a managed care entity to manage its funded provider network which included BHS funded (SAPT and State General Funds) and Medicaid treatment providers. With the change that occurred January 1, 2013 regarding Medicaid funded services, this contractor continues to manage BHS funded SUD treatment, treatment for those individuals with 3rd and subsequent DUI's which is funded by the Department of Corrections, and treatment for those individuals with Problem Gambling issues. An RFP was recently issued and the same contractor will continue act as the ASO of these services. The BHS Funded providers are required to be Medicaid providers to ensure continuity of services. This contract is overseen by the Director of Addiction Services and designated staff.

There are 284 licensed SUD treatment providers across the state. Of these 284, forty three providers, with a total of 94 locations statewide, are designated to provide BHS funded treatment services. These providers offer a range of funded services including assessment, outpatient, intensive outpatient, reintegration, social detox, and intermediate. They are also able to provide support services (transportation), person centered case management, and overnight boarding for children in residential services at the designated women's programs. Peer Mentor services are also funded for all funding sources. Medicaid funded providers are able to offer and bill for Medicaid case management. All addiction treatment services are based on clinical need/medical necessity and providers must obtain authorization to provide the services. A service code for sub-acute detox (listed as Acute Detox in the licensing regulations) was added. Providers can bill both for BHS Funded treatment and Medicaid for this service.

SBIRT codes also were added. Providers are only able to bill this service under Medicaid. Policy for approving required training and then contracting to track approved providers of this service are a responsibility of the Director of Addiction Services. Licensed Addiction Counselors are approved to provide SBIRT outside of SUD programs. BHS continues to identify a marketing plan to increase the use of this service.

Several of the programs licensed to provide substance use disorder treatment are also Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs). Several SUD providers have begun to collaborate with primary care providers and health care facilities to work toward providing more cohesive care across the state. One provider has staff placed in two hospitals to help make referrals as needed when individuals are seen in the emergency room and identified as possibly having an SUD problem.

In the coming year, an RFP will be developed for the entire SUD treatment system. Feedback and input will be obtained from Stakeholders and other interested parties regarding this process. It is hoped a new rate structure will be implemented that will incentivize providers to increase the quality of their services to include the continued use of a curriculum or best practice or implementation of an evidence based practice.

Prevention Infrastructure

In state fiscal year 2015, the Kansas Department for Aging and Disability Services (KDADS) recognized the opportunity to expand prevention efforts to be inclusive of substance use prevention, mental health promotion, suicide prevention, and problem gambling prevention to enhance the behavioral health of Kansas communities. In an effort to develop a more integrated and innovative prevention system, holistically addressing multiple behavioral health concerns, while allowing increased resources for local level, community driven prevention efforts, KDADS issued a Request for Information (RFI) in February of 2015 and subsequently released a Request For Proposal (RFP) process in May of 2015. KDADS held the intention to create a comprehensive and interconnected system that is data driven, outcomes and result oriented, innovative, collaborative, and adaptable among four key areas: 1) community-level grants for implementation of the Strategic Prevention Framework (SPF), 2) data collection, analysis and evaluation, 3) facilitative training and technical assistance, and 4) behavioral health education, resource and information dissemination, consumer outreach and advocacy.

In July of 2015, the SSA awarded five (5) contracts, which include both state and federal funds, as a result of the competitive RFP process. DCCCA, Inc. will provide statewide training and technical assistance to community coalitions, community initiatives, and KDADS projects that may be focused on one or more behavioral health concerns (substance abuse prevention, problem gambling awareness and prevention, suicide prevention, mental health promotion). The Center for Learning Tree Institute will continue to provide statewide, regional and local-level behavioral health data collection, analysis, and evaluation, including the administration of the Kansas Communities that Care Student Survey and expand data collection to include outreach and data gathering from the 18-25 year old population. Wichita State University – Center for Community Support and Research was awarded the contract for statewide behavioral health education, resource and information dissemination, consumer outreach and advocacy, including the development of a statewide prevention communications hub and the development and facilitation of a statewide prevention coalition. To expand prevention outreach two organizations, Keys for Networking, Inc. and NAMI Kansas, Inc., were awarded contracts to provide behavioral health education, resource and information dissemination, consumer outreach and advocacy with a specific focus on creating and maintaining adequate capacity to support families and individuals in crisis and providing guidance to families and individuals in accessing appropriate services within communities, educational entities, and home environments.

This re-design process allowed the state to reduce the costs associated with administration and streamline the provision of support services including training and technical assistance as well as data collection and evaluation. These efficiencies have created opportunities for KDADS to directly fund community-level prevention initiatives; these grants will be allocated toward implementation of the strategic prevention framework at the local level which will include the completion of data-driven assessments, identification of priority prevention outcomes and populations, and development of plans that respond to the needs of these targeted groups

efficiently and effectively through the implementation of evidence-based strategies to ultimately reduce substance use and abuse. Community mini-grants will be awarded during state fiscal year 2016 with a more extensive community level grant program planned for implementation during state fiscal year 2017.

This new infrastructure will also provide support to all KDADS awarded discretionary grants including the Partnership for Success II which will continue through FFY2016 in a no cost extension phase and the Partnership for Success 2015 which will begin in October of 2015.

Problem Gambling

In 2007, K.S.A 79-4805 established the Problem Gambling and Addictions Grant Fund from a percentage of net revenues from three state-owned casinos. Through this funding, Kansas provides problem gambling treatment, a public awareness campaign, helpline services, crisis interventions, prevention programs in the state-owned casino regions, workforce development for certified gambling counselors, and grants for strategies implementation by community problem gambling task forces. The abovementioned system re-design will be working to better integrate problem gambling, prevention, education, and awareness efforts more broadly into a comprehensive approach to behavioral health prevention efforts.

Community Mental Health Centers (CMHC's)

Under Kansas Statutes Annotated (KSA) 19-4001 et. seq., and KSA 65-211 et. seq., 26 licensed Community Mental Health Centers (CMHCs) currently operate in the state. These Centers have a combined staff of over 4,000 providing mental health services in all 105 counties of the state. Together they form an integral part of the total mental health system in Kansas. Each of the 26 licensed CMHCs operating in Kansas have a separate duly elected and/or appointed board of directors. Each of these boards is accountable to the citizens served, its county officials, the state legislature, and the governor; and all have reporting responsibilities to the national level of government.

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

Projects and Services in Kansas for Children and Families

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

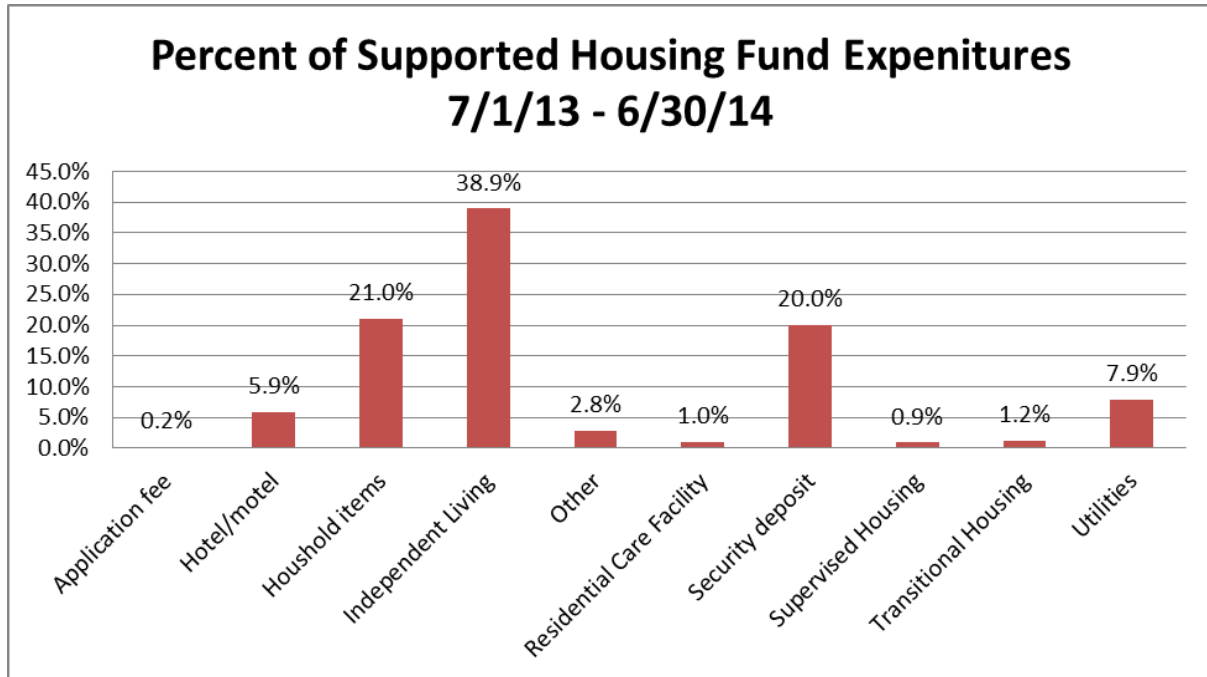
to state hospitals or other in-patient treatment or Juvenile Justice Programs due to severe challenging behaviors.

Housing and Homelessness Services

Supported Housing Fund Program

The Kansas Department for Aging and Disability Services, Behavioral Health Services Commission fund the Supported Housing Fund Program (SHF) with state general funds in the amount of \$535,714. The SHF is able to provide “tenant-based housing first” assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is accomplished by providing temporary flexible funds for their housing needs. In FY2014, funds from the Supported Housing Fund program assisted 1264 individuals with obtaining or maintaining housing.

Below is a breakdown of how the SHFs were used in FY 2014:



Interim Housing Program

The Behavioral Health Services Commission also funds an Interim Housing Program. As a response to policy to prevent discharging individuals into homelessness, Kansas’ mental health system saw a need to create more “interim” housing options for individuals leaving Nursing Facilities for Mental Health or State Psychiatric Hospitals who are without permanent housing arrangements. In FY 2016, BHS funded seven Interim Housing (IH) projects. Interim Housing is defined as short-term housing that is used until a more permanent housing arrangement can be made. Unlike Supported Housing Fund Grant, which provides tenant-based assistance, these funds provide “project-based rental assistance.” Project-based housing provides immediate assistance, without the need for the individual to undergo a housing search, traditional tenant screening process, and acquisition of the furniture and items necessary to establish a household

while still in-patient in a hospital setting. Upon entering the IH project, the CMHCs Housing and Homeless Specialists and other case managers immediately begin providing the assistance necessary for the resident to obtain more permanent housing. Collectively, the FY 15 IH grantees assisted 100 individuals gain housing in the community. Of those individuals who exited the program, 83% moved into a community-based living situation by the end of the grant term. The IH program assisted 21 individuals who were chronically homeless.

Kansas Balance of State Continuum of Care

KDADS-BHS contracts with the Kansas Statewide Homeless Coalition (KSHC) to coordinate the Balance of State Continuum of Care (BoS CoC) planning process and the annual Homeless Assistance Grant submissions (\$54,000 State General Funds). Since 2004, KSHC has coordinated the submission of the Continuum of Care Funding application on behalf of the Balance of State Continuum of Care. Annually, the BoS CoC receives approximately \$2,852,823 in HUD funds to support transitional and permanent supportive housing programs as well as the HMIS system for the BoS CoC. The CoC funding is used to support ten programs offering permanent housing, containing 62 – one bedroom units, 12 – two bedroom units, and 9 – three bedroom units. The CoC funding is used to support nine transitional housing programs containing 51 – one bedroom units, 42 – two bedroom units, 12 – three bedroom units and 2 four bedroom units. The CoC funding is also used to support the Homeless Management Information System for the Balance of State Continuum of Care.

Annual Statewide Summit on Housing and Homelessness

KDADS-BHS also partially underwrites the annual Kansas Statewide Summit on Homelessness and Housing with \$8,000 in state general funds. Approximately 200 people attend and local, state and national speakers present workshops on the latest information to end homelessness and increasing affordable housing.

SSI/SSDI, Outreach, Access, and Recovery

In 2009, Kansas KDADS-BHS applied for technical assistance funding from Bazelon Mental Health Center and Homeless Resource Center to secure the services of Policy Research Associates (PRA). Both applications were approved. PRA conducted a SSI/SSDI, Outreach, Access, and Recovery (SOAR) a statewide planning forum with stakeholders in August 2009 and conducted a train-the-trainer (TTT) workshop for 24 people in October 2009. Between 2009 – 2014, over 345 people went through trainings in Kansas, including staff from community mental health centers, other community based service providers, faith-based groups, substance use providers, law enforcement, city and state officials, veterans administration staff, and hospital staff.

The Kansas SOAR trainers stopped providing new SOAR trainings due to the SOAR TA Center developing a SOAR Online Training program. Since the development of this online training, people interested in SOAR are referred to the online training.

Since 2009, Kansas has maintained a cumulative approval rate of 81%. In 2014, Kansas was designated as one of the “Top Ten” SOAR states.

Kansas SOAR 2009-2014 Data	
Total decisions	549

Number approved	443
Cumulative Approval rate	81%
2014 Approval rate	88%
Average days to decision	130

Recovery Oriented Services

Recovery oriented services have been recognized as more effective and efficient than the traditional medical model. Over the years, Kansas has made significant progress in creating a recovery oriented service infrastructure. Certification programs for mental health peer specialists to learn to provide peer support have become an established vehicle at community mental health centers to adopt a recovery model of service provision with certified peer specialists in meaningful, effective roles. A peer-run infrastructure of thirteen (13) recovery oriented consumer run organizations that are consumer-operated and consumer-governed providing peer supports are supported by KDADS-BHS through funding, technical assistance and support. State University participation in State Medicaid Administration contribute invaluable expertise to help support implementation and fidelity of evidence based practices such as Strengths Model CPST, IDDT, IMR, Family Psychoeducation, Supported Housing and Supported Employment. Consumer and family education, referral and supports are obtained through contractual agreements between KDADS-BHS and the Kansas Consumer Advisory Council, National Alliance on Mental Illness - Kansas, and KEYS for Networking.

Suicide Prevention

Current data from the Kansas Department of Health and Environment (KDHE) indicates that the current suicide rate for Kansas is 14.7 per 100,000 population; compared to the national rate of 13.0 per 100,000 population. Suicide is the second leading cause of death for the 15-24 age group and the fourth leading cause of death in the 5-14 age group. This trend underscores the importance of integrating prevention efforts so communities in Kansas can understand the relationship that is oftentimes shared between risk factors that may lead to the development of a behavioral health concern.

Over the years KDADS has worked with multiple partners to address suicide prevention, though direct resources have been limited. KDADS through our Behavioral Health Planning Council facilitates a suicide prevention sub-committee; the subcommittee has representation from multiple stakeholder groups across the state and works to create an annual goals and priorities in an effort to improve policy, programs, and services. The sub-committee also works in collaboration with KDADS to write and implement the state's suicide prevention plan. This plan was updated during and the state recently released an updated plan that is inclusive of approaches that are outlined in the National Strategy to Prevent Suicide.

Headquarters Counseling Center was awarded a Garret Lee Smith suicide prevention grant in 2012 on behalf of the state. As a result of that grant award the Kansas Youth Suicide Prevention Resource Center (KSPRC) was launched, the KSPRC was designed to support the creation and development of local suicide prevention coalitions and school-based suicide prevention strategies across the state. The KSPRC offers training and technical assistance to communities in the promotion of systematic change in public policies and procedures; they also maintain a registry of certified suicide prevention trainers, as well as a statewide registry of suicide prevention coalitions and other important suicide prevention resources. Headquarters also operates the

National Suicide Prevention Lifeline (NSPL) that serves the entire state of Kansas. Since late 2013, KDADS has been working diligently to formalize partnerships and collaborations with Headquarters with the intention of seeking greater opportunity to leverage resources and funding to address suicide prevention and shared risk factors. This partnership has led to the creation of two federal grant proposals and frequent collaboration on multiple prevention projects. During this planning period KDADS intend to work diligently with partners to seek to build awareness around suicide and increase levels of prevention training for communities and behavioral health providers. Additionally, suicide prevention resources and information referrals strategies will be aligned with other communication strategies under our new prevention system leading to a strengthened and more holistic approach.

Forensics

Significant numbers of individuals, both youth and adult, living with serious mental illness experience encounters with law enforcement agencies and end up in the criminal justice system where the recognition and treatment of mental illness is not the primary mission. In FY15, 38% of the KDOC inmate population is mentally ill, and 10% of this number is severely and persistently mentally ill. Since 2006, the mentally ill population has increased by 126%. KDOC mental health facilities are consistently full and have waiting lists for inmate placement. KDADS-BHS, in collaboration with the newly formed Justice Involved Youth and Adult (JIYA) SC of the Governor's Mental Health Services Planning Council work closely together to carry out the vision that justice involved youth and adults with behavioral health needs achieve recovery. Efforts include creating a recovery oriented system of care for individual's with behavioral health needs in or at risk for involvement in the justice system through policy recommendations and planning focused on prevention, diversion, treatment and reentry through close collaboration with constituents representing behavioral health services, juvenile and adult corrections, law enforcement, courts, education, consumers and families, regional prevention centers, and treatment providers.

PRTF's and RCF's

Behavioral Health Services staff manages and coordinate the services of the Psychiatric Residential Treatment Facility and Community. While continuing to develop and implement policies and programs for inpatient, residential, and community treatment for children's mental health, staff actively support implementation of programs for transitioning recovering youth to the Serious and Emotional Disturbance Waiver (SED) and to other community services and resources. Currently Kansas is implementing the best practice of Positive Behavioral Supports into Community Based Mental Health Centers supported by a statewide tiered support structure for systems.

Additionally BHS staff direct and implement research regarding PRTFs and state hospital alternatives for recovering youth utilizing the results in developing efficient and effective policies, procedures, and standards. Rate Setting, payment, grant and financial documentation are all part of the recovery processes behavioral health staff have responsibility for maintaining along with reporting accurate information to federal and state agencies. BHS staff plans, organizes, leads, and coordinates PRTF provider and stakeholder meetings, along with planning organizing, managing and administrating the Kansas' state hospital alternatives for children. Staff approves payment for state hospital alternatives that are the responsibility of Behavioral Health Services to ensure all necessary services are provided to recovering youth. BHS assumes

responsibility for forecasting and projecting current and future usage. The goal is to ensure quality, effective and efficient mental health services that support recovery in children and their families to live safe, healthy, successful, self-determined lives in their home, school, and community.

SED Waivers

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

Systems Strengths and Needs

Prevention System Strengths and Needs

Kansas has a strong history of using data to make decisions regarding prevention programming—since 1996 we have been collecting student data annually thru the Kansas Communities that Care Student Survey which contributes to our commitment to making data driven decisions regarding prevention efforts. In addition we have infused the elements of the Strategic Prevention Framework (SPF) throughout our prevention system and continue to adapt and innovate our system to be more in alignment with SAMHSA priorities.

In an effort to ensure Kansas is agile and on the cutting edge, the prevention system has recently been re-organized in an effort to move our prevention initiatives toward greater community ownership and to more holistically address shared risk and protective factors across behavioral health concerns. Our intention was to eliminate duplication, create efficiencies and consistency which will ultimately lead to increased funding for the local level implementation of evidence-based strategies. A secondary focus was on how we address multiple behavioral health concerns by looking at data across the lifespan with a focus on those indicators of risk and protection that are shared. We anticipate much growth and planning to take place during the next two federal fiscal years but believe that our commitment to being data-driven and strategic will help achieve greater outcomes that can only benefit communities in our state.

As a result of this assessment process and our last CSAP site visit gaps in data were identified. Kansas does not have readily available data to examine the need of the young adult population, those in the age range of 18-21. KDADS also realizes that we are working with new contractors on building a system to support behavioral health prevention in Kansas and FFY2016 may be a year of planning and building and more implementation in FFY2017.

SUD Treatment Strengths and Needs

SUD Treatment needs continue to be determined by the evaluation of treatment demand as collected from the BHS integrated data system. This information system collects real time client

level data from every funded provider receiving SAPT block grant funds. This data allows for a rich data set in which to evaluate trends over time and direct available funds where they are most needed. Because the client data is linked to provider billing on a fee for service grant reimbursement method, a high degree of accountability exists to ensure that the data is reliable. BHS was able to utilize the statewide needs assessment completed in 2007 to assess treatment needs across the state. It enabled BHS to look at secondary data and assess the need for those persons who not captured in the current information system. The comprehensive needs assessment also provided synthetic estimates to help with strategic planning. The Legislative Division of Post Audits is currently conducting an audit of SUD services and the impact individuals with SUD issues have on other systems, specifically department of corrections, department of children and family services and the two state hospitals who serve individuals with mental health diagnosis and those who have co-occurring issues. Once this audit is completed and the recommendations are provided BHS will evaluate any gaps in SUD services and how we can work with those other systems to improve services and refer to needed services.

The BHS Quality Committee continues to meet to review reports created by the contractor for SUD treatment services. This committee is made up of State staff and other stakeholders. BHS/SUD staff review the reports and conduct an aggregate analysis of the data to be presented and approved by the committee. One report specifically shows where individuals are served and if they are referred for treatment outside their county of residence. This helps to identify gaps in services.

Kansas is fortunate to have nine (9) designated women's programs that serve pregnant women and women with children. We monitor these programs via a report from our contracted provider for BHS (BG) funds. We also monitor BG requirements through onsite visits. These providers have gender specific curriculum that supports women in treatment and helps them to move into recovery. Providers who assess priority women are required to make three referrals for treatment one of which must be a designated women's program. Providers are monitored to ensure this priority population is admitted within 48 hours of initial contact. Providers who do not have the capacity to admit the client within the required timeframe contacts the contractor and/or BHS staff to help make a referral.

BHS has been working on ensuring IVDU individuals enter treatment within fourteen days from initial contact. However, we have identified several issues that have prohibited BHS and providers from meeting this timeframe. BHS has chosen to focus on the fourteen day timeframe and not include the one hundred and twenty day time frame as this was difficult to track. BHS has continued to work with providers to improve their access to care required timeframes.

After working closely with one Kansas tribe, BHS has been able to license their behavioral health center for SUD treatment. They plan to become a Medicaid funded provider and BG funding has been set aside for their agency. BHS staff continues to participate in a Tribal meeting where they primarily discuss Medicaid funding. However, BHS staff has been able to give an overview of the SUD system and the importance of serving all individuals including tribal members. It is hoped once the newly licensed tribal location will provide data that will enable to us to identify other tribal needs.

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

Mental Health

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

39-1608. Mental health centers to develop community assessment of needs and plan to provide community based mental health services; approval by secretary; annual reviews and reports; amendments to plan; rules and regulations; guidelines for conduct of assessments of need, for development and operation of system of services and for periodic reporting to the secretary. (a) On or before October 1, 1991, and in accordance with rules and regulations adopted by the secretary each mental health center shall prepare and adopt a community assessment of needs and a plan to provide community based mental health services for persons who are residents of the service delivery area of the mental health center and shall submit such assessment of needs and plan to the secretary for approval. Among other provisions, such plan shall include the provision of services to all targeted population members who apply therefor.

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

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

In 2015, the needs assessment focused on transitional care services. The housing options assessed include the following:

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

What currently exists throughout the 26 CMHC system is shown in the table below.

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. What currently exists (The number of individuals for whom each option is available)?	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
Other housing options?*	Yes		No							
	#	%	#	%						
	7	28.00	18	72.00						

Note: * The response from one agency is missing

The first column represents the number of CMHCs that do not offer the housing option listed. For Interim housing, 16 CMHCs do not offer this service, 10 do offer the service. Structured care environments are offered the least of the listed alternatives and Short-term respite is offered the most.

The three most frequently identified barriers to making transitional housing options and accompanying services available include: funding, resources not available in the community, and capacity.

What CMHCs would develop if resources were unlimited is represented in the following table.

13. If resources were unlimited, what transition options would your center develop in both housing and services? Please be specific. ****

	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.

Crisis stabilization beds or respite care for children and interim housing/other short-term housing are identified as priorities to meet current needs.

Planning

KDADS/Behavioral Health Services met to discuss the planning process. It was decided based on several data sources that new priorities would be added. These data sources included the final recommendations from the Governor’s Mental Health Task Force and the Adult Care Continuum Committee. As a result the following new priorities were established in additions to the required priorities:

Goal: Establish integrated SUD/MH peer services that support individuals in their recovery

Objective: To review, identify, research, and align peer services

Strategies:

- Develop a survey and disseminate to current Peer Specialists and Peer Mentors
- Research and identify best practices
- Assess current system in Kansas
- Create Work group
- Create focus groups (at least 3)
- Identify changes to be implemented
- Create a plan for changes

Indicators:

- Committee formed of BHS staff, members of the Governor’s Behavioral Health Planning Council and other stakeholders
- Input collected on current manuals and processes from surveys, and focus groups
 - Survey conducted and data analyzed
 - Focus groups conducted and comments organized and analyzed
- Research conducted from all States with these services in place

- Creation of implementation plan to include any fiscal or regulatory impacts

Base line: We have no baseline at this time

1 year indicators:

- Committee formed of BHS staff and stakeholders
- Input collected on current manuals and processes from surveys, and focus groups
 - Survey conducted and data analyzed
 - Focus groups conducted and comments organized and analyzed
- Research conducted from all States with these services in place

2nd year indicators:

- Creation of implementation plan

Council Planning

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

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

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

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

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

Activities of the Council

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

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

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

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

Subcommittees of the Council are:

- Housing & Homelessness
- Children
- Supported Employment
- Suicide Prevention
- Rural and Frontier
- Justice Involved Youth and Adults
- The Kansas Citizens Committee on Alcohol and Drug Abuse
- Prevention
- Veterans
- Vocational

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

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

SUD treatment

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

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

A report from the contracted administrative service organization shows the number and percentage of women referred to a designated women's facility by funding source. This data is collected from the Kansas Client Placement Criteria (KCPC) extract which is given to the contractor on a regular basis. The detailed report includes the place where the assessment took place and the facility where the treatment was received (if recommended) assessment facility, level of treatment recommended (if recommended), the treatment facility (when admitted) and where the woman was referred to and admitted to a designated women's facility. The summary portion of the report includes the following by pregnant women and women with children:

1. All pregnant women and women with children assessed for treatment
2. Number and percent recommended for Level 1, Level 2, Level 3 (stratified by Intermediate, Reintegration and Detox) and Level 4
3. Number and percent of women who admitted to recommended treatment
4. Number and percent of women who did not admit to recommended treatment
5. Number and percent of women who admitted to a Designated Women's Facility.

The following are conclusions from an aggregate analysis of the report presented at the August 2015 Quality Committee:

- 21.21% of Women with Children admitted to SUD Treatment (Level 1) utilize a Designated Women's Treatment Program.
- 5.45% of Women with Children admitted to Treatment (Level 2) utilize a Designated Women's Treatment Program.
- 6.06% of women with children admitted to treatment (Level 3.1 Reintegration) utilized a Designated Women's Treatment Program.
- 61.82% of women with children admitted to treatment (Level 3.3 Intermediate) utilized a Designated Women's Treatment Program.
- 5.45% of women with children admitted to treatment (Level 3.2D Social Detox) utilized a Designated Women's Treatment Program.
- 6.25% of Pregnant Women admitted to SUD Treatment (Level 1) utilize a Designated Women's Treatment Program.

- 6.25% of Pregnant Women admitted to SUD Treatment (Level 2) utilize a Designated Women's Treatment Program.
- 0.00% of Pregnant Women admitted to SUD Treatment (Level 3.1 Reintegration) utilize a Designated Women's Treatment Program.
- 62.5% of Pregnant Women admitted to SUD Treatment (Level 3.3 Intermediate) utilize a Designated Women's Treatment Program.
- 25.0% of Pregnant Women admitted to SUD Treatment (Level 3.2D Social Detox) utilize a Designated Women's Treatment Program.
- 37.84% of Pregnant Women who are recommended to Level 1 treatment do not attend.
- 10.81% of Pregnant Women who are recommended to Level 2 treatment do not attend.
- 0.00% of Pregnant Women who are recommended to Level 3.1 Reintegration treatment do not attend.
- 51.35% of Pregnant Women who are recommended to Level 3.3 Intermediate treatment do not attend.
- 0.00% of Pregnant Women who are recommended to Level 3.2D Social Detox treatment do not attend.
- 49.51% of Women with Children who are recommended to Level 1 treatment do not attend.
- 17.59% of Women with Children who are recommended to Level 2 treatment do not attend.
- 1.95% of Women with Children who are recommended to Level 3.1 Reintegration treatment do not attend.
- 29.32% of Women with Children who are recommended to Level 3.3 Intermediate treatment do not attend.
- 1.63% of Women with Children who are recommended to Level 3.2D Social Detox treatment do not attend.

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

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

KDADS/BHS wants to support priority women participating in the designated women's programs to ensure their needs are fully met. In 2011 a study was conducted examining

women's treatment and what makes it successful. Several emerging trends were discovered including women not engaging in treatment and short lengths of stay. This suggests that initial engagement is key to retention and engagement in treatment. The following recommendation was an example of the result of the study:

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

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

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

A report from the contracted managed care entity includes 2 indicators 1) calculated from the initial contact date of contact and date offered, and 2) the first treatment session post assessment taken from paid claims data. Data for IVDU individuals is calculated using the KCPC initial contact and the first paid claim after the assessment and does not include the indicator for assessment offered. The KCPC data is given to the contractor on a regular basis

Two versions of the Access to Care Report, 1) provided quarterly to show a monthly snapshot within the quarter, and 2) a trended version by quarter for the fiscal year. Data is reported in aggregate to the Quality Committee and once approved posted on the contractor's website for all providers in their network.

The following are indicators and benchmarks were established using 18 months data (07/13 through 12/14) and are included in the report:

- Pregnant women (Urgent) assessment offered baseline was set at 89.4%
- Pregnant women (Urgent) first treatment post assessment baseline 42.1%
- IVDU 14 day admission baseline was set at 50.1%
- IVDU 120 day admission baseline was set at 62.3%

A review of the FY 2014 Access to Care report for IVDU clients indicated that 802 assessments that were completed between July 1, 2013 and June 30, 2014 recommended treatment for IVDU members. Of the 802 assessments, 377 individuals were admitted to treatment within 14 days, and an additional 426 admitted to treatment within 120 days of the assessment.

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

assessed by RADACs admitted to treatment within 14 days of first contact at a rate of 17.6%. (I don't have this current stat; was taken from the initiation and engagement PIP)

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

Also during FY 2014, Interim Services (lower level of care) were provided to 17.4% of the IVDU members awaiting admission to treatment.

This data is closely monitored to ensure providers meet the 14 day State/Federal requirement for access to care and the 120 day Federal requirement. Additional data may be used from the KCPC and paid claims to analysis for compliance.

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

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

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

4. SUD Needs Assessment

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

Another report that is required of the contracted managed care organization allows us to monitor if members are being served in their home region, thus can help us identify service gaps. The BHS Admissions Outside of Region Report is based on the member's home region. It looks at

the total number of assessment conducted in each region, and then breaks down the data into four categories: 1) treated inside region, 2) treated outside region, 3) did not go to treatment, or 4) treatment not recommended. This data consistently shows that the majority of clients do not go out of their region for treatment services.

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

The contracted ASO has developed a data driven residential wait list program to ensure pregnant women and IV drug users are given preference in admission to treatment facilities funded by SABG. The wait list is updated weekly by adding individuals who were assessed and recommended residential treatment, that have not admitted, from the previous week. Individuals on the list are given a priority status based on federal regulations; 1- pregnant IV drug using women, 2- pregnant women, 3- IV drug users, and 4- all others.

As part of the wait list program, the contractor collects bed availability on a weekly basis from residential providers and disseminates to the State and Regional Alcohol Drug Assessment Centers (RADACs). The contractor works with KDADS to ensure federal priority population individuals are admitted to treatment within timeframes; and that interim services are provided when admission is not possible within 48 hours.

Assessing providers are contractually required to offer three options for treatment facilities; one of which must be a designated women's treatment program if the individual is a pregnant woman or woman with children. In addition, providers are required to coordinate medical care including prenatal care for women, and pediatric care including immunizations for their children. KDADS and the managed care organization have developed an effective system to monitor program compliance with regulations; identifying and correcting deficiencies as necessary.

KDADS/BHS is in the midst of a Post Legislative Audit. This audit is gathering data to determine if increased access to substance abuse treatment might reduce state costs. This Legislative Division has been gathering data over the past several months and we hope to use some of their conclusions as we make further decisions about SUD treatment in Kansas.

Prevention

KDADS utilized the Kansas Behavioral Health Epidemiological profile and information presented in the 2013 and 2014 Kansas Behavioral Health Barometer provided to states by the Substance Abuse and Mental Health Services Administration, and changes in the prevention infrastructure to identify primary prevention needs and gaps.

The Kansas statewide epidemiological profile that was originally published in 2006 was updated by the state's epidemiological core team to include behavioral health indicators and the final document was published in 2015. Data sources in the updated profile include the following:

Behavior Risk Factor Surveillance System (BRFSS) – The BRFSS is a random digit dialing (RDD) telephone survey. The CDC has developed the questionnaire to ensure compatibility across states. Core questions are asked annually all states and states have the option of adding in supplemental questions concerning specific health behaviors and conditions.

Centers for Disease Control and Prevention, National Center for Health Statistics.

Underlying Cause of Death 1999-2013 on CDC WONDER Online Database- Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Data set is published by the U.S. Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Office of Analysis and Epidemiology. The county-level national mortality and population data has been derived from the U.S. records of deaths (death certificates) since 1979. Death rates are calculated per 100,000 persons. (Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Mar 27, 2015 4:36:19 PM)

Drug Enforcement Administration (DEA) - Environmental Photographic Interpretation Center's (EPIC) Database : Methamphetamine Clandestine Lab Seizure Statistics reports include only that information that has been reported to EPIC by contributing agencies and may not necessarily reflect total seizures nationwide. Data is reported without corroboration, modification, or editing by EPIC, and, accordingly, EPIC cannot guarantee the timeliness, completeness, or accuracy of the information reported therein. The data and any supporting documentation relied upon by EPIC to prepare this report are the property of the originating agency.

Gambling Behaviors and Attitudes Among Adult Kansans - This 2012 study was conducted by Kansas City-based Whitworth Ballou, LLC, on behalf of KDADS. It was the first statewide study of adult gambling behaviors and attitudes since the opening of three state-owned casinos. Utilizing telephone survey methods, researchers interviewed 1,600 anonymous adults in late 2012. Respondents were randomly selected from landline and cell phone numbers located across the state.

Kansas Bureau of Investigation (KBI) – Information from local and statewide law enforcement is reported to KBI. The information collected is on the number of offenses reported to law enforcement as well as the number or arrests made. In some law enforcement agencies only summary information is reported and not detailed individual accounts.

Kansas Communities That Care (KCTC) -The KCTC is a school-based survey for students in grades 6, 8, 10, and 12 in Kansas. The KCTC is utilized to gather information concerning youth prevalence of various risk factors such as alcohol, tobacco, other drugs, gang involvement, and many others. In addition, the KCTC is utilized to gather information concerning individual and community risk and protective factors.

Kansas Department of Aging & Disability Services (KDADs) – Data was provided from the Treatment Episodic Data Set (TEDS) regarding community mental health admissions and substance abuse treatment admissions.

Kansas Department for Children & Families: Prevention and Protection Services– Count data was provided from the Foster Care / Adoption Summary Reports site regarding children removed from the home into out of home placement by primary removal reason.

Kansas Department of Corrections (KDOC)– Count data was obtained from the KDOC Annual Report – Offender Population /Adult Court Commitments map as to the number of adult admissions during each fiscal year by county of offender commitment.

Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics, Office of Health Assessment—Data was provided from KDHE regarding deaths due to illicit drugs as underlying cause, specified by mortality due to external causes as unintentional drug poisoning and psychiatric causes based on psychiatric diagnosis.

Kansas Department of Revenue Cigarette and Tobacco Enforcement Agent, Controlled Buy database – Kansas performs unannounced compliance checks on a random sample of all retailers and vendors of tobacco. Specifically these compliance checks are used to monitor the sales of tobacco to minors. Alcohol and Beverage Control (ABC) imposes fines upon individuals failing these checks. Results of the SYNAR report are used in the Kansas Substance Abuse Prevention and Treatment Block Grant.

Kansas Department of Transportation—Data was obtained from accident statistics reports (Alcohol- Related Summaries) regarding the number of motor vehicle accidents which involved alcohol, the number of those accidents resulting in fatalities, and the age of the drivers involved.

Kansas Information for Communities (KIC) – Death Statistics KIC is based on resident data compiled from death certificates filed with the Bureau of Epidemiology and Public Health Informatics at the Kansas Department of Health and Environment. This KIC module will produce counts, population-based crude death rates, and population-based age adjusted death rates. All three of these measures can be calculated by cause of death, year, age-group, sex, race, Hispanic origin, and county of residence.

Birth Statistics KIC is based on resident data (See residency compiled from birth certificates filed with Bureau of Epidemiology and Public Health Informatics at the Kansas Department of Health and Environment.) This KIC module includes only live birth outcomes. Most statistics on live births are reported as a percentage of the total number of events. Births where an outcome or characteristic is missing are excluded from the total number of events. While every effort is made to assure the KIC data summaries parallel the results in the Kansas Annual Summary of Vital Statistics, some slight differences may occur.

Cancer Statistics KIC is based on Kansas resident data compiled from reports of cancer cases provided to the Kansas Cancer Registry (KCR), which is operated by the University of Kansas

Medical Center under a Kansas Department of Health and Environment contract. This KIC module produces counts, population-based crude rates, and population-based age-adjusted rates.

Kansas Problem Gambling Helpline – Kansas Department of Aging and Disability Services contracts with Kansas Health Solutions to operate the Problem Gambling Helpline. Trained professionals are available 24 hours a day to answer questions, explain warning signs and treatment options, and provide referrals for certified problem gambling counselors.

Kansas State Department of Education (KSDE) – The KSDE data collection systems provides information on all school based offenses. Information is collected on the nature of suspensions and expulsions, including if the offense is related to alcohol, tobacco, or other drugs.

Kansas Vital Statistics (KVS) – The KVS provide information on all births, pregnancies, marriages, divorces, and deaths in Kansas and among Kansas residents. Information is collected on many risk and protective factors surrounding the event as well as extensive demographic information. Information is available at the statewide and sub-state level.

Monitoring The Future (MTF) – The MTF survey is an annual school-based survey of youth in grades 8, 10, and 12 nationally. The MTF survey is utilized to gather national trend information concerning drug use trend and patterns.

National Survey of Substance Abuse Treatment Services (N-SSATS) – The N-SSATS (formerly the Uniform Facility Data Set) is an annual census of all treatment facilities listed on the I-SATS. Information is collected on the location, organization, structure, services, and utilization of substance abuse treatment facilities in the United States. The data are used for program administration and policy analysis. Information from the survey is also used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the on-line Substance Abuse Treatment Facility Locator, two widely used resources for referrals to treatment.

National Survey on Drug Use or Health (NSDUH) – The NSDUH is an annual household survey of individuals aged 12 and older. The main foci of the survey are to obtain information concerning consumption patterns and dependence of alcohol, tobacco, and other illicit drugs. Over sampling occurs to provide statewide level estimates in addition to national estimates.

SAMHSA's Center for Mental Health Services (CMHS): Kansas Mental Health National Outcome Measures (NOMS) – Community Mental Health Services Uniform Reporting System provides guidance and technical assistance to decision makers at all levels of government on the design, structure, content, and use of mental health information systems, with the ultimate goal of improving the quality of mental health programs and services delivery. CMHS operates the only program in the nation that focuses on the development of data standards that provide the basis for uniform, comparable, high-quality statistics on mental health services, making it a model in the health care statistics field.

ValueOptions of Kansas - Under the direction of the Kansas Department for Aging and Disability Services (KDADS), ValueOptions administers inpatient and outpatient substance use

disorder treatment services for members eligible for Substance Abuse Prevention and Treatment (SAPT) BHS funded services and all addiction services funded by the Problem Gambling and Addictions Fund.

In 2005, Kansas received an SEOW grant to begin the process of establishing a sustainable infrastructure to examine indicators for substance abuse in Kansas, the most preventable underlying cause of disease and death. A multi-agency design team was formed to begin work to profile the burden of substance use in the state. The data collected informed a larger planning committee that worked through a layered comprehensive statewide needs assessment process to prioritize and focus the state's prevention efforts. The *Kansas Substance Abuse Epidemiological Indicators Profile* included indicator and trend data from 2000-2005 focusing on consumption and consequences related to alcohol, cigarette, marijuana and use as well as other-related drugs. The profile reported youth and adult measures of mortality, morbidity and crime resulting from substance use. Indicator data was reported by age, gender, and race.

The SEOW was reconvened and repurposed in late 2012 in order to respond to the need to reassess and re-evaluate state alcohol, tobacco, and other drug priority outcomes and future directions for Substance Abuse Prevention and Treatment Block Grant funding, as well as for the Strategic Prevention Framework Partnership for Success initiative that began in October 2012. The data covered in this updated profile was inclusive of 2006-2011. Information was presented from health agencies, treatment agencies, law enforcement agencies, and revenue agencies. The goal was to provide a comprehensive look at the current state of substance abuse so that priority areas may be identified and addressed. Utilizing a broad array of information from multiple sectors allows for a more complete picture of substance abuse related consequence and consumption pattern. During the compilation of various data sources, specific data gaps were identified in the realm of substance abuse prevention. These data gaps, while not as significant as the information available, provide examples of possible improvements to build a completely comprehensive picture of substance abuse in Kansas.

In 2013, Kansas received supplemental grants to allow SPF-PFS II grantees to expand and enhance the activities of the SEOW. This involved developing a key set of indicators to describe the magnitude and distribution of substance-related consequences and consumption patterns across the state and in grantee communities of high need. The SEOW developed a set of key indicators that, in addition to substance use, would apply to KDADS's broader behavioral health focus. The expanded indicators included: youth and adult prescription drug abuse, substance use treatment, problem gambling treatment, depression and suicide, and adverse childhood experiences (ACEs). The SEOW also expanded its approach to include influencing factors known to be associated with poor behavioral health. In April, 2015, the expanded work of the SEOW resulted in a new document, the *Kansas Behavioral Health Profile*.

Beginning with the original profile, and with each subsequent update, the data gathered and reported by the SEOW has informed prevention planning. The information was used to prioritize state focus for underage drinking with the SPF-SIG and continues to guide planning around broader behavioral health measures described.

This allows communities to have a more comprehensive look at how indicators that are predictive of one or more behavioral health issue may be prioritized for intervention. In

addition, the state can look at potential areas of need or disproportion by comparing age, gender and race.

Based on the prioritization of the updated State Epidemiological Profile and information gleaned from the 2014 Kansas Behavioral Health Barometer, three priorities have been identified as priorities for the SAPT Block Grant funded prevention infrastructure supported by BHS.

1. Prevalence of alcohol consumption among youth and young adults between the ages of 10-18.
2. Perceived risk of harm for regular marijuana use among youth and young adults between the ages of 12-18.
3. Strengthen primary prevention efforts across multiple behavioral health concerns through the coordinated reduction of co-occurring risk factors and increase of associated protective factors.

As a result of this assessment process and our last CSAP site visit gaps in data were identified. Kansas does not have readily available data to examine the need of the young adult population, those in the age range of 18-21. However, we have initiated steps to address this gap as a part of prevention system re-organization. Our evaluation contractor will work with KDADS to create a plan to identify a means of data collection for the population and subsequently develop an action plan to collect data in an effort to help us target resources specifically for this population. KDADS also realizes that we are working with new contractors on building a system to support behavioral health prevention in Kansas and FFY2016 will be a year of planning and building capacity for greater community-level implementation of comprehensive strategic plans in FFY2017.

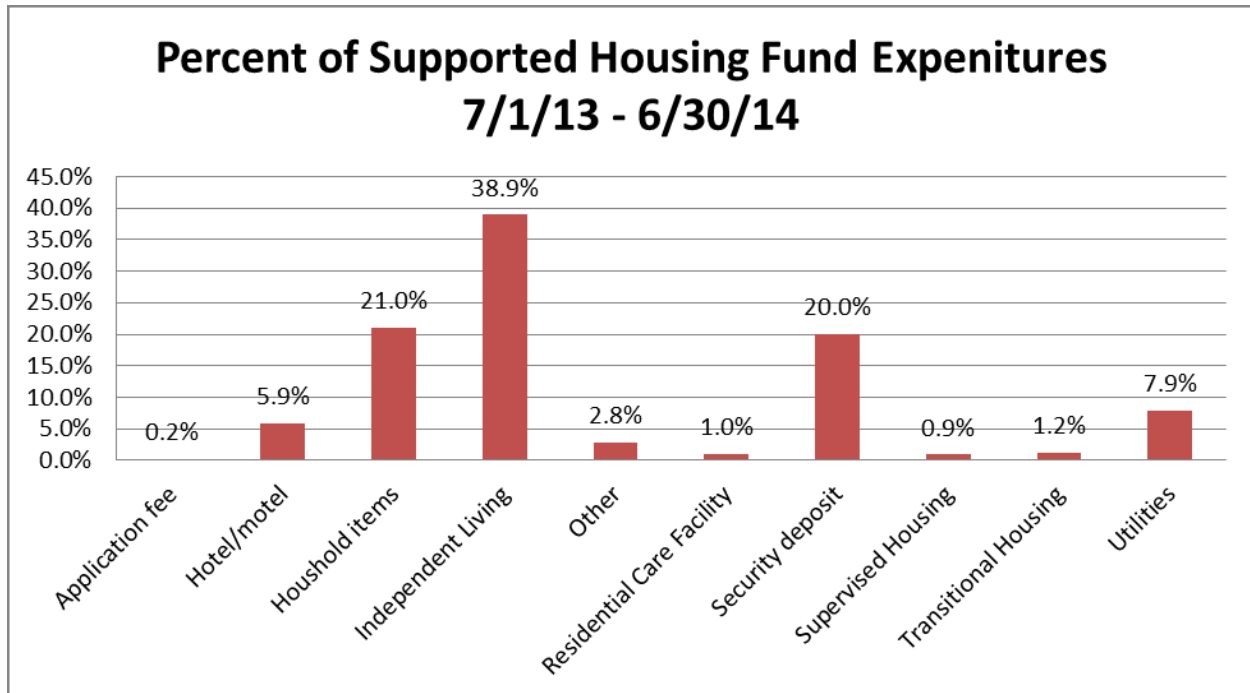
Mental Health:

Housing and Homelessness Services

Supported Housing Fund Program

The Kansas Department for Aging and Disability Services, Behavioral Health Services Commission fund the Supported Housing Fund Program (SHF) with state general funds in the amount of \$535,714. The SHF is able to provide “tenant-based housing first” assistance on a temporary, limited basis by supporting eligible individuals who are experiencing a mental illness to obtain and maintain housing in the least restrictive environment possible. This is accomplished by providing temporary flexible funds for their housing needs. In FY2014, funds from the Supported Housing Fund program assisted 1264 individuals with obtaining or maintaining housing.

Below is a breakdown of how the SHFs were used in FY 2014:



Interim Housing Program

The Behavioral Health Services Commission also funds an Interim Housing Program. As a response to policy to prevent discharging individuals into homelessness, Kansas’ mental health system saw a need to create more “interim” housing options for individuals leaving Nursing Facilities for Mental Health or State Psychiatric Hospitals who are without permanent housing arrangements. In FY 2016, BHS funded seven Interim Housing (IH) projects. Interim Housing is defined as short-term housing that is used until a more permanent housing arrangement can be made. Unlike Supported Housing Fund Grant, which provides tenant-based assistance, these funds provide “project-based rental assistance.” Project-based housing provides immediate assistance, without the need for the individual to undergo a housing search, traditional tenant screening process, and acquisition of the furniture and items necessary to establish a household while still in-patient in a hospital setting. Upon entering the IH project, the CMHCs Housing and Homeless Specialists and other case managers immediately begin providing the assistance necessary for the resident to obtain more permanent housing. Collectively, the FY 15 IH grantees assisted 100 individuals gain housing in the community. Of those individuals who exited the program, 83% moved into a community-based living situation by the end of the grant term. The IH program assisted 21 individuals who were chronically homeless.

Kansas Balance of State Continuum of Care

KDADS-BHS contracts with the Kansas Statewide Homeless Coalition (KSHC) to coordinate the Balance of State Continuum of Care (BoS CoC) planning process and the annual Homeless

Assistance Grant submissions (\$54,000 State General Funds). Since 2004, KSHC has coordinated the submission of the Continuum of Care Funding application on behalf of the Balance of State Continuum of Care. Annually, the BoS CoC receives approximately \$2,852,823 in HUD funds to support transitional and permanent supportive housing programs as well as the HMIS system for the BoS CoC. The CoC funding is used to support ten programs offering permanent housing, containing 62 – one bedroom units, 12 – two bedroom units, and 9 – three bedroom units. The CoC funding is used to support nine transitional housing programs containing 51 – one bedroom units, 42 – two bedroom units, 12 – three bedroom units and 2 four bedroom units. The CoC funding is also used to support the Homeless Management Information System for the Balance of State Continuum of Care.

Annual Statewide Summit on Housing and Homelessness

KDADS-BHS also partially underwrites the annual Kansas Statewide Summit on Homelessness and Housing with \$8,000 in state general funds. Approximately 200 people attend and local, state and national speakers present workshops on the latest information to end homelessness and increasing affordable housing.

SSI/SSDI, Outreach, Access, and Recovery

In 2009, Kansas KDADS-BHS applied for technical assistance funding from Bazelon Mental Health Center and Homeless Resource Center to secure the services of Policy Research Associates (PRA). Both applications were approved. PRA conducted a SSI/SSDI, Outreach, Access, and Recovery (SOAR) a statewide planning forum with stakeholders in August 2009 and conducted a train-the-trainer (TTT) workshop for 24 people in October 2009. Between 2009 – 2014, over 345 people went through trainings in Kansas, including staff from community mental health centers, other community based service providers, faith-based groups, substance use providers, law enforcement, city and state officials, veterans administration staff, and hospital staff.

The Kansas SOAR trainers stopped providing new SOAR trainings due to the SOAR TA Center developing a SOAR Online Training program. Since the development of this online training, people interested in SOAR are referred to the online training. Since 2009, Kansas has maintained a cumulative approval rate of 81%. In 2014, Kansas was designated as one of the “Top Ten” SOAR states.

Kansas SOAR 2009-2014 Data	
Total decisions	549
Number approved	443
Cumulative Approval rate	81%
2014 Approval rate	88%
Average days to decision	130

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

SUD Treatment

The current AAPS system (KCPC) is designed and written in FoxPro, which is an end-of-life software tool. FoxPro is scheduled to be phased out by Microsoft in the year 2015. When this occurs the agency will no longer have Microsoft updates/support for the AAPS Integrated Data System. Additionally support staff for upgrades and maintenance has been severely reduced which puts current processing at risk.

The workflows and business requirements for AAPS and licensing for the divisions of DBHS (now BHS) have been documented in preparation of future conversion.

In July 2012 AAPS was integrated both with Mental Health and then into the Department of Aging. With this move, the Kansas Department for Aging and Disability Services (KDADS) was formed. As a result of the integration with Aging, new technology became available for developing a replacement system. The Information Technology section of KDADS has begun working with program staff to develop the replacement for the AAPS Integrated Data System using Oracle APEX framework.

The new AAPS system is being written and integrated with two existing proven web based applications. It will include a licensing maintenance, certification and survey system and an assessment and Plan of Care system. These systems provide many of the functional attributes identified in the business requirements which include real time processing, role-based security, and ad hoc reporting as well as the items listed above.

The scope of the project is to convert the KCPC and Facility Maintenance systems which will include the existing functionality and provide additional enhancements based on functionality in the already existing systems. A future proposed enhancement will be an interface between the providers and the KDADS system.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

BHS/SUD staff develops and implements all policy regarding SAPT and Medicaid substance use disorders treatment. As a result all Medicaid SUD providers are required to use the current BHS data system. Included in the data system are modalities of care and other billable services that if approved, each provider is eligible to use for reimbursement. Clients are associated with funding sources and the contracted managed care entity ensures the proper reimbursement mechanism is used for each client served. No barriers have been identified as Kansas already utilizes an encounter based system. The new system this data will be stored in and that providers will

utilize is used by the entire KDADS agency. Data is collected for aging, HCBS waiver programs, and SED waiver. Data from the MMIS (Medicaid) system is fed into this system for the other programs. There are no plans at this time to use this type of data feed for SUD, however we are able to utilize the Medicaid data.

Similarly, the Automated Information Management System (AIMS) for mental health outpatient services will transition into the KDADS data system. At this time it remains with a contractor that has managed the system since 2001.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Yes. However, we are exploring the possibilities for the development of a better unique client identifier to coincide with the new AAPS system. The current system utilizes an algorithm utilizing the first and last name and birthdate. The current data system also develops a unique treatment episode identifier. We continue to explore how the data system will work at the most efficient level for the clients and the treatment programs, but still be in compliance with 42 CFR, part 2.

To enhance our capacity to provide unique client-level data for all individuals served within the Kansas public mental health system, BHS maintains several information management systems. The Automated Information Management System (AIMS) is the primary decision support tool for planning and quality improvement at the state level. Client-level admission, assessment, and discharge information is collected on all individuals receiving public mental health services, regardless of insurance type or payment source. Information on the type, frequency and duration of mental health services provided by the CMHC is collected at the client-level for individuals in our targeted population. This at-risk population includes adults with a severe and persistent mental illness (SPMI) who are enrolled in community support services and children and youth with a serious emotional disturbance (SED) enrolled in community-based services.

In addition, BHS has established viable connectivity with a variety of unique information management systems that enhance and inform the decision-making process at all levels of our public mental health system. Information about each of these systems is outlined below.

State Mental Health Hospitals (SMHH)

One of the key systems used in conjunction with the AIMS is the statewide inpatient hospital database. Each of the three state-operated mental health hospitals in Kansas provides BHS with a monthly file containing data in a standardized format. These separate files are combined to provide statewide reporting, expanding our capacity for tracking and reporting of the mental health population.

State Alternatives to Mental Health Hospitals for Youth

Since 2006, BHS has provided an alternative to state-operated inpatient mental health treatment for youth under age 18 through a contract with KVC Health Systems, Inc. KVC inpatient facilities provide BHS with client-level data in a standardized format that is merged with AIMS and adult (SMHH) data, expanding our capacity for tracking and reporting of the mental health population of youth receiving state-contracted inpatient treatment.

State Mental Health Managed Care System:

On January 1st, 2013, Kansas implemented a section 1115(a) Medicaid demonstration project called KanCare. From a systems development stand-point, BHS continues to be intricately involved in the design and implementation of this large-scale project, ensuring noticeable and effective representation for the individuals served through the Kansas public mental health system.

Additional Administrative Data Systems utilized by BHS

BHS has established or pending agreements with various state agencies and contractors for the exchange of client level data for distinct populations that provides critical information to our shared decision-making process, including:

Information about children and youth during treatment at all state-licensed Psychiatric Residential Treatment Facilities (PRTF).

Results from all Inpatient Screening Assessments performed by our Community Mental Health Centers, including determinations, type and frequency.

Detailed assessments of individuals residing in Kansas Nursing Homes for Mental Health (NFMH).

Information about children with mental health needs who have been placed in state custody and removed from their family home.

Provide information regarding current efforts to assist providers with developing and using EHRs

As part of the current BHSIS contract with SMDI, BHS has initiated processes designed to improve our current IT system. The primary focus of this effort is to address issues related to data interoperability. Although BHS does not have funding to create a statewide health information exchange, over the past several years, we have assisted 24 of the 27 CMHCs in transitioning to shared data systems. This consolidation of vendor services has allowed the

CMHCs to maintain consistency, implement timely system modifications, and reduce costs. This has positioned them for standardized development of Electronic Health Records. The remaining centers operate within a county-structured system or maintain a proprietary system.

Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment

To track and report MHBG expenditures by service through an encounter/claims based approach would require extensive modifications to the CMHCs' claims systems and the AIMS. Given severe limitations placed on the state's mental health budget over the past several years, such changes would not be feasible without considerable support from state and federal governments to support this effort.

Although the AIMS system collects information about the client's specific insurance coverage associated with the mental health services they have received, CMHCs in Kansas have not historically been required to provide AIMS with detail of the separate funding streams they use to pay for distinct mental health services for individuals not covered by Medicaid or other government or private insurance.

To provide this information for Kansas 2015 MH Block Grant Table 5 MHBG Expenditures By Service, BHS required each CMHC to identify and report on the area(s) within their organizations in which Block Grant funds were expended. For SFY2016, each CMHC is required to provide additional information to further identify the number of individuals and services purchased by Block Grant funds. Specifically, for each service purchased with MHBG funds during FY2016, the CMHC will report the anticipated number of uninsured/underinsured clients who will benefit, number of service hours (if applicable) and how expenditures are tracked. CMHCs will submit quarterly reports to the BHS Community Mental Health Quality Improvement Field Staff for monitoring.

Identify the specific technical assistance needs the state may have regarding data and information technology

BHS is in the process of developing solutions for the following priority areas identified in our current Kansas BHSIS contract:

Establishment of a client identifier for AIMS that remains viable across service delivery systems

Implementation of an efficient process for a systematic closure of inactive client records in the AIMS system

4. If not, what changes will the state need to make to be able to collect and report on these measures?

NA

Prevention

Individual-level data collection for substance abuse prevention is anonymous, self-reported attitude, behavioral and demographics data collected from the Kansas Communities That Care (KCTC) student survey, prevention education pre-and-post surveys. Rosters or demographic estimates are used calculate numbers served from implementation of population-based strategies. Data are not reported at the individual participant level but are collected and use to report group or aggregate data to inform program and population outcomes.

Program data collection for substance abuse prevention is entered into an Online Documentation and Support System (ODSS). The ODSS allows communities to report their implementation activity online. Program activities can be tracked, coded and aggregated to support evaluation of program success including changes in community programs policies and practices. In addition, prevention education **program data collection** and reporting consists of aggregate individual level data. Data can be aggregated and reported by various individual demographics (gender, race, ethnicity, and region). Unique identification codes are used to match pre and post survey data to statistically report program outcomes and impact depending on the strategy. Population-based substance abuse strategies are reported by numbers directly served or estimated numbers reached through implementation.

Youth **county and state level** data are reported for various substance use indicators and known risk and prevention measures. These data are used to measure progress toward community and state level targeted goals and objectives.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Reduce underage drinking
 Priority Type: SAP
 Population(s): PP

Goal of the priority area:

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

Objective:

Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address underage alcohol use through the implementation of evidence-based prevention strategies.

Strategies to attain the objective:

Implementation and evaluation of evidence-based programs, policies and practices reflective of priorities identified from the community-level needs assessment process and outlined in local-level strategic plans in funded communities that address the selected state level priority area.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Decrease past 30-day alcohol use among students in grades 6, 8, 10, and 12 in Kansas.
 Baseline Measurement: 19.91% (2014)
 First-year target/outcome measurement: 19.0% (2016)
 Second-year target/outcome measurement: 18.5% (2017)

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

KCTC Data Caveat: Due to legislated active consent requirements, for the Kansas Communities That Care Survey participation rates have decreased below the threshold for state-level reporting in 2015. However, efforts are in progress to increase school district participation in subsequent years in order to ensure the availability of high quality, reliable, and valid annual and trend data.

Indicator #: 2
 Indicator: Number of new or modified evidence-based strategies targeting underage drinking.
 Baseline Measurement: 0
 First-year target/outcome measurement: 10
 Second-year target/outcome measurement: 15

Data Source:

KU Workgroup for Community Health, Online Documentation and Support System

Description of Data:

Community-level reporting of strategy implementation

Data issues/caveats that affect outcome measures::

Due to the changes in the behavioral health prevention system, baseline has been set at zero. Implementation will be based on community level behavioral health assessments which have not been completed at this time.

Indicator #: 3
Indicator: Number of media and information dissemination strategies targeting underage drinking.
Baseline Measurement: 0
First-year target/outcome measurement: 10
Second-year target/outcome measurement: 15

Data Source:

KU Workgroup for Community Health, Online Documentation and Support System

Description of Data:

Community-level Media and Services Provided coding and documentation of strategy implementation

Data issues/caveats that affect outcome measures::

Due to the changes in the behavioral health prevention system, baseline has been set at zero. Implementation will be based on community level behavioral health assessments which have not been completed at this time.

Priority #: 2
Priority Area: Perceived risk of harm with underage marijuana use
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Increase perceived risk of harm for regular marijuana use among students in grades 6, 8, 10, and 12.

Objective:

Completion of community-level comprehensive strategic planning and provision of supports for community initiatives utilizing all steps of the Strategic Prevention Framework to address marijuana use through the implementation of evidence-based prevention strategies.

Strategies to attain the objective:

Implementation and evaluation of evidence-based programs, policies and practices reflective of priorities identified from the community-level needs assessment process and outlined in local-level strategic plans in funded communities that address the selected state level priority area.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: How much do you think people risk harming themselves (physical or in other ways) if they: smoke marijuana regularly (slight risk, moderate risk, or great risk)?
Baseline Measurement: 84.29% (2014)
First-year target/outcome measurement: 84.79% (2016)
Second-year target/outcome measurement: 85.29% (2017)

Data Source:

Kansas Communities That Care (KCTC) Student Survey

Description of Data:

Survey Data, Prevalence Indicator

Data issues/caveats that affect outcome measures::

KCTC Data Caveat: Due to legislated active consent requirements, for the Kansas Communities That Care Survey participation rates have decreased below the threshold for state-level reporting in 2015. However, efforts are in progress to increase school district participation in subsequent years in order to ensure the availability of high quality, reliable, and valid annual and trend data.

Indicator #: 2

Indicator: Number of new or modified evidence-based strategies targeting perceived risk of harm associated with regular marijuana use.

Baseline Measurement: 0

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 10

Data Source:

KU Workgroup for Community Health, Online Documentation and Support System

Description of Data:

Community-level reporting of strategy implementation

Data issues/caveats that affect outcome measures::

Due to the changes in the behavioral health prevention system, baseline has been set at zero. Implementation will be based on community level behavioral health assessments which have not been completed at this time.

Indicator #: 3

Indicator: Number of media and information dissemination strategies targeting perceived risk of harm associated with regular marijuana use.

Baseline Measurement: 0

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 10

Data Source:

KU Workgroup for Community Health, Online Documentation and Support System

Description of Data:

Community-level Media and Services Provided coding and documentation of strategy implementation

Data issues/caveats that affect outcome measures::

Due to the changes in the behavioral health prevention system, baseline has been set at zero. Implementation will be based on community level behavioral health assessments which have not been completed at this time.

Priority #: 3

Priority Area: Behavioral Health Prevention and Promotion

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Educate, promote, disseminate resources, and advocacy to support suicide prevention, mental health promotion and the reduction of co-occurring risk factors and increase in associated protective factors.

Objective:

Increase collaboration across multiple community-level coalitions, sectors and/or initiatives, for example connecting suicide prevention coalitions with SUD coalitions.

Strategies to attain the objective:

Infrastructure enhancement, creating collaborations, outreach, education and information dissemination and the implementation of evidence-based strategies that address multiple behavioral health issues.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of new collaborative partnerships to address behavioral health and associated risk and protective factors.

Baseline Measurement: 0

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 5

Data Source:

Contractor reporting, monitoring and accountability for infrastructure development.

Description of Data:

Monthly contractor progress reporting, including qualitative and quantitative indicators

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Development and adoption of a charter for behavioral health prevention and promotion by the Prevention Subcommittee of the Governor's behavioral health planning council.

Baseline Measurement: 0

First-year target/outcome measurement: Development

Second-year target/outcome measurement: Adoption

Data Source:

Contractor reporting, monitoring and accountability for infrastructure development.

Description of Data:

Monthly contractor progress reporting, including qualitative and quantitative indicators

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of prevention education, media and information dissemination strategies relating to behavioral health prevention and promotion.

Baseline Measurement: 0

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 15

Data Source:

Contractor reporting, monitoring and accountability for infrastructure development.

Description of Data:

Monthly contractor progress reporting, including qualitative and quantitative indicators

Data issues/caveats that affect outcome measures::

Priority #: 4
Priority Area: SAPT BG funded pregnant women and women with children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

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

Objective:

To ensure this priority population is admitted to designated women's treatment which according to research affords them a greater certainty of success

Strategies to attain the objective:

Compare baseline data with current data to see if strategy's have been effective
Continue to prepare aggregate analysis and present data/report at the Quality committee
Continue to ensure contracts contain language mandating at assessment this population have at 3 choices of providers and at least one of these choices is a women's program

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of SAPT BG funded pregnant and women and women with dependent children served in DWP will increase by 2%
Baseline Measurement: Women: 741 admitted to treatment; of those 177 or 23.89% admitted to DWF during FY15
First-year target/outcome measurement: 24% of women rwill be eferred to DWP in FY 16
Second-year target/outcome measurement: 26% of women will be referred to DWP in FY 17

Data Source:

KCPC-Kansas Client Placement Criteria
Administrative Services Organization reports

Description of Data:

Report from managed care entity showing the percentage of women referred to a designated women's facility by funder. The detailed report will include the place where the assessment took place and the facility where the treatment was received (if recommended). The summary portion of the report will include the following by pregnant women and women with children:
1. Total recommended for treatment
2. Recommended for Level I - Level 3
3. Members who went to treatment
4. Members who did not go to treatment
5. Members who went to a designated Women's facility.

Provider Contracts.

Data issues/caveats that affect outcome measures::

KDADS/BHS is in the process of converting it's current data system to one that is now in place at it's parent agency. It is hoped this will improve the data but could initially impact the outcomes.

Priority #: 5
Priority Area: SAPTBG Funded IVDU clients
Priority Type: SAT
Population(s):
Goal of the priority area:

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

Objective:

To admit IVDU clients into treatment within the required timeframes

Strategies to attain the objective:

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

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

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

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

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

A waitlist project has been included in the new ASO contract. Clients on the wait list will be prioritized by pregnant women and IVDU clients.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: IVDU clients are admitted to treatment within the required timeframe
Baseline Measurement: 14 day admission to treatment- 50.1% and 120 day admission to treatment- 62.3%
First-year target/outcome measurement: 14 days 52% and 120 days 65%
Second-year target/outcome measurement: 14 days 54% and 120 days 68%

Data Source:

KCPC
ASO claims data and Access to Care Report

Description of Data:

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

Data issues/caveats that affect outcome measures::

Kansas uses a higher standard and requires providers to admit IVDU clients within a 14 day timeframe.

Priority #: 6
Priority Area: TB screening
Priority Type: SAT

Population(s): TB

Goal of the priority area:

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

Objective:

Tuberculosis screening is provided to all persons entering a substance abuse treatment service.

Strategies to attain the objective:

100% of all KDADS/BHS funded providers will meet contractual TB Block Grant requirements.

100% of KDADS/BHS funded providers are monitored for TB Block Grant requirements during site visits.

KDADS/BHS Consultants will ensure 100% compliance with providers regarding having both policies and protocol for TB risk assessments during KDADS/BHS funded on-site reviews.

KDADS/BHS Consultants will ensure 100% compliance with providers when reviewing TB Logs at all KDADS / BHS funded on-site reviews.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	SUD providers will meet all federal and contractual requirements
Baseline Measurement:	unavailable at this time
First-year target/outcome measurement:	100 % of all providers will meet requirements
Second-year target/outcome measurement:	100 % of all providers will meet requirements

Data Source:

licensure visit information
Corrective action plan

Description of Data:

review of State regulations that include the federal requirements

Data issues/caveats that affect outcome measures::

Most of the deficiencies were related to staff not having a current TB test or record in their file. This is a state requirement. Most client related TB requirements were met by providers.

Priority #: 7

Priority Area: Adults with SPMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Priority #: 8
Priority Area: Youth with SED
Priority Type: MHS
Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of youth with a SED being served in each CMHC catchment area will increase.
Baseline Measurement: Numerator: Number of youth with SED who receive CMHC services Denominator: Total estimated youth population in Kansas under age 18 Rate: Numerator/Denominator multiplied by 10,000
First-year target/outcome measurement: 372 youth per 10,000 Kansas residents under age 18 received public mental health services in FY13
Second-year target/outcome measurement: 403 youth per 10,000 Kansas residents under age 18 received public mental health services in FY13

Data Source:

AIMS/U.S. Census estimate

Description of Data:

Client-level detail is carried in the AIMS on each consumer with SED.

Data issues/caveats that affect outcome measures::

None

Priority #: 9
Priority Area: Adult SMHH hospital readmissions within 30 days
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: Numerator: The number of adults readmitted to the SMHH within 30 days. Denominator: The total number of SMHH discharges during the fiscal year.

First-year target/outcome measurement: The percentage of adults readmitted to a SMHH within 30 days during FY13 was 11.84%.

Second-year target/outcome measurement: The percentage of adults readmitted to a SMHH within 30 days during FY15 was reduced to 11.52%.

Data Source:

State Hospital MRM data

Description of Data:

SMHH facilities provide admission/discharge information on all clients admitted for inpatient psychiatric treatment.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Youth State Hospital Alternative (SHA) readmissions

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Youth State Hospital Alternative (SHA) readmissions within 30 days will remain stable or decrease.

Objective:

Decrease youth re-admissions to SHA facilities.

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of youth under age 18 that are readmitted to state hospital alternative facilities within 30 days of discharge will remain stable or decrease during the fiscal year.

Baseline Measurement: Numerator: The number of youth readmitted to the SHA within 30 days. Denominator: The total number of SHA discharges during the fiscal year.

First-year target/outcome measurement: The percentage of youth readmitted within 30 days to an SHA was 17.67% during FY13.

Second-year target/outcome measurement: The estimated percentage of youth readmitted within 30 days to an SHA is 7.95% during FY15.

Data Source:

SHA administrative data provided quarterly to the SMHA.

Description of Data:

The SHA contractor provides the SMHA with client-level admission and discharge information quarterly.

Data issues/caveats that affect outcome measures::

Final numbers for FY15 are not yet available.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$18,051,788		\$28,108,116	\$2,816,000	\$32,456,648	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$4,126,802		\$0	\$0	\$2,112,738	\$0	\$0
b. All Other	\$13,924,986		\$28,108,116	\$2,816,000	\$30,343,910	\$0	\$0
2. Substance Abuse Primary Prevention	\$5,521,444		\$0	\$1,768,056	\$1,692,216	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$226,094		\$0	\$0	\$774,982	\$0	\$176,414
11. Total	\$23,799,326	\$0	\$28,108,116	\$4,584,056	\$34,923,846	\$0	\$176,414

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$91,531,726	\$1,217,754	\$184,557,580	\$0	\$0
6. Other 24 Hour Care		\$0	\$38,603,554	\$0	\$79,378,852	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$6,412,305	\$219,096,808	\$0	\$20,557,410	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)		\$754,390	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$377,195	\$14,824,514	\$0	\$3,744,080	\$0	\$0
11. Total	\$0	\$7,543,890	\$364,056,602	\$1,217,754	\$288,237,922	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$164,471
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$3,408,044	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$1,274,000	\$85,085
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$2,549,500	\$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$	\$922,448
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$80,500	\$223,343
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$140,000	\$215,650
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$88,000	\$24,025
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$1,752,000	\$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$5,818,000	\$394,798
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$	\$243,652
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$	\$
Total	\$15,110,044	\$2,273,472

Footnotes:

A portion of the SABG Block Grant Primary Prevention Funding is utilized for Resource Development Activities

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$9,025,894
2 . Substance Abuse Primary Prevention	\$2,760,722
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$113,047
6. Total	\$11,899,663

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
			SA Block Grant Award
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		\$862,433
	Total		\$862,433
Education	Universal		
	Selective		
	Indicated		
	Unspecified		\$249,580
	Total		\$249,580
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		\$13,866
	Total		\$13,866
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		\$27,731
	Total		\$27,731

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	\$291,176
	Total	\$291,176
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	\$249,580
	Total	\$249,580
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Other	Universal	
	Selective	
	Indicated	
	Unspecified	\$27,731
	Total	\$27,731
Total Prevention Expenditures		\$1,722,097
Total SABG Award*		\$11,899,663
Planned Primary Prevention Percentage		14.47 %

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

Footnotes:

Kansas uses primary prevention block grant funds for resource development - see Table 6a.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Column Total		
Total SABG Award*	\$11,899,663	
Planned Primary Prevention Percentage	0.00 %	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

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

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$517,730	\$0	\$0	\$517,730
2. Quality Assurance	\$0	\$0	\$0	
3. Training (Post-Employment)	\$0	\$0	\$0	
4. Education (Pre-Employment)	\$0	\$0	\$0	
5. Program Development	\$140,887	\$0	\$0	\$140,887
6. Research and Evaluation	\$0	\$0	\$0	
7. Information Systems	\$380,008	\$0	\$0	\$380,008
8. Total	\$1,038,625			\$1,038,625

Footnotes:

Kansas uses primary prevention block grant funds for resource development - see Table 5a.



Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	\$157,628
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$157628
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

1. The Health Care System and Integration

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?
10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
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11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

Prevention

As part of infrastructure enhancement efforts and planning for systems-level services and outcomes integration across behavioral health prevention and promotion, within the Kansas prevention system a number of initiatives will be supported to address and support greater health care system integration. Preliminarily, efforts will focus on capacity development within the system across prevention providers to address issues relevant to integration, although assessment and strategic planning will also serve as focal points throughout FFY16 and FFY17. Given that the Kansas prevention system is now comprised (effective July 1, 2015) of a new system of contractors responsible for community-level training, technical assistance, education, advocacy, and resource dissemination, and behavioral health promotion, this is a prime opportunity for visioning and moving forward with a more integrated approach.

Examples for which greater coordination and integration can take place within the Kansas behavioral health system with a strong prevention component and leveraging of resources within the prevention network are in three key areas:

1. Workforce Development with Targeted Training and Cross-Discipline Education

Formal education, training, and coaching will be provided to the contractors within the Kansas prevention network, to ensure an understanding of the degree to which they have a role to play in assisting communities in working toward access and integrated prevention, treatment, and recovery supports for vulnerable populations, groups for which health disparities exist, as well as those individuals experiencing, or at risk for, mental illness or other behavioral health conditions. As part of contractor education, outcome measures will be developed as part of an evaluation framework, which will also include performance measures and process indicators for integration. Workforce

development education and training topics will include, but not be limited to, integrated care models and best practices, comprehensive, broad-scope community strategic planning approaches to provide a foundation for integration, Adverse Childhood Experiences and co-occurring behavioral health issues, and tactics for community-level mobilization, collaboration, and engagement across sectors and providers for more coordinated approaches to behavioral health and wellness.

2. Infusion into Community-Level Strategic Planning

Rather than restricting community-level strategic planning to substance use prevention, given the existence of shared risk and protective factors, extant state-wide data sets, and best practices, it is far more efficient and effective to provide supports to communities which allow them to engage in comprehensive strategic planning across behavioral health, with corresponding development of a logic model and action plans that are inclusive of the continuum of care and have a lifespan orientation. Prevention providers will be trained in this approach to comprehensive community behavioral health strategic planning, and expected to support the implementation of this approach within communities in which services are delivered. While strategic planning and selection of evidence-based strategies and best practices across behavioral health will be facilitated at the community level, examples of strategies for infusion into community-level behavioral health strategic plans includes the use of education and advocacy approaches for local behavioral health providers to engage in proactive screening and referral for vulnerable, at-risk, or identified individuals and populations for prevention and wellness education, health risks (such as heart disease, hypertension, elevated cholesterol, and diabetes), and access to recovery supports.

3. Integration into Promotion, Advocacy, and Resources for Families and Consumers

Individuals experiencing mental/behavioral health challenges have an increased probability of experiencing concomitant impacts on their quality of life, and lifespan, due to untreated yet chronic and preventable issues such as cardiovascular disease, diabetes, obesity, hypertension, and substance abuse. Consumers and family members will also be targeted for education and outreach, to ensure understanding of the need for advocacy and the availability of resources to ensure early identification and referral for these needs and issues. Similarly, contracted providers within the Kansas prevention network will be provided education regarding the integration continuum, levels of integrated health care, and models for how behavioral and physical health services can be integrated to improve services for consumers in order to achieve improved health outcomes.

Section K. Primary and Behavioral Health Care Integration Activities

Kansas implemented the SMI Health Home model in August of 2014. The SMI population is defined as anyone with a primary diagnosis of one or more of the following:

- Schizophrenia
- Bipolar and major depression
- Delusional disorders
- Personality disorders
- Psychosis not otherwise specified
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

The goal of Health Homes is to improve care and health outcomes, lower Medicaid costs, and reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid members.

Health Homes is an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703, allows states under the state plan option or through a waiver, the authority to implement Health Homes effective January 1, 2011. The purpose of Health Homes is to provide the opportunity to States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness.

Health Homes services are provided to a subset of the Medicaid population with complex chronic health and/or behavioral health needs whose care is often fragmented, uncoordinated and duplicative.

This population includes categorically and medically needy beneficiaries served by Medicaid managed care or fee-for-service and Medicare/Medicaid dually eligible beneficiaries who meet Health Homes criteria. Individuals served in a Health Homes must have at least two chronic conditions; or one qualifying chronic condition and be at risk of developing another; or one serious mental illness. The chronic conditions described in Section 1945(h)(2) of the Social Security Act include, but are not limited to, the following:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Overweight as evidenced by a body mass index (BMI) of 25
- HIV/AIDS
- Other Chronic Conditions

The Health Homes service delivery model is designed to provide cost-effective services that facilitate access to a multidisciplinary array of medical care, behavioral health care and community-based social services and supports for individuals with chronic medical and/or behavioral health conditions. Health Homes services support the provision of coordinated, comprehensive medical and behavioral health services through care coordination and integration. The goal of these core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT), and avoid unnecessary care. Section 1945(h)(4) of the Social Security Act defines Health Homes services as "comprehensive and timely high quality services" and includes six Health Homes services to be provided by designated Health Homes providers.

Health Homes Services include:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
5. Individual and family support, which includes authorized representatives; and
6. Referral to community and social support services if relevant.

In the Health Home model Kansas has chosen, the three KanCare managed care organizations (MCOs) serve as the Lead Entities (LEs) for Health Homes and contract with community providers to be Health Homes Partners (HHPs). Together, they provide the six core services and share the payment provided

by the State. The contracts between the LEs and the HHPs spell out which entity is providing each of the core services and how the payment is divided.

For Health Homes members who are SMI, the Lead Entity and the Health Homes Partner must jointly:

1. Provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees;

2. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay;

3. Ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services;

4. Provide quality-driven, cost-effective Health Homes services in a culturally competent manner that addresses health disparities and improves health literacy;

5. Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers;

6. Demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner:

- a. Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act;

- b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines;

- c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

- d. Coordinate and provide access to mental health and substance abuse services

- e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;

- f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and,

- g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;

7. Demonstrate the ability to report required data for both state and federal monitoring of the program.

Kansas Department for Health and Environment (KDHE), in cooperation with varied stakeholders and representatives from KDADS, MCOs and KUMC partners and advised by Kansas Foundation for Medical Care, the External Quality Review Organization of Kansas, formed a quality sub-group to develop quality goals and measures to assess the Health Homes delivery model. The Health Homes quality program incorporates federally required reporting for eight mandated areas comprised of hospital admission, chronic disease management, coordination of care, program implementation, processes and lessons learned quality and clinical outcomes, cost savings and admissions to skilled nursing facilities.

To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data for the CMS Core Set of Measures and state-specific quality goals. This assessment may include a combination of claims, administrative, and qualitative data. Where possible, Kansas utilizes metrics where benchmark data is currently available and collected, such as HEDIS (Healthcare Effectiveness Data and Information Set). Data for each goal and measure will be collected through defined quality

processes aligned to state and regional benchmarks as defined in the Kansas Health Homes Quality Goals and Measures.

Nicotine dependence:

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

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

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

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

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

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

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

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

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

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

2. Health Disparities

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, gender, LGBT, and age?

The BHS integrated data system for SUD treatment collects all required TEDs data which includes, race, gender, and age. This information will continue to be collected and submitted as required. This data is also used to make decisions about treatment need.

When BHS merged into the Kansas Department of Aging resulting in the creation of KDADS (Kansas Department for Aging and Disability Services), new technology became available for developing a replacement data system. The Information Technology section of KDADS has begun working with program staff to develop the replacement for the BHS Integrated Data System using Oracle APEX framework.

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

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

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

Work continues on the new system and BHS staff and IT staff continues to meet. Final recommendations should be made to IT staff by BHS staff. These two units will work together to develop testing protocol, and a training plan.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

Questions were added to the BHS Integrated Data system to gather information at the time of assessment about the client's language and any barriers that may exist. This information is used by treatment programs when making programmatic and clinical decisions. BHS is able to gather information if needed.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

BHS implemented a service code for support services many years ago. Providers are able to utilize this code to bill for interpretation services.

5. Is there state support for cultural and linguistic competency training for providers?

There is no state training for cultural competence as our resources (fiscal and staff) prohibit providing this service to providers.

Prevention

The Kansas prevention system has a critical role and contribution as it relates to the reduction of, and the reduction of the impact of, health disparities related to substance abuse and dependence. Ways in which the Kansas prevention system will work toward conducting assessment, capacity development, and planning efforts throughout FFY16 and subsequent years to address this issue include:

- Utilization of epidemiological data, including the Kansas Behavioral Health Profile, to enhance understanding of the incidence, risk factors, and consequences associated with substance abuse and behavioral health issues across diverse groups which may be defined but are not limited to characteristics including race, ethnicity, age, and gender.
- Strengthening and enhancing data sets, capacity, infrastructure, and resources for community, state, and systems-level ability to assess, plan, deliver services, and monitor effectiveness of prevention efforts disaggregated by, and tailored to, vulnerable, at-risk, or other populations at risk for disparities.
- Improving supports and resources provided to communities for more coordinated and effective comprehensive planning and implementation of strategies and best practices to

address diverse groups at risk for substance abuse and health consequences associated with behavioral health challenges.

- Providing information dissemination, education, and training with regard to substance abuse, dependence, and behavioral health issues related to diverse populations at the consumer, community, and provider level to support the identification and utilization of evidence-based approaches and best practices in promotion, prevention, early identification, treatment, and recovery.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

3. Use of Evidence in Purchasing Decisions

1. Describe specific staff responsible for tracking and disseminating information regarding evidence –based or promising practices.

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

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

2. How is the information used regarding evidence-based or promising practices in your purchasing or policy decisions?

BHS/SUD does not currently use information and/or data about evidence-based or promising practices in our purchasing and/or policy decisions. BHS/SUD does not currently have contract language or policy which requires providers to implement EBPs. Some providers are voluntarily implementing EBPs, typically Cognitive Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET), yet there is no systematic implementation of these EBPs. BHS/SUD continues to be interested in building capacity around EBP's and the appropriate implementation within SUD treatment providers. BHS staff will be working with the contracted administrative service organization to bid the SUD system out in 2017. There are plans to include some language around an incentive rate if a provider is at least using a best practice.

BHS/MH does not currently use information and/or data about evidence-based or promising practices in our purchasing and/or policy decisions. CMHCs determine which, if any, EBPs will be implemented at their center. Through Medicaid, incentives are available to CMHCs for implementation of 2 EBPs and one promising practice by allowing enhanced rates when high fidelity is achieved. This is monitored annually and CMHC staff are certified. Certifications are sent to BHS/MH, approved and sent to each of the MCOs.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

BHS/SUD staff is not currently providing any formal education to the State Medicaid agency about purchasing services based on evidence based practices.

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

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

BHS/SUD continues to develop a plan to determine the readiness of SUD providers to move towards a pay for performance model. It is hoped to use the information obtained in the survey to implement this model. This survey will include questions on: business models, staffing plans, use of EBP's with fidelity, quality improvement plan, continuum of services, ROSC, etc.

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

5. Which value based purchasing strategies do you use in your state: (list in application)

Not applicable for BHS/SUD and MH at this time.

Prevention

The Prevention and Promotion programs at KDADS include the following requirements that relate to evidence in purchasing:

- requires a systems-level decision making and selection process;
- parameters that allow for making evidence-based strategy research findings and databases (e.g., NREPP) easily accessible to decision makers;
- offers guidance for strengths and limitations of approaches in terms of efficacy, applicability, and ability to achieve targeted outcomes with identified populations, and;
- guidance on how to interpret the strength of evidence in the context of local community characteristics and needs, data, and levels of risk and protective factors across disparate populations in order to ensure best fit, alignment, and intensity.

The use of evidence-based parameters for strategy selection and purchasing at the community level with regard to prevention will be supported by KDADS in a number of ways, and has been an ongoing priority in past years. Because community prevention partnerships and providers are largely comprised of volunteers, often their level of knowledge and familiarity with the use of evidence in the selection and implementation of prevention strategies is limited at best. As such, KDADS will ensure that community prevention groups and initiatives will receive education and training, resources and coaching, to assist them in understanding criteria for evidence-based strategy selection, guidance for applying research findings to local context and conditions and

interpreting strength of evidence, and finalizing strategy selection. In addition, education will be made available to prevention contractors through KDADS to ensure understanding of the basic framework for evidence-based purchasing/strategy selection, utilizing key criteria across four domains: scientific, socio-cultural, organizational, and health promotion. Using such a framework will also allow for the inclusion of performance measures and process measures into an overall evaluation framework to determine the degree to which evidence-based purchasing criteria are used in strategy selection, and subsequent implementation, efforts. Additionally, all proposed community-level prevention strategies will be reviewed for approval based upon evidence-based definitions and criteria established by CSAP, such that SAPT block grant prevention funds support those prevention strategies with sufficient strength of evidence, population appropriateness, and alignment with targeted local risk and protective factors, while also taking into consideration needs for tailoring and adaptation without compromising fidelity (in the case of programs), and maximization of saturation and intensity. Further strengthening this process will be the use and consideration of evaluation findings and data at the state and local level, as available, relating the impact and outcomes associated with strategy implementation, to bolster decision making processes.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

4. Prevention for Serious Mental Illness

Prevention

In terms of contribution to the prevention of serious mental illness, prevention providers have an unparalleled opportunity to offer resources and capacity development at the state systems level, and in terms of direct application and impact, at the community level. The identification and treatment of individuals at high clinical risk or in the prodromal or predromal phase, through contribution and involvement of providers across the continuum of care, offers promise of altering the course of the illness, reducing severity, impact, consequences, and disability, and maximizing recovery. Recent research also strongly suggests that the behavior problems and difficulties that are putative precursors of serious mental illness such as schizophrenia are potential targets for prevention in terms of both selective and indicated populations, as well as case identification and early intervention. Research indicates that poor peer relations and interpersonal efficacy, the presence of internalizing behaviors and symptoms, and poor affective control pose difficulties for both young people and their parents or caregivers; and although the enhancement of social skills and affective control may not forestall the development of SMI, there is evidence that enhancing interpersonal skills and social competencies, and improving affective control can enhance the quality of life and improve post-episode recovery and psychosocial functioning.

As such, the Kansas prevention system is positioned to play a significant role in ensuring that communities, coalitions, and key sectors and organizations across the state are provided with resources, guidance, training, and technical assistance to become more cognizant of linkages between early psychosocial functioning, affective control, exposure to chronic/episodic or severe early childhood trauma (e.g., Adverse Childhood Experiences), screening resources, methods for coordination and referral for services, and evidence-based strategies and programs that can bolster functioning or address these issues at the earliest point of behavioral identification. Capacity development in this regard will increase community-level ability to infuse behavioral health prevention and promotion into local-level comprehensive strategic planning. Additionally, given the inter-relationship between risk factors for substance abuse and many that are predictive of behavioral health issues, comprehensive community strategic planning targeting these shared risk factors can be supported by the Kansas prevention system to ensure thoroughness, efficacy, and alignment for achieving a broad array of substance abuse prevention and behavioral health outcomes.

Environmental Factors and Plan

5. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)

Narrative Question:

The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside is over the FY 2015 level. The appropriation bill specifically requires the 10 percent set-aside to fund only those evidence-based programs that target FEP. The law specifically stated:

"...the funds from set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis".

Previous appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of set aside funds for individuals with early SMI, including those without psychosis. However, the new language specifically requires states to focus their efforts only on FEP.

States that are currently utilizing FY 2016 set-aside funds for early SMI other than psychosis must now refocus their efforts to service only those with FEP. SAMHSA will allow states that already signed a contract or allocated money to their providers using the FY 2016 funds to complete these initiatives through the end of their contract or by the end of September 30, 2016, whichever comes first. States may continue to support these efforts using the general MHBG funds; however, the set-aside allocation must be used for efforts that address FEP. Nothing precludes states from utilizing its non-set-aside MHBG funds for services for individuals with early SMI.

If states have other investments for people at high risk of SMI, they are encouraged to coordinate those programs with early intervention programs supported by the MHBG. This coordination will help ensure high risk individuals are swiftly identified and engaged in evidence-based services should they develop into diagnosable SMI. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at high risk of SMI.

States can implement models which have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented.

SAMHSA and NIMH in conjunction with National Association of State Mental Health Program Directors (NASMHPD) will continue to ensure that technical assistance and technical resources are available to states as they develop and implement their plan.

States will be required to revise their two-year plan to propose how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. Upon submission, SAMHSA will review the revised proposals and consult with NIMH to make sure they are complete and responsive. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than Coordinated Specialty Care (CSC) approach developed via the RAISE initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. With consultation with NIMH as needed, the proposals will be either accepted, or requests for modifications to the plan will be discussed and negotiated with the State. SAMHSA will notify each State once the revised proposals are approved.

This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. SAMHSA is also required within six months of the appropriations statute enactment to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short term description of the program. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow.

States must submit their plan revision request proposal into the FY 2016-2017 Block Grant Application under the following section:

Section III. Behavioral Health Assessment and Plan, C. Environmental Factors and Plan, #5. Evidence-Based Practices for First Episode Psychosis.

The state must revise the following for the 10 percent set-aside for first episode psychosis:

1. An updated description of the states chosen evidence-based practice for the 10 percent set-aside initiative.
2. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
3. A budget showing how the set-aside and additional state or other supported funds, if any, will be utilized for this purpose.
4. The states provision for collecting and reporting data, demonstrating the impact of this initiative.
5. Any foreseen challenges.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

5. Evidence Based Practices for Early Intervention (5 percent)

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

Kansas utilized the Block Grant 5 % set aside to develop and issued a Request for Proposal (RFP) that was for eligible applicants from one of the 26 Community Mental Health Centers (CMHC) within the state for competitive bid. The RFP would create a pilot for establishing a Coordinated Specialty Care (CSC) program designed to provide early interventions services for persons experiencing first episode psychosis (FEP). The proposals provided for early episode Serious Mental Illness (SMI) interventions; including early psychotic disorders which incorporate the RAISE model of intervention and supports by NIMH.

Funds are used to serve individuals with a severe mental illness who within one week to two years have experienced their first episode of psychosis. The age range of the target population is 15-25 year olds. The diagnosis that is used for inclusion in the program, following the recommendations of the RAISE model, include: schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, psychosis not otherwise specified and delusional disorder.

2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.

Funds were awarded to Wyandot Center for Community Behavioral Healthcare, Inc. in 2015. Wyandot has established an Early Intervention Team (EIT) and has completed all required trainings. They began accepting participants in the program in April 2015. From April 1st to May 31st there were 16 referrals; 6 were accepted into the program and 13 were pending at the time of the report.

Services provided by the EIT RAISE program of Wyandotte Community Mental Health Center/PACES (WCCBH/PACES) include the following:

- A Qualified Mental Health Professional (QMHP) acting as Team Leader will provide assessment and diagnosis of early psychosis after referral from initial entry points; ensure overall coordination of the RAISE services and interventions; provide Cognitive Behavioral Therapy for psychosis (CBTP) specialized therapeutic intervention that focuses on creating a collaborative therapeutic alliance; ensure intensive case management by WCCBH/PACES is provided to each participant; and provide and/or coordinate crisis intervention services individually through WCCBH Emergency and Stabilization Services and Rainbow Services, Inc., (Rainbow Services Incorporated, the Regional Recovery Center for Wyandotte and Johnson Counties and a sister organization to WCCBH) and be responsible for information and data gathering, safety planning, and outreach and engagement.
- A Recovery Coach will provide RAISE designed social skills training to each participant, weekly participation groups, monthly family groups for education and support and strengthening relationships, school coordination, and outreach and engagement.

- An Employment/Education Specialist provided via WCCBH’s award-winning, Exemplary Fidelity rated Supported Employment evidence-based practice, will focus on engagement or re-engagement with work or school or pursuing new educational/work opportunities
- A PACES psychiatrist will provide medical prescribing services; engage in shared decision-making; provide psychopharmacological and wellness education; and adhere to the RAISE protocols of prescribing practices (commonly referred to as “start low and go slow” and indicating specific medications as front-line pharmacological interventions).

In addition to these CBS/EIT interventions based upon the RAISE model that this grant proposal is requesting funding to implement, each participant in the program will have access to the wide array of community mental health services offered by WCCBH and PACES. These are not part of the grant request, but are nonetheless available to participants in this specialized treatment intervention regardless of payer source:

- Intensive Case Management Services provided by WCCBH’s Young Adult Case Management Team and/or PACES case management/wraparound facilitator staff
- Integrated treatment for mental health and substance use problems provided in partnership with Heartland Regional Alcohol Drug Assessment Center
- Group psycho-education (WCCBH and PACES as options)
- On-demand 24/7 crisis services (therapy, medications, hospitalization and PRTF pre-admission screens) via WCCBH’s 8am-8pm Emergency and Stabilization Services department
- SSI/SSDI Outreach Access and Recovery (SOAR) benefits services
- Hospital Liaison services for admission, treatment and discharge planning from state hospitalization
- Crisis Stabilization/Respite services operating 24-7, 365 to provide short-term supportive crisis stabilization and supports through both WCCBH/ PACES
- Jail diversion services staffed WCCBH through the county’s Bureau of Justice grant
- Crisis Intervention Teams (CIT) provided by the Kansas City Kansas Police and Sheriff’s departments in partnership with WCCBH/PACES
- 24/7 access to specialized crisis phone line services, who will work with the Team Leader to ensure immediate access to crisis intervention planning and access 24/7/365
- Medication delivery services 7 days per week, up to twice per day
- Access to subsidized housing and housing assistance through WCCBH’s partner organization, Kim Wilson Housing
- WCCBH’s Health and Wellness clinic- an on-site primary care service
- Genoa, a full-service, on-site pharmacy services and patient assistance programs for medications for individuals who are un- or under-insured
- Integrated Primary Care Coordination with WCCBH’s Health Homes initiative
- Certified Art Therapy and Studio
- Peer Support Services
- Mental Health Attendant Care Services

It is important to note that all of these services are provided within the context of WCCBH’s commitment to evidence-based, person-centered, recovery-oriented, strengths-based practice for every person served by the organization. In addition, WCCBH/PACES are in the process of becoming fully trauma-informed organizations, partnering with Wichita State University

and the local organization, THRIVE, to implement trauma-informed initiatives across the family of organizations.

3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

EIT Implementation Update January 1, 2015 through February 28th, 2015

Timeline	Grant Requirement Tasks	Status
Before Implementation:	<ol style="list-style-type: none"> 1. RA1SE intervention reviewed/RPF 2. Insurance and financial concerns address, WCCBH/PACES committed to providing RA1SE services in program based on need regardless of payer source 3. Types of clients, referral network, program structure & services, and geographic boundaries of the RA1SE program identified. 4. Decisions made re: staffing, including position reassignment and team structures for YA team and PACES staff. 5. Supported Employment position identified so position split between RA1SE and non-RA1SE participants. 	<ol style="list-style-type: none"> 1. October 6, 2014 Stakeholders from Wy Inc., PACES and Wyandot Center met 2. Discussion w Fiscal services completed. 3. Initial program structure created and committed to paper and document, including informational brochure, list of referral network organizations, structure within Wyandot Center and Paces (including representation from both organizations) identified, geographic boundary described as Wyandotte County 4. Staffing patterns set, 1.0 QMHP, .5 Recovery Coach, .5 Supported Employment Specialists, .2 Medical Psychiatric provider make up core team. Addition of PACES Liaison identified, oriented to EIT, and fully participating in program design/development and decision-making moving forward. 5. Supported Employment team identified .5 position is needed but staff member not yet chosen.
January 2015	Director and SC performed the	

	<p>following tasks:</p> <ol style="list-style-type: none"> 1. Solidify program structure and services, including operational location of team to reduce stigma and ensure attractive accessibility to participants. 2. Meet with Heartland RADAC. Identify staff to act as “de facto” member of RA1SE team. 3. Create specific assessment tools related to admission 4. Write job descriptions for QMHP Team Leader, Recovery Coach and Supported Employment/Education Specialist. Advertise positions. 5. Interview potential applicants 6. Provide internal training for clinicians at referral access points to discuss overview, screening tool and referral flowcharts 7. 3 CM’s, 2 Serv. Coord., 1 Dir, 1 Wraparound provider, 2 trainers familiarize concepts of program and make-up of team. 	<ol style="list-style-type: none"> 1. Program structure and services solidified, operational decision made to place team within the Transitional Aged Youth Team within adult psychiatric rehabilitation program. Location of program away from traditional mental health center site is pending resources for such a move. 2. Director met with Heartland RADAC Director, commitment secured to identify point person from this SUD provider to act as de-facto member of the RA1SE team. 3. Assessment tools created, however will be modified pending site visit to existing RA1SE site set for late March, early April, and contribution from QMHP Team Leader 4. Job Descriptions written for all positions. QMHP Team Leader position (only position hiring for) posted internally 5. No potential applicants identified during this month 6. Created PowerPoint and EIT referral decision diagram to educate internal staff. Director and Service Coordinator performed internal training for all clinicians at referral access points to review PowerPoint, discuss overview, and referral decision diagram. Overall 6 different teams were informed about the EIT program and referral processes. 7. TAY case management team
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		educated about new EIT, both service coordinators (2) educated and participating in processes in lieu of including CM trainers.
February 2015	<ol style="list-style-type: none"> 1. Consult KU SSW SE EBP re: adaptation of model to ensure it meets the needs of individuals 15-18 yrs. 2. QMHP Team leader is hired. Begins trainings including agency set-ups, TIC, Motivational Interviewing, person-centered language and recovery-oriented practice, Tech needs and trainings related to RA1SE. 3. Recovery Coach is hired. Begin related trainings as above. 4. All RA1SE Team members/supervisory Staff involved meet to discuss structure of team meetings, shared-decision making, and service implementation for participants. 5. Each member becomes familiar with components, concepts and literature re: psychosocial ed. of schizophrenia, warning signs, impact on functioning & importance of early intervention. 6. Consult internal performance outcome staff to create outreach and referral tracking systems, data collection processes, other tracking tools for outcome reporting and program management. 	<ol style="list-style-type: none"> 1. Director met with KU IPS EBP consultant, to discuss use of IPS with 15-18 year old population, and received enthusiastic feedback to proceed with using the model with the TAY age group. Director was advised, however, to keep outcomes data separate from adult outcomes data. Process discussed with SE Service Coordinator and no concerns are present to initiate data collection. 2. QMHP interviews held after position posted externally. Director and SC interviewed 5 qualified applicants, and 1 was chosen and accepted the position. Since this was an internal candidate, staff have already received agency set-up, TIC, person-center language and recovery-oriented practice training, and technology needs are in place. 3. Recovery Coach is already employed and chosen on the TAY team, and in March, will begin trainings under the guidance of the QMHP to fulfil new role as part-time TAY case manager and part-time Recovery Coach. 4. All team members have been unable to meet to discuss these decision points due to delay in hiring QMHP Team Leader. These tasks will still occur, just delayed until

		<p>March.</p> <p>5. Members will become familiar with EIT components, etc., in March.</p> <p>6. Director, SC and IT staff met to discuss data reporting strategies for data collection, and these processes have been decided upon and are ready to be implemented once clients are taken into the EIT team. We will use a standardized Assessment, and some Excel spreadsheet tracking to report data outcomes once participants are identified and enrolled in the EIT (see attached document "EIT Data template")</p>
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Other progress:

1. Correspondence with RA1SE Program at the Burrell Center in Springfield, MO, has resulted in an upcoming site-visit set for the last week in March/first week in April with the Director, Service Coordinators (from TAY and PACES) and QMHP Team Lead attending. Agenda set and includes:
 - Meet with your RA1SE staff members, including team leader, therapist, recovery specialist, education specialist, physician, etc.- any team members that could be available.
 - Have an overview of the team, including:
 - History of the program
 - Funding structure/source
 - Structure within your agency
 - Current description of the program
 - Barriers you experienced
 - Outcomes you've seen
 - Discussion of some questions including:
 - Use of assessment tools for EIT participants, examples
 - Discussion of how the family outreach/support component works, and who on the team takes the lead in this role
 - Your experience of recruitment of participants- people already in services at Burrell versus people never seen in your system before, etc.
 - Sharing lived experience and wisdom
 - Any pointers, suggestions, thoughts and considerations for a new program starting from the ground up
 - Tour of physical facility, meeting spaces, etc.
 - Meeting with a consumer who has participated in the EIT, or a family member, if at all possible

2. Arrangements made for training at the Beck Institute to train Service Coordinator and QMHP team lead in Cognitive Behavioral Therapy for Schizophrenia (this was the first training offered this year, and was later than we had hoped but still getting it done early in the 2nd quarter of EIT implementation).
3. Service Coordinator met with Director of Communications to complete brochure for referral sources for the EIT (will attach at next update as brochure hasn't been printed yet).

4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

ORGANIZATION NAME: WYANDOT CENTER

Description	Proposed Budget	Percent of Total	Grant Funding	Match Funding	Total Funding
1) Personnel	\$155,667	91.6%	\$160,586	\$0	\$160,586
2) Travel & Subsistence	\$5,344	3.1%	\$5,344	\$0	\$5,344
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6) Staff Education & Training	\$6,000	3.5%	\$6,000	\$0	\$6,000
8) Other 1	\$2,900	1.7%	\$2,900	\$0	\$2,900
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11) Other 4 - (Please Specify)	\$0	0.0%	\$0	\$0	\$0
12) Indirect	\$0	0.0%	\$0	\$8,700	\$8,700
Total Proposed Budget	\$169,911	100.0%	\$174,830	\$9,200	\$184,030

5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

KDADS upon start of this program had regular monthly telephone calls with program director and other staff as needed. Required in the contract is quarterly narrative report and financial invoices. KDADS will continue to provide technical assistance and communication as needed. Site visit planned in January 2016 and others as needed. KDADS also provides opportunities for program staff to participate in website educational trainings and information sharing when they are announced by SAMHSA or others.

5. Evidence Based Practices for Early Intervention (5 percent)

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

Kansas utilized the Block Grant 5 % set aside to develop and issued a Request for Proposal (RFP) that was for eligible applicants from one of the 26 Community Mental Health Centers (CMHC) within the state for competitive bid. The RFP would create a pilot for establishing a Coordinated Specialty Care (CSC) program designed to provide early interventions services for persons experiencing first episode psychosis (FEP). The proposals provided for early episode Serious Mental Illness (SMI) interventions; including early psychotic disorders which incorporate the RAISE model of intervention and supports by NIMH.

Funds are used to serve individuals with a severe mental illness who within one week to two years have experienced their first episode of psychosis. The age range of the target population is 15-25 year olds. The diagnosis that is used for inclusion in the program, following the recommendations of the RAISE model, include: schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, psychosis not otherwise specified and delusional disorder.

2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.

Funds were awarded to Wyandot Center for Community Behavioral Healthcare, Inc. in 2015. Wyandot has established an Early Intervention Team (EIT) and has completed all required trainings. They began accepting participants in the program in April 2015. From April 1st to May 31st there were 16 referrals; 6 were accepted into the program and 13 were pending at the time of the report.

Services to be provided:

Services provided by the EIT RAISE program of Wyandotte Community Mental Health Center/PACES (WCCBH/PACES) include the following:

A Qualified Mental Health Professional (QMHP) acting as Team Leader will provide assessment and diagnosis of early psychosis after referral from initial entry points; ensure overall coordination of the RAISE services and interventions; provide Cognitive Behavioral Therapy for psychosis (CBTP) specialized therapeutic intervention that focuses on creating a collaborative therapeutic alliance; ensure intensive case management by WCCBH/PACES is provided to each participant; and provide and/or coordinate crisis intervention services individually through WCCBH Emergency and Stabilization Services and Rainbow Services, Inc., (Rainbow Services Incorporated, the Regional Recovery Center for Wyandotte and Johnson Counties and a sister organization to WCCBH) and be responsible for information and data gathering, safety planning, and outreach and engagement.

- A Recovery Coach will provide RAISE designed social skills training to each participant, weekly participation groups, monthly family groups for education and support and strengthening relationships, school coordination, and outreach and engagement.
- An Employment/Education Specialist provided via WCCBH's award-winning, Exemplary Fidelity rated Supported Employment evidence-based practice, will focus on engagement or re-engagement with work or school or pursuing new educational/work opportunities
- A PACES psychiatrist will provide medical prescribing services; engage in shared decision-making; provide psychopharmacological and wellness education; and adhere to the RAISE protocols of prescribing practices (commonly referred to as "start low and go slow" and indicating specific medications as front-line pharmacological interventions).

In addition to these CBS/EIT interventions based upon the RAISE model that this grant proposal is requesting funding to implement, each participant in the program will have access to the wide array of community mental health services offered by WCCBH and PACES. These are not part of the grant request, but are nonetheless available to participants in this specialized treatment intervention regardless of payer source:

- Intensive Case Management Services provided by WCCBH's Young Adult Case Management Team and/or PACES case management/wraparound facilitator staff
- Integrated treatment for mental health and substance use problems provided in partnership with Heartland Regional Alcohol Drug Assessment Center
- Group psycho-education (WCCBH and PACES as options)
- On-demand 24/7 crisis services (therapy, medications, hospitalization and PRTF pre-admission screens) via WCCBH's 8am-8pm Emergency and Stabilization Services department
- SSI/SSDI Outreach Access and Recovery (SOAR) benefits services
- Hospital Liaison services for admission, treatment and discharge planning from state hospitalization
- Crisis Stabilization/Respite services operating 24-7, 365 to provide short-term supportive crisis stabilization and supports through both WCCBH/ PACES
- Jail diversion services staffed WCCBH through the county's Bureau of Justice grant
- Crisis Intervention Teams (CIT) provided by the Kansas City Kansas Police and Sheriff's departments in partnership with WCCBH/PACES
- 24/7 access to specialized crisis phone line services, who will work with the Team Leader to ensure immediate access to crisis intervention planning and access 24/7/365
- Medication delivery services 7 days per week, up to twice per day
- Access to subsidized housing and housing assistance through WCCBH's partner organization, Kim Wilson Housing
- WCCBH's Health and Wellness clinic- an on-site primary care service
- Genoa, a full-service, on-site pharmacy services and patient assistance programs for medications for individuals who are un- or under-insured
- Integrated Primary Care Coordination with WCCBH's Health Homes initiative
- Certified Art Therapy and Studio
- Peer Support Services
- Mental Health Attendant Care Services

It is important to note that all of these services are provided within the context of WCCBH's commitment to evidence-based, person-centered, recovery-oriented, strengths-based practice

for every person served by the organization. In addition, WCCBH/PACES are in the process of becoming fully trauma-informed organizations, partnering with Wichita State University and the local organization, THRIVE, to implement trauma-informed initiatives across the family of organizations.

3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

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DELIVERABLES

Grantee will submit six(6) quarterly narrative and financial reports (18month contract) to KDADS Coordinated Specialty Care Initiative manager. Quarterly reports are due no later than 15 days after the one of the month following each quarter's end and shall include quarterly outcomes:

- 1) Number of individuals served,
- 2) Number of referrals,
- 3) Duration of untreated psychosis;
- 4) Individuals retention at 3 months;
- 5) Monitoring of antipsychotic agents;
- 6) Number of individuals supported with employment and educational services;
- 7) Number of individuals working and/or going to school;
- 8) Family educational and supportive intervention outcomes;(reducing intensity of anxiety, onset of negativity and criticism, adjustment in expectations and performance demands etc.);
- 9) Individual social recovery outcomes(building relationships, external stressors, etc.);
- 10) Number of individuals served with integrated treatment for mental health a and substance use;
- 11) Number of individuals diverted from hospitals and/or PRTF placements.(crisis interventions, hospital visits, inpatient episodes).

OUTCOMES/GOALS

The main goal of this grant is to establish a community or regional program team that will support prevention of psychotic disorders by early detection and intervention. This includes a comprehensive array of services that can be offered and individualized to meet the needs of each participant.

Intervention components should include:

- 1)assertive case management,
- 2)Individual or group psychotherapy,
- 3)Supported employment and education services,
- 4)Family education and support,
- 5)Low doses of select antipsychotic agents,
- 6)Collaborative, recovery-oriented approach involving clients, treatment team members and when possible relatives as active participants.

Provide innovative, evidenced based, recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms. Teams will help people achieve their goals for school, work and relationships

- 4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.**

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KDADS upon start of this program had regular monthly telephone calls with program director and other staff as needed. Required in the contract is quarterly narrative report and financial invoices. KDADS will continue to provide technical assistance and communication as needed. Site visit planned in January 2016 and others as needed. KDADS also provides opportunities for program staff to participate in website educational trainings and information sharing when they are announced by SAMHSA or others.

This is all we have presently because they had to hire and train staff in the RAISE model; they have just begun seeing clients (in April) so we have very little data presently to provide but will have more data and outcomes in future quarters. The revised budget is at bottom of document.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

6. Participant Directed Care

SUD Treatment

There are no plans at this time to implement a voucher program for SUD treatment and/or support systems. We have developed several types of support services designed to help individuals pre-treatment and while in treatment. These include those listed below:

Person Centered Case Management- Is used to linking individuals to services needed to assist in recovery. Areas in which this service can help: Housing, Financial, Vocational, Educational, Mental health, and Physical health.

Support Services- Occurs outside of the agency. Some examples of this service are: transportation to and from Court, Appointments, Pharmacy, and Emergencies (such as medical or mental health). It can be used to transport members to the appropriate facility for their level of care for access to care purposes, transporting members to Substance Abuse appointments. In addition, it can be utilized to provide translation services for Deaf members or members who speak a language other than English.

Peer Support- Provides and advocates for effective recovery-based services that allow people to thrive in their communities and access naturally occurring community supports.

Overnight boarding for children entering residential treatment with their mother- This service can be billed for BG or Medicaid clients since this is not a service covered by Medicaid.

Prevention

Participant directed care, and improvements in person-centered service delivery, has implications across the spectrum of prevention, treatment, and recovery. Assisting individuals in gaining access to care, expanding options, and coordinating services and supports in communities such that individuals are offered choices and self-determination opportunities across the IOM continuum of care moves states forward in developing and enhancing more integrated and responsive systems for behavioral health prevention and promotion. In Kansas, the prevention system is strongly oriented toward building capacity for comprehensive community-level strategic planning for behavioral health utilizing the Strategic Prevention Framework. This approach enables communities to acquire the knowledge and skills necessary to conduct a comprehensive behavioral health assessment, establish priorities that may include shared risk and protective factors (e.g., ACEs) that address both substance abuse prevention needs as well as other co-occurring behavioral health issues, and develop a comprehensive strategic plan that is inclusive of best practices and evidence-based strategies across the continuum of care.

In terms of participant directed care, such an approach to comprehensive community assessment and planning creates a context in which community prevention partnerships and initiatives can mobilize appropriate sectors, organizations, and service providers and develop an integrated strategic plan that blends existing services and resources across the continuum of care, creates opportunities for pursuing diverse funding that can be braided to support evidence-based strategy implementation across disciplines to support the provision of new or enhanced evidence-based approaches to address gaps or needs in services, and to develop a menu of options for individuals in any stage – be it prevention, treatment, or recovery – to access services that serve multiple

purposes. For example, through the development of an integrated and comprehensive behavioral health strategic plan in a given community, prevention strategies such as the evidence-based Strengthening Families program could be made available to individuals in treatment to assist in forestalling the potential development of risk for their children by enhancing communication skills, family management practices, and positive behavioral guidelines. The Kansas prevention system is currently developing the capacity of the prevention training and technical assistance providers and other contractors to be able to support communities in developing such an integrated vision of, and ability to strategically plan for, innovations in broad-scope local planning for wellness and behavioral health.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

7. Program Integrity

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

Each area of KDADS/BHS, SUD, MH, and Prevention has developed a program integrity plan to ensure these funds are spent according to Federal Regulations.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

The BHS/SUD treatment team has a program integrity/quality assurance plan in place for monitoring the contracted Administrative Service Organization (ASO) that oversees and authorizes SUD treatment services funded with SAPT BG funds. These requirements are also included in the ASO's contract which is monitored closely by BHS staff. BHS has policy in place for the specific requirements and monitors providers to ensure these are met. This ASO is required to include the Block Grant requirements into each provider in their network who receives BHS funds (a combination of SAPT BG funds, SGF funds, Fee funds, and Problem Gambling and other addiction funds). BHS staff reviews and approves this contract prior to the ASO sending it out to providers.

For BHS/MH block grant funds (MHBGF) are allocated through an annual contract with the CMHCs which targets the un/under insured SPMI and SED populations. Services and service categories which can be provided with MHBGF are limited to those identified by the Governor's Behavioral Health Services Planning Council. These include:

- a. Supported employment
- b. Permanent supported housing
- c. Recovery housing
- d. Peer Support
- e. Transportation
- f. Medication management
- g. Intensive home-based crisis services
- h. Evidence Based Therapies (e.g., ACT, DBT, MST, etc.)
- i. Mobile crisis response where the person is
- j. Peer-based crisis services
- k. 23 hour observation bed

A regional model is being used for allocation of MHBG funds. The Regional Model brings specialized and evidenced-based services to every region including rural areas. The RRCs will equip the mental health system to serve a wider variety of challenges through collaboration, capacity building and resource sharing among the individual CMHCs that comprise the region.. The RRCs will expand the mental health system's funding by leveraging MHBG funds with other resources to accomplish long-term goals. A systemic perspective, which creates potential for more efficiency and more cost savings is encouraged.

For FY16, each Region will identify exactly what is purchased within each service category so that expenditures can be monitored.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

a. Budget review;

A recent process had been put into place where the entire management team for BHS will conduct a review of the budget and allocations and claims submitted for each BHS contract or grant. This review will be conducted in conjunction with other pertinent individuals including the Budget Director and assigned Fiscal staff on a monthly basis. This review will be completed to determine the appropriate funds are expended for prevention, SUD treatment, mental health services, support services, and administration.

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

b. Claims/payment adjudication;

The contractor for SUD treatment services is required to submit claims data to a designated fiscal person. The KDADS staff person is able to review and determine funds have been spent appropriately. A KDADS data person is also able to match this information against data obtained through our KCPC system which collects the number of units requested by the provider and approved by the ASO. This data can also be matched against the MMIS system to ensure the clients were not eligible in the Medicaid system, while receiving services. If SAPT BG dollars were utilized the provider is expected to re-pay the SAPT monies paid.

c. Expenditure report analysis;

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

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

BHS staff ensures that Block Grant funds and State dollars used for the Community Medication Program pays for the uninsured population as well as individuals not covered by Medicaid. BHS has policy in place which indicates in order to receive services the person meets the following criteria:

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

OR

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

This criterion is also listed on the application form to get approved for assistance. If the criteria are not met then the claims do not get allowed by the contractor and/or BHS staff.

For mental health a regional model is used for allocation of block grant funds. Each CMHC works within 1 of 5 KDADS specified regions to enhance a strengths-based recovery environment for individuals and families served by the CMHC system. Each Region will submit a plan for each MHBG approved service to be purchased with MHBG funds. Included in the plan the Region shall identify what service(s) are to be provided, the projected number of uninsured/underinsured clients who will benefit, the number of service hours (if applicable), the cost for providing the service(s), and how expenditures will be tracked. The plan(s) are subject to approval by KDADS prior to distribution of funding. The Region shall submit program and financial reports as developed by KDADS quarterly to the Community Mental Health Quality Improvement Field Staff for monitoring

d. Compliance reviews;

A BHS/SUD staff person is assigned to conduct biennial onsite reviews of funded treatment providers. This review consists of a review of the following: clinical charts, Access to Care tracking, program wait lists, policy and procedure manuals, and client interviews. The result of this review is forwarded to the ASO who then communicates with the provider. If a corrective action plan is needed the ASO and BHS staff work together to ensure the provider comes into compliance. If BHS/SUD staff discover or have questions about any clinical file or billing during the annual licensure visits, they notify the Director of Addiction Services who then discusses the issue with the ASO. A decision could be made to conduct a further review where the ASO requests client’s files and matches documentation against claims submitted. This process has resulted in recoupment.

The Community Medication Support Program is monitored by a BHS staff that reviews and approves weekly invoices as well as applications that require special consideration. The information provided by Prescription Network of Kansas allows the state to run utilization reports by individual mental health centers. We can track monthly dollars spent and the number of persons served each month with the medication assistance program.

Community Mental Health Quality Improvement Field Staff will review quarterly reports submitted by each region and compare content with on-site observations and documentation review conducted at each CMHC within a given region.

e. Client level encounter/use/performance analysis data; and

KDADS requires that all funded SUD treatment providers to utilize the integrated data base, the Kansas Client Placement Criteria (KCPC). This tool includes ASAM II criteria and determines the appropriate level of care and medical necessity. It also collects the required data elements for SAMHSA (TEDS and

NOMS). A fee for service is in place and providers must request units of service through the KCPC system. The request is then reviewed by the ASO. Services must be authorized by the ASO and a claim submitted through their claims system. Encounter data is collected through the KCPC and the ASO's claim system and matched to ensure all claims paid are authorized. KDADS staff and staff from the ASO partner to complete chart reviews to ensure documentation is in place for each service authorized and paid. Performance, gathered from the onsite reviews and Licensing visits conducted by KDADS, staff and utilization are factors when determining allocations for the next year.

f. Audits.

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

Individual CMHCs are required to submit independent audits bi-annually. KDADS staff reviews this to ensure financial stability within their corporate organization. These audits are to be submitted to KDADS Department of Audits to ensure providers are meeting general accounting practices and are financially viable.

4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

KDADS staff in conjunction with the staff of the ASO for SUD treatment services reviews the contract language to ensure all federal requirements are included. The ASO's fiscal staff develops several formulas to distribute funds available. These formulas include any funding decreases or increases, utilization, and performance issues. KDADS management staff and the ASO then meet to discuss the methodology to be applied. Special considerations and gaps in service are also considered when making the allocations. Rates for each type of service have been set and are reviewed occasionally to determine if any changes need to be made.

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

For mental health KDADS shall issue an advance payment of 25% of the total compensation. Upon receipt of the financial and deliverable reports, a subsequent quarterly payment shall be made during the first month of each quarter in October 2015, January 2016 and April 2016 for the reported amount expended. However, the quarterly payment will be reduced by one-third of the advance payment plus remaining difference of quarterly expended amount reported.

If compliance is not achieved by August 15, 2016, any outstanding payments for work that has not been demonstrated as complete shall not be paid with regard to this contract.

5. Does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

BHS/SUD staff and the contracted ASO provide technical assistance to providers as requested or needed. Providers are required and monitored to ensure they not only have policy in place for licensure and Block Grant requirements but also their practices match their policy.

BHS/MH staff will review regional plans and funds will be disbursed upon approval. Quality and safety standards will be considered in the approval process.

6. How does the state ensure block grant funds and state dollars are used for the four purposes listed in the application?

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

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

Prevention

KDADS maintains a number of oversight practices to for monitoring, compliance, and assuring program integrity with regard to the prevention set-aside of the SAPT Block Grant. Project officers within the KDADS prevention team are assigned to all funded communities receiving prevention funding through the SAPTG, and in this role are responsible for ensuring compliance with funding restrictions and requirements, ensuring non-duplication of services and non-supplantation per funding agreements with communities, assuring that funding is spent down as approved for the implementation of evidence-based prevention strategies, and assuring that requisite fiscal and progress reporting is submitted, as well as required local-level data collection for all specified evaluation measures and targeted outcomes. This includes formal annual budget reviews, action plan reviews, evaluation data reviews, and coordination with the Evaluation Team and Evidence-Based Strategies Workgroup to ensure that funded strategies meet the CSAP and Kansas criteria for evidence-based approaches.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:
No technical assistance is needed related to this section.

Footnotes:

8. Tribes

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.

KDADS Behavioral Health Services Commission (BHS) engage in regular and meaningful consultation and collaboration with tribal officials in the development of state policies that have tribal implications.

K.S.A 39-1610 (statute establishing the Governor's Behavioral Health Services Planning Council) was amended to include adding the Governor's Tribal Liaison to the Council. Tribal issues and concerns are considered in developing the State plan.

BHS staff has participated with and/or communicated with the Tribal Technical Advisory Group. This group typically focuses on Medicaid and the new KanCare Medicaid initiative in Kansas, however, they were interested in information about how their clinics could bill for SUD treatment services.

2. Describe any current activities between the state, tribes, and tribal populations.

The GBHSPC Chair, KDADS Council liaison, and the KDADS Director of Addiction Services began discussions with the appointed State Director of Native American Affairs regarding development of a process for state consultation with the tribes in Kansas. The Native American Affairs Office was opened in the summer of 2011 with the primary purpose of serving as the liaison to the Governor to ensure that Native American concerns and needs are addressed in state policy making decisions. This office coordinates intergovernmental communications between tribal governments, the Governor's Office, and other state agencies. There are four federally recognized tribes in Kansas that have reservations. The tribes are:

- The Iowa Tribe of Kansas and Nebraska
- The Kickapoo Tribe of Indians in Kansas
- The Prairie Band Potawatomi Nation
- The Sac and Fox Nation

The process for direct consultation with the four Kansas tribal governments is that the State Director of Native American Affairs would be appointed by the Governor as a member of the GBHSPC. This appointee serves as liaison to the GBHSPC, establishing consultation with tribes, and facilitates direct input to BHS and the GBHSPC on needs. This information is used to for, recommendations for services to the tribes through block grant initiatives. The State Director will also be a resource for services needed for the urban Native American population in Kansas that are not tribal members to one of the 4 recognized Kansas tribes.

The Director of Addiction Services has worked with one tribe for approximately 18 months to become licensed SUD treatment provider. This will enable this tribe to bill for Medicaid SUD treatment services. They are now licensed and are working to become credentialed with the three Managed Care Organizations for Medicaid. Some BHS funding (a combination of SAPT Block Grant funds, State General Funds, Fee funds, and Problem Gambling and other Addictions Funds) have been set aside for this tribe once they indicate they are ready to begin utilizing this funding stream.

Prevention

As part of both SAPTBG and SPF-PFS II prevention efforts, KDADS has been engaged in collaborative prevention efforts with the Prairie Band Potawatomi Nation (PBPN) since 2012 to increase partnership and engagement in prevention efforts within the reservation as well as the Jackson County area in which tribal lands are sited. This has strengthened the relationship between KDADS and PBPN tribal officials, and facilitated the award of prevention funds to the tribe to support underage drinking prevention efforts through the SPF-PFS II. Additionally, KDADS has coordinated with tribal health services to ensure that county-wide underage drinking prevention efforts supported by funding through the SAPTBG are aligned with, coordinated with, and enhance, but non-duplicated, in terms of strategies implemented on the PBPN reservation that are funded through the PFS II.

This partnership has entailed relationship and capacity development, integration with tribal health services, tribal adaptations for the Strategic Prevention Framework to ensure cultural responsiveness and fit, and the delivery of extensive training and technical assistance in the area of foundational prevention science. As a result, PBPN is in the process of implementing an array of evidence-based prevention strategies to address underage drinking that include a local media campaign and multiple information dissemination modalities, prevention education for parents via MADD Power of Parents and for youth via Life of an Athlete, high visibility patrols and increased enforcement in high-risk areas of the reservation for underage drinking and substance abuse, and tribal council advocacy for strengthening consequences following underage alcohol infractions (e.g., minor in possession, minor in consumption).

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

Primary Prevention for Substance Abuse

1. Please indicate if the state has an active SEOW. If so, please describe:

- **The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);**
- **The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and**
- **The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).**

The Kansas statewide epidemiological profile that was originally published in 2006 was updated by the state's epidemiological core team to include behavioral health indicators and the final document was published in 2015. Data sources in the updated profile include the following:

- **Behavior Risk Factor Surveillance System (BRFSS)** – The BRFSS is a random digit dialing (RDD) telephone survey. The CDC has developed the questionnaire to ensure compatibility across states. Core questions are asked annually all states and states have the option of adding in supplemental questions concerning specific health behaviors and conditions.
- **Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2013 on CDC WONDER Online Database-** Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Data set is published by the U.S. Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Office of Analysis and Epidemiology. The county-level national mortality and population data has been derived from the U.S. records of deaths (death certificates) since 1979. Death rates are calculated per 100,000 persons. (Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Mar 27, 2015 4:36:19 PM)
- **Drug Enforcement Administration (DEA) - Environmental Photographic Interpretation Center's (EPIC) Database :** Methamphetamine Clandestine Lab Seizure Statistics reports include only that information that has been reported to EPIC by contributing agencies and may not necessarily reflect total seizures nationwide. Data is reported without corroboration, modification, or editing by EPIC, and, accordingly, EPIC cannot guarantee the timeliness, completeness, or accuracy of the information reported therein. The data and any supporting documentation relied upon by EPIC to prepare this report are the property of the originating agency.
- **Gambling Behaviors and Attitudes Among Adult Kansans** - This 2012 study was conducted by Kansas City-based Whitworth Ballou, LLC, on behalf of KDADS. It was the first statewide study of adult gambling behaviors and attitudes since the opening of three state-owned casinos. Utilizing telephone survey methods, researchers interviewed 1,600 anonymous adults in late 2012. Respondents were randomly selected from landline and cell phone numbers located across the state.
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- **Kansas Department of Transportation**—Data was obtained from accident statistics reports (Alcohol-Related Summaries) regarding the number of motor vehicle accidents which involved alcohol, the number of those accidents resulting in fatalities, and the age of the drivers involved.
- **Kansas Information for Communities (KIC) – Death Statistics** KIC is based on resident data compiled from death certificates filed with the Bureau of Epidemiology and Public Health Informatics at the Kansas Department of Health and Environment. This KIC module will produce counts, population-based crude death rates, and population-based age adjusted death rates. All three of these measures can be calculated by cause of death, year, age-group, sex, race, Hispanic origin, and county of residence.
- **Birth Statistics** KIC is based on resident data (See residency compiled from birth certificates filed with Bureau of Epidemiology and Public Health Informatics at the Kansas Department of Health and Environment.) This KIC module includes only live birth outcomes. Most statistics on live births are reported as a percentage of the total number of events. Births where an outcome or characteristic is missing are excluded from the total number of events. While every effort is made to assure the KIC data summaries parallel the results in the Kansas Annual Summary of Vital Statistics, some slight differences may occur.

- **Cancer Statistics KIC** is based on Kansas resident data compiled from reports of cancer cases provided to the Kansas Cancer Registry (KCR), which is operated by the University of Kansas Medical Center under a Kansas Department of Health and Environment contract. This KIC module produces counts, population-based crude rates, and population-based age-adjusted rates.
- **Kansas Problem Gambling Helpline** – Kansas Department of Aging and Disability Services contracts with Kansas Health Solutions to operate the Problem Gambling Helpline. Trained professionals are available 24 hours a day to answer questions, explain warning signs and treatment options, and provide referrals for certified problem gambling counselors.
- **Kansas State Department of Education (KSDE)** – The KSDE data collection systems provides information on all school based offenses. Information is collected on the nature of suspensions and expulsions, including if the offense is related to alcohol, tobacco, or other drugs.
- **Kansas Vital Statistics (KVS)** – The KVS provide information on all births, pregnancies, marriages, divorces, and deaths in Kansas and among Kansas residents. Information is collected on many risk and protective factors surrounding the event as well as extensive demographic information. Information is available at the statewide and sub-state level.
- **Monitoring The Future (MTF)** – The MTF survey is an annual school-based survey of youth in grades 8, 10, and 12 nationally. The MTF survey is utilized to gather national trend information concerning drug use trend and patterns.
- **National Survey of Substance Abuse Treatment Services (N-SSATS)** – The N-SSATS (formerly the Uniform Facility Data Set) is an annual census of all treatment facilities listed on the I-SATS. Information is collected on the location, organization, structure, services, and utilization of substance abuse treatment facilities in the United States. The data are used for program administration and policy analysis. Information from the survey is also used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the on-line Substance Abuse Treatment Facility Locator, two widely used resources for referrals to treatment.
- **National Survey on Drug Use or Health (NSDUH)** – The NSDUH is an annual household survey of individuals aged 12 and older. The main foci of the survey are to obtain information concerning consumption patterns and dependence of alcohol, tobacco, and other illicit drugs. Over sampling occurs to provide statewide level estimates in addition to national estimates.
- **SAMHSA's Center for Mental Health Services (CMHS): Kansas Mental Health National Outcome Measures (NOMS)** – Community Mental Health Services Uniform Reporting System provides guidance and technical assistance to decision makers at all levels of government on the design, structure, content, and use of mental health information systems, with the ultimate goal of improving the quality of mental health programs and services delivery. CMHS operates the only program in the nation that focuses on the development of data standards that provide the basis for uniform, comparable, high-quality statistics on mental health services, making it a model in the health care statistics field.
- **ValueOptions of Kansas** - Under the direction of the Kansas Department for Aging and Disability Services (KDADS), ValueOptions administers inpatient and outpatient substance use disorder treatment services for members eligible for Substance Abuse Prevention and Treatment (SAPT) BHS funded services and all addiction services funded by the Problem Gambling and Addictions Fund.

In 2005, Kansas received an SEOW grant to begin the process of establishing a sustainable infrastructure to examine indicators for substance abuse in Kansas, the most preventable underlying cause of disease and death. A multi-agency design team was formed to begin work to profile the burden of substance use in the state. The data collected informed a larger planning committee that worked through a layered comprehensive statewide needs assessment process to prioritize and focus the state's prevention efforts. The *Kansas Substance Abuse Epidemiological Indicators Profile* included indicator and trend data from 2000-2005 focusing on consumption and consequences related to alcohol, cigarette, marijuana and use as well as other-related drugs. The profile reported youth and adult measures of mortality, morbidity and crime resulting from substance use. Indicator data was reported by age, gender, and race.

The SEOW was reconvened and repurposed in late 2012 in order to respond to the need to reassess and re-evaluate state alcohol, tobacco, and other drug priority outcomes and future directions for Substance Abuse Prevention and Treatment Block Grant funding, as well as for the Strategic Prevention Framework Partnership for Success initiative that began in October 2012. The data covered in this updated profile was inclusive of 2006-2011. Information was presented from health agencies, treatment agencies, law enforcement agencies, and revenue agencies. The goal was to provide a comprehensive look at the current state of substance abuse so that priority areas may be identified and addressed. Utilizing a broad array of information from multiple sectors allows for a more complete picture of substance abuse related consequence and consumption pattern. During the compilation of various data sources, specific data gaps were identified in the realm of substance abuse prevention. These data gaps, while not as significant as the information available, provide examples of possible improvements to build a completely comprehensive picture of substance abuse in Kansas.

In 2013, Kansas received supplemental grants to allow SPF-PFS II grantees to expand and enhance the activities of the SEOW. This involved developing a key set of indicators to describe the magnitude and distribution of substance-related consequences and consumption patterns across the state and in grantee communities of high need. The SEOW developed a set of key indicators that, in addition to substance use, would apply to KDADS's broader behavioral health focus. The expanded indicators included: youth and adult prescription drug abuse, substance use treatment, problem gambling treatment, depression and suicide, and adverse childhood experiences (ACEs). The SEOW also expanded its approach to include influencing factors known to be associated with poor behavioral health. In April, 2015, the expanded work of the SEOW resulted in a new document, the *Kansas Behavioral Health Profile*.

Beginning with the original profile, and with each subsequent update, the data gathered and reported by the SEOW has informed prevention planning. The information was used to prioritize state focus for underage drinking with the SPF-SIG and continues to guide planning around broader behavioral health measures described.

This allows communities to have a more comprehensive look at how indicators that are predictive of one or more behavioral health issue may be prioritized for intervention. In addition, the state can look at potential areas of need or disproportion by comparing age, gender and race.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

In addition to supporting the ability to identify trends, locate geographic prevalence and risk/protective factor hotspots, and make data-driven decisions concerning substance abuse prevention priorities at the state and systems level, needs assessment data from the Kansas SEOW Behavioral Health Indicators Profile will also support the ability of the Kansas prevention system to engage in targeted outreach and mobilization in communities identified as high need while lacking in prevention response capacity (e.g., low readiness, low functioning or non-existence coalition, poor sector involvement or engagement, low or ineffective strategy

implementation), which will allow for capacity development in communities demonstrating high need and bolstering their ability to engage in more effective prevention processes. As such, smaller scale funding allocations will be made as funds are available for capacity development in this regard.

Current community-level allocation of SAPTBG prevention funds to local coalitions or other prevention partnerships are based on variables which include: fidelity to the SPF process and submission of deliverables demonstrating completion of milestones and benchmarks associated with each of the steps within the planning phase (assessment, capacity, and planning), completion of a needs assessment process entailing the identification and prioritization of at least 1-2 local prevalence outcomes, and approximately 2-5 targeted local risk and protective factors, completion of a logic model/theory of change and action plans for each primary evidence-based strategy, and creation (in conjunction with the Evaluation Team) of an evaluation framework outlining key process and outcome indicators and corresponding data collection needs for all funded strategies. Upon submission of these SPF deliverables, materials are reviewed by KDADS staff and subject matter experts including the Evaluation Team to ensure accuracy, comprehensiveness, alignment, assessment and prioritization integrity, and alignment, fit, saturation, intensity, and appropriateness of all proposed strategies. Following review and approval – or as needed, requested revisions are completed and resubmitted – funding allocations are made to support each community’s proposed line-item budget for strategy implementation. In this way needs assessment data at the community level is integral to the process of awarding funding to communities to support local prevention efforts in a manner that is both data-driven, outcome-focused, and maintains fidelity to the SPF process, yet retains local support and ownership.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Given the recent transition to a new set of prevention contractors, focus throughout FY16 will entail comprehensive assessment, planning, and capacity development activities. As a preliminary step the identification of core competencies, skill sets, and foundational learning needs across the spectrum of behavioral health (as well as linked to ICRC domains and competencies for certification to ensure correspondence) will be conducted. Following this process, the Evaluation Team will collaborate with KDADS to conduct a workforce capacity assessment to determine levels of extant behavioral health workforce skills, experience, and abilities. Using this data, KDADS will then coordinate the provision of training (either on-site, web-based, or in combination) and education sessions to address learning needs. Follow-up coaching opportunities will also be made available for prevention contractors, to support the application and utilization of information provided through training and educational efforts, as well as create an opportunity for cross-discipline application of content and interaction of providers as part of a learning community for prevention excellence (e.g., suicide prevention, problem gambling prevention, behavioral health prevention and promotion).

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

Kansas maintains a certification process, standards and requirements, and board to support statewide certification of the state prevention workforce. Kansas ICRC Prevention Specialist standards (updated October 2013) includes 2000 hours of experience across ICRC domains, 120 hours of education across domains, 120 hours of supervision with 10 hours specific to each respective domain, successful completion of the ICRC Prevention Specialist Examination, and adherence to the code of ethics. The Kansas Prevention Certification Board is a member of ICRC, responsible for the credentialing of prevention, addiction treatment, and recovery professionals.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

The Kansas Department for Aging and Disability Services (KDADS) utilizes four primary sources for making training and technical assistance available to the prevention workforce. In conjunction with workforce needs assessment and identification of learning needs based upon emerging issues and trends across the spectrum of behavioral health, an annual training schedule is developed and implemented by identified subject matter experts within the system, through the Southwest Resource Team (CAPT), or via technical assistance request through CSAP to ensure foundational knowledge and skill development among contractor organizations and their respective staff members. In FY16, this will be accomplished following the completion of a workforce capacity survey. It is anticipated that while the prevention workforce is comprised of skilled and experienced personnel, it will be of critical importance to engage in more frequent provision of training and learning opportunities to ensure all individuals use and employ the same approaches, resources, tactics, and skill sets as they translate this to the provision of training and technical assistance at the community level. As such, structured and regularly facilitated coaching and feedback opportunities will be provided to ensure appropriate application of knowledge and skills by the prevention workforce, as well as opportunities for engagement and co-learning with the Kansas Prevention Project Team.

c. A formal mechanism to assess community readiness to implement prevention strategies.

As part of the SPF assessment phase, Kansas utilizes the Tri-Ethnic Community Readiness model as the primary measure of community readiness, which is conducted in all funded communities in addition to community collaboration and capacity assessment, as well as the requisite completion of a comprehensive needs assessment. The Tri-Ethnic Community Readiness Assessment involves the completion of a series of local key informant surveys, with data obtained scored on the basis of six dimensions of community readiness – that is, community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue of concern, and resources related to the issue. Scoring across these six dimensions, range on a nine-point scale, beginning with no awareness, through initiation, to high community ownership. This provides qualitative and quantitative data, collected as part of repeated evaluation measures in funded communities, that enables communities to build into local prevention capacity development plans specific strategies and approaches for increasing and enhancing readiness over time.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

At the state level, substance abuse consumption/prevalence, risk and protective factor, and consequence data is used on an annual basis to identify geographic hot spots, areas of high need that require targeted outreach, emergent trends, and state-level priorities using epidemiological criteria including magnitude, five-year trend, and comparison, with these data-informed decisions guiding the direction of the Kansas prevention system in terms of mobilization, training and capacity development, resource dissemination, and in communities receiving prevention set-aside funding from the SAPTBG, supports for the implementation of locally-selected evidence-based strategies. However, on a more universal indirect basis, environmental prevention efforts including statewide media campaign focus and design, messaging, targeted audience(s), and key educational concepts are also developed, refined, and updated based upon data from the State Epidemiological Outcomes Workgroup (SEOW) and the Kansas Behavioral Health Indicators Profile.

Additionally, at the community level, consumption/prevalence data and risk and protective factor scale scores and individual indicators are used extensively for local-level needs assessment, outcomes selection and prioritization, and strategic planning processes. This data, available at the county level and disaggregated by subpopulation by dimensions including age, gender, race, and ethnicity, are vital for targeting appropriate prevalence and risk and protective factor outcomes as part of SPF needs assessment, as well as for selecting high-impact, appropriate, and aligned evidence-based prevention strategies, in addition to serving an integral role in the development of a comprehensive local evaluation plan and subsequent outcomes-based evaluation.

At the local level, depending on the substance abuse prevalence priorities targeted, and the prioritized risk and/or protective factors, the evidence-based strategies implemented (e.g., prevention education, enforcement, information dissemination, policy or practice change) is contingent on the outcomes targeted for change. Training, resources, and technical assistance are then provided to communities to assist them in the implementation of the evidence-based strategies that were selected locally during the strategic planning process; however, in many instances there are similarities in the targeted substances or risk factors across many Kansas communities and coalitions, and in those instances, statewide media messaging may be developed to assist with uniformity of messaging, bolstering saturation, and high-volume resource development and dissemination, or in the case of training, those evidence-based programs that have been more commonly selected across funded communities may be coordinated such that a training of trainers is provided for multiple communities as a cost-savings and efficiencies measure.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

There is currently no formalized strategic plan to guide prevention activity; however development of a new plan in partnership with the newly funded contractors is a priority for FY16. Our belief is that people are oftentimes more supportive of work that they help create, thus our intention was to create the document in partnership with new providers after contract awards were determined. While no formalized document exists we did develop six key priority areas that were included in our request for proposal process and within our new prevention agreements, these will be infused within our statewide plan as well. These six foci are:

1. Alignment with the SPF

The SPF is a five-step approach built on identifying community-based risk and protective factors and using gathered data to select, implement, and evaluate appropriate evidence-based and sustainable prevention programs, practices, and policies intended to lead to population-level outcomes.

2. Strategic Integration across Behavioral Health

The model of risk-focused prevention allows for the assessment and identification of shared risk and protective factors common to substance abuse, problem gambling, suicide, and mental health disorders. It is possible to assess and identify shared risk factors, such as Adverse Childhood Experiences (ACEs), for an array of problem behaviors and reduce and respond to these risks with aligned evidence-based interventions funded through braided sources. At a minimum, integration is sought across all behavioral health system prevention programs including substance abuse prevention, problem gambling prevention and awareness, mental health promotion, and suicide prevention.

3. Innovative Approaches and Leverage

To be more in line with SAMHSA funding allocation ratios (85% towards community level processes that lead to the implementation of evidence based strategies and 15% towards administrative costs) and comprehensively address more communities' needs around the totality of behavioral health prevention,

KDADS/BHS is compelled to find new and innovative approaches and practices that leverage resources, capture more community-level investment, and achieve intended outcomes.

4. Facilitation of Community Change through Training and Technical Assistance (T/TA)

Training and TA must demonstrate effectiveness in facilitating actionable community level strategic planning and implementation of innovative solutions that are sustainable at the community level. The provision of training and technical assistance should be offered in a manner that builds community capacity, supports, guidance, coaching, and feedback necessary for communities to be able to autonomously engage in effective prevention processes associated with all five steps of the SPF, including cultural competency and sustainability.

5. Community Ownership

Community ownership is crucial to future prevention initiatives, and communities need to autonomously create broad-scope and multi-sector collaborations that are locally-driven and sustainable.

6. Data Collection & Analysis

To complete state and community level assessments, identify outcomes, and develop strategic plans the collection, analysis, and aggregation of data across multiple disciplines is imperative.

- 7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.**

Kansas uses a group referred to as the SPF Project Team for the coordination and involvement of subject matter experts for each phase of the Strategic Prevention Framework, that is, assessment, capacity, planning, implementation, and evaluation. In the role of Planning Phase specialists, the Planning Core Team members, in conjunction with KDADS staff, serves as the state's Evidence Based Programs and Strategies Workgroup. Responsibilities subsumed by this role include: review of all proposed strategies by funded communities/coalitions to ensure strategies meet the CSAP and Kansas criteria for being evidence-based – this includes a research and literature review to determine strength of evidence, identification of conditions such as normative populations and settings that may necessitate adaptations, evaluation data from the strategy developers as well as any Kansas-specific evaluation data from previous implementation of respective strategies, and completion of a consensus review process with all workgroup members before finalizing approval or establishing criteria for revisions or modifications for proposed strategies which is provided to communities. Through this process a number of commonly utilized strategies have received previous review and approval for implementation as evidence-based strategies, but evaluation data is collected at the program, participant, and strategy level for all individual strategies and reviewed on an annual basis with regard to efficacy and cost-effectiveness, which may also influence the degree to which strategies are approved for implementation by funded communities.

In Kansas, SAPTBG funded prevention activities are coordinated with other funded prevention initiatives to ensure uniformity in outcomes, science-based prevention processes, assessment data and evaluation methodologies, training and technical assistance delivery, and alignment of outcomes. For example, communities allocated prevention funding as part of the SAPTBG prevention set-aside, through an initiative referred to as K-SPF (Kansas Strategic Prevention Framework), are provided the same guidance, training, and parameters for outcomes targeting and acquisition, as do grantee communities involved in the Kansas PFS II initiative. Data is provided in the same format, through an online portal and county reports for both initiatives are set up such that these resources are aligned. In terms of progress reporting, via quarterly reports and requisite reporting on the Online Documentation and Support System (ODSS), requirements are the same, as

are supports and resources developed and provided by the Evaluation Team and the SEOW. This ensures efficiencies and consistencies across initiatives, as well as the ability to address statewide outcomes through tailored efforts at the local level, regardless of source of funding.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

The SAPTBG funding only supports one specific prevention strategy that is utilized statewide, which is the It Matters media campaign. The campaign targets underage drinking and marijuana use. This strategy was selected as a broad environmental information dissemination approach which allows for a high degree of saturation, frequency, and duration, impacting a maximal number of individuals as part of universal indirect prevention efforts. The It Matters media campaign is adaptable and is tailored at the community level so that it can be culturally responsive, focus on various target groups and risk factors, and include local messaging and taglines, while maintaining consistency of branding, look, and feel for content recognition and retention. This media strategy is the sole statewide prevention strategy in use. However, at the local level, communities completing the planning phase of the Strategic Prevention Framework and submitting required deliverables corresponding to SPF milestones and benchmarks are eligible to apply for KSPF funding to support the implementation of evidence-based prevention strategies outlined in their respective logic models and strategic plans – although these strategies are selected within individual communities, and aligned with local priorities in terms of targeted risk and protective factors, although prevalence outcomes are aligned with those at the state level (i.e., either prevention and reduction of past 30-day alcohol use, binge drinking, and/or marijuana use).

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

As a required component of the Kansas SPF assessment process, communities are required to complete a comprehensive needs assessment, capacity assessment, readiness assessment, and assessment of existing community resources. This resources assessment, corresponding with the Communities That Care Community Resources Assessment (CRA), is designed to identify the pre-existing evidence-based prevention strategies in place that address prioritized prevalence outcomes and targeted local risk and/or protective factors. SABG funds are not eligible to support these pre-existing strategies, that is, clear parameters are provided during the assessment and planning phase regarding ensuring that SABG funds do not supplant prior sources of funding for prevention services and programming. Additionally, this requirement ensuring non-supplantation is included into funding agreements with communities through which SABG funds are allocated.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Both process indicators and outcomes indicator data are collected as part of the evaluation framework for SAPTBG funded communities as well as other initiatives including the SPF-PFS II. In all instances, process indicators collected as part of evaluation measures include, but are not limited to: indicators of saturation (e.g., numbers served, number of participants in attendance, number of individuals impacted by policy or practice change), and indicators of fidelity, dosage, or duration (number of sessions delivered, length of sessions, frequency of program delivery). Specific for evidence-based programs, as well as prevention education activities, participant sign-in sheets and attendance rosters allow for unduplicated counts of numbers served as well as for compiling data related to participant demographics. For environmental approaches that are universal-indirect in nature, demographic estimates are used to calculate numbers served for these population-based strategies.

This data is used to determine scope of impact at the community level, as well as at the state level, in terms of exposure to content, messaging, and materials associated with evidence-based strategy implementation. It also allows for determination of the degree to which evidence-based prevention strategies are implemented on a geographic basis and identification of under-served, high-need areas of the state. Further, this data is used not just for state level process evaluation but also as part of semi-annual coaching and technical assistance provided to communities with regard to saturation, impact, and intensity to allow them to make use of evaluation and outcomes findings in order to enhance and improve the implementation of evidence-based strategies by making mid-course adjustments.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state’s prevention system?

As part of outcomes-based evaluation of state and local prevention outcomes, the following prevalence outcome data are collected on an annual basis: past 30-day alcohol use, binge drinking, and past 30-day marijuana use – with all indicators aggregated for students completing the Kansas Communities That Care student survey in grades 6, 8, 10, and 12. In addition, risk and protective factor scales scores and indicators are also monitored on an annual basis, which include for each targeted substance the following: perceived risk of harm, favorable attitudes toward use, friends who engage in use, perceived availability, and favorable parental attitudes toward use. At the community level, additional risk and protective factors may be prioritized and targeted with specific evidence-based strategies, with this risk and protective factor data tailored to the community as part of a comprehensive evaluation plan. Given the parameters established for achieving change in targeted prevalence and risk and protective factor outcomes, statewide evaluation utilizes both changes in magnitude as well as trend analysis to establish evidence of progress in these areas, on either a three-year or five-year time frame. In addition to prevalence and risk and protective factor indicators, prevention education program data collection and monitoring includes aggregate participant-level data. Data is aggregated and reported by a range of individual characteristics including gender, race, ethnicity, and region, and unique participant identifiers are used to match pre and post survey data in order to statistically determine program outcomes and impact, through t-tests or analysis of variance.

Primary Prevention for Substance Abuse

1. Please indicate if the state has an active SEOW. If so, please describe:

- **The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);**
- **The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and**
- **The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).**

The Kansas statewide epidemiological profile that was originally published in 2006 was updated by the state's epidemiological core team to include behavioral health indicators and the final document was published in 2015. Data sources in the updated profile include the following:

- **Behavior Risk Factor Surveillance System (BRFSS)** – The BRFSS is a random digit dialing (RDD) telephone survey. The CDC has developed the questionnaire to ensure compatibility across states. Core questions are asked annually all states and states have the option of adding in supplemental questions concerning specific health behaviors and conditions.
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- **Kansas Vital Statistics (KVS)** – The KVS provide information on all births, pregnancies, marriages, divorces, and deaths in Kansas and among Kansas residents. Information is collected on many risk and protective factors surrounding the event as well as extensive demographic information. Information is available at the statewide and sub-state level.
- **Monitoring The Future (MTF)** – The MTF survey is an annual school-based survey of youth in grades 8, 10, and 12 nationally. The MTF survey is utilized to gather national trend information concerning drug use trend and patterns.
- **National Survey of Substance Abuse Treatment Services (N-SSATS)** – The N-SSATS (formerly the Uniform Facility Data Set) is an annual census of all treatment facilities listed on the I-SATS. Information is collected on the location, organization, structure, services, and utilization of substance abuse treatment facilities in the United States. The data are used for program administration and policy analysis. Information from the survey is also used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the on-line Substance Abuse Treatment Facility Locator, two widely used resources for referrals to treatment.
- **National Survey on Drug Use or Health (NSDUH)** – The NSDUH is an annual household survey of individuals aged 12 and older. The main foci of the survey are to obtain information concerning consumption patterns and dependence of alcohol, tobacco, and other illicit drugs. Over sampling occurs to provide statewide level estimates in addition to national estimates.
- **SAMHSA's Center for Mental Health Services (CMHS): Kansas Mental Health National Outcome Measures (NOMS)** – Community Mental Health Services Uniform Reporting System provides guidance and technical assistance to decision makers at all levels of government on the design, structure, content, and use of mental health information systems, with the ultimate goal of improving the quality of mental health programs and services delivery. CMHS operates the only program in the nation that focuses on the development of data standards that provide the basis for uniform, comparable, high-quality statistics on mental health services, making it a model in the health care statistics field.
- **ValueOptions of Kansas** - Under the direction of the Kansas Department for Aging and Disability Services (KDADS), ValueOptions administers inpatient and outpatient substance use disorder treatment services for members eligible for Substance Abuse Prevention and Treatment (SAPT) BHS funded services and all addiction services funded by the Problem Gambling and Addictions Fund.

In 2005, Kansas received an SEOW grant to begin the process of establishing a sustainable infrastructure to examine indicators for substance abuse in Kansas, the most preventable underlying cause of disease and death. A multi-agency design team was formed to begin work to profile the burden of substance use in the state. The data collected informed a larger planning committee that worked through a layered comprehensive statewide needs assessment process to prioritize and focus the state's prevention efforts. The *Kansas Substance Abuse Epidemiological Indicators Profile* included indicator and trend data from 2000-2005 focusing on consumption and consequences related to alcohol, cigarette, marijuana and use as well as other-related drugs. The profile reported youth and adult measures of mortality, morbidity and crime resulting from substance use. Indicator data was reported by age, gender, and race.

The SEOW was reconvened and repurposed in late 2012 in order to respond to the need to reassess and re-evaluate state alcohol, tobacco, and other drug priority outcomes and future directions for Substance Abuse Prevention and Treatment Block Grant funding, as well as for the Strategic Prevention Framework Partnership for Success initiative that began in October 2012. The data covered in this updated profile was inclusive of 2006-2011. Information was presented from health agencies, treatment agencies, law enforcement agencies, and revenue agencies. The goal was to provide a comprehensive look at the current state of substance abuse so that priority areas may be identified and addressed. Utilizing a broad array of information from multiple sectors allows for a more complete picture of substance abuse related consequence and consumption pattern. During the compilation of various data sources, specific data gaps were identified in the realm of substance abuse prevention. These data gaps, while not as significant as the information available, provide examples of possible improvements to build a completely comprehensive picture of substance abuse in Kansas.

In 2013, Kansas received supplemental grants to allow SPF-PFS II grantees to expand and enhance the activities of the SEOW. This involved developing a key set of indicators to describe the magnitude and distribution of substance-related consequences and consumption patterns across the state and in grantee communities of high need. The SEOW developed a set of key indicators that, in addition to substance use, would apply to KDADS's broader behavioral health focus. The expanded indicators included: youth and adult prescription drug abuse, substance use treatment, problem gambling treatment, depression and suicide, and adverse childhood experiences (ACEs). The SEOW also expanded its approach to include influencing factors known to be associated with poor behavioral health. In April, 2015, the expanded work of the SEOW resulted in a new document, the *Kansas Behavioral Health Profile*.

Beginning with the original profile, and with each subsequent update, the data gathered and reported by the SEOW has informed prevention planning. The information was used to prioritize state focus for underage drinking with the SPF-SIG and continues to guide planning around broader behavioral health measures described.

This allows communities to have a more comprehensive look at how indicators that are predictive of one or more behavioral health issue may be prioritized for intervention. In addition, the state can look at potential areas of need or disproportion by comparing age, gender and race.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

In addition to supporting the ability to identify trends, locate geographic prevalence and risk/protective factor hotspots, and make data-driven decisions concerning substance abuse prevention priorities at the state and systems level, needs assessment data from the Kansas SEOW Behavioral Health Indicators Profile will also support the ability of the Kansas prevention system to engage in targeted outreach and mobilization in communities identified as high need while lacking in prevention response capacity (e.g., low readiness, low functioning or non-existence coalition, poor sector involvement or engagement, low or ineffective strategy

implementation), which will allow for capacity development in communities demonstrating high need and bolstering their ability to engage in more effective prevention processes. As such, smaller scale funding allocations will be made as funds are available for capacity development in this regard.

Current community-level allocation of SAPTBG prevention funds to local coalitions or other prevention partnerships are based on variables which include: fidelity to the SPF process and submission of deliverables demonstrating completion of milestones and benchmarks associated with each of the steps within the planning phase (assessment, capacity, and planning), completion of a needs assessment process entailing the identification and prioritization of at least 1-2 local prevalence outcomes, and approximately 2-5 targeted local risk and protective factors, completion of a logic model/theory of change and action plans for each primary evidence-based strategy, and creation (in conjunction with the Evaluation Team) of an evaluation framework outlining key process and outcome indicators and corresponding data collection needs for all funded strategies. Upon submission of these SPF deliverables, materials are reviewed by KDADS staff and subject matter experts including the Evaluation Team to ensure accuracy, comprehensiveness, alignment, assessment and prioritization integrity, and alignment, fit, saturation, intensity, and appropriateness of all proposed strategies. Following review and approval – or as needed, requested revisions are completed and resubmitted – funding allocations are made to support each community’s proposed line-item budget for strategy implementation. In this way needs assessment data at the community level is integral to the process of awarding funding to communities to support local prevention efforts in a manner that is both data-driven, outcome-focused, and maintains fidelity to the SPF process, yet retains local support and ownership.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Given the recent transition to a new set of prevention contractors, focus throughout FY16 will entail comprehensive assessment, planning, and capacity development activities. As a preliminary step the identification of core competencies, skill sets, and foundational learning needs across the spectrum of behavioral health (as well as linked to ICRC domains and competencies for certification to ensure correspondence) will be conducted. Following this process, the Evaluation Team will collaborate with KDADS to conduct a workforce capacity assessment to determine levels of extant behavioral health workforce skills, experience, and abilities. Using this data, KDADS will then coordinate the provision of training (either on-site, web-based, or in combination) and education sessions to address learning needs. Follow-up coaching opportunities will also be made available for prevention contractors, to support the application and utilization of information provided through training and educational efforts, as well as create an opportunity for cross-discipline application of content and interaction of providers as part of a learning community for prevention excellence (e.g., suicide prevention, problem gambling prevention, behavioral health prevention and promotion).

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

Kansas maintains a certification process, standards and requirements, and board to support statewide certification of the state prevention workforce. Kansas ICRC Prevention Specialist standards (updated October 2013) includes 2000 hours of experience across ICRC domains, 120 hours of education across domains, 120 hours of supervision with 10 hours specific to each respective domain, successful completion of the ICRC Prevention Specialist Examination, and adherence to the code of ethics. The Kansas Prevention Certification Board is a member of ICRC, responsible for the credentialing of prevention, addiction treatment, and recovery professionals.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

The Kansas Department for Aging and Disability Services (KDADS) utilizes four primary sources for making training and technical assistance available to the prevention workforce. In conjunction with workforce needs assessment and identification of learning needs based upon emerging issues and trends across the spectrum of behavioral health, an annual training schedule is developed and implemented by identified subject matter experts within the system, through the Southwest Resource Team (CAPT), or via technical assistance request through CSAP to ensure foundational knowledge and skill development among contractor organizations and their respective staff members. In FY16, this will be accomplished following the completion of a workforce capacity survey. It is anticipated that while the prevention workforce is comprised of skilled and experienced personnel, it will be of critical importance to engage in more frequent provision of training and learning opportunities to ensure all individuals use and employ the same approaches, resources, tactics, and skill sets as they translate this to the provision of training and technical assistance at the community level. As such, structured and regularly facilitated coaching and feedback opportunities will be provided to ensure appropriate application of knowledge and skills by the prevention workforce, as well as opportunities for engagement and co-learning with the Kansas Prevention Project Team.

c. A formal mechanism to assess community readiness to implement prevention strategies.

As part of the SPF assessment phase, Kansas utilizes the Tri-Ethnic Community Readiness model as the primary measure of community readiness, which is conducted in all funded communities in addition to community collaboration and capacity assessment, as well as the requisite completion of a comprehensive needs assessment. The Tri-Ethnic Community Readiness Assessment involves the completion of a series of local key informant surveys, with data obtained scored on the basis of six dimensions of community readiness – that is, community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue of concern, and resources related to the issue. Scoring across these six dimensions, range on a nine-point scale, beginning with no awareness, through initiation, to high community ownership. This provides qualitative and quantitative data, collected as part of repeated evaluation measures in funded communities, that enables communities to build into local prevention capacity development plans specific strategies and approaches for increasing and enhancing readiness over time.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

At the state level, substance abuse consumption/prevalence, risk and protective factor, and consequence data is used on an annual basis to identify geographic hot spots, areas of high need that require targeted outreach, emergent trends, and state-level priorities using epidemiological criteria including magnitude, five-year trend, and comparison, with these data-informed decisions guiding the direction of the Kansas prevention system in terms of mobilization, training and capacity development, resource dissemination, and in communities receiving prevention set-aside funding from the SAPTBG, supports for the implementation of locally-selected evidence-based strategies. However, on a more universal indirect basis, environmental prevention efforts including statewide media campaign focus and design, messaging, targeted audience(s), and key educational concepts are also developed, refined, and updated based upon data from the State Epidemiological Outcomes Workgroup (SEOW) and the Kansas Behavioral Health Indicators Profile.

Additionally, at the community level, consumption/prevalence data and risk and protective factor scale scores and individual indicators are used extensively for local-level needs assessment, outcomes selection and prioritization, and strategic planning processes. This data, available at the county level and disaggregated by subpopulation by dimensions including age, gender, race, and ethnicity, are vital for targeting appropriate prevalence and risk and protective factor outcomes as part of SPF needs assessment, as well as for selecting high-impact, appropriate, and aligned evidence-based prevention strategies, in addition to serving an integral role in the development of a comprehensive local evaluation plan and subsequent outcomes-based evaluation.

At the local level, depending on the substance abuse prevalence priorities targeted, and the prioritized risk and/or protective factors, the evidence-based strategies implemented (e.g., prevention education, enforcement, information dissemination, policy or practice change) is contingent on the outcomes targeted for change. Training, resources, and technical assistance are then provided to communities to assist them in the implementation of the evidence-based strategies that were selected locally during the strategic planning process; however, in many instances there are similarities in the targeted substances or risk factors across many Kansas communities and coalitions, and in those instances, statewide media messaging may be developed to assist with uniformity of messaging, bolstering saturation, and high-volume resource development and dissemination, or in the case of training, those evidence-based programs that have been more commonly selected across funded communities may be coordinated such that a training of trainers is provided for multiple communities as a cost-savings and efficiencies measure.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

There is currently no formalized strategic plan to guide prevention activity; however development of a new plan in partnership with the newly funded contractors is a priority for FY16. Our belief is that people are oftentimes more supportive of work that they help create, thus our intention was to create the document in partnership with new providers after contract awards were determined. While no formalized document exists we did develop six key priority areas that were included in our request for proposal process and within our new prevention agreements, these will be infused within our statewide plan as well. These six foci are:

1. Alignment with the SPF

The SPF is a five-step approach built on identifying community-based risk and protective factors and using gathered data to select, implement, and evaluate appropriate evidence-based and sustainable prevention programs, practices, and policies intended to lead to population-level outcomes.

2. Strategic Integration across Behavioral Health

The model of risk-focused prevention allows for the assessment and identification of shared risk and protective factors common to substance abuse, problem gambling, suicide, and mental health disorders. It is possible to assess and identify shared risk factors, such as Adverse Childhood Experiences (ACEs), for an array of problem behaviors and reduce and respond to these risks with aligned evidence-based interventions funded through braided sources. At a minimum, integration is sought across all behavioral health system prevention programs including substance abuse prevention, problem gambling prevention and awareness, mental health promotion, and suicide prevention.

3. Innovative Approaches and Leverage

To be more in line with SAMHSA funding allocation ratios (85% towards community level processes that lead to the implementation of evidence based strategies and 15% towards administrative costs) and comprehensively address more communities' needs around the totality of behavioral health prevention,

KDADS/BHS is compelled to find new and innovative approaches and practices that leverage resources, capture more community-level investment, and achieve intended outcomes.

4. Facilitation of Community Change through Training and Technical Assistance (T/TA)

Training and TA must demonstrate effectiveness in facilitating actionable community level strategic planning and implementation of innovative solutions that are sustainable at the community level. The provision of training and technical assistance should be offered in a manner that builds community capacity, supports, guidance, coaching, and feedback necessary for communities to be able to autonomously engage in effective prevention processes associated with all five steps of the SPF, including cultural competency and sustainability.

5. Community Ownership

Community ownership is crucial to future prevention initiatives, and communities need to autonomously create broad-scope and multi-sector collaborations that are locally-driven and sustainable.

6. Data Collection & Analysis

To complete state and community level assessments, identify outcomes, and develop strategic plans the collection, analysis, and aggregation of data across multiple disciplines is imperative.

- 7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.**

Kansas uses a group referred to as the SPF Project Team for the coordination and involvement of subject matter experts for each phase of the Strategic Prevention Framework, that is, assessment, capacity, planning, implementation, and evaluation. In the role of Planning Phase specialists, the Planning Core Team members, in conjunction with KDADS staff, serves as the state's Evidence Based Programs and Strategies Workgroup. Responsibilities subsumed by this role include: review of all proposed strategies by funded communities/coalitions to ensure strategies meet the CSAP and Kansas criteria for being evidence-based – this includes a research and literature review to determine strength of evidence, identification of conditions such as normative populations and settings that may necessitate adaptations, evaluation data from the strategy developers as well as any Kansas-specific evaluation data from previous implementation of respective strategies, and completion of a consensus review process with all workgroup members before finalizing approval or establishing criteria for revisions or modifications for proposed strategies which is provided to communities. Through this process a number of commonly utilized strategies have received previous review and approval for implementation as evidence-based strategies, but evaluation data is collected at the program, participant, and strategy level for all individual strategies and reviewed on an annual basis with regard to efficacy and cost-effectiveness, which may also influence the degree to which strategies are approved for implementation by funded communities.

In Kansas, SAPTBG funded prevention activities are coordinated with other funded prevention initiatives to ensure uniformity in outcomes, science-based prevention processes, assessment data and evaluation methodologies, training and technical assistance delivery, and alignment of outcomes. For example, communities allocated prevention funding as part of the SAPTBG prevention set-aside, through an initiative referred to as K-SPF (Kansas Strategic Prevention Framework), are provided the same guidance, training, and parameters for outcomes targeting and acquisition, as do grantee communities involved in the Kansas PFS II initiative. Data is provided in the same format, through an online portal and county reports for both initiatives are set up such that these resources are aligned. In terms of progress reporting, via quarterly reports and requisite reporting on the Online Documentation and Support System (ODSS), requirements are the same, as

are supports and resources developed and provided by the Evaluation Team and the SEOW. This ensures efficiencies and consistencies across initiatives, as well as the ability to address statewide outcomes through tailored efforts at the local level, regardless of source of funding.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

SAPTBG funding in Kansas supports the implementation of evidence-based primary prevention strategies outlined in local-level, community logic models and strategic plans that align with local priorities in terms of targeted risk and protective factors and align with the prevalence outcomes at the state level.

A specific menu of primary prevention programs, practices, and policies in the six prevention strategies are not provided to communities. However communities are required to implement strategies that are listed on the National Registry of Effective Programs and Practices (NREPP) or other registries of evidence-based or model programs. For strategies not listed on registries, communities must submit documentation that supports the strategies evidence of effectiveness in addressing their selected priorities named in planning. The SPF Project Team reviews submitted documentation for approval prior to the implementation of said strategy.

Communities will be guided through the SPF process to ensure that evidence-based prevention strategies are selected and implemented that: are tailored to 2-5 specific risk and protective factors targeted at the local level as the result of comprehensive assessment, include multiple primary and secondary environmental and individual approaches, include a mix of bolstering protective factors while reducing risk factors, are implemented with high fidelity while responsive to the need for culturally-responsive adaptations, are inclusive of multiple community domains and sectors, and address effectiveness gaps.

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

In addition to comprehensive plans developed at the local level that are broad-based and inclusive of multiple core strategies with EBS infused throughout, the statewide It Matters media campaign will continue to be utilized and enhanced to support targeted information dissemination. The campaign targets underage drinking and marijuana use. This strategy was selected as a broad environmental information dissemination approach which allows for a high degree of saturation, frequency, and duration, impacting a maximal number of individuals as part of universal indirect prevention efforts. The It Matters media campaign is adaptable and is tailored at the community level so that it can be culturally responsive, focus on various target groups and risk factors, and include local messaging and taglines, while maintaining consistency of branding, look, and feel for content recognition and retention.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

As a required component of the Kansas SPF assessment process, communities are required to complete a comprehensive needs assessment, capacity assessment, readiness assessment, and assessment of existing community resources. This resources assessment, corresponding with the Communities That Care Community Resources Assessment (CRA), is designed to identify the pre-existing evidence-based prevention strategies in place that address prioritized prevalence outcomes and targeted local risk and/or protective factors. SABG funds are not eligible to support these pre-existing strategies, that is, clear parameters are provided during the assessment and planning phase regarding ensuring that SABG funds do not supplant prior sources of funding for prevention services and programming. Additionally, this requirement ensuring non-supplantation is included into funding agreements with communities through which SABG funds are allocated.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Both process indicators and outcomes indicator data are collected as part of the evaluation framework for SAPTBG funded communities as well as other initiatives including the SPF-PFS II. In all instances, process indicators collected as part of evaluation measures include, but are not limited to: indicators of saturation (e.g., numbers served, number of participants in attendance, number of individuals impacted by policy or practice change), and indicators of fidelity, dosage, or duration (number of sessions delivered, length of sessions, frequency of program delivery). Specific for evidence-based programs, as well as prevention education activities, participant sign-in sheets and attendance rosters allow for unduplicated counts of numbers served as well as for compiling data related to participant demographics. For environmental approaches that are universal-indirect in nature, demographic estimates are used to calculate numbers served for these population-based strategies.

This data is used to determine scope of impact at the community level, as well as at the state level, in terms of exposure to content, messaging, and materials associated with evidence-based strategy implementation. It also allows for determination of the degree to which evidence-based prevention strategies are implemented on a geographic basis and identification of under-served, high-need areas of the state. Further, this data is used not just for state level process evaluation but also as part of semi-annual coaching and technical assistance provided to communities with regard to saturation, impact, and intensity to allow them to make use of evaluation and outcomes findings in order to enhance and improve the implementation of evidence-based strategies by making mid-course adjustments.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

As part of outcomes-based evaluation of state and local prevention outcomes, the following prevalence outcome data are collected on an annual basis: past 30-day alcohol use, binge drinking, and past 30-day marijuana use – with all indicators aggregated for students completing the Kansas Communities That Care student survey in grades 6, 8, 10, and 12. In addition, risk and protective factor scales scores and indicators are also monitored on an annual basis, which include for each targeted substance the following: perceived risk of harm, favorable attitudes toward use, friends who engage in use, perceived availability, and favorable parental attitudes toward use. At the community level, additional risk and protective factors may be prioritized and targeted with specific evidence-based strategies, with this risk and protective factor data tailored to the community as part of a comprehensive evaluation plan. Given the parameters established for achieving change in targeted prevalence and risk and protective factor outcomes, statewide evaluation utilizes both changes in magnitude as well as trend analysis to establish evidence of progress in these areas, on either a three-year or five-year time frame. In addition to prevalence and risk and protective factor indicators, prevention education program data collection

and monitoring includes aggregate participant-level data. Data is aggregated and reported by a range of individual characteristics including gender, race, ethnicity, and region, and unique participant identifiers are used to match pre and post survey data in order to statistically determine program outcomes and impact, through t-tests or analysis of variance.

Primary Prevention for Substance Abuse

1. Please indicate if the state has an active SEOW. If so, please describe:

- **The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);**
- **The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and**
- **The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).**

The Kansas statewide epidemiological profile that was originally published in 2006 was updated by the state's epidemiological core team to include behavioral health indicators and the final document was published in 2015. Data sources in the updated profile include the following:

- **Behavior Risk Factor Surveillance System (BRFSS)** – The BRFSS is a random digit dialing (RDD) telephone survey. The CDC has developed the questionnaire to ensure compatibility across states. Core questions are asked annually all states and states have the option of adding in supplemental questions concerning specific health behaviors and conditions.
- **Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2013 on CDC WONDER Online Database-** Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Data set is published by the U.S. Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Office of Analysis and Epidemiology. The county-level national mortality and population data has been derived from the U.S. records of deaths (death certificates) since 1979. Death rates are calculated per 100,000 persons. (Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Mar 27, 2015 4:36:19 PM)
- **Drug Enforcement Administration (DEA) - Environmental Photographic Interpretation Center's (EPIC) Database :** Methamphetamine Clandestine Lab Seizure Statistics reports include only that information that has been reported to EPIC by contributing agencies and may not necessarily reflect total seizures nationwide. Data is reported without corroboration, modification, or editing by EPIC, and, accordingly, EPIC cannot guarantee the timeliness, completeness, or accuracy of the information reported therein. The data and any supporting documentation relied upon by EPIC to prepare this report are the property of the originating agency.
- **Gambling Behaviors and Attitudes Among Adult Kansans** - This 2012 study was conducted by Kansas City-based Whitworth Ballou, LLC, on behalf of KDADS. It was the first statewide study of adult gambling behaviors and attitudes since the opening of three state-owned casinos. Utilizing telephone survey methods, researchers interviewed 1,600 anonymous adults in late 2012. Respondents were randomly selected from landline and cell phone numbers located across the state.
- **Kansas Bureau of Investigation (KBI)** – Information from local and statewide law enforcement is reported to KBI. The information collected is on the number of offenses reported to law enforcement as well as the number or arrests made. In some law enforcement agencies only summary information is reported and not detailed individual accounts.

- **Kansas Communities That Care (KCTC)** -The KCTC is a school-based survey for students in grades 6, 8, 10, and 12 in Kansas. The KCTC is utilized to gather information concerning youth prevalence of various risk factors such as alcohol, tobacco, other drugs, gang involvement, and many others. In addition, the KCTC is utilized to gather information concerning individual and community risk and protective factors.
- **Kansas Department of Aging & Disability Services (KDADS)** – Data was provided from the Treatment Episodic Data Set (TEDS) regarding community mental health admissions and substance abuse treatment admissions.
- **Kansas Department for Children & Families: Prevention and Protection Services**– Count data was provided from the Foster Care / Adoption Summary Reports site regarding children removed from the home into out of home placement by primary removal reason.
- **Kansas Department of Corrections (KDOC)** – Count data was obtained from the KDOC Annual Report – Offender Population /Adult Court Commitments map as to the number of adult admissions during each fiscal year by county of offender commitment.
- **Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics, Office of Health Assessment**—Data was provided from KDHE regarding deaths due to illicit drugs as underlying cause, specified by mortality due to external causes as unintentional drug poisoning and psychiatric causes based on psychiatric diagnosis.
- **Kansas Department of Revenue Cigarette and Tobacco Enforcement Agent, Controlled Buy database** – Kansas performs unannounced compliance checks on a random sample of all retailers and vendors of tobacco. Specifically these compliance checks are used to monitor the sales of tobacco to minors. Alcohol and Beverage Control (ABC) imposes fines upon individuals failing these checks. Results of the SYNAR report are used in the Kansas Substance Abuse Prevention and Treatment Block Grant.
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- **Kansas Vital Statistics (KVS)** – The KVS provide information on all births, pregnancies, marriages, divorces, and deaths in Kansas and among Kansas residents. Information is collected on many risk and protective factors surrounding the event as well as extensive demographic information. Information is available at the statewide and sub-state level.
- **Monitoring The Future (MTF)** – The MTF survey is an annual school-based survey of youth in grades 8, 10, and 12 nationally. The MTF survey is utilized to gather national trend information concerning drug use trend and patterns.
- **National Survey of Substance Abuse Treatment Services (N-SSATS)** – The N-SSATS (formerly the Uniform Facility Data Set) is an annual census of all treatment facilities listed on the I-SATS. Information is collected on the location, organization, structure, services, and utilization of substance abuse treatment facilities in the United States. The data are used for program administration and policy analysis. Information from the survey is also used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the on-line Substance Abuse Treatment Facility Locator, two widely used resources for referrals to treatment.
- **National Survey on Drug Use or Health (NSDUH)** – The NSDUH is an annual household survey of individuals aged 12 and older. The main foci of the survey are to obtain information concerning consumption patterns and dependence of alcohol, tobacco, and other illicit drugs. Over sampling occurs to provide statewide level estimates in addition to national estimates.
- **SAMHSA's Center for Mental Health Services (CMHS): Kansas Mental Health National Outcome Measures (NOMS)** – Community Mental Health Services Uniform Reporting System provides guidance and technical assistance to decision makers at all levels of government on the design, structure, content, and use of mental health information systems, with the ultimate goal of improving the quality of mental health programs and services delivery. CMHS operates the only program in the nation that focuses on the development of data standards that provide the basis for uniform, comparable, high-quality statistics on mental health services, making it a model in the health care statistics field.
- **ValueOptions of Kansas** - Under the direction of the Kansas Department for Aging and Disability Services (KDADS), ValueOptions administers inpatient and outpatient substance use disorder treatment services for members eligible for Substance Abuse Prevention and Treatment (SAPT) BHS funded services and all addiction services funded by the Problem Gambling and Addictions Fund.

In 2005, Kansas received an SEOW grant to begin the process of establishing a sustainable infrastructure to examine indicators for substance abuse in Kansas, the most preventable underlying cause of disease and death. A multi-agency design team was formed to begin work to profile the burden of substance use in the state. The data collected informed a larger planning committee that worked through a layered comprehensive statewide needs assessment process to prioritize and focus the state's prevention efforts. The *Kansas Substance Abuse Epidemiological Indicators Profile* included indicator and trend data from 2000-2005 focusing on consumption and consequences related to alcohol, cigarette, marijuana and use as well as other-related drugs. The profile reported youth and adult measures of mortality, morbidity and crime resulting from substance use. Indicator data was reported by age, gender, and race.

The SEOW was reconvened and repurposed in late 2012 in order to respond to the need to reassess and re-evaluate state alcohol, tobacco, and other drug priority outcomes and future directions for Substance Abuse Prevention and Treatment Block Grant funding, as well as for the Strategic Prevention Framework Partnership for Success initiative that began in October 2012. The data covered in this updated profile was inclusive of 2006-2011. Information was presented from health agencies, treatment agencies, law enforcement agencies, and revenue agencies. The goal was to provide a comprehensive look at the current state of substance abuse so that priority areas may be identified and addressed. Utilizing a broad array of information from multiple sectors allows for a more complete picture of substance abuse related consequence and consumption pattern. During the compilation of various data sources, specific data gaps were identified in the realm of substance abuse prevention. These data gaps, while not as significant as the information available, provide examples of possible improvements to build a completely comprehensive picture of substance abuse in Kansas.

In 2013, Kansas received supplemental grants to allow SPF-PFS II grantees to expand and enhance the activities of the SEOW. This involved developing a key set of indicators to describe the magnitude and distribution of substance-related consequences and consumption patterns across the state and in grantee communities of high need. The SEOW developed a set of key indicators that, in addition to substance use, would apply to KDADS's broader behavioral health focus. The expanded indicators included: youth and adult prescription drug abuse, substance use treatment, problem gambling treatment, depression and suicide, and adverse childhood experiences (ACEs). The SEOW also expanded its approach to include influencing factors known to be associated with poor behavioral health. In April, 2015, the expanded work of the SEOW resulted in a new document, the *Kansas Behavioral Health Profile*.

Beginning with the original profile, and with each subsequent update, the data gathered and reported by the SEOW has informed prevention planning. The information was used to prioritize state focus for underage drinking with the SPF-SIG and continues to guide planning around broader behavioral health measures described.

This allows communities to have a more comprehensive look at how indicators that are predictive of one or more behavioral health issue may be prioritized for intervention. In addition, the state can look at potential areas of need or disproportion by comparing age, gender and race.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

In addition to supporting the ability to identify trends, locate geographic prevalence and risk/protective factor hotspots, and make data-driven decisions concerning substance abuse prevention priorities at the state and systems level, needs assessment data from the Kansas SEOW Behavioral Health Indicators Profile will also support the ability of the Kansas prevention system to engage in targeted outreach and mobilization in communities identified as high need while lacking in prevention response capacity (e.g., low readiness, low functioning or non-existence coalition, poor sector involvement or engagement, low or ineffective strategy

implementation), which will allow for capacity development in communities demonstrating high need and bolstering their ability to engage in more effective prevention processes. As such, smaller scale funding allocations will be made as funds are available for capacity development in this regard.

Current community-level allocation of SAPTBG prevention funds to local coalitions or other prevention partnerships are based on variables which include: fidelity to the SPF process and submission of deliverables demonstrating completion of milestones and benchmarks associated with each of the steps within the planning phase (assessment, capacity, and planning), completion of a needs assessment process entailing the identification and prioritization of at least 1-2 local prevalence outcomes, and approximately 2-5 targeted local risk and protective factors, completion of a logic model/theory of change and action plans for each primary evidence-based strategy, and creation (in conjunction with the Evaluation Team) of an evaluation framework outlining key process and outcome indicators and corresponding data collection needs for all funded strategies. Upon submission of these SPF deliverables, materials are reviewed by KDADS staff and subject matter experts including the Evaluation Team to ensure accuracy, comprehensiveness, alignment, assessment and prioritization integrity, and alignment, fit, saturation, intensity, and appropriateness of all proposed strategies. Following review and approval – or as needed, requested revisions are completed and resubmitted – funding allocations are made to support each community’s proposed line-item budget for strategy implementation. In this way needs assessment data at the community level is integral to the process of awarding funding to communities to support local prevention efforts in a manner that is both data-driven, outcome-focused, and maintains fidelity to the SPF process, yet retains local support and ownership.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Given the recent transition to a new set of prevention contractors, focus throughout FY16 will entail comprehensive assessment, planning, and capacity development activities. As a preliminary step the identification of core competencies, skill sets, and foundational learning needs across the spectrum of behavioral health (as well as linked to ICRC domains and competencies for certification to ensure correspondence) will be conducted. Following this process, the Evaluation Team will collaborate with KDADS to conduct a workforce capacity assessment to determine levels of extant behavioral health workforce skills, experience, and abilities. Using this data, KDADS will then coordinate the provision of training (either on-site, web-based, or in combination) and education sessions to address learning needs. Follow-up coaching opportunities will also be made available for prevention contractors, to support the application and utilization of information provided through training and educational efforts, as well as create an opportunity for cross-discipline application of content and interaction of providers as part of a learning community for prevention excellence (e.g., suicide prevention, problem gambling prevention, behavioral health prevention and promotion).

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

Kansas maintains a certification process, standards and requirements, and board to support statewide certification of the state prevention workforce. Kansas ICRC Prevention Specialist standards (updated October 2013) includes 2000 hours of experience across ICRC domains, 120 hours of education across domains, 120 hours of supervision with 10 hours specific to each respective domain, successful completion of the ICRC Prevention Specialist Examination, and adherence to the code of ethics. The Kansas Prevention Certification Board is a member of ICRC, responsible for the credentialing of prevention, addiction treatment, and recovery professionals.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

The Kansas Department for Aging and Disability Services (KDADS) utilizes four primary sources for making training and technical assistance available to the prevention workforce. In conjunction with workforce needs assessment and identification of learning needs based upon emerging issues and trends across the spectrum of behavioral health, an annual training schedule is developed and implemented by identified subject matter experts within the system, through the Southwest Resource Team (CAPT), or via technical assistance request through CSAP to ensure foundational knowledge and skill development among contractor organizations and their respective staff members. In FY16, this will be accomplished following the completion of a workforce capacity survey. It is anticipated that while the prevention workforce is comprised of skilled and experienced personnel, it will be of critical importance to engage in more frequent provision of training and learning opportunities to ensure all individuals use and employ the same approaches, resources, tactics, and skill sets as they translate this to the provision of training and technical assistance at the community level. As such, structured and regularly facilitated coaching and feedback opportunities will be provided to ensure appropriate application of knowledge and skills by the prevention workforce, as well as opportunities for engagement and co-learning with the Kansas Prevention Project Team.

c. A formal mechanism to assess community readiness to implement prevention strategies.

As part of the SPF assessment phase, Kansas utilizes the Tri-Ethnic Community Readiness model as the primary measure of community readiness, which is conducted in all funded communities in addition to community collaboration and capacity assessment, as well as the requisite completion of a comprehensive needs assessment. The Tri-Ethnic Community Readiness Assessment involves the completion of a series of local key informant surveys, with data obtained scored on the basis of six dimensions of community readiness – that is, community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue of concern, and resources related to the issue. Scoring across these six dimensions, range on a nine-point scale, beginning with no awareness, through initiation, to high community ownership. This provides qualitative and quantitative data, collected as part of repeated evaluation measures in funded communities, that enables communities to build into local prevention capacity development plans specific strategies and approaches for increasing and enhancing readiness over time.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

At the state level, substance abuse consumption/prevalence, risk and protective factor, and consequence data is used on an annual basis to identify geographic hot spots, areas of high need that require targeted outreach, emergent trends, and state-level priorities using epidemiological criteria including magnitude, five-year trend, and comparison, with these data-informed decisions guiding the direction of the Kansas prevention system in terms of mobilization, training and capacity development, resource dissemination, and in communities receiving prevention set-aside funding from the SAPTBG, supports for the implementation of locally-selected evidence-based strategies. However, on a more universal indirect basis, environmental prevention efforts including statewide media campaign focus and design, messaging, targeted audience(s), and key educational concepts are also developed, refined, and updated based upon data from the State Epidemiological Outcomes Workgroup (SEOW) and the Kansas Behavioral Health Indicators Profile.

Additionally, at the community level, consumption/prevalence data and risk and protective factor scale scores and individual indicators are used extensively for local-level needs assessment, outcomes selection and prioritization, and strategic planning processes. This data, available at the county level and disaggregated by subpopulation by dimensions including age, gender, race, and ethnicity, are vital for targeting appropriate prevalence and risk and protective factor outcomes as part of SPF needs assessment, as well as for selecting high-impact, appropriate, and aligned evidence-based prevention strategies, in addition to serving an integral role in the development of a comprehensive local evaluation plan and subsequent outcomes-based evaluation.

At the local level, depending on the substance abuse prevalence priorities targeted, and the prioritized risk and/or protective factors, the evidence-based strategies implemented (e.g., prevention education, enforcement, information dissemination, policy or practice change) is contingent on the outcomes targeted for change. Training, resources, and technical assistance are then provided to communities to assist them in the implementation of the evidence-based strategies that were selected locally during the strategic planning process; however, in many instances there are similarities in the targeted substances or risk factors across many Kansas communities and coalitions, and in those instances, statewide media messaging may be developed to assist with uniformity of messaging, bolstering saturation, and high-volume resource development and dissemination, or in the case of training, those evidence-based programs that have been more commonly selected across funded communities may be coordinated such that a training of trainers is provided for multiple communities as a cost-savings and efficiencies measure.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

There is currently no formalized strategic plan to guide prevention activity; however development of a new plan in partnership with the newly funded contractors is a priority for FY16. Our belief is that people are oftentimes more supportive of work that they help create, thus our intention was to create the document in partnership with new providers after contract awards were determined. While no formalized document exists we did develop six key priority areas that were included in our request for proposal process and within our new prevention agreements, these will be infused within our statewide plan as well. These six foci are:

1. Alignment with the SPF

The SPF is a five-step approach built on identifying community-based risk and protective factors and using gathered data to select, implement, and evaluate appropriate evidence-based and sustainable prevention programs, practices, and policies intended to lead to population-level outcomes.

2. Strategic Integration across Behavioral Health

The model of risk-focused prevention allows for the assessment and identification of shared risk and protective factors common to substance abuse, problem gambling, suicide, and mental health disorders. It is possible to assess and identify shared risk factors, such as Adverse Childhood Experiences (ACEs), for an array of problem behaviors and reduce and respond to these risks with aligned evidence-based interventions funded through braided sources. At a minimum, integration is sought across all behavioral health system prevention programs including substance abuse prevention, problem gambling prevention and awareness, mental health promotion, and suicide prevention.

3. Innovative Approaches and Leverage

To be more in line with SAMHSA funding allocation ratios (85% towards community level processes that lead to the implementation of evidence based strategies and 15% towards administrative costs) and comprehensively address more communities' needs around the totality of behavioral health prevention,

KDADS/BHS is compelled to find new and innovative approaches and practices that leverage resources, capture more community-level investment, and achieve intended outcomes.

4. Facilitation of Community Change through Training and Technical Assistance (T/TA)

Training and TA must demonstrate effectiveness in facilitating actionable community level strategic planning and implementation of innovative solutions that are sustainable at the community level. The provision of training and technical assistance should be offered in a manner that builds community capacity, supports, guidance, coaching, and feedback necessary for communities to be able to autonomously engage in effective prevention processes associated with all five steps of the SPF, including cultural competency and sustainability.

5. Community Ownership

Community ownership is crucial to future prevention initiatives, and communities need to autonomously create broad-scope and multi-sector collaborations that are locally-driven and sustainable.

6. Data Collection & Analysis

To complete state and community level assessments, identify outcomes, and develop strategic plans the collection, analysis, and aggregation of data across multiple disciplines is imperative.

- 7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.**

Kansas uses a group referred to as the SPF Project Team for the coordination and involvement of subject matter experts for each phase of the Strategic Prevention Framework, that is, assessment, capacity, planning, implementation, and evaluation. In the role of Planning Phase specialists, the Planning Core Team members, in conjunction with KDADS staff, serves as the state's Evidence Based Programs and Strategies Workgroup. Responsibilities subsumed by this role include: review of all proposed strategies by funded communities/coalitions to ensure strategies meet the CSAP and Kansas criteria for being evidence-based – this includes a research and literature review to determine strength of evidence, identification of conditions such as normative populations and settings that may necessitate adaptations, evaluation data from the strategy developers as well as any Kansas-specific evaluation data from previous implementation of respective strategies, and completion of a consensus review process with all workgroup members before finalizing approval or establishing criteria for revisions or modifications for proposed strategies which is provided to communities. Through this process a number of commonly utilized strategies have received previous review and approval for implementation as evidence-based strategies, but evaluation data is collected at the program, participant, and strategy level for all individual strategies and reviewed on an annual basis with regard to efficacy and cost-effectiveness, which may also influence the degree to which strategies are approved for implementation by funded communities.

In Kansas, SAPTBG funded prevention activities are coordinated with other funded prevention initiatives to ensure uniformity in outcomes, science-based prevention processes, assessment data and evaluation methodologies, training and technical assistance delivery, and alignment of outcomes. For example, communities allocated prevention funding as part of the SAPTBG prevention set-aside, through an initiative referred to as K-SPF (Kansas Strategic Prevention Framework), are provided the same guidance, training, and parameters for outcomes targeting and acquisition, as do grantee communities involved in the Kansas PFS II initiative. Data is provided in the same format, through an online portal and county reports for both initiatives are set up such that these resources are aligned. In terms of progress reporting, via quarterly reports and requisite reporting on the Online Documentation and Support System (ODSS), requirements are the same, as

are supports and resources developed and provided by the Evaluation Team and the SEOW. This ensures efficiencies and consistencies across initiatives, as well as the ability to address statewide outcomes through tailored efforts at the local level, regardless of source of funding.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

The SAPTBG funding only supports one specific prevention strategy that is utilized statewide, which is the It Matters media campaign. The campaign targets underage drinking and marijuana use. This strategy was selected as a broad environmental information dissemination approach which allows for a high degree of saturation, frequency, and duration, impacting a maximal number of individuals as part of universal indirect prevention efforts. The It Matters media campaign is adaptable and is tailored at the community level so that it can be culturally responsive, focus on various target groups and risk factors, and include local messaging and taglines, while maintaining consistency of branding, look, and feel for content recognition and retention. This media strategy is the sole statewide prevention strategy in use. However, at the local level, communities completing the planning phase of the Strategic Prevention Framework and submitting required deliverables corresponding to SPF milestones and benchmarks are eligible to apply for KSPF funding to support the implementation of evidence-based prevention strategies outlined in their respective logic models and strategic plans – although these strategies are selected within individual communities, and aligned with local priorities in terms of targeted risk and protective factors, although prevalence outcomes are aligned with those at the state level (i.e., either prevention and reduction of past 30-day alcohol use, binge drinking, and/or marijuana use).

We anticipate that a robust combination of CSAP's **Six Core Strategies** will be implemented as part of locally specific data driven approach to prevention.

We anticipate multiple communities across the state will continue to implement the 'It Matters' media campaign which was developed in 2008 as part of our SPF- SIG Grant, this campaign which originally focused on underage drinking prevention has been expanded to include messages on marijuana prevention and other substances and plans are under development to design messages that also target co-occurring shared risk and protective factors and allow us to address suicide prevention and mental health promotion. This will account for the majority of our **information dissemination** strategies.

We anticipate funding ten to fifteen communities thru a competitive request for proposal(RFP) process; these communities will complete a strategic planning process based on the SPF process that includes conducting a comprehensive needs assessment, capacity and readiness assessments, completing a strategic planning, identifying strategies that are evidence-based, and completing and implementation and evaluation plan. Communities will be supported by a statewide project team throughout this process enabling them to more effectively implement prevention programming and achieve outcomes; this is how we will accomplish our **community-based processes**.

Once communities complete a strategic plan and identify appropriate evidence-based strategies they will receive implementation funding, funding that is comprehensive enough to allow for implementation of an array of strategies that include programs, practices, and policy changes. Previously community funding was limited and strategies that were implemented were not comprehensive and the implementation of environmental strategies and education was limited. Our new approach which will be fully implemented beginning in July of 2016 will allow for the greater implementation of **environmental strategies**, in fact our training and technical assistance will place emphasis on environmental strategies.

The Kansas Prevention Collaborative is largely responsible for providing support for community-based prevention education efforts by developing the capacity of coalitions and other prevention partnerships to engage in effective local prevention activities. The Prevention Collaborative staff with DCCCA, Inc. will continue to offer support, technical assistance, training, and other resources to community-based prevention organizations that enable them to engage in **prevention education** efforts tailored to local needs. Community capacity for the implementation of prevention education initiatives – that is, two-way communication such as trainings, presentations, or other activities intended to affect life or social skills – will be cultivated among prevention staff. This will be accomplished through skill-building activities, training of trainers, demonstration, coaching, and guided instruction for coalitions and other partnerships. Trainings will be presented so that these providers learn essential skill sets and acquire sufficient content expertise to provide prevention education autonomously at the local level.

Additionally, the Kansas Prevention Infrastructure will examine a variety of avenues, strategically and methodologically, to enable prevention practitioners the ability to deliver prevention education through a variety of technological outlets (for example, online facilitation or virtual distance learning). These capacity building efforts will not be limited to existing coalitions, community organizations, and key leaders, but will also be extended to include youth.

Although the greatest proportion of **problem identification and referral** activities are addressed through the Kansas SAPT Block Grant-funded treatment infrastructure, the Prevention Collaborative will assist in ensuring accurate and timely referrals to treatment facilities. Referrals are provided to individuals throughout the state on an as-needed basis, or upon request.

Given the complexity and interrelated nature of substance abuse and mental illness, along with the growing body of research relating to co-morbidity, methods for increasing the knowledge and capacity of the Kansas Prevention Collaborative to assist community coalitions in addressing these issues will be explored. Capacity development in this area will, in turn, enable more comprehensive and effective community planning, engagement, and educational efforts, including those targeting health service providers, medical professionals, and other key stakeholders.

The Kansas Prevention Collaborative will continue to support **drug-free activities**. This includes, at the local level, opportunities for children and youth to participate in activities that exclude the use alcohol, tobacco, and other drugs, and allows for meaningful involvement, leadership development, community service, or positive social engagement and interaction. These activities will be coordinated and implemented via community coalitions through a comprehensive, local assessment process, identifying those activities most appropriate and likely to produce a positive impact, garnering resources to support implementation of the activity, and evaluating efforts. Additionally, mechanisms for increasing youth involvement in the implementation of evidence-based prevention strategies will serve a secondary purpose of enhancing the availability of drug-free alternatives as well as prevention education opportunities for other youth through involvement in prevention programs.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

As a required component of the Kansas SPF assessment process, communities are required to complete a comprehensive needs assessment, capacity assessment, readiness assessment, and assessment of existing community resources. This resources assessment, corresponding with the Communities That Care Community Resources Assessment (CRA), is designed to identify the pre-existing evidence-based prevention strategies in place that address prioritized prevalence outcomes and targeted local risk and/or protective factors. SABG funds are not eligible to support these pre-existing strategies, that is, clear parameters are provided during the

assessment and planning phase regarding ensuring that SABG funds do not supplant prior sources of funding for prevention services and programming. Additionally, this requirement ensuring non-supplantation is included into funding agreements with communities through which SABG funds are allocated.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Both process indicators and outcomes indicator data are collected as part of the evaluation framework for SAPTBG funded communities as well as other initiatives including the SPF-PFS II. In all instances, process indicators collected as part of evaluation measures include, but are not limited to: indicators of saturation (e.g., numbers served, number of participants in attendance, number of individuals impacted by policy or practice change), and indicators of fidelity, dosage, or duration (number of sessions delivered, length of sessions, frequency of program delivery). Specific for evidence-based programs, as well as prevention education activities, participant sign-in sheets and attendance rosters allow for unduplicated counts of numbers served as well as for compiling data related to participant demographics. For environmental approaches that are universal-indirect in nature, demographic estimates are used to calculate numbers served for these population-based strategies.

This data is used to determine scope of impact at the community level, as well as at the state level, in terms of exposure to content, messaging, and materials associated with evidence-based strategy implementation. It also allows for determination of the degree to which evidence-based prevention strategies are implemented on a geographic basis and identification of under-served, high-need areas of the state. Further, this data is used not just for state level process evaluation but also as part of semi-annual coaching and technical assistance provided to communities with regard to saturation, impact, and intensity to allow them to make use of evaluation and outcomes findings in order to enhance and improve the implementation of evidence-based strategies by making mid-course adjustments.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

As part of outcomes-based evaluation of state and local prevention outcomes, the following prevalence outcome data are collected on an annual basis: past 30-day alcohol use, binge drinking, and past 30-day marijuana use – with all indicators aggregated for students completing the Kansas Communities That Care student survey in grades 6, 8, 10, and 12. In addition, risk and protective factor scales scores and indicators are also monitored on an annual basis, which include for each targeted substance the following: perceived risk of harm, favorable attitudes toward use, friends who engage in use, perceived availability, and favorable parental attitudes toward use. At the community level, additional risk and protective factors may be prioritized and targeted with specific evidence-based strategies, with this risk and protective factor data tailored to the community as part of a comprehensive evaluation plan. Given the parameters established for achieving change in targeted prevalence and risk and protective factor outcomes, statewide evaluation utilizes both changes in magnitude as well as trend analysis to establish evidence of progress in these areas, on either a three-year or five-year time frame. In addition to prevalence and risk and protective factor indicators, prevention education program data collection and monitoring includes aggregate participant-level data. Data is aggregated and reported by a range of individual characteristics including gender, race, ethnicity, and region, and unique participant identifiers are used to match pre and post survey data in order to statistically determine program outcomes and impact, through t-tests or analysis of variance.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

10. Quality Improvement Plan

KDADS has continued its process to integrate the Mental Health, Substance Use Disorders, Prevention, and Problem Gambling units into Behavioral Health Services (BHS). Effective August 10, 2015, BHS was streamlined into its own Commission called the Behavioral Health Services Commission. The new Commission incorporated the two psychiatric hospitals under the BHS Commission and moved all HCBS services into a separate Commission. William Rein, JD was assigned as the BHS Commissioner. This change was based on our state's efforts to more comprehensively coordinate Behavioral Health services and further improve our integration efforts. Organizational changes are currently being finalized with KDADS. The Integration Sub-Committee has been meeting monthly to set Strategic Integration Plan. This work will continue once organizational changes have been finalized. Attached is the current draft of the BHS Comprehensive Quality Improvement Plan. It includes the following:

BHS Adverse Incident Reporting

In December 2013, KDADS Mental Health and Substance Use Disorder programs began using a web-based system for reporting and documenting adverse incident reports (AIR). The adverse incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed or funded by KDADS. The AIR system provides for a fluid notification process and has the ability to track and trend all incidents. In May of 2015, providers were notified electronically of the new KDADS BHS Adverse Incident Protocol and Policy. Providers were thus advised of the expectation to follow the new reporting system. The web based reporting system allows for a seamless process of notifying the three managed care organizations, the contracted administrative service organization, and KDADS field staff about the ongoing status of adverse incidents. The agreed upon definitions are as follows:

1. Preventable death- Any death that occurs as a direct result of the actions (or lack thereof) of any BHS provider that can be reasonably confirmed by the providers or upon medical examination
2. Physical abuse - Any allegation of intentionally or recklessly causing physical harm to a consumer by any other person, while receiving a BHS service.
3. Inappropriate sexual contact - Any allegation of intentional touching of a sexual nature, of any consumer, who does not give consent or is incapable of resisting or declining consent due to mental deficiency, or disease, or fear of retribution or hardship. In addition:
 - a. Consumers receiving services in any KDADS BHS licensed or certified program who are under the age of 18 years of age cannot give consent
 - b. Any allegation of intentional touching of a sexual nature, by a provider, towards a consumer is inappropriate sexual contact
4. Misuse of medications - The incorrect administration or mismanagement of medication, by someone providing a BHS service which result in or could result in serious injury or illness to a consumer.

5. Psychological abuse - A threat or menacing conduct directed toward an individual that result in or might reasonably be expected to cause emotional distress, mental distress or fear to an individual.
6. Neglect - The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
7. Suicide - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
8. Suicide attempt - A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
9. Serious injury – An unexpected occurrence involving the significant impairment of the physical condition of a consumer. Serious injury specifically includes loss of limb or function.
10. Elopement – The unplanned departure from an inpatient unit or facility where a consumer leaves without prior notification or permission or staff escort.
11. Natural disaster – Any closure or evacuation of a facility due to fire, storm damage or mechanical system failure that may result in major expenditures or work stoppage or any significant event affecting consumers.

An adverse incident is reported if the event occurred while the individual was participating in a KDADS BHS paid service or on any premises owned or operated by a provider or facility licensed by KDADS. Each incident is reported using the KDADS Adverse Incident Report (A.I.R) web based tool at www.aging.ks.gov within 24 hours of the provider becoming aware of the occurrence of the adverse incident.

All reportable adverse incidents are documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports may be reviewed jointly by the KDADS designated staff and the ASO or MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS BHS policies and procedures (note procedures may be slightly different depending on provider type). These reports are assigned to a KDADS SUD or MH staff member and are investigated. As a result of the investigation, a corrective action plan, prevention plan or performance improvement plan may be required of the provider. All MH incidents are tracked and trended and each provider has baseline outcome measures to continuously decrease the number and/or type of critical incidents and serious occurrences.

Documentation:
Policy

BHS Complaints/Grievance

BHS accepts complaints or grievances from any source. Complaints and Grievances are tracked through separate MH and SUD log or database. The Logs track details such as source of complaint, date of complaint, assigned staff and disposition of case. Complaints/grievances are staffed with a BHS director and assigned for investigation when standard or regulation violations are indicated. Assigned BHS document all investigation activities using a complaint/grievance

form. Investigations may result in referral to another agency for follow up, request for a Corrective Action Plan, Performance Improvement Plan, closure of case or referral to KDADS legal for further direction. Upon completion of the investigation a written report with the results of the investigation will be forwarded to the complainant.

Documentation:
Policy
CGI log template
Access database

BHS Medicaid

KanCare is the program through which the State of Kansas administers Medicaid. Launched in January, 2013, KanCare is delivering whole-person, integrated care to more than 360,000 consumers across the state. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare health plans are: Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and United Healthcare Community Plan of Kansas (United).

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the State of Kansas. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as operates the state hospitals and institutions.

In order to cover all the arenas in which the Medicaid program is monitored, and to coordinate activities and plan consistently, KDADS/BHS has formed a team consisting of the Directors of SUD and of Mental Health, the KDADS Medicaid Director, the BH Health Homes liaison, the Medicaid Managed Care contract monitor and the Data Integration Specialist. This team meets regularly to share information from various meetings including data reports, minutes and other materials. This forum is also used to assure a consistent message is communicated across venues when there are concerns or suggestions for change.

KDADS/BHS has created a data team to determine what we want to know as the KanCare program moves forward. This will assist us with identifying the reports that are most important to us among the myriad produced by the 3 MCOs. The team will review relevant reports on a regular basis in order to determine if desired outcomes are being achieved.

Documentation:
Reports
Meeting Notes

BHS Addictions:

Standards of Care/Licensure:

By Statute all programs providing substance use disorder treatment must be licensed by KDADS/BHS. KDADS/BHS has regulations in place “Standards for Licensure/Certification of

Alcohol and/or Other Drug Abuse Treatment Programs.” The minimum standards of care for substance use disorder treatment programs in Kansas are contained in Standards for Licensure/Certification of Alcohol and Other Drug Abuse Treatment Programs (as authorized by KSA 39-708c and 65-4016). The minimum standards include requirements for Program Management; Clinical Program Staffing; Quality Improvement Systems; Accessibility, Environment and Transportation; General Program Standards; Alcohol and Other Drug Treatment Services; Licensure/Certification.

KDADS/BHS monitors providers at on-site visits. The frequencies of the visits are based on provider performance. Programs that have no major deficiencies for two years in a row may be eligible for up to a three year license. Currently, approximately less than 20% of Kansas providers receive a three year license. If any deficiencies are noted during a site visit, providers are required to submit a corrective action plan within 30 days and have all deficiencies corrected/implemented within 90 days. KDADS/BHS has policies and protocols which outline the licensure/certification and the corrective action plan processes. Additionally, KDADS/BHS collects and compiles all site visits data, including deficiencies, for the purpose of trending, reporting purposes, and continuous quality improvement. The data reports are shared at quarterly provider meetings and with KDADS/BHS staff in order to improve inter-rater reliability. This process supports a continuous internal and external quality improvement process.

KDADS/BHS plans to make revisions to the standards to include: requirements for the licensure of addiction counselors specialized Women’s services, criminal background checks for staff, Electronic Health Records, and electronic counseling (telemedicine).

Documentation:

Standards of Care

Policy and Procedures

Monitoring tool and reports

Corrective Action forms

SAPT BG Monitoring:

KDADS/BHS contracts with ValueOptions of Kansas (VO/KS), who is an Administrative Service Organization (ASO), for the oversight and administration of SAPT BG funds used for treatment services. KDADS/BHS requires VO/KS to include all of the SAPT BG requirements in the provider agreements. KDADS/BHS has protocol and a monitoring tool that is used in conjunction with a tool utilized for the licensure of the treatment programs. KDADS/BHS staff has recently completed conducting SAPT BG monitoring site visits for FY2015. If a program has any SAPT BG deficiency, the program is required to complete a Performance Improvement Plan. The Performance Improvement Plans are monitored by VO/KS to ensure compliance and implementation. KDADS/BHS collects and compiles all deficiencies from the SAPT BG site visits for the purpose of trending, reporting, and continuous quality improvement. Training and technical assistance will be provided as needed to any provider identified. KDADS completes these on-site monitoring visits with all SAPTBG funded providers every other year. The alternate year BHS develops a State quality improvement plan and technical strategies. The quality improvement plan addresses corrections that BHS, the treatment program, or the ASO

needs to take in order to improve compliance to the federal regulations. These are implemented and corrections made prior to the compliance visits in the next year.

Documentation:

Policy and Protocol

Monitoring tool

Performance Improvement Plan

Fiscal Monitoring:

KDADS/BHS has two levels of fiscal monitoring; one for the Administrative Service Organization and the other with the SUD providers.

KDADS/BHS requires the inclusion of language in the Administrative Service Organization contracts with providers regarding the submission of fiscal audits to KDADS/BHS.

KDADS/BHS requires any non-federal entity that expends \$500,000 or more in a year of Federal awards must have a program specific audit conducted for that year in accordance with the provisions of OMB Circular A-133. In addition to the requirements of the A-133 audit, the provider may be required to conduct a separate limited scope engagement with an agreed upon procedure. These additional procedures will be designated in the terms and conditions of the award.

For entities that do not fall under the audit requirements (expend less than \$500,000 in a year in Federal awards or State awards or expend more than \$500,000 in State awards) the provider shall have a limited scope engagement with agreed-upon procedures and/or be subject to internal monitoring performed by KDADS/BHS staff determined at the time of the negotiation of the award.

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

Documentation:

Policy

Contract Language

Reports

Monitoring of the Administrative Service Organization:

KDADS/BHS has multiple quality improvement processes in place to measure, evaluate and provide oversight on the Administrative Service Organization, ValueOptions of Kansas.

The contracted ASO is required to submit weekly, semi-monthly or monthly reports that include an accumulator (providers allocations and utilization), claims payment (to providers) timeliness and accuracy, weekly claims report, check register, and independent audited financial statements. KDADS staff is assigned to monitor compliance with the reports to ensure the report was

received by the due date, the correct methodology is used, and the benchmark, if applicable, was met. KDADS staff is assigned to monitor for compliance and report any discrepancies to the staff assigned to oversee the contract. Monthly meetings are held internally with the assigned staff. Pertinent issues are discussed at these meetings and any joint decisions are made concerning the ASO or the provider network.

The Administrative Service Organization, ValueOptions of Kansas, and KDADS/BHS staff meets monthly for business meetings. The purpose of the meeting is to discuss ongoing business issues associated with the management and monitoring of the program. Topics include reporting and accountability concerning member or provider issues; claims processing or payment issues; or any contractual, system, clinical, financial, coordination, training, or other issues associated with programs. ValueOptions of Kansas takes minutes for the purpose of reference and shared decision making. Additionally, KDADS has a monthly internal contract meeting which discusses any “hot topics”, areas of concern, provider performance issues and performance improvement.

Problem gambling treatment services and provider credentialing services have recently moved from prevention services to addiction services. With this transition, we are working diligently to get measures in place that will allow us the ability to monitor services for compliance and providers for performance.

Documentation:

Monitoring Work plan for Performance Measures

Reports

Meeting notes

Quality Improvement Monitoring Work plan for Performance Measures:

KDADS/BHS requires the Administrative Care Organization (ValueOptions of Kansas) to submit the following reports:

- Appointment Access (Referral timeframes) Quarterly and Annually
- Problem Gambling Access to Care Quarterly and Annually
- Problem Gambling Referral to Services Monthly
- SAPT Waitlist Report Quarterly and Annually
- AAPS Admissions Outside of Region (Block Grant Access) Quarterly and Annually
- Designated Women’s Facilities Quarterly and Annually
- Interim Services Report Quarterly and Annually
- Out of State Placement Quarterly and Annually
- Higher Levels of Care Utilization Report Quarterly and Annually
- Lower levels of Care Utilization Report Quarterly and Annually
- Over and Under Utilization Report (Average Length of Stay) Quarterly and Annually
- Grievance Report Annual
- Appeals Report Semi Annual, Annual
- Adverse Incident Report Semi Annual, Annual
- Claims Payment Timelines & Accuracy Report Monthly
- Provider Satisfaction Survey Annual
- Provider Report Card Annual

Documentation:
Monitoring Work plan for Performance Measures
Reports

Quality Committee of Kansas:

KDADS/BHS has implemented a state SUD quality committee. The Quality Committee consists of State staff, providers (including quality directors representing large and small providers across the state), and a consumer. The committee (overseen by the Director of Addiction Services) is data driven and reviews and makes recommendations on reports prepared by state staff and the administrative care organization. The Quality Committee may request additional data reports or more in-depth reviews of SUD topics which may be of interest to the committee. KDADS/BHS is responsible for sharing reports generated by the Administrative Care Organization for review, gathering feedback, and identifying possible performance improvement projects.

Documentation:
Policy and Charter
Aggregate Analysis

Mental Health

Psychiatric Residential Treatment Facilities (PRTFs):

PRTFs provide out of home residential psychiatric treatment to children and adolescents whose mental health needs cannot be effectively and safely met in a community setting. These programs are intended to provide active treatment in a structured therapeutic environment for children and youth with significant functional impairments resulting from an identified mental health diagnosis, substance use diagnosis, sexual abuse disorders, and/or mental health diagnosis with co-occurring disorder (i.e., substance related disorders, intellectual/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues).

Documentation:
Standards
Interpretative Guidelines

Private Psychiatric Hospitals (PPHs):

PPHs are “free-standing” community hospitals that provide only acute inpatient psychiatric services.

Documentation:
Guidelines

Residential Care Facilities (RCFs):

RCFs provide housing and needed supports to persons with serious and persistent mental illness that cannot find their own housing and who need staff support to live successfully in the community. KDADS licenses RCFs, but does not provide them any direct financial support.

However, due to a serious incident occurring in a facility that refused to be licensed, the legislature changed the statute requiring more facilities to be licensed. KDADS has written regulations to comply with this statute change and is awaiting official approval. In the meantime, current regulations are enforced.

Facilities Quality Improvement Field Staff:

Three Facility Quality Improvement staff, one supervisor, and one Mental Health Nurse hold the 9 Psychiatric Residential Treatment Facilities (PRTFs), the 32 Residential Care Facilities (RCFs), and the three 3 free standing Private Psychiatric Hospitals (PPHs) accountable to basic requirements of health and safety, licensing regulations, and active treatment standards for participating in Medicaid funding. This is done by completing routine and special surveys, investigating critical incidents and serious occurrences, and ensuring the facilities appropriately, timely and successfully address critical incidents and correct substandard care and treatment. The adverse incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices. Providers report all adverse incidents involving individuals receiving services by agencies licensed or funded by KDADS online through the Adverse Incident Report (AIR) web portal within 24 hours of becoming aware of the incident. These reports are assigned to a Facility Quality Improvement Field Staff and are investigated. As a result of the investigation, a prevention plan or performance improvement plan may be required of the provider. All incidents are tracked and trended and each provider has baseline outcome measures to continuously decrease the number and/or type of critical incidents and serious occurrences.

Other outcome measures include length of stays (LOS), restraints and seclusions, family engagement in treatment, recidivism, and quality of life.

Community Mental Health Quality Improvement Staff:

Five Community Mental Health Quality Improvement staff and one supervisor hold the 26 Community Mental Health Centers accountable to basic requirements of health and safety, licensing regulations, contract compliance and active treatment standards for participating in Medicaid funding. Kansas Community Mental Health Centers enter into a contract with Behavioral Health Services annually. Performance measures and the process for implementing a performance improvement plan are defined. The following is an excerpt from the SFY16 contract:

A. OUTCOME MEASURES

The CMHC is expected to improve its performance on the outcome measures listed below (1-9). Performance improvement planning shall be initiated based upon the trend specific to the CMHC for each outcome. Discussion and further study shall result if the trend for a given outcome begins to move in a negative direction. A performance improvement plan may be initiated at any time upon agreement between KDADS and the CMHC, but shall be developed in the event of a negative trend that persists for 3 consecutive months.

The CMHC will use recognized performance improvement methods to develop and implement a performance improvement plan to improve its performance on the identified outcome(s).

If the CMHC believes that improving performance on the outcome(s) is beyond its control, the CMHC may, within 15 days submit a written request to be exempted from developing and implementing a performance improvement plan. The request will include data to substantiate the reason(s) for requesting the exemption. KDADS will evaluate the request and notify the CMHC in writing within 15 days of receiving the request whether or not the exemption request was justified.

All FY2016 Outcomes will specifically monitor the uninsured/underinsured target population served by each CMHC. The target population will be determined by the Medicaid eligibility status in effect at the end of each reporting period. KDADS will share available outcomes and trend lines with the CMHC at least quarterly and as often as monthly.

Outcomes 1-3 are priorities.

1. Admissions adult: The rate of State Mental Health Hospital (SMHH) admissions for adults residing within the CMHC catchment area who have been screened for admission to an inpatient psychiatric facility for psychiatric services.

Measure: Admission Rate is determined by dividing the Numerator by the Denominator and multiplying the quotient by 10,000.

Numerator: The number of adult admissions to a SMHH as a result of a mental health inpatient screen performed by Community Mental Health Center staff. Inpatient psychiatric facilities include state-operated psychiatric inpatient facilities, local/regional inpatient psychiatric facilities, and local/regional medical facilities providing psychiatric services.

Denominator: The number of all adults (age 18 and over) within the CMHC catchment area based on the most recent US Census County estimates available at the start of the contract period.

Data Source: Inpatient Screening Database (IPS).

Reported: Monthly by responsible CMHC reported in IPS

2. Adult Re-admissions within 30 days of discharge: Percent of screening determinations resulting in readmissions of adults, age 18 and over, to any SMHH, or private psychiatric hospital, occurring within 30 days of previous discharge.

Numerator: Number of adults discharged from SMHH, or private psychiatric hospital, with a subsequent readmission occurring within 30 days.

Denominator: Total number of Adult discharges from SMHH, or private psychiatric hospital occurring within 30 days of reporting period.

Data Source: Inpatient Screening Database (IPS).

Reported: Monthly by responsible CMHC reported in IPS

3. Children and Adolescents Re-admissions within 30 and 90 days of discharge: Percent of screening determinations resulting in readmissions of youth, age 17 and under, to any inpatient hospital for children and adolescents, private psychiatric hospital (including state hospital alternatives), or PRTF, within 30 and 90 days of previous discharge.

Numerator: Number of youth discharged from inpatient hospitalization for children and adolescents, private psychiatric hospital, or PRTF with a subsequent readmission within 30 or 90 days.

Denominator: Total number of Youth discharges from inpatient hospitalization for children and adolescents, private psychiatric hospital, state hospital alternative, or PRTF occurring within 30 or 90 days of reporting period.

Data Source: Inpatient Screening Database (IPS).

Reported: Monthly by responsible CMHC reported in IPS.

4. Employment: The percentage of consumers with an SPMI who improve their vocational status within the reporting period.

Numerator: Total points achieved by CMHC based on the vocational status of each individual with an SPMI who has received a Community Support Service (CSS) service within the last 90 days.

Denominator: Total number of individuals with an SPMI receiving a CSS service within the last 90 days, who can be considered in the workforce multiplied by 6 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

5. Housing: The percentage of consumers with an SPMI who improve their residential arrangement within the reporting period.

Numerator: Total CSR points achieved by CMHC based on the residential arrangement of each individual with an SPMI who has received a CSS service within the last 90 days.

Denominator: Total number of individuals with an SPMI receiving a CSS service within the last 90 days multiplied by 5 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

6. Adult Penetration Rate: The per capita number of consumers with an SPMI the CMHC serves.

Numerator: Number of unduplicated consumers with an SPMI that have received CSS services within the last 90 days.

Denominator: Number of persons living in the CMHC catchment area in the adult age range.

Data Source: AIMS system.

Reported: Quarterly.

7. Children and Adolescent Penetration Rate: The per capita number of youth with an SED the CMHC serves.

Numerator: Number of unduplicated youth with an SED that have received CBS services within the last 90 days.

Denominator: Number of persons living in the CMHC catchment area in the youth age range.

Data Source: AIMS system.

Reported: Quarterly.

8. Increase the percentage of children/youth with an SED receiving Community Based Services (CBS) who are discharged because case management goals have been achieved (includes services closed and transferred to other CMHC services).

Numerator: Number of children/youth with an SED who were discharged from CBS services because case management goals were achieved.

Denominator: Number of children/youth with an SED who were discharged from CBS services during the reporting period.

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

- 9.a.1. Access standards post SMHH for adults: Face-to-face contact, unless refused by client, within 3 calendar days of discharge from a SMHH. If the consumer refuses services, the dates, times, and reasons why a face-to-face contact did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of adults receiving CSS services who had a face to face contact within 3 calendar days of discharge from a SMHH

Denominator: Number of adults receiving CSS services discharged from a SMHH during the previous month

Data Source: Chart reviews

Reported: Monthly by established catchment areas

- 9.a.2. Access standards post state hospital alternative (SHA) or a PRTF: Face-to-face contact, unless refused by client, within 3 calendar days of discharge from a SHA or a PRTF. If the consumer refuses services, the dates, times, and reasons why a face-to-face contact did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of children/adolescents receiving CBS services who had a face to face contact within 3 calendar days of discharge from a SHA or a PRTF

Denominator: Number of children/adolescents receiving CBS services discharged from a SHA or a PRTF during the previous month

Data Source: Chart reviews

Reported: Monthly by established catchment areas

- 9.b.1. Therapeutic intervention including Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, and/or Therapy (not an intake), within 3 business days of discharge from a SMHH for adults, unless refused by client. If the consumer refuses services, the dates, times, and reasons why a therapeutic intervention did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of adults receiving CSS services who had a therapeutic intervention within 3 business days of discharge from a SMHH

Denominator: Number of adults receiving CSS services discharged from a SMHH during the previous month

Data Source: AIMS, IPS and State MH Hospital Database

Reported: Monthly by established catchment areas

- 9.b.2.** Therapeutic intervention including Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, and/or Therapy (not an intake), within 3 business days of discharge from a SHA or a PRTF for children/adolescents, unless refused by client. If the consumer refuses services, the dates, times, and reasons why a therapeutic intervention did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of children/adolescents receiving CBS services who had a therapeutic intervention within 3 business days of discharge from a SHA or a PRTF

Denominator: Number of children/adolescents receiving CBS services discharged from a SHA or a PRTF during the previous month

Data Source: AIMS, State MH Alternative Hospital Database (KVC Prairie Ridge and Wheatland), PRTF ROM

Reported: Monthly by established catchment areas

- 9.c.1** Medication appointment within 30 calendar days of discharge from a SMHH, adults.

Numerator: Number of adults receiving CSS services who had a medication appointment within 30 calendar days of discharge from a SMHH

Denominator: All SMHH discharges that occurred during the previous month

Data Source: AIMS, IPS and State MH Hospital Database

Reported: Monthly by established catchment areas

- 9.c.2** Medication appointment within 30 calendar days of discharge from a SHA or a PRTF, children/adolescents.

Numerator: Number of children/adolescents receiving CBS services who had a medication appointment within 30 calendar days of discharge from a SHA or a PRTF

Denominator: All SHA or PRTF discharges that occurred during the previous month

Data Source: AIMS, State MH Alternative Hospital Database (KVC Prairie Ridge and Wheatland), PRTF ROM

Reported: Monthly by established catchment areas

The following outcomes (10-12) shall continue to be monitored and performance improvement planning shall be implemented only if the CMHCs outcome dips below 85% in a quarter.

- 10.** Children and Adolescent Residential Status: The percentage of youth with an SED who improve their residential status within the reporting period. The CMHC shall be assigned a score based on the residential status of each youth who have received Community Based Services (CBS) within the last 90 days. See Appendix C for assignment of point values, CBS service code list, determination of service requirement and explanation of residential statuses considered for this performance measure.

Numerator: Total CSR points achieved by CMHC receiving at least one CBS service within the last 90 days based on the residential status of each youth with an SED.

Denominator: Total number of youth with an SED receiving a CBS service within the last 90 days multiplied by 5 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR).
Reported: Monthly by established catchment area.

11. Independent Living: The percentage of consumers with an SPMI who live independently. The CMHC shall report the percentage of consumers with an SPMI who are living independently.

Numerator: Number of consumers with an SPMI that have received CSS services in the last six months who are living independently.

Denominator: Total number of consumers with an SPMI that have received CSS services in the last six months.

Data Source: AIMS system/ Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

12. Education: The percentage of youth with an SED receiving CBS who attend school regularly. The CMHC shall report the percentage of youth with an SED who received CBS services and are attending school regularly.

Numerator: Number of youth with an SED that have received CBS services within the last six months who are attending school with less than 5 unexcused absences.

Denominator: Total number of youth with an SED that have received CBS services within the last six months.

Data Source: AIMS system (CSR).

Reported: Twice per year by established catchment areas..

Documentation:

Data reports

Performance Improvement Plans

Prevention

Given the transition of the Kansas prevention network to a new system of providers (effective July 2015), with the intention of enhancing and improving quality and expediency of training and technical assistance, integration of behavioral health, and increased efficiencies that allow for greater community-level funding to support the implementation of evidence-based prevention strategies, a quality improvement plan for prevention services aligned with a system-wide evaluation framework and long-term strategic plan is currently in development. However, as part of the developing outcomes and objectives for prevention system quality improvement, several key goal areas have been identified: 1) quality improvement monitoring and evaluation, 2) communication and feedback strategies, 3) service delivery standards and role delineation across providers, and 4) behavioral health infusion with integration of advocacy and promotion into community-level prevention efforts. Throughout the ensuing 18 months, these goal areas will be developed into a formal quality improvement plan that will be implemented and monitored as part of systems-level evaluation efforts to ensure progress toward improved service delivery and achievement of SAPTBG prevention outcomes.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach".⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

75 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

76 <http://www.samhsa.gov/trauma-violence/types>

77 <http://store.samhsa.gov/product/SMA14-4884>

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

11. Trauma

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

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

BHS/Mental Health (BHS/MH) does not have policy that directs Community Mental Health Centers (CMHC) to screen clients for a personal history of trauma. CMHC's have an assessment process which mental health clinicians use when interviewing individuals. As part of the assessment there is a history component that asks individual if they have been a victim or perpetrator of physical, emotional and/or sexual abuse.

2. Describe the state's policies that promote the provision of trauma-informed care.

BHS/SUD does not have specific policies mandating all SAPT funded SUD treatment providers connect individuals who self-report histories of trauma to trauma focused therapy or policies which promote the provision of trauma-informed care for substance use disorder treatment providers.

BHS/MH at this time does not have policies which promote the provision of trauma-informed care.

The BHS Commission has a draft policy for trauma informed systems of care (TISC) to begin the process for implementation. The purpose of this policy is to foster a behavioral health care system that employs and practices principles that are trauma sensitive and trauma-informed to individuals served by the Kansas Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and licensed and/or certified providers. With understanding the importance of a TISC system we have developed a BHS strategic plan. This plan has been developed and structured to serve as a guide for the implementation of best practices, strategic and highly-leveraged enhancements for partnership and service delivery, and sustainment and capacity development at the community, provider, and systems level. It further serves to provide an aligned and unified direction for statewide efforts to strengthen the Kansas infrastructures for substance use disorder treatment, primary

prevention, and mental health, while also aligning with national efforts and the strategic direction established by the Substance Abuse and Mental Health Services Administration (SAMHSA) for behavioral health and wellness.

The strategic plan also outlines the core principles that guide Kansas's efforts for prevention, treatment, and recovery across the spectrum of behavioral health. Through the goals and objectives outlined in this document, Kansas communities and providers will be effectively supported and well-positioned to affect processes, strategies, and services that respond behavioral health needs through the implementation of data-informed, outcome-focused, and evidence-based programs, policies and practices. BHS wants to ensure effectiveness and continuity across the continuum of care through a focus centered on the seven following attributes, values, and best practices. The following seven (7) strategic goals serve as a core foundation for our work, serving and supporting Kansans, while also setting the standard for policy, practice, and service delivery across initiatives.

1. Utilization of a Continuum of Care that encompasses primary prevention, early intervention, treatment, and recovery oriented systems of care.
2. Infusion of a Trauma Informed Care framework into service provision that involves understanding, recognizing and identifying, and responding to the effects of all variants and levels of trauma.
3. Establishment of highly-leveraged collaboration and partnership opportunities at all levels to maximize impact, outreach, and effectiveness in efforts to address and respond to an array of behavioral health needs.
4. Application of the foundational processes and practices essential for the provision of an integrated system of care.
5. Development and sustainment of a high degree of system-level and provider-level capacity to ensure that service delivery is timely, responsive, and effective in meeting the needs of individuals, and are available, accessible, and aligned with targeted need – that is, the right services, at the right time, in the right place.
6. Promotion and infusion of Evidence-Based Programs/Evidence-Based Strategies across the spectrum of care to ensure effectiveness of service delivery for individuals, families, and communities.
7. Integration of a data-informed, outcome-focused, and quality-driven approach to assessment, planning, implementation, and evaluation of services to maximize effectiveness of efforts across initiatives.

BHS/SUD continues to have contractual requirements for the Designated Women's Facilities to arrange for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse and parenting. The Designated Women's treatment facilities are the only SAPT Funded programs contractually responsible for therapeutic interventions to include

appropriate referrals for issues related to unhealthy relationships to include sexual, physical and emotional abuse.

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

BHS/SUD does not mandate the provision of evidence-based trauma specific interventions for SAPT funded clients over a life span.

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

BHS/SUD does not provide trainings to increase capacity of providers to deliver trauma-specific interventions.

BHS has a TISC statewide conference in the planning stages for November 2015 to provide education and to build a platform for the new TISC model.

For fiscal year 2016 BHS has a contract in place with Wichita State University, Center Community Support and Research to provide training to the BHS Commission on TISC.

Prevention

KDADS Prevention and Promotion services has identified the need to build capacity, develop an integrated approach and infrastructure, and provide supports and resources to ensure community-level and systems-level ability to effectively and sustainably address trauma and modifiable shared risk and protective factors associated with trauma (e.g., Adverse Childhood Experiences) across the lifespan.

It is also critical that community education and workforce development be provided to ensure understanding of the association between individuals with experiences of trauma and those being served in multiple service sectors, including foster care, the child welfare system, juvenile justice, the criminal justice system, as well as those individuals experiencing changes across the spectrum of behavioral health. It is imperative that the Kansas prevention system continue to develop workforce and community capacity to assist communities in ensuring that prevention and other supportive services make use of best practices from the research relating to trauma-informed care, to ensure accessibility, trust, improved outcomes, and to ensure that services adhere to key principles including: safety, trust and transparency, peer support, empowerment, collaboration, sensitivity to cultural (and other demographic or other variables defining diversity) and gender issues, and incorporation of screening for trauma and exposure to Adverse Childhood Experiences into service delivery and referral processes. As part of this effort, KDADS will provide education to prevention contractors to enhance their knowledge base and capacity to educate communities in terms of tactics, principles, and approaches for integrating trauma-

informed care into prevention and promotion efforts associated with behavioral health planning and implementation.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

13. Criminal and Juvenile Justice

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

The Suspension of Medicaid workgroup is chartered to: Initiate the suspension rather than termination of Medicaid/ disability benefits for eligible Track the implementation of the Kansas Eligibility and Enforcement System (KEES). There is a direct link between Kansas Department of Health and Environment's (KDHE) ability to electronically "turn off" and "turn on" benefits for individuals becoming incarcerated as well as releasing from incarceration. When implemented, KEES will be a streamlined enrollment system, with faster approvals for requested programs. Benefits could be processed within a day of an applicant going online and providing correct and verifiable information. The workgroup is exploring replication of the plan with the county jails and city lock-ups. They are developing a plan for implementation. They will also explore replication of the plan with Larned State Hospital for the sexual predator and psychiatric units when medical hospitalization occurs.

Additionally, a KDOC workgroup is involved in establishing an RFP through the Department of Labor to gain access to VINE (Victim Information and Notification Everyday), the National Victim Notification Network. This service tracks the custody status of offenders 24 hours a day. If designated agencies have access to this network, notification can be provided to KDHE regarding when to "turn off" eligibility for incarcerated individuals who no longer are eligible for benefits and "turn on" eligibility upon their release into the community.

The State of Kansas is not a Medicaid expansion state but KDOC does attempt to identify those incarcerated offenders that have been or are eligible for Medicaid under Kansas law. They also work to get those offenders that are in re-entry into coverage under the ACA.

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

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

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

In lieu of evaluation at LSSP, evaluations performed under K.S.A. 22-3301 by a community mental health center are reimbursed at a rate of \$315 per evaluation by Behavioral Health

Services. In FY12, 345 evaluations were performed by CMHCs in Kansas. Evaluations performed by private psychiatric or other psychiatric clinics are not reimbursed by BHS.

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

KDOC and the Court Services administrate the Level of Service Inventory–Revise (LSI-R) to all their offenders. The LSI-R is a quantitative survey of offender attributes and their situations relevant to level of supervision and treatment decisions. Designed for ages 16 and older, the LSI–R helps predict parole outcome, success in correctional halfway houses, institutional misconducts, and recidivism. The 54 items are based on legal requirements and include relevant factors needed for making decisions about risk and treatment. The LIS-R is used to assist in the allocation of resources, help make decisions about probation and placement, make appropriate security level classifications, and assess treatment need and progress.

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

The interface between the mental health, substance use disorders and criminal justice systems is substantial. The increased involvement of people with mental illness and or substance use disorders in the criminal justice system has been a serious problem for state and local governments for some time.

Kansas Behavioral Health Services has been very involved with the Kansas Department of Corrections (KDOC) in a cooperative manor for many years. We continue to develop programs and supports that enhance recovery and diversion efforts with the focus on increased community collaboration to improve systems coordination between behavioral health providers (community mental health centers, substance use disorder treatment providers, and state hospitals) and criminal justice.

In 2001 BHS and KDOC first entered a Memorandum of Agreement that was to fulfill a new statute requirement of the legislature to provide SUD treatment services to all persons convicted of 4 or more driving under the influence(DUI) charges. This program was designed by the two agencies to provide a system that would service the offender during the mandated year after incarceration for services that promoted recovery. Under the MOA a multidisciplinary process was developed of Case Coordination Services and intensive case management with the

cooperative efforts of the Regional Alcohol and Drug Assessment Centers, the KDOC Parole services, SUD treatment providers, the justice system, the offender and other stakeholders relevant to the recovery of the offenders. Approximately 650 offenders were provided service under this program each year. The success of the program led to the revision of the DUI laws in Kansas, and the change of the law to be moved from 4th offence to the 3rd and sequential offences of DUI. It was expanded to include offenders in all 31 judicial districts and brought in partners of Community Corrections and Court Services.

This service model of a strength based care coordination and multidisciplinary team approach has been foundational in the services for offenders in Kansas in other programs including the diversion program for first time drug offenders known as SB123 that is under the Sentencing Commission, and reentry programs under the KDOC.

We have continued to improve services under this model with ongoing development of Recovery Oriented Systems of Care (ROSC), and the inclusion of peer mentoring/recovery coaches with lived experiences in SUD and or mental illness being an intrigue component of the recovery services.

Governor Sam Brownback, legislative leaders and Kansas Supreme Court Chief announced formation of a bipartisan panel that will examine Kansas' juvenile justice system and recommend comprehensive reforms aimed at improving public safety and outcomes for youth. The State of Kansas is receiving technical assistance from the Pew Charitable Trusts, Public Safety Performance Project, to comprehensively examine Kansas' juvenile justice system and to develop data-driven policies based upon research and built upon consensus among key stakeholders from across our state. New research and new approaches have emerged to offer states a wide range of effective and cost-effective options for protecting public safety, holding juvenile offenders accountable, and improving recidivism and other outcomes for children and families while containing costs. To examine the Kansas system, leaders of the executive, judicial, and legislative branches of government have established a bipartisan, inter-branch Juvenile Justice Workgroup which will publish its findings and recommendations in November 2015. KDADS will be following the progress of this Governors workgroup and will utilize the GBHSPC -JIYA subcommittee in providing support and recommendations of any new service for Juveniles in Kansas

The Governor of Kansas established a Mental Health Task Force in FY 14. As a result of recommendation from the taskforce the state directed \$500,000 in funding to be utilized for Diversion services for persons with Mental illness and /or SUD that were involved with or at risk for involvement in mental health institutions or the criminal justice system. Funding from this initiative was used to expand the availability of the 5 Day Crisis Intervention Training (CIT) provided by the Kansas Law Enforcement Training Center (KLETC) to an additional 30 law enforcement officers. KDADS also contacted with KLETC to contract with the National Council for Behavioral Health to provide a training of trainers for 34 Law enforcement officers,

first responders and KDOC personnel for certification as a trainers for Mental Health First Aid. The new trainers were also supplemented additional funding upon certification to also be certified in public safety and the veteran competency as enhancements of the MH first aid training. KLETC also was funded to provide 6 on day introductory training at location around the state for an introductory course of CIT. The KLETC also was funded to provide a 6 module web based training using components from the CIT and MH first aid training. This web based training is now available all law enforcement and corrections personnel in Kansas. The Governor's task force funding also provide for awards of 4 mini grants of \$10,000, and five large diversion focused grants totaling \$432,980.00.

KDADS has been part of the Justice Reinvestment Behavioral Health Programming Work Group that is utilizing funding through the legislature and the Justice Department to implement reentry recovery services based on ROSC principals and the care coordination model.

The Governors Behavioral Health Service Planning Council has a subcommittee named the Justice Involved Youth and Adults (JIYA) committee. The JIYA Subcommittee convenes constituents at a policy level to carry out the vision and mission with the intent to promote actions for state level change through policy recommendations and planning. The subcommittee's charter is for the purpose of:

1. Develop a strategic plan to identify goals and objectives for state level change through policy and planning.
2. Formulate and prioritize strategies to achieve objectives of the strategic plan.
3. Implement strategies through workgroups, including timeline for completion.
4. Develop project management process for monitoring of the strategic plan.
5. Issue annual policy recommendations and planning to the Secretary from the Departments on Aging and Disability Services (KDADS), Children and Families (DCF), and Corrections (KDOC).

Three workgroups are working under the JIYA subcommittee. The Diversion and Prevention workgroup is chartered to: Expand pre and post arrest diversion programs, such as crisis intervention team programs and specialty courts, such as mental health courts, drug courts, and juvenile courts. The Collaboration and Access to Care work group is chartered to: 1. Increased community collaboration to improve systems coordination between behavioral health providers (community mental health centers, substance use disorder treatment providers, and state hospitals) criminal justice (law enforcement, courts, county jails, state correctional facilities) 2. To address access to community-based resources at reentry /discharge from incarceration (including adults, juveniles and probation/parole) with a focus on a recovery oriented system of care and reducing recidivism.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

KDADS has provided its Peer Mentoring Certification training and Persons Centered Case Management Certification at no cost to KDOC peer and corrections staff workers in Kansas Criminal justice programs.

KDOC has also provided state wide availability of training to BHS SUD treatment providers by Eva Kishimoto, Research Associate of the University of Cincinnati Corrections Institute. Participants receive training on identification of offender behavioral health needs, screening for behavioral health problems, effective supervision strategies for offenders with behavioral health needs, and incorporation of risk/need information in case planning. Participants will also be able to engage in facilitated discussions about improving coordination between supervision staff and treatment providers.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

13. State Parity Efforts

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

Currently BHS staff is unaware of any fiscal resources being set aside. However, the State Medicaid Authority has already begun addressing this topic. It is hoped BHS will be able to gain access to any plans they have in the future.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about the benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

BHS is not currently involved in this effort.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

14. Medication Assisted Treatment

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance abuse disorders?

The Kansas Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) has worked hard over the past 10 years to educate traditional treatment providers regarding the use of medication- assisted treatment, specifically methadone treatment. Now, most of the residential treatment providers in the State collaborate with Methadone Clinics to admit those individuals who continue to struggle with other illicit drugs and need a higher level of care. This collaboration includes the State Opioid Treatment Authority (SOTA) and the approval of exceptions to decrease barriers to medication while in treatment. This has included educating the treatment providers on medication diversion, safety, and how the medication is administered. This has been essential to the care of pregnant women in need of a higher level of care.

Language will be included in all provider contracts in the future stating the requirement to work with any client on or in need of medication assisted treatment. Also, several treatment providers already have either a working relationship or a contract with a physician who has the ability to prescribe buprenorphine. These types of relationships will be encouraged to enable those on medication to get the counseling services needed.

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

KDADS/BHS has information on its website to help those individuals looking for a methadone clinic. An attempt was made to contact all physicians listed on SAMHSA's Physician Locator (approved to prescribe buprenorphine) for referral purposes. The result however was disappointing. Many of the physicians were not actually providing this service or providing it in a limited manner. It would be helpful if SAMHSA could work with the DEA to provide an up to date list of those actively prescribing so appropriate referrals can be made.

BHS staff will encourage providers who are already partnering with primacy care agencies to discuss this with those partners as a viable treatment option for those individuals in need of medication-assisted treatment. The SOTA meets with the Methadone providers on a quarterly basis. Those providers are encouraged to conduct outreach to local healthcare providers, hospitals, and emergency rooms. They have experienced some resistance in this area but continue to work with their medical directors to help in this area.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used

appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against the misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

The SOTA has contacted the State Medicaid Authority to gain more insight regarding the prescription drug formulary and how any medications can be added if needed. Buprenorphine is on the formulary list but the extent of its use is unknown at this time. More research will be conducted in this area including a request for data.

BHS does have peer mentors in place however they are not trained in this area. It has been proposed to add more information in the required training so they are able to support individuals with their use of medication during treatment. This would involve a policy change and the development of additional training.

The SOTA already works with residential treatment programs who admit methadone clients to ensure all protocols are followed. This includes notifying the clinic if the client self-discharges. The clinic responsible for the medication picks up the client's lock box and returns it to the clinic in hopes the client will return.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

When developing facilities that comingle individuals with mental health needs and SUD services how can CFR 42 (confidentiality) be addressed?

Developing psychiatric advanced directives.

Operationalizing serves for individuals with co-occurring disorders when the funding streams are so different.

Footnotes:

16. Crisis Services

Crisis Prevention and Early Intervention

Crisis Intervention/Stabilization

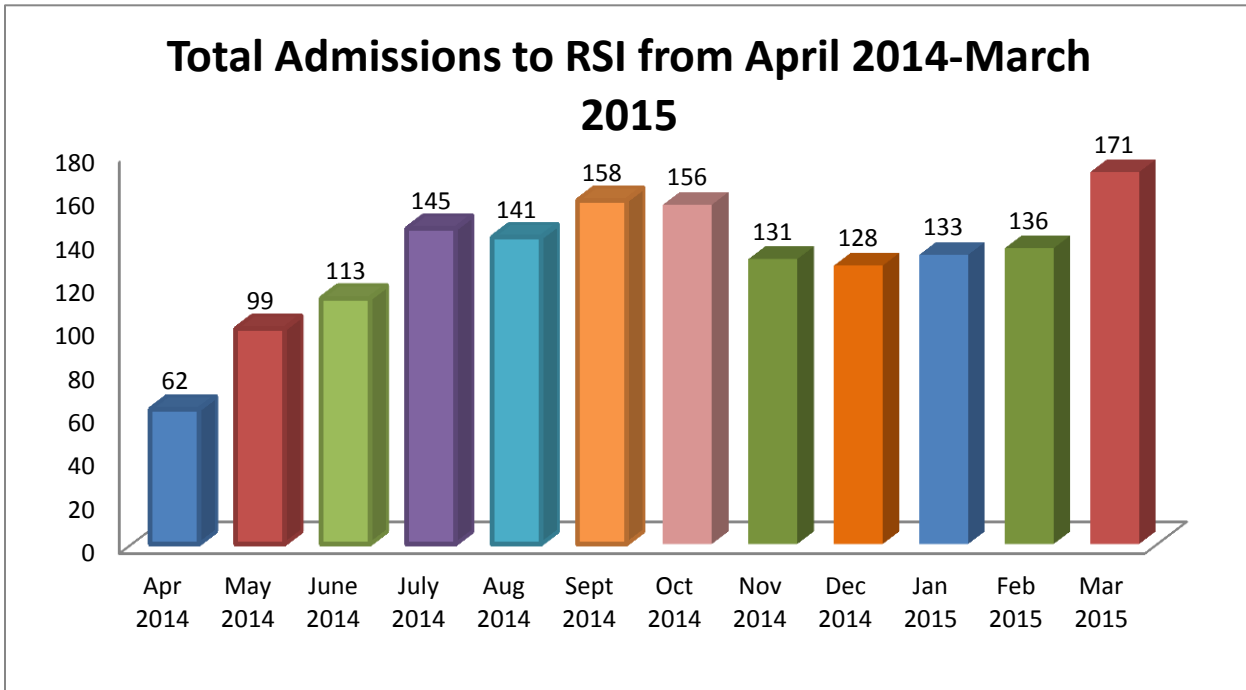
In April of 2014, the State entered in to a contract with two Community Mental Health Centers and a Substance Use Disorder Provider, to implement a new model of crisis intervention and stabilization. The key goals of this facility are:

- To divert consumers from unnecessary and inappropriate use of state hospitals and jails;
- To establish and support alternative community programming that will decrease reliance on Osawatomie State Hospital (OSH) to provide for individuals who may not need inpatient hospitalization, but have no other resources to meet their needs;
- To decrease admissions to OSH of individuals who could be stabilized in the community in 10 days or less by connecting these persons to services/resources in their home communities; and,
- To increase 24-hour community options for individuals with co-occurring mental health and substance use disorders.

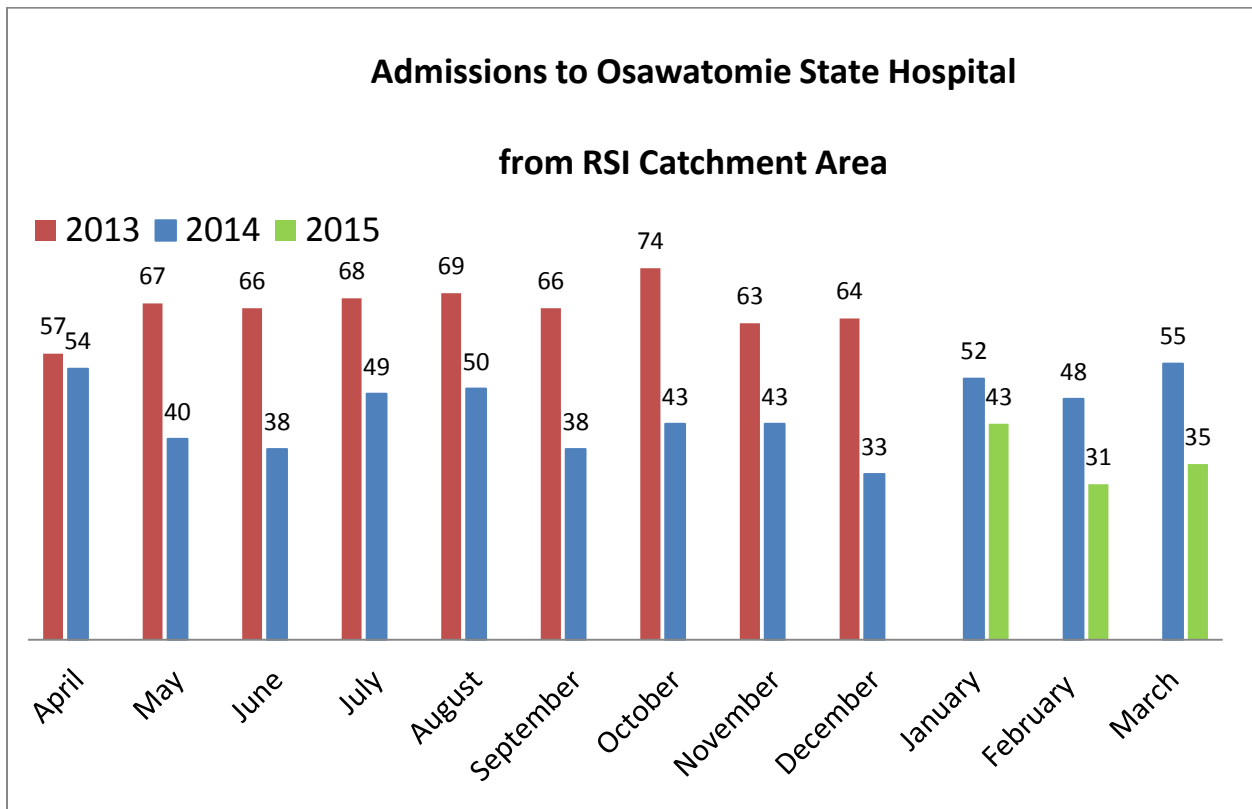
The facility, Rainbow Services Inc. (RSI) is located in the same facility that formally operated a State Mental Health Hospital. The facility provides a “one-stop shop” for individuals experiencing a behavioral health crisis to be assessed 24 hours a day, seven days per week. In addition to 24 hour triage the facility provides:

- 23 hour Crisis Observation;
- Sobering beds for individuals who are experiencing intoxication; and,
- Crisis Stabilization Services.

Below is a snapshot of the first year's data:

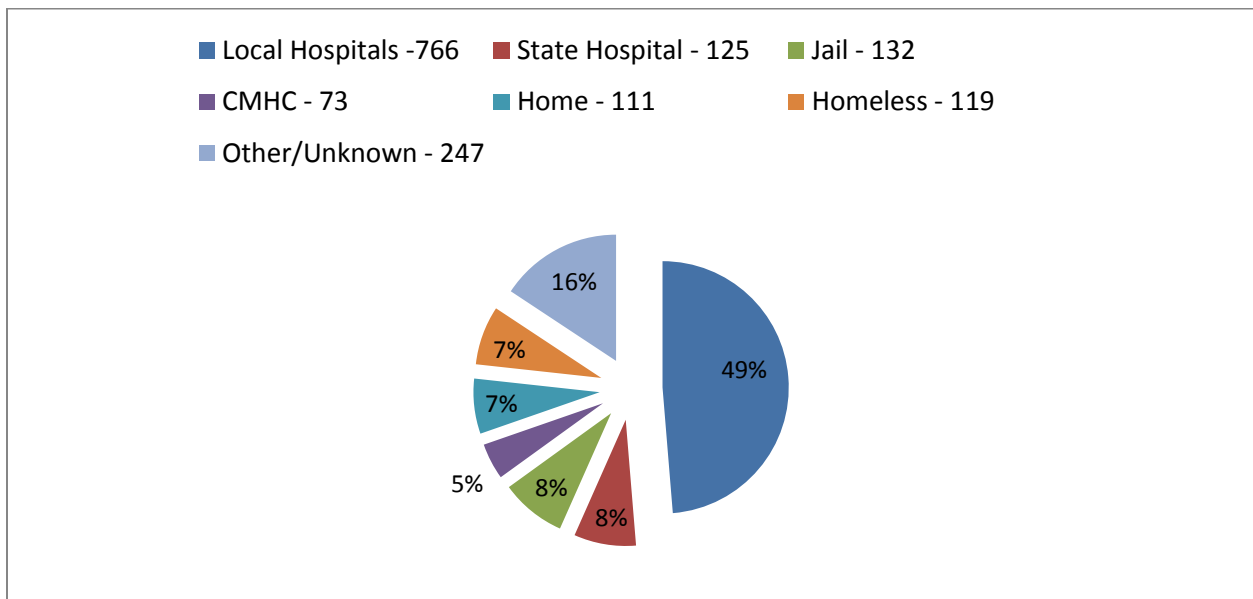


From April 2014 to July 2015 RSI has triaged a total of 2,378 of those 1,443 have been unique individuals.



The above graph reflects an admission from this region’s catchment area to the State Mental Health Hospital has decreased on average more than 30%.

The below graph reflects where individuals would have gone if RSI was not available as reported by clients and/or the individuals who provided the transportation to RSI. 49% of all individuals would have gone to a local hospital if RSI services were not available. RSI has formed a unique partnership with the Emergency Medical Response system in Johnson County. For calls that involve individuals who are inebriated a field test is done which includes a breathalyzer, blood pressure, and BS test. If an individual meets the criteria identifying for RSI sobering services the EMS responder contacts RSI on a radio that is located at RSI and they do a direct admit from the field to RSI. Due to funding barriers this process is still being developed.



In October 2014, KDADS entered into a contract with Region 2 - South Central Mental Health Center, to provide a continuum of crisis services. The purpose of this project is to provide a single location and comprehensive system of care for integrated assessment, triage, stabilization, engagement, and referral to ongoing supports and services for those experiencing a behavioral health crisis. The Community Crisis Continuum project expands existing crisis services to promote rapid stabilization and avoid Emergency Department (ED) admissions, local hospitalizations, state hospitalizations and jail bookings. This project improves coordination among agencies, improves overall care and improves hospital diversion outcomes while reducing costs through community treatment and elimination of duplicate services. The geographic area served is Sedgwick, Butler and Sumner Counties. The target population includes children, adolescents and adults who are at risk of a higher level of care, including voluntary or involuntary local and state hospitalization, due to a mental health crisis and/or a crisis related to a substance use disorder. The target population includes those who are uninsured, under insured, or who have no known payer source. The project expands existing crisis services through the

addition of: 23 hour crisis stabilization (6 recliners); Crisis sobering services with average length of stay of 8-12 hours (5-6 beds); and social detox and with average length of stay of 3-5 days (10 beds). Services for children will not be housed at the Community Crisis Center. COMCARE will expand children's crisis residential services at a separate site through a partnership with Wichita Children's Home (1 bed).

Non grant-funded crisis services provided in this model in Region 2 include: Short term crisis residential stabilization, mobile crisis services, 24-hour crisis hotline, peer warm line (evenings,) and mental health crisis transportation.

Crisis services expanded through this grant are:

- 23 hour crisis observation (Implemented 1/29/2015)
- Expanded children's crisis residential stabilization (Implemented 1/2/2015)
- Sobering Services (Implemented 2/25/2015)
- Social and Medical Detox Services (Implementation May1,2015)
- Peer crisis services (April 2015)
- Substance use disorder related crisis transportation (implementation April 2015)

Total services provided through this grant as of July 30, 2015 are:

- Children's Crisis -80
- Crisis Observation- 585
- Crisis Sobering- 198
- Crisis Detox-112

Law Enforcement Crisis Services

More than 60% of adults with serious mental illness and more than 50% of children with a serious emotional disturbance are not in treatment. As a result, many adults and children have regular contact with law enforcement stemming from petty crimes and behaviors which place them at risk for arrest and incarceration. Individuals with serious mental health disorders need treatment, not incarceration. The criminalization of mental illness exacerbates the stigma associated with mental illness. Because of this, we have shifted a significant portion of the cost of untreated mental illness to local law enforcement personnel. In Kansas, untreated SMI is associated with an estimated 21,000 incarcerations according to a 2012 study published by the Health Care Foundation of Greater Kansas City. This means that our law enforcement officers are at the forefront of encounters with a large number of persons with serious mental illness. Over the years, there has been steady growth in the training of law enforcement personnel at all levels in Crisis Intervention Team (CIT) training as a primary pre-arrest diversion strategy. Adopted by the 2012 legislature, HCR 5032 documents the important role CIT training plays in decriminalizing mental illness and/or substance use disorders.

Traditionally, the state has approved funding for two 40-hour trainings to maintain the momentum of CIT by providing training to law enforcement officers in the tenets of CIT to de-

escalate crisis situations and, where possible, to divert individuals with mental illness and/or substance use disorders into treatment options rather than jail. The state received funding in 2015 through the recommendations of the Governors Mental Health Task Force initiative to expand the availability of the 5-Day 40 hour Crisis Intervention Training (CIT) provided by the Kansas Law Enforcement Training Center (KLETC) to an additional 30 law enforcement officers.

KDADS also contracted with KLETC and the National Council for Behavioral Health to provide a training of trainers for 34 Law enforcement officers, first responders, and KDOC personnel for Mental Health First Aid. These new trainers were also supplemented additional funding to become certified in Public Safety and Veteran Competency as enhancements of the Mental Health First Aid training.

KLETC also received additional funding to provide 6 one-day trainings at location around the state for an introductory course to CIT and to provide a 6 module web-based training using components from the CIT and Mental Health First Aid training. This training is now available to all law enforcement and corrections personnel in Kansas.

Recovery Oriented Services

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

A peer-run infrastructure of thirteen (13) recovery oriented consumer run organizations that are consumer-operated and consumer-governed providing peer supports are supported by KDADS-BHS through funding, technical assistance and support.

State university participation in State Medicaid Administration contributes invaluable expertise to help support implementation and fidelity of evidence based practices such as Strengths Based Case Management, CPST, IDDT, IMR, Family Psychoeducation, Supported Housing, and Supported Employment.

Consumer and family education, referral and supports are obtained through contractual agreements between KDADS-BHS and the Kansas Consumer Advisory Council, National Alliance on Mental Illness - Kansas, and KEYS for Networking.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

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

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

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

16. Recovery

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

Recovery has been a priority of KDADS and the SAMHSA definition of recovery is commonly accepted in practice. The agency does employ staff members who are self-disclosed and in long term recovery as are many of our grantees and contractors. While the agency currently does not have a policy that would prioritize hiring individuals who are in recovery in all positions, we do require that those who occupy a Consumer Affairs Coordinator position be in recovery and give priority status to veterans. Many of our agency grant and contracts have a recovery focus and include peer services in the delivery.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

Peer support and person centered case management services are both billable under the SAPT block grant. Services are based in the strength principals, and self-directed wellness planning is included in both services. The services are to be delivered with the treatment participant present and preferably delivered in the community. Both services are to be integrated into the treatment plan when the utilization of the services is included in the treatment process.

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

Peer Mentoring services are provided in both Mental Health (MH) and ~~in~~ SUD services. Persons who are self-identified as having lived experience and who have established recovery may complete a state approved training process and apply for certification. Additionally, our state recognizes that a large number of our peer mentors have at some point in time come in contact with our state correctional system. In response to this correlation, we are currently working with the Kansas Department of Corrections (KDOC) to increase learning opportunities for our mentors that focus on criminal thinking.

The state is currently planning to partner with Consumer Run Organizations (CROs), in both the rural and urban areas of our state in Fiscal Year (FY) 2016 to expand their organizations to begin offering Medicaid billable, peer support through the State's Managed Care Organizations (MCOs).

The design for CRO calls for the development of three levels of certification to establish skills to provide services of peer to peer support/mentoring. Levels of Certification include:

- Level One CROs- Provided peer support through lived experience
- Level Two CROs- Billable Peer Support. By providing a structure that would allow for CRO's to employ members that are Certified Peer Specialists (CPSs),

they would be able to provide members support with life issues that are not crisis motivated. CSPs would also serve in a role that would allow them to assist CRO members in bridging gaps that would prevent them from returning to the community after leaving services.

- Level three CRO- Create peer crisis diversion homes that would provide short term peer support to individuals in psychiatric crisis who can be served in the community. The ultimate goal of this arrangement would be to help them stabilize and re-enter into independent living. Training peer companions will assist residents in learning self/community help tools with the underlying goal of avoiding future emergency room, inpatient hospitalizations or involvement with law enforcement.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

Currently there are two types of certification for Peer Mentors. The MH Peer Mentor is called a Certified Peer Specialist (CPS). Currently they are provided training at no cost through Wichita State University/ Center for Community Support and Research (CCSR). As of 2015, introductory training classes are available at various locations in the state which allows for any self-identified consumer of mental health services in recovery to participate. The intent of this design was to increase capacity for peer to peer services and to allow for persons to have exposure to the scope of practice and needed skills prior to employment, as well as to establish opportunities for developing capacity for services for persons that wish to provide peer support as a volunteer. This level one training has been offered in Consumer Run Organizations (CRO) as an initiative to help the CROs increase their use and quality for providing peer support.

The CROs in Kansas are the foundational infrastructure for the delivery of peer services for persons who have or who are experiencing mental illness. They are also beginning to recognize, self-identify and develop supportive programming to help support persons that are dealing with co-occurring disorders.

Substance Use Disorders (SUD) Peer Mentors are currently able to seek two levels of certification. The first level of certification is as a Peer Mentor in Training. A Peer Mentor in Training can provide billable service for up to one year in a SUD licensed treatment program before they must complete the training for the second level of certification as a Kansas certified Peer Mentor. Guidelines are set for mentors in training that control the number of hours of direct service they can provide a week and the amount of supervision required.

Training of Peer Mentors includes information on cultural competence and special populations as well as trauma informed care. Much of the training has been focused on building capacity in the workforce, but currently advanced trainings are being considered that would include more in depth training in specific populations including military culture, criminal thinking, age and gender specific and sexual preference. There will also be a social marketing plan developed to attract a more diversified workforce for recovery support position.

Currently the established SUD Recovery Centers in Kansas are programs collocated within licensed SUD treatment programs. They are staffed by peers and have peers in supervisory and management positions. Kansas has certified peers that have both certifications for MH and SUD peer services. We are attempting to build ~~this~~ capacity for co-occurring peer services through recruitment of persons that self-disclose their dual recovery.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

The state has contracted with Wichita State University Center for Community Support and Research as well as Kansas University for development of programs and providing the research and implementation of best practices. Much of the states work has been guided by the documents written by ~~works of~~ William White. The Mid-American ATTC has worked with KDADS on development and training initiatives for Recovery Oriented Systems of Care. Curriculum development for the SUD peer mentoring certification included Washburn University and Allen County Community College ~~in the development~~. KDADS representative to the National Treatment Network under NASADAD has co-chaired the ROSC committee for 5 years and has used the information and resources shared ~~through the committee~~ from other states across the nation in the development of programing in Kansas.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

The Kansas Citizens Committee which serves as an advisory committee to the Secretary has stakeholder representation from around the state. These individuals gather information from persons in the community which they then share with the committee and may include in recommendations to the Secretary. The structural change of the Governors Mental Health Services Planning Council to become the Governors Behavioral Health Services Planning Council (GBHSPC) adds the following new positions: two persons in long term recovery from SUD, a family member of a person experiencing SUD, a peer mentor of persons with SUD, a provider of SUD services and a provider of prevention services.

The GMHSPC and its six subcommittees all have individual and family participation. Each subcommittee values the individual and family perspective and voice.

Youth Leaders in Kansas (YLinK)

Behavioral Health contracts with Wichita State University (WSU) to promote support of the YLinK program statewide. The YLinK program is an innovative peer-to-peer support and leadership program promoting the opportunity for youth to develop personal and community leadership and advocacy skills, which includes the leadership and ownership of their individual youth site program, self-advocacy skills and peer-to-peer support with the support and guidance from parents, both fathers and mothers, ages 12 to 18 with a severe emotional disturbance (SED). The program is youth-driven where youth participants have the primary responsibility for program activities, and parents serve in an advisory capacity; in an encouraging rather than

directive style. Parents participate in a supportive role during semi-monthly meetings that focus on youth identifying qualities of leadership and developing an action plan through participation in group-selected activities.

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

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

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

List of some of the Outcome Measures for YLinK this year:

- 1) 90 % of youth will have an understanding of youth leadership and its impact on the community, themselves individually; as evidenced by self-report to WSU/CCSR, parent/guardian and their youth leadership group (YLG) by June 30, 2016.
- 2) YLG average will increase by 20% in their leadership skills and will have used and/or demonstrated skill/skills; as evidenced by self-report to WSU/CCSR, parent/guardian and their youth leadership group (YLG) by June 30, 2016.
- 3) 20% of youth at each site will participate in at least one activity or meeting where they have been able to speak about bullying and/or stigma; as evidenced by self-report to WSU/CCSR, parent/guardian and their YLG by June 30, 2016.
- 4) Each youth site will have participated in at least one activity in their community and at the state level that supports the reduction of stigma and/or bullying; as evidenced by self-report to WSU/CCSR, parent/guardian and their YLG by June 30, 2016.
- 5) 60% of youth will be able to relate to others by using their wellness story; as evidenced by self-report to WSU/CCSR, parent/guardian and their YLG by June 30, 2016.

- 6) Each youth site will have participated in an activity in their community and/or at the state level which supports “making life better for youth with a mental illness”; as evidenced by providing a presentation of said activity at the Annual Conference held in June 2016.
- 7) Each youth site will develop and implement a mental health awareness project relating to youth in their community; as evidenced by the YLG processing and participation notes provided to WSU/CCSR.
- 8) 20% increase of YLG average will report improved peer relationships (developing and maintaining friendship, increased empathy and social self –efficacy); as evidenced by self-report in the WSU/CCSR research and evaluation survey.
- 9) 80% of YLG sites will participate in the Annual Advocacy Day in Topeka; as evidenced by attending the KDADS office meet and greet on Advocacy Day.

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

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

Kansas is unique in that we have several different peer to peer services. Specifically, we have the following in place: Recovery Specialist, Certified Peer Specialists, Parent Support and Training. These groups cover both MH and SUD. KDADS/BHS provides SUD Peer Mentoring Certification Training and Person Centered Case Management certification training at no cost to the participant.

We have established a Kansas Policy Academy workgroup which represents both MH and SUD organizations/agencies, MCOs, peer to peer service providers and consumers. We are working closely with BRSS TACS who is supporting us with resources and educational materials as well as working with us on developing a statewide Mission, Vision and Strategic Plan. The goals of the workgroup are to:

- 1) Establish Kansas Policy Academy Team.
- 2) Obtain information on current systems and programs in the state and how they work presently. SWOT Analysis
- 3) Learn about effective strategies, tools and resources to support recommendation and implementation.
- 4) Address strengths, needs and barriers in the system with recommendation to move the system forward.
- 5) Promotion of peer to peer services statewide
- 6) Establish, build and implement a statewide evaluation process.

Funding is provided to the Friends of Recovery Association for promotion of recovery community functions which are organized by Oxford House members and Alumni members. Funding is also provided to support a statewide Oxford House member's summit based on the design of the Oxford House World Conference each year. Funding is provided to Oxford House members to hold a state women's workshop each year. Consumer run organizations in Mental Health are supported through funding of Wichita State University Center for Community Support & Research (CCSR) and through the Kansas Consumer Advocacy Council (CAC). Support is provided to fund the CAC annual recovery conference. Funding was provided to support the development of the Washburn University Recovery College development by sending student and faculty representation to Texas Tech University for introduction and training to their Recovery College support program. Funding is provided to support Kansas chapter of NAMI.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

We are currently measuring the units of peer implemented billable services and seeking to build capacity. Additionally, we are in a Technical Assistance process with BRSS TAC to evaluate the states services, identify quality measures, and develop marketing plans for ROSC services.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

The CRO Network has received training and programs through a grant that was awarded to the Kansas Consumer Advisory Council (CAC) to implement a program called Get Healthy Kansas. This program involves training CROs across the state over a two year process in issues including tobacco cessation, wellness promotion and co-morbid health conditions.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

The Housing and Homeless Subcommittee of the Governors Behavioral Health Services Planning Counsel has made recommendations and will continue to work with KDADS Housing and Employment specialist. KDADS supports Housing First initiatives and works with the Mental health centers to support placement of clients through the use of community housing specialists in permanent and affordable housing.

11. Describe how the state is supporting the employment and educational needs of individuals served.

KDAD recognizes that employment is one of the best indicators for successful treatment and recovery. For example, the outcomes of grants targeting DUI offenders in treatment and with TANF recipients with SUD issues include employment. Additionally, KDADS encourages CMHCs to have employment specialists on staff. KDADS also has pilot grants that are focused on employment with chronic homeless populations.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

17. Community Living and the Implementation of Olmstead

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

Kansas does not have a state Olmstead plan in place. The Kansas Department for Aging and Disability Services has continued to coordinate other activities to ensure persons with behavioral health disorders are served in the least restrictive environment.

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 for providing 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.

Many of the Kansas Community Mental Health Centers have implemented evidenced-based, emerging best practices and promising practices to provide a high level of care to their clients. These practices include; IPS Supported Employment, Strengths Model of Case Management, Integrated Dual Disorders Treatment, Illness Self-Management and Recovery, Family PsychoEducation, CommonGround Shared Decision Making, and Peer Support Services.

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.

In an effort to augment and strengthen the existing IPS Supported Employment Services in Kansas, KDADS applied for the SAMHSA Grant Transforming Lives through Supported Employment. With the receipt of this grant, KDADS created the Enhancing Supported Employment in Kansas Project (ESEK). The ESEK project will enhance Kansas' capacity to provide and expand IPS Supported Employment Services to uninsured or under insured adults suffering from a serious mental illness, including those who have a mental illness and a co-occurring substance use disorder. The expected outcome is for Kansas to strengthen the existing infrastructure needed to maintain and expand supported employment services throughout the state and increase the number of individuals with serious mental illness and co-occurring mental and substance use disorders that obtain and retain competitive employment.

Through a grant RFP process, KDADS awards grants (Interim Housing Grants) to CMHCs to be used to create and/or maintain housing programs for persons with a severe and persistent mental illness discharging from state funded institutions and those whom are experiencing homelessness. The funds are used by the CMHCS to lease units and offer immediate access to short-term community based housing coupled with supportive services. The Interim Housing projects provide short term housing, usually up to six months, as an alternative to discharging from a State institution into homelessness.

KDADS has a contract with Kim Wilson Housing to administer the Supported Housing Funds (SHF) program. Supported Housing Funds are allocated to CMHCS to be used to provide financial assistance for rent assistance, deposits, and other housing related costs. Allowable expenses include providing assistance for rental costs, housing and utility payments and deposits,

purchase of essential household items, including appliances and furniture, moving costs, application fees, and other expenses that allow a person to maintain or obtain housing.

The Friends of Recovery (FORA) project provides support for the sustainability and expansion of Oxford Houses in Kansas. FORA manages the revolving loan fund for the startup of new Oxford houses in Kansas by developing rental/landlord agreements. They provide conflict resolution, support outreach workers to establish new housing and membership. Oxford Houses are democratically run, self-supporting recovery houses for people with a substance use disorders. The number of residents in an Oxford House may range from six to fifteen.

The PATH Grant is administered by the Center for Mental Health Services Homeless Programs Branch within SAMHSA. Allocations are made to States and territories on a formula grant basis. For FFY2014, Kansas will receive \$382,978 in Federal PATH Funds. KDADS provides \$152,034 in State general funds as a match to the Federal PATH funds. The total amount of PATH funding is \$535,012. Through a grant RFP process, KDADS awards PATH funds (federal combined with state matching funds) to community mental health centers to provide the PATH allowable services, including street outreach, case management and services not supported by mainstream mental health programs.

KDADS has a contract with the Kansas Statewide Homeless Coalition. KSHC utilizes the funds to carry out the duties of the Collaborative Applicant for the Balance of State Continuum of Care, as defined by Housing & Urban Development and to host an annual statewide educational forum. As the Collaborative applicant, KSHC acts as the lead agency that applies for the HUD Continuum of Care grant funds on behalf of the Balance of State Continuum of Care (CoC) Homeless Services Network. In 2014, the CoC Program grantees in the Balance of State CoC received \$2,419,503 in homeless assistance grants from Housing and Urban Development for housing and services targeted to homeless individuals and families.

SOAR is an approach that helps states increase access to mainstream benefits for people who are homeless or at risk of homelessness. Case Managers trained in SOAR have a better understanding of how to get an application for benefits approved. In Kansas, KDADS has led an effort to implement SOAR throughout Kansas. After four years of implementation, all CMHCS have at least one staff trained in SOAR. The average approval rate in Kansas for SOAR assisted applications is 80% with an average approval time of 113 days. In comparison, the national approval rate for applications not following the SOAR process is 30%. This number reduces to about 16% for persons experiencing homelessness or those at risk of becoming homelessness.

The Housing & Homeless Specialist with KDADS is the SOAR State Lead and coordinates the implementation of SOAR throughout Kansas. CMHCS receive no state funds for the SOAR project. The SOAR Workers bill the targeted case management service code for their time spent assisting clients using the SOAR model.

CMHCS are encouraged to identify a position to serve as the CMHC Housing Specialist. The CMHC Housing Specialists should be the experts of housing resources in the community. The Housing specialists should have extensive knowledge of tenant rights and responsibilities as listed under the Tenant and Landlord Act. Housing Specialists outreach and establish relationships with landlords and housing developers to create more housing options for their consumers. Assist consumers and case managers as they search for housing or help with the consumer maintaining his or her housing. The State does not reimburse the CMHCS for the CMHC Housing Specialist positions. The Housing Specialists bill TCM and CPST service codes, when appropriate for their work.

Money Follows the Person is a federal demonstration grant to help residents of qualified institutional settings (at least 18 years old and residing in Nursing Facilities and Institutions for people with intellectual/developmental disabilities) move back in their communities to live. Services could include assistance finding housing, assistance with helping the resident identify and develop natural support systems and transition funds. The resident may receive up to \$2,500 in Transition Funds to help with setting up housing/household items and other needs they may have. The federal award for MFP is \$800,000.

2. How are individuals transitioned from hospital to community settings?

As required by Kansas statute, community mental health centers designate staff to serve as a liaison with the state mental health hospitals. As the designated SMHH liaison, these individuals are required to carry out the following duties:

- Regularly visit at the hospital with every person admitted to a state psychiatric hospital from the serve area of the center, whether on a voluntary or involuntary basis;
- Participate in the discharge planning of each person admitted to a state psychiatric hospital from the serve area of the center in order to facilitate the return of that person to the community
- Be empowered by the center to commit the center to specified services upon the discharge and return to the community of any person admitted to a state psychiatric hospital from the service area; and
- Coordinate the treatment provided at the state psychiatric hospital with the treatment provided by either the center or any affiliated provider with which the center has an affiliation agreement.

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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.

A final report from this Adult Continuum of Care Committee was submitted to the Secretary of KDADS on July 24th, 2015. This report included a description of the current status of the components of the behavioral health system, gaps or areas of need, and a list of recommendations. This committee will continue to meeting to evaluate the State's progress toward implementing the recommendations.

KDADS repurposed funding to redesign the Rainbow Mental Health Hospital.

Kansas operates programs that assist persons with Severe Mental Illness (SMI) and Serious Emotional Disturbance (SED) who are 18-22 obtain and/or maintain housing. The Interim Housing program provides immediate housing for persons living in the community but who are homeless or for persons who are homeless who are leaving a state hospital, Nursing Facility for Mental Health or any other state funded institution or system of care setting. The goal of Interim Housing Grant is for CMHCs to provide immediate housing, instead of discharging individuals to homeless shelters, and then assisting participants to rapidly obtain permanent housing. As part of the Supported Housing Program, each SHF participant is required to complete a housing stability plan. This plan addresses the consumer's current living status and current income. The consumer and case manager work to develop a stability plan that helps the consumer develop a budget for new housing options or to maintain current housing. Each CMHC employs a Housing Specialist who works with local landlords and local public housing authorities to increase safe, decent and affordable housing options. Case managers then work with the consumer to find housing that is affordable and fits the needs of the consumer. KDADS has incorporated the housing stability plan into the GMHI and will be considered as part of contract negotiations. Kansas supports the development, support, and oversight of the revolving loan fund for Oxford Houses in Kansas through a grant to Friends of Recovery Association (FORA). They have been involved in the support of Oxford House in Kansas for over 15 years. Currently they support 67 houses in Kansas and continue to seek new properties for new house expansion. The grant funding also includes support and development of the alumni association of past Oxford members, for the promotion of recovery community activities by the chapters, peer to peer services to Oxford members, and promotion of ROSC in communities. Behavioral Health Services (BHS) has traditionally provided funding to support a statewide network of 21 Consumer Run Organizations (CROs) to promote recovery through peer recovery supports to

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

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Kansas is not involved with any litigation or settlement agreements with DOJ.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

18. Children and Adolescents Behavioral Health Services

1. How will the State establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?

The SUD regulations for adolescent treatment establish a process to monitor not only clinical documentation and other program requirements but safety and quality measures as well. These include criminal background checks and child abuse and neglect registry checks for any person having direct contact with the youth served in SUD treatment.

Today, the Kansas mental health system offers an array of home and community-based supportive services to children with serious emotional disturbance and their families. The primary purpose of such an approach to mental health services is to provide the supportive services necessary which allow a child to be maintained in the least restrictive setting possible, preferably at home with their family, and results in preventing the need for hospitalization or other out of home placement.

The key to such services is coordination. A “Wrap Around” model of service delivery is followed; emphasizing a strengths based approach that considers bio-psycho-social influences when assessing needs. Individualized service plans are developed on behalf of each child in collaboration with parents and/or caretakers. These plans combine intensive mental health care with services of schools (both regular and special education), court services, the Juvenile Justice Authority, hospitals, the Child Welfare System (Foster Care, Adoption, and Family Preservation), and other forms of supportive services, both informal and formal.

A home and community-based model of intervention for a child is contingent upon parent choice, commitment to the goal of keeping the child at home, and active involvement in their child’s treatment process. It must be determined that less intensive services are insufficient to meet the child’s needs. The primary focus of work with children who are experiencing serious emotional disturbance is to (1) stabilize a child in the least restrictive environment, preferably at home with their family; (2) support the child’s caretakers in meeting the needs of their child; (3) strengthen the family’s coping skills; and (4) link the family with appropriate community agencies and social resources to create an extended, natural support system (Snyder, 1990). The result of these foci is prevention of the need for hospitalization or other out of home placement. Although services target the child with serious emotional disturbance, the focus of intervention and/or support typically includes the family and upholds the belief that the best way to provide services to a child is through strengthening and empowering the family.

Data Systems

The AIMS system is a succession of processes that result in a comprehensive data set which reflects demographic, client status, and encounter data for the mental health consumers served by local CMHCs. Data generated through the AIMS is used by the SMHA for federal reporting, quality improvement, and contract monitoring. The CMHCs’ business arm, the Association of Community Mental Health Centers in Kansas, uses AIMS data for legislative reporting and lobbying. The CMHCs use AIMS data for local quality improvement efforts. Thus, data collected via the AIMS are used for continuous quality improvement of the system, continuous

quality improvement at individual CMHCs, and ongoing systemic advocacy at the local, state, and federal levels. The AIMS has, therefore, become a collective priority for the entire public mental health system.

The following language is included in the Community Mental Health Centers Contracts:

OUTCOME MEASURES

The CMHC is expected to improve its performance on the outcome measures listed below (1-9). Performance improvement planning shall be initiated based upon the trend specific to the CMHC for each outcome. Discussion and further study shall result if the trend for a given outcome begins to move in a negative direction. A performance improvement plan may be initiated at any time upon agreement between KDADS and the CMHC, but shall be developed in the event of a negative trend that persists for 3 consecutive months.

The CMHC will use recognized performance improvement methods to develop and implement a performance improvement plan to improve its performance on the identified outcome(s).

If the CMHC believes that improving performance on the outcome(s) is beyond its control, the CMHC may, within 15 days submit a written request to be exempted from developing and implementing a performance improvement plan. The request will include data to substantiate the reason(s) for requesting the exemption. KDADS will evaluate the request and notify the CMHC in writing within 15 days of receiving the request whether or not the exemption request was justified.

All FY2016 Outcomes will specifically monitor the uninsured/underinsured target population served by each CMHC. The target population will be determined by the Medicaid eligibility status in effect at the end of each reporting period. KDADS will share available outcomes and trend lines with the CMHC at least quarterly and as often as monthly.

Outcomes 1-3 are priorities.

- 1. Admissions adult:** The rate of State Mental Health Hospital (SMHH) admissions for adults residing within the CMHC catchment area who have been screened for admission to an inpatient psychiatric facility for psychiatric services.

Measure: Admission Rate is determined by dividing the Numerator by the Denominator and multiplying the quotient by 10,000.

Numerator: The number of adult admissions to a SMHH as a result of a mental health inpatient screen performed by Community Mental Health Center staff. Inpatient psychiatric facilities include state-operated psychiatric inpatient facilities, local/regional inpatient psychiatric facilities, and local/regional medical facilities providing psychiatric services.

Denominator: The number of all adults (age 18 and over) within the CMHC

catchment area based on the most recent US Census County estimates available at the start of the contract period.

Data Source: Inpatient Screening Database (IPS).

Reported: Monthly by responsible CMHC reported in IPS

2. Adult Re-admissions within 30 days of discharge: Percent of screening determinations resulting in readmissions of adults, age 18 and over, to any SMHH, or private psychiatric hospital, occurring within 30 days of previous discharge.

Numerator: Number of adults discharged from SMHH, or private psychiatric hospital, with a subsequent readmission occurring within 30 days.

Denominator: Total number of Adult discharges from SMHH, or private psychiatric hospital occurring within 30 days of reporting period.

Data Source: Inpatient Screening Database (IPS).

Reported: Monthly by responsible CMHC reported in IPS

3. Children and Adolescents Re-admissions within 30 and 90 days of discharge: Percent of screening determinations resulting in readmissions of youth, age 17 and under, to any inpatient hospital for children and adolescents, private psychiatric hospital (including state hospital alternatives), or PRTF, within 30 and 90 days of previous discharge.

Numerator: Number of youth discharged from inpatient hospitalization for children and adolescents, private psychiatric hospital, or PRTF with a subsequent readmission within 30 or 90 days.

Denominator: Total number of Youth discharges from inpatient hospitalization for children and adolescents, private psychiatric hospital, state hospital alternative, or PRTF occurring within 30 or 90 days of reporting period.

Data Source: Inpatient Screening Database (IPS).

Reported: Monthly by responsible CMHC reported in IPS.

4. Employment: The percentage of consumers with an SPMI who improve their vocational status within the reporting period.

Numerator: Total points achieved by CMHC based on the vocational status of each individual with an SPMI who has received a Community Support Service (CSS) service within the last 90 days.

Denominator: Total number of individuals with an SPMI receiving a CSS service within the last 90 days, who can be considered in the workforce multiplied by 6 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

5. Housing: The percentage of consumers with an SPMI who improve their residential arrangement within the reporting period.

Numerator: Total CSR points achieved by CMHC based on the residential arrangement of each individual with an SPMI who has received a CSS service within the last 90 days.

Denominator: Total number of individuals with an SPMI receiving a CSS service within the last 90 days multiplied by 5 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

6. Adult Penetration Rate: The per capita number of consumers with an SPMI the CMHC serves.

Numerator: Number of unduplicated consumers with an SPMI that have received CSS services within the last 90 days.

Denominator: Number of persons living in the CMHC catchment area in the adult age range.

Data Source: AIMS system.

Reported: Quarterly.

7. Children and Adolescent Penetration Rate: The per capita number of youth with an SED the CMHC serves.

Numerator: Number of unduplicated youth with an SED that have received CBS services within the last 90 days.

Denominator: Number of persons living in the CMHC catchment area in the youth age range.

Data Source: AIMS system.

Reported: Quarterly.

8. Increase the percentage of children/youth with an SED receiving Community Based Services (CBS) who are discharged because case management goals have been achieved (includes services closed and transferred to other CMHC services).

Numerator: Number of children/youth with an SED who were discharged from CBS services because case management goals were achieved.

Denominator: Number of children/youth with an SED who were discharged from CBS services during the reporting period.

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

- 9 .a.1. Access standards post SMHH for adults: Face-to-face contact, unless refused by client, within 3 calendar days of discharge from a SMHH. If the consumer refuses services, the dates, times, and reasons why a face-to-face contact did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of adults receiving CSS services who had a face to face contact within 3 calendar days of discharge from a SMHH

Denominator: Number of adults receiving CSS services discharged from a SMHH during the previous month

Data Source: Chart reviews

Reported: Monthly by established catchment areas

- 9.a.2.** Access standards post state hospital alternative (SHA) or a PRTF: Face-to-face contact, unless refused by client, within 3 calendar days of discharge from a SHA or a PRTF. If the consumer refuses services, the dates, times, and reasons why a face-to-face contact did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of children/adolescents receiving CBS services who had a face to face contact within 3 calendar days of discharge from a SHA or a PRTF

Denominator: Number of children/adolescents receiving CBS services discharged from a SHA or a PRTF during the previous month

Data Source: Chart reviews

Reported: Monthly by established catchment areas

- 9.b.1.** Therapeutic intervention including Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, and/or Therapy (not an intake), within 3 business days of discharge from a SMHH for adults, unless refused by client. If the consumer refuses services, the dates, times, and reasons why a therapeutic intervention did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of adults receiving CSS services who had a therapeutic intervention within 3 business days of discharge from a SMHH

Denominator: Number of adults receiving CSS services discharged from a SMHH during the previous month

Data Source: AIMS, IPS and State MH Hospital Database

Reported: Monthly by established catchment areas

- 9.b.2.** Therapeutic intervention including Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, and/or Therapy (not an intake), within 3 business days of discharge from a SHA or a PRTF for children/adolescents, unless refused by client. If the consumer refuses services, the dates, times, and reasons why a therapeutic intervention did not occur within the required timeframe shall be documented in the client's file.

Numerator: Number of children/adolescents receiving CBS services who had a therapeutic intervention within 3 business days of discharge from a SHA or a PRTF

Denominator: Number of children/adolescents receiving CBS services discharged from a SHA or a PRTF during the previous month

Data Source: AIMS, State MH Alternative Hospital Database (KVC Prairie Ridge and Wheatland), PRTF ROM

Reported: Monthly by established catchment areas

- 9.c.1** Medication appointment within 30 calendar days of discharge from a SMHH, adults.

Numerator: Number of adults receiving CSS services who had a medication appointment within 30 calendar days of discharge from a SMHH

Denominator: All SMHH discharges that occurred during the previous month

Data Source: AIMS, IPS and State MH Hospital Database

Reported: Monthly by established catchment areas

9.c.2 Medication appointment within 30 calendar days of discharge from a SHA or a PRTF, children/adolescents.

Numerator: Number of children/adolescents receiving CBS services who had a medication appointment within 30 calendar days of discharge from a SHA or a PRTF

Denominator: All SHA or PRTF discharges that occurred during the previous month

Data Source: AIMS, State MH Alternative Hospital Database (KVC Prairie Ridge and Wheatland), PRTF ROM

Reported: Monthly by established catchment areas

The following outcomes (10-12) shall continue to be monitored and performance improvement planning shall be implemented only if the CMHCs outcome dips below 85% in a quarter.

10. Children and Adolescent Residential Status: The percentage of youth with an SED who improve their residential status within the reporting period. The CMHC shall be assigned a score based on the residential status of each youth who have received Community Based Services (CBS) within the last 90 days. See Appendix C for assignment of point values, CBS service code list, determination of service requirement and explanation of residential statuses considered for this performance measure.

Numerator: Total CSR points achieved by CMHC receiving at least one CBS service within the last 90 days based on the residential status of each youth with an SED.

Denominator: Total number of youth with an SED receiving a CBS service within the last 90 days multiplied by 5 (highest point value possible).

Data Source: AIMS system/Client Status Reports (CSR).

Reported: Monthly by established catchment area.

11. Independent Living: The percentage of consumers with an SPMI who live independently. The CMHC shall report the percentage of consumers with an SPMI who are living independently.

Numerator: Number of consumers with an SPMI that have received CSS services in the last six months who are living independently.

Denominator: Total number of consumers with an SPMI that have received CSS services in the last six months.

Data Source: AIMS system/ Client Status Reports (CSR).

Reported: Monthly by established catchment areas.

- 12. Education:** The percentage of youth with an SED receiving CBS who attend school regularly. The CMHC shall report the percentage of youth with an SED who received CBS services and are attending school regularly.

Numerator: Number of youth with an SED that have received CBS services within the last six months who are attending school with less than 5 unexcused absences.

Denominator: Total number of youth with an SED that have received CBS services within the last six months.

Data Source: AIMS system (CSR).

Reported: Twice per year by established catchment areas.

Kansas has contracted with three Managed Care Organizations (MCO) which provide children and families greater choice of care. This also ensures a child and their family's timely access to services and a provider within a specified time frame in rural, semi-urban and urban communities across the state. With the MCO's in place this will also increase the accountability of our system. The MCO's will be capable of identifying gaps and barriers within our system.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use and co-occurring disorders?

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

R03-715. Supplemental Requirements for Adolescent Services

A. A licensee providing services to adolescents shall comply with the following standards:

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

- of children and adolescents.
- c. Providing counseling and education for the family members of children or adolescents served in the program.
 - d. Providing staff training to enhance staff understanding of child and adolescent development and substance abuse.
 - e. Methods of disciplining children and adolescents.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

The Department for Children and Families (DCF) requested support and collaboration from Kansas Department for Aging and Disability Services (KDADS) and Kansas Department of Health and Environment (KDHE) in assisting them with the development of a State Plan to decrease the prevalence of psychotropic medication prescriptions among children in out-of-home (OOH) placement within the Kansas foster care system. From a University of Kansas study and the statutory mandates required of states DCF, KDADS and KDHE have joined together to work collaboratively to support the decrease in prevalence of prescribing medications to out-of-home placement foster care youth across the state. The purpose of this advisory team is to collaborate with other prescribing child services systems. KDADS supported DCF efforts by writing a work plan that they have implemented into their state plan.

KDADS also facilitates quarterly meetings with DCF, KDHE and Juvenile Justice Authority (JJA) department staff to provide a collaborative effort in supporting each other with information about each other's system process, policies and procedures; updates on new or existing programs; discussion around youth cases etc. This has been very beneficial not only for the state department staff, but also for our direct service providers/staff. Outcomes are showing an increase in communication and collaboration among direct service providers/staff in their own communities. This is a big plus for children and families when systems work closer together supporting them with resources to help meet their needs. Many creative ideas/resources and treatment plans have come from this work.

4. How will the state provide training in evidence based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

Some of the strengths in the children's system are the mental health services available to children and adolescents across the state. In Kansas there are little to no EBP's in children's mental health services; KDADS recognizes the importance and need for EBP's in the state and has incorporated EBP's as one of the main goals in their Strategic Plan.

KDADS understands the importance of providing quality, effective and useful trainings to direct service staff who work with clients on a day-to-day basis and their supervisors. KDADS contracts with the state universities to support research in evidenced based practice models and provision of trainings. KDADS provides new case manager supervisor, Case Management and Attendant Care direct service staff trainings through a collaborative contract with Wichita State University (WSU). Components of the training are the Strengths Model, Family Driven, HCBS

SED Waiver, basic documentation and ethics. There is a web based component that is to be completed prior to attending a “live” training event. WSU is the main hub for all of this type of trainings across the state.

Kansas State University at the request of KDADS has developed a practice protocol and training for In-Home Family Therapy (HBFT) using the concepts from several theoretical frameworks which include; Multisystem and Functional Family Therapy. HBFT identifies aspects of home-based family therapy that are distinct from traditional, in-office therapy. To bridge the gap between office-based work and home-based practice HBFT addresses several unique challenges associated with working with families’ in their homes. HBFT provides greater access to family data and a direct view of family functioning which can be overwhelming at times. HBFT helps clinicians dissect new data and focus treatment with a result that is a family-driven approach with unique phases of therapy and crucial adaptations that must be met at each phase. HBFT looks at common family issues and places a priority on the use of supervision and therapist’s self-care support to enhance their home – based work.

From data presently gathered from the Outcome Ratings Scale (ORS) on average therapists participating in the HBFT model and following to fidelity show that the families they are working with are just below the area that denotes the possibility of deterioration, which is expected working with SED population. HBFT service model is utilized most often with multi-problem families and progress can be very slow. The best predictors of progress in stability in these families are the scores which note a slight improvement over time. In the Session Rating Scale (SRS) on average HBFT therapists who participate in fidelity have SRS scores that reflect a “fair alliance” meaning that clients receiving this service believe that they are being heard and working on the goals that they the family are wanting addressed. Research shows repeatedly that clients ratings of the alliance are far more predictive of improvement than the type of intervention or the therapists ratings of the alliance.

Parent Support Service (PSS): Kansas PST was initially developed in the 1990’s in a mental health systems of care initiative called Kan-Focus funded by SAMHSA. There were five Community Mental Health Centers who within this funding opted to develop direct employees for PST service. Outcomes from their data were later used to provide the support of PST as a billable service under Medicaid for youth and their families who enrolled in the Kansas HCBS/SED Waiver (S5110) and to convince legislature to allocate funding for expansion of the new system of care model to include PST services across the state. The University of Kansas (KU) over the last 6 years at the request of KDADS has developed a practice protocol and training for PST. The PST service definition supports the guidelines set by the Federation of Families for Children’s Mental Health who introduced the Family Driven Paradigm.

The PST Practice Protocol – predicts changes in the following outcomes:

- Caregiver social support
- Parenting style
- Family empowerment
- Caregiver strain
- Community stability
- Home stability

From data collected and the development of 8 pilot sites across the state, KU was able to show that the delivery of Parent Support and Training services with a high level of fidelity to the PST Practice Protocol results in an increased level of stability in the home, as evidenced by fewer residential placements with fewer moves to more restrictive levels of placement.

Additionally, though *Community Stability* is not directly predicted by either independent variable, its significant correlation with *Home Stability* suggests that when *Home Stability* – which is influenced by *Model Fidelity* – is at a high level, *Community Stability* will also be present at a high level. These findings support the theory that providing support to caregivers of children with SED, in addition to direct services to the child, promotes sustainability for the child to reside safely in the least restrictive environment – the child’s home.

The Kansas Parent Support Network developed a *Code of Ethics* in 2007; which they considered important to them in work related activities. This has been incorporated into the Practice Protocol.

Parent Support as an emerging practice which works around a family-centered philosophy. The Parent Support fidelity model outcomes from preliminary findings show the effectiveness of family engagement in children’s service delivery. Here are some of the findings:

- 1) When the PST Practice Protocol is carried out with higher fidelity, caregivers are more likely to have lower caregiver strain, higher family empowerment and better involvement in treatment.
- 2) When the referral process to PST services is carried out with higher fidelity, youth spend fewer days in foster care.
- 3) When the engagement strategies of the PST Practice Protocol are carried out with higher fidelity, youth are less likely to spend days in more restrictive placement.
- 4) When PST interventions are carried out with higher fidelity, caregivers are more likely to feel youth are safe at home.
- 5) When PST interventions are carried out with higher fidelity, youth spend fewer days in more restrictive placements.
- 6) When PST interventions are carried out with higher fidelity, youth are less likely to have contact with law enforcement.

One of the unique qualities of PST is that most are parents of an SED child, there are a few grandparents and foster parents who provide the service as well. Currently there are 37 Parent Support Specialists providing this peer-to-peer service in 26 CMHCs in the state. Starting in FY 16 KU will provide a web based PST training in the model for all who provide the service across the state. KU is also in the beginning stages of working with the HCBS IDD Waiver staff to look at PST supporting families and youth who are IDD and /or co-occurring.

Wraparound: University of Kansas at the request of KDADS provides to all CMHC’s wraparound information, education and evidenced based training to wraparound facilitators and technical support. This assists CMHC direct service staff with a best practice that will has shown to improve client outcomes and facilitate more consistent statewide wraparound practices by supporting system development and capacity building.

Strengths Based Case Management is presently being researched and a training developed that will look similar to the EBP in the adult arena with the KU Adult Contract.

5. How will the state monitor and track service utilization, costs, and outcomes for children and youth with mental, substance abuse and co-occurring disorders?

For SUD treatment services, the contracted ASO is required to submit weekly, semi-monthly or monthly reports that include an accumulator (providers allocations and utilization), claims payment (to providers) timeliness and accuracy, weekly claims report, check register, and independent audited financial statements. BHS staff is able to track utilization and length of stay from data collected from the KCPC (BHS integrated data system) and claims data of youth in the SUD treatment programs. Other data is also collected and reviewed on a regular basis. This includes gender, age, co-occurring, drug of choice, and race. This data is distributed to providers at quarterly provider meetings and when requested by stakeholders.

MH

The AIMS is a succession of processes that result in a comprehensive data set, which is currently comprised of 85 data fields that reflect demographic, client status, and encounter data for the mental health consumers served by local CMHCs. Data generated through the AIMS since September 2002 are used by the SMHA for federal reporting, quality improvement, and contract monitoring. The CMHCs' business arm, the Association of Community Mental Health Centers in Kansas, uses AIMS data for legislative reporting and lobbying. The CMHCs use AIMS data for local quality improvement efforts. Thus, data collected via the AIMS are used for continuous quality improvement of the system, continuous quality improvement at individual CMHCs, and ongoing systemic advocacy at the local, state, and federal levels. The AIMS has, therefore, become a collective priority for the entire public mental health system.

With the conclusion of SAMHSA's Data Infrastructure Grant (DIG) Kansas entered into contract with Synectics (SMDI), the primary contractor to SAMHSA for collection, evaluation and reporting of Behavioral Health data. Since that time, Kansas has actively participated in the Behavioral Health Services Information System (BHSIS), a program within SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ), by providing a full set of Mental Health Client-Level Data annually. Over the next two years, Kansas will continue to work collaboratively with SMDI and other federal, state and local participants to design and build capacity to transition to a coordinated data file submission of Substance Abuse and Mental Health treatment via the Treatment Episode Data Set (TEDS).

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

The licensing regulations for SUD treatment require the following for educational services for those adolescent in residential SUD treatment:

- If residential services are provided, the program must make arrangements for the continuity of the client's academic education that are appropriate to the developmental

needs of the child or adolescent served and meet applicable federal, state, and local requirements.

This regulation is monitored during the onsite licensure visits to ensure adolescents educational needs are continue to be met.

A liaison specifically to assist schools with assuring identified children are connected with available mental health and/or substance abuse treatment has not been identified. Community Mental Health Centers are required to establish relationships with other community providers pre K.A.R. 30-60-18 *Each center, in order to facilitate the coordination of services between itself and other agencies and the referral of consumers, both to the center by others and by the center to other providers of services, shall establish and maintain cooperative working relationships with those local public and private agencies who are also likely to provide services to consumers including the following...(e) public and private schools and other education agencies.*

7. What age is considered the cut-off in the state for receiving behavioral health service in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including plans in place for youth in foster care.

To receive mental health services in the child/adolescent system the youth must be under age 18, or under the age of 22 and have been receiving community-based mental health services prior to the age of 18 that must be continued for optimal benefit.

The licensing regulations for SUD treatment include the following definitions:

- Adolescent--An individual 17 years of age or younger.
- Adult--An individual 18 years of age or older.

The regulations also include the language below regarding placing adolescents in the appropriate type of group:

Counseling groups for children and adolescents must be specifically designed to meet their developmental and treatment needs. If adolescent clients participate in groups that include adult clients, documentation in the client file must include:

- a. clinical justification for placement in the group,
- b. a description of how the adolescents developmental and treatment needs can be met within the group.

If an SUD treatment believes it is appropriate to place an individual identified in the adult definition in an adolescent group then they are able to submit a request for an exception to the rule. This exception includes drug of choice, failure in an adult setting and any developmental factors

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

19. Pregnant Women and Women with Dependent Children

- 1. The implementing regulation *requires* the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state (Kansas) uses to accomplish this.**

Behavioral Health Services Substance Abuse Quality Team publishes and distributes a newsletter called the Provider Press biannually to communicate with all licensed programs in Kansas. September 2014 issue contained an article which described the benefits and attributes of a Designated Women's program (DWP). Article was contributed and written by the clinical director of one of our licensed DWP's. The issue also included a directory of all DWP's in Kansas with their contact information and services provided. The January 2015 issue contained an article highlighting a particular Kansas DWP and its services located in Salina. KDADS website contains several resources such as a referral line phone # that is answered by a representative 24/7. Meetings are held bi-annually at 3 locations throughout the state to discuss any changes, updates or concerns. Providers share successes and/or obstacles and network with each other. Kansas has made strides in developing a more integrated Mental Health and Substance Abuse treatment approach and, through this collaboration; DWP's have been encouraged to communicate with Community Mental Health Centers.

Pregnant women in Kansas are prioritized for admission to treatment through several measures. DWP's are required to have a process to inquire and document, from the initial point of contact, if that individual is pregnant. This insures all providers are identifying and scheduling women for admission within the 48 hour timeframe. Included in the Administrative Service Organization contract is the requirement to compile access to care reports and present this data to KDADS. Kansas is currently developing a new assessment system which will continue to improve our data tracking methods.

- 2. Discuss how the state (Kansas) currently ensures that pregnant women are admitted to treatment within 48 hours.**

Each DWP enters into a contract with the ASO which requires the program to meet access to care standards giving priority admission to pregnant women and admission of pregnant women within 48 hours. In addition, assessing providers are contractually required to offer three options for treatment facilities; one of which must be a designated women's treatment program if the individual is a pregnant woman or woman with children. In addition, providers are required to coordinate medical care including prenatal care for women, and pediatric care including immunizations for their children.

3. Discuss how the state (Kansas) currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

Each DWP enters into a contract with the ASO which requires the program to provide interim services if there is insufficient capacity. The provision of interim services is being monitored biennially through Block Grant monitoring visits with BHS Program Consultants. Interim Services information has been built into the assessment system currently under development in Kansas. Through this newly designed assessment tool, providers will have the ability to provide a more consistent, effective and efficient means of administering interim services to pregnant women.

4. Discuss who within your state (Kansas) is responsible for monitoring the requirements in 1-3.

Each program is required to keep an accurate, current tracking mechanism for referrals and the disposition of each referral. Assessment (Kansas Client Placement Criteria) is completed, to determine level of care, for each woman served which tracks the date of referral, date assessment was offered and date assessment occurred. Program Consultants complete biennial site visits to each program to monitor compliance with access to care requirements. During the alternate years, quality assurance, technical assistance and training are provided to improve outcomes and increase percentage of admission and retention. The Quality Committee meets quarterly to review trends and discuss improvement needs. The Women's Services Network designee is assigned to serve as the state's Designated Women's Program expert to provide programs with one point person for questions or concerns. Director of Addiction Services serves to determine allocations, reviews and approves all site visit reports from licensure visits and also monitors capacity. The Administrative Service Organization is required to compile reports for BHS to review. A BHS staff member is assigned specifically to monitor set indicators for the BG reporting. This individual provides data to (Value Options) who monitors completed site visit reports, receives and approves the programs Corrective Action Plans and verifies implementation of the corrections.

5. How many programs serve pregnant women and their infants: please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP). Answer: Inpatient=0 Acute Detox=0 Social Detox=2 Therapeutic Community=0 Intermediate=5 Reintegration=6 Intensive Outpatient=6 Outpatient=6 Early Intervention=6 Assessment & Referral=9

a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

None

- b. **Are there geographic areas within the state (Kansas) that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?**

Levels of Care: Intermediate level of care alone is provided in the West region of state which includes at least 43 of the state's counties. Outpatient level of care is not available in the KC Metro region of the state. Reintegration is not available West of Lawrence. Reintegration is not available in the KC Metro area. MAT: there are no Designated Women's programs in KS that provide MAT.

6. **How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP). Answer:** Inpatient=0 Acute Detox=0 Social Detox=2 Therapeutic Community=0 Intermediate=5 Reintegration=6 Intensive Outpatient=6 Outpatient=6 Early Intervention=6 Assessment & Referral=9

- a. **How many of the programs offer medication assisted treatment for the pregnant women in their care?**

None

- b. **Are there geographic areas within the state (Kansas) that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?**

Levels of Care: Intermediate level of care alone is provided in the West region of state which includes at least 43 of the state's counties. Outpatient level of care is not available in the KC Metro region of the state. Reintegration is not available West of Lawrence. Reintegration is not available in the KC Metro area. MAT: there are no Designated Women's programs in KS that provide MAT.

7. **Indicate areas of technical assistance needed related to this section.**

We are currently working with the BHS Adult Consumer Affairs Coordinator that is in the process of developing guidelines and a checklist for trauma informed screening for program environment. We would like to develop a monitoring/quality program in this area. Any literature or education would be appreciated.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:



KANSAS SUICIDE PREVENTION PLAN

REVISED 2014



KANSAS SUICIDE PREVENTION PLAN

REVISED 2014

Preamble

Suicide is a public health concern and requires a public health approach to prevention efforts. Suicide is preventable. In 2012, Kansas experienced 505 deaths by suicide. This was a 31.5 percent increase over 2011 deaths by suicide. Efforts that had been ongoing for decades were reinforced and many new suicide prevention initiatives were launched. An objective of these efforts was to produce a revision to the state plan to better reflect the capabilities of the administration and to better adhere to the 2012 National Strategy for Suicide Prevention (developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention).

Kansas Behavioral Health Services, housed under the Kansas Department for Aging and Disability Services, has made significant strides in building public-private partnerships to develop and accomplish its suicide prevention goals and objectives. This report will outline the steps taken and the activities and responsibilities necessary to accomplish additional suicide prevention goals and objectives across the human lifespan. The Kansas Department of Health and Environment (KDHE) is a key partner in state-wide suicide prevention by contributing surveillance data and establishing relationships with other public and private partners. Additionally, KDADS supports the Suicide Prevention Subcommittee of the Governor's Behavioral Health Planning Council in contributing, advising and implementing suicide prevention efforts around the state.

The most current suicide rate for Kansas per 100,000 in population is 14.7 compared to the national rate of 13.0 per 100,000 population. In 2013, Kansas was ranked 24th highest in suicide rates in the nation.¹ Suicide is the second leading cause of death in Kansas for the 15-24 age group. The 2013 Kansas Annual Summary of Vital Statistics reports that:

In 2013, 426 Kansas residents died due to suicide, down 15.6 percent from 505 suicide deaths in 2012. More than four-fifths (81.2 percent) of suicide victims were male. The two age groups with the largest number of suicides were 45-54 (94 deaths) and 55-64 (76 deaths).²

Kansas is a profoundly rural state, with one-third of the population living in two-thirds of its land mass; 57 percent of the population is located in nine of the state's 105 counties and only five counties have populations greater than 100,000. The size and rural nature of our state present unique problems to delivering health care. Kansas has 99 counties which are deemed by the federal government as mental health professional shortage areas, the exception being our six urban counties.

As indicated in the 2012 National Strategy for Suicide Prevention it is the efforts of individual citizens providing leadership in their home communities that will ultimately determine the success of this plan in meeting prioritized goals and objectives. Local leaders are encouraged to use this plan as a guide to shaping suicide prevention efforts in their communities.

Activities

In an effort to customize the national strategies to fit the needs of Kansans, several surveys were conducted and meetings were held in 2013 to prioritize and rank suicide prevention efforts. This plan reflects the input from Kansans involved with suicide prevention.

Nearly a dozen Kansas communities have established either county or regional suicide prevention coalitions, bringing local resources together to address this serious public health concern. More than half of these coalitions were formed in the two years prior to this plan being revised.

Kansas professionals, researchers, advocates and consumers continue to improve the understanding of suicide prevention in Kansas. More than 200 individuals have attended statewide summits on suicide prevention, and more than 3,000 Kansans completed suicide prevention training since 2013.

Statement of Goals and Objectives

List of priorities (goals and objectives from Substance Abuse and Mental Health Services Administration guidance and items not explicitly in the National Strategy for Suicide Prevention)

1. Integrate prevention efforts across the lifespan that take into account co-morbidity of illnesses and disorders, e.g. suicide and substance-use disorders. This will better identify risk and protective factors associated with suicidal behavior or ideation.
2. Increase the prevention, intervention and management training of personnel in mental health, behavioral health, education, law enforcement and primary care fields.
3. Increase the continuity of care and linkages to healthcare for suicidal individuals, ensuring safe transitions in care at the point of hospital and emergency room discharge or other periods of heightened suicide risk.
4. Use a data-driven approach to provide those at risk (both populations and geographic areas) with resources, training and awareness of suicide prevention. Additionally, these data should inform the development of local and regional cluster response plans.
5. Establish parameters for evaluation to determine if initiatives have been effective and successful in reducing the suicide rate in Kansas. This information should be used to update and revise the plan on a regular basis once particular goals are met.

Goals and Objectives (Ranked)

The following goals and objectives were developed using focus groups and surveys of stakeholders in the state, as well as the 2014 Guidance for State Suicide Prevention Leadership and Plans from SAMHSA and the 2012 National Strategy for Suicide Prevention³.

Goals

Objectives

Goal 1: Integrate prevention efforts across the lifespan that take into account co-morbidity of illnesses and disorders, e.g. suicide and substance use disorders. This will better identify risk and protective factors associated with suicidal behavior or ideation.

1. Kansas will develop and sustain public-private partnerships to advance suicide prevention.
2. Kansas will establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.
3. Kansas will integrate suicide prevention into any relevant health care reform efforts.
4. Kansas will integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities

Goal 2: Increase the prevention, intervention and management training of behavioral health, school personnel, and primary care professionals, including restriction of access to means.

1. Kansas will develop, implement, and monitor effective programs that promote wellness and suicide prevention and related behaviors.
2. Kansas will provide training to community and clinical service providers on the prevention of suicide and related behaviors.
3. Kansas will promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.
4. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Goal 3: Increase the continuity of care and linkages to healthcare for suicidal individuals, ensuring safe transitions in care during discharge or other periods of heightened suicide risk.

1. Kansas will promote suicide prevention as a core component of health care services.
2. Kansas will promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Goal 4: Use a data-driven approach to provide those at risk (both populations and geographic areas) with resources, training and awareness of suicide prevention.

Goal 5: Establish parameters for evaluation to determine if initiatives have been effective and successful in reducing the suicide rate in Kansas. This information should be used to update and revise the plan on a regular basis once particular goals are met.

1. Kansas will increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action (National Violent Death Reporting System). 2. Kansas will promote and support research on suicide prevention.
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1. Kansas will evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Plan for Implementation

Public-private Partnerships

In 2012, very few local suicide prevention coalitions existed in the state although the efforts of those in place (Sedgwick, Barton, Harvey, Shawnee, and Johnson Counties to name a few) would serve as models to develop and enhance infrastructure. In 2013, the Kansas Youth Suicide Prevention project, a SAMHSA-funded initiative of Headquarters, Inc. in Lawrence, awarded mini-grants to support the creation of six new coalitions around the state and provided technical assistance with their projects and planning. Eight new coalitions were funded in 2015. With the work of all of the coalitions, old and new, thousands of individuals have been trained in suicide prevention awareness, intervention or clinical management.

It is important to highlight the evolving nature of these initiatives so that we may understand how to best utilize their efforts. The local coalitions were essentially the arbiters of those tasks and objectives. However there was little oversight from state agencies regarding evaluation, establishing standards and protocols or collecting useful data. In December 2013, Headquarters, Inc. (a National Suicide Prevention Lifeline crisis center and suicide prevention resource center for Kansas) and the Kansas Department of Aging and Disability Services (KDADS) created a public-private partnership to address some of these concerns, including sustainability of current initiatives.

Headquarters, Inc. and local coalitions are currently working with KDADS and the Kansas Department of Health and Environment (KDHE) to create a statewide prevention coalition that would be able to provide technical assistance, funding, guidance and evaluation for the activities and objectives that take place. The statewide coalition is to be developed with a vision to establish and foster additional public-private partnerships and to implement specific objectives, e.g. local suicide prevention coalitions collaborating with Regional Prevention Centers.

In addition to fostering those relationships, the statewide prevention coalition will combine the efforts and membership of other public health prevention fields, including but certainly not limited to, intimate partner violence prevention, substance-use disorder prevention and tobacco prevention. This will also require the formalization of those public-private partnerships with state agencies through MOUs or contracts. The ability to include individuals and agencies from other

disciplines would facilitate the development of appropriate suicide prevention protocols for different settings, fact sheets for co-occurring protective and risk factors and other tools and resources for local coalitions.

One way to address sustainability is to build in protocols, best practices and culture change among existing systems that will not require on-going funding. At a local level these systems are likely to be public schools, hospitals, prevention centers, health clinics, law enforcement and community mental health centers.

Prevention, Intervention, and Management Training for All Settings

In 2013 the Kansas Suicide Prevention Resource Center (KSPRC) website was developed, immediately making available access to resources for suicide prevention in one site for all those in the state. In 2014, with the addition of a Statewide Training Coordinator position, KSPRC also became the place for individuals to find information about specific training protocols as well as identify available trainers in Kansas. Future plans for these resources include a Trainers Registry that will highlight and feature particular trainings, when and where they will be held, and who will be performing the training.

In conjunction with the burgeoning Statewide Prevention Coalition, KSPRC will help to promote the use of evidence-based practices and training modalities in all settings that are on the Best Practices Registry from the national Suicide Prevention Resource Center. Promotion will focus on clinical intervention in behavioral health (Assessing and Managing Suicide Risk [AMSR], QPR-T and Responding to Suicide Risk [RRSR]), training for medical professionals and emergency departments (Kognito, RRSR), EMTs/first responders (Kognito), law enforcement (Connect/Kognito), school faculty and staff (various training) and other gatekeepers and clinicians around the state. KDADS and Headquarters, Inc. are working toward collaborating with prevention providers to provide community stakeholders, other gatekeepers and clinicians suicide prevention training on various levels at various settings.

Increase Health Care Linkages

Care linkages, or continuity of care, are maintained when one care provider links to another care provider. As a result the transition of care is smooth and uninterrupted for the client, and the essential clinical information is provided.

Creating a culture of shared service responsibilities is paramount to directly addressing suicide risk in suicidal individuals. Professionals in each level of patient interaction need to have a clear and defined understanding of safe and effective best practice-informed transitions. When a patient who is screened and shows suicidal ideation or behavior is referred to a different or higher level of care, it is imperative that the referred clinician is capable of addressing that suicidal ideation or behavior in an appropriate therapeutic manner. This can be accomplished through a comprehensive policy structure to address standards of care transitions and training. These standards must require screening, assessment, therapeutic engagement and client empowerment, intervention, treatment responses and follow-up procedures. Utilization of evaluation methods such as root-cause analysis should be used to assess breakdowns in care procedures and to help target policy and practice improvements.⁴

Furthermore, appropriate communication of critical care information, medical records or behavioral health records between these professional levels of care is very important. Developing these relationships between organizations, and even between differing practices can be very time consuming and difficult to manage. For instance, creating healthcare linkages (connections from one level of care or clinician to another) between an emergency department and a client's privately retained psychologist can be affected by privacy regulations or administrative barriers. Likewise, it can be difficult to navigate the steps to create an effective follow-up system between a crisis center and an emergency department.

The KSPRC can provide communities technical assistance with creating those linkages and policy development with guidance from SAMHSA, Suicide Prevention Resource Center (SPRC), and the National Action Alliance for Suicide Prevention. KSPRC will also be able to provide training to those professionals involved in the care of suicidal individuals and any care transitions that may occur.

Identification

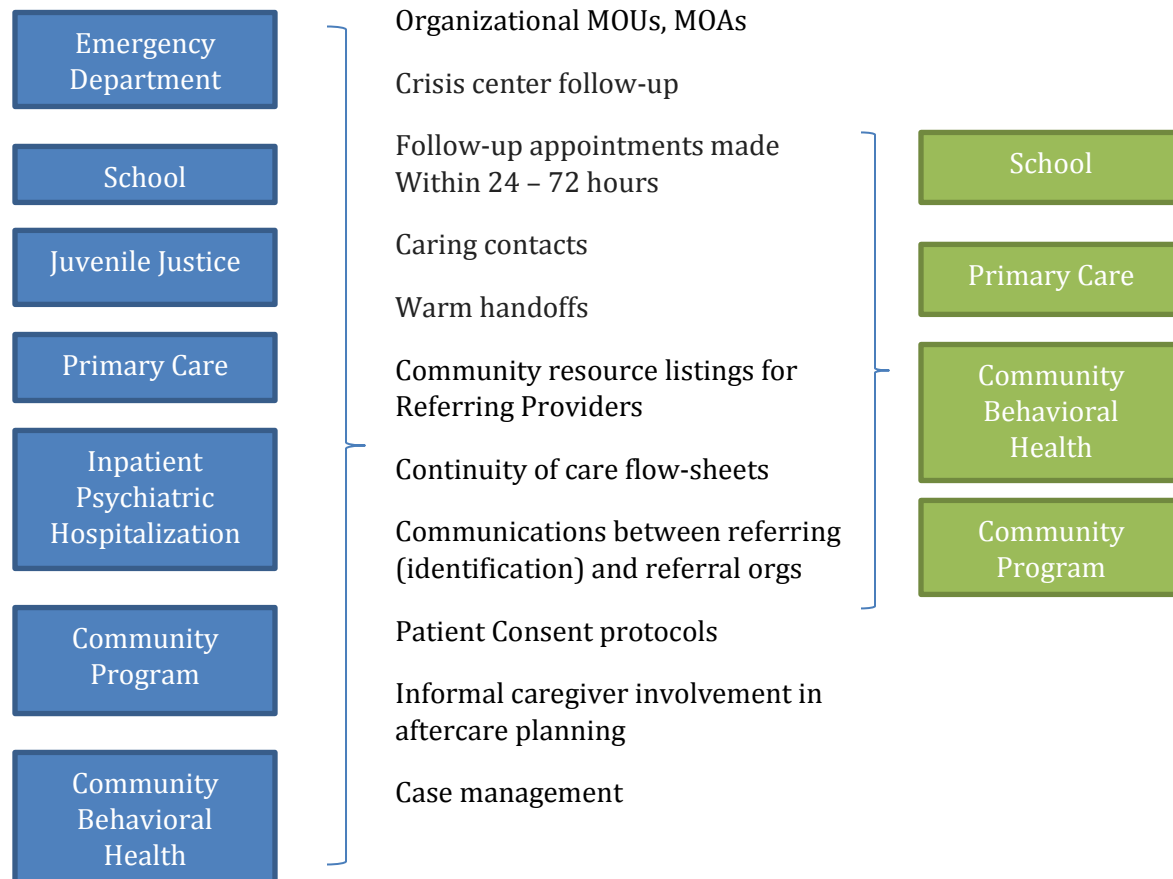
Settings in which at risk individuals are identified

Enhancing Linkages

Strategies or services to enhance linkages with the Aftercare/Ongoing Care provider

Aftercare/Ongoing Care

Settings in which at risk individuals receive ongoing care/suicide risk management services



(Suicide Prevention Resource Center, 2014)

A training needs assessment of behavioral health (Community Mental Health Centers, psychiatric inpatient/outpatient, SUD), primary care, EMTs/first responders, law enforcement, crisis centers and schools for use of depression and suicidal ideation screenings is a low cost activity local communities can conduct.

Findings from these evaluations can help create linkages to ensure effective and safe transitions of care for at-risk individuals. This will be outlined further below in the context of the Strategic Prevention Framework (SPF).

Data-driven Approach and Evaluation

Using materials disseminated by KDHE, including the Annual Summary of Vital Statistics and the newly established NVDRS participation, Kansas has an exciting new opportunity to truly steer efforts and initiatives backed by informative data. Collaboration between the local coalitions, the Statewide Prevention Coalition, KDADS, KDHE, and KSPRC will be necessary to collect, interpret, and subsequently utilize the data to move initiatives forward. It will likely be the responsibility of the same individuals and agencies to determine protocols for local program evaluation to assess the effectiveness of said initiatives.

For the purposes of evaluation, it is beneficial to observe system frameworks that are already implemented within prevention initiatives so that new ones are not duplicating prior efforts. For example, SAMHSA’s Strategic Prevention Framework (SPF), is currently being used in substance abuse prevention efforts across the state. The SPF is a planning process that informs the “selection, implementation, and evaluation of evidence-based culturally appropriate, sustainable prevention activities. The SPF’s effectiveness begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process.” The steps to build infrastructure necessary for effective and sustainable prevention include 1) Assessing needs; 2) Building capacity; 3) Planning; 4) Implementing; and 5) Evaluating.⁵

There are a few features of the SPF that are particularly appropriate for an integrated approach to suicide prevention. The SPF focuses on outcome-based prevention, population-level change, prevention across the lifespan and data-driven decision-making processes. These aspects align parallel to those outlined both in the National Strategy for Suicide Prevention and the state plan. The core aspect of cultural competence in program planning and implementation ensures that all populations and individuals within the community are provided with appropriate services.

Strategic Prevention Framework

Step 1. Assess Needs

1. Collecting Data
2. Setting Priorities
3. Risk and Protective Factors
4. Available Resources to Support Prevention Efforts
5. Community Readiness to Address Identified Prevention Problems or Needs

Step 2. Build Capacity

1. Improving awareness [of suicide] and readiness of stakeholders to address these problems.
2. Strengthening existing partnerships and/or identifying new opportunities for collaboration.
3. Improving organizational resources.
4. Developing and preparing the prevention workforce.

Step 3. Plan (Local coalition level)

1. Prioritize the risk and protective factors [for suicidal behaviors].
2. Select evidence-based prevention interventions.
3. Develop a community-level logic model that links the previous two activities with objective outcomes.

Step 4. Implement

1. Fidelity and Adaptation (select appropriate programs and potentially customize to fit the target population)
2. Implementation Factors (Practitioner selection, consultation, evaluation, etc.)
3. Action Plan Development

Step 5. Evaluation

1. Evaluation in the Context of the SPF
2. Communicating Evaluation Results
3. Developing a Dissemination Plan

If funding is made available for the evaluation of prevention programs, use of an independent third-party evaluator is highly recommended. However, local efforts by community leaders to find and implement low-cost solutions are important for the success of the initiative. Surveying of community providers to determine how they are identifying, referring and following up with suicidal clients is one example. Results from provider surveys can help evaluate the impact of suicide prevention training and help with the development of local cluster response plans.

Annual Action Plan

Given the broad scope of the Kansas Suicide Prevention State Plan, it is necessary to recognize that progress towards these goals and objectives will be made incrementally. It must also be realized that the rate of this progress will vary significantly from one locality to another across the state. Therefore there is a need to evaluate progress and decide whether initiatives were successful or if changes need to be made to meet goals of the plan.

Each year an annual action plan will be drafted that assigns individualized specific tasks to various plan stakeholders around the state. These tasks will be connected to achieving the objectives of the plan. Tasks will be developed voluntarily with local plan stakeholders, and each task will be measurable and realistic. Each task will be evaluated individually based on whether it has been completed successfully or is still in progress. Tasks in the plan that have been completed successfully will be coded Green, those in progress will be coded Yellow, and those that have halted or failed will be coded Red.

Evaluation of the Annual Action Plan activities will occur at a local level and be consolidated by KDADS for the purpose of reporting to stakeholders.

Additionally every three years, the priorities and goals of the Kansas Suicide Prevention State Plan will be reviewed by KDADS with plan stakeholders in effort to make sure that it continues to address the needs of Kansans. An action plan will be developed and reviewed annually.

Appendix A.

Training Protocols (From the SPRC Best Practices Registry; www.sprc.org/bpr)

Featured Training Protocols:

1. Applied Suicide Intervention Skills Training (ASIST)

Information below found at <https://www.livingworks.net/programs/asist/>

Any individual age 16 or older, regardless of prior experience or training, can become an ASIST-trained caregiver. Developed in 1983 and regularly updated to reflect improvements in knowledge and practice, ASIST is the world's leading suicide intervention workshop. During the two-day interactive session, participants learn to intervene and help prevent the immediate risk of suicide. More than a million people have taken the workshop and studies have proven that the ASIST method helps reduce suicidal feelings for those at risk.

Workshop features:

- Presentations and guidance from two LivingWorks registered trainers
- A scientifically proven intervention model
- Powerful audiovisual learning aids
- Group discussions
- Skills practice and development
- A balance of challenge and safety

Each ASIST workshop shares many core features that make up the LivingWorks international standard. Here is what you can expect at your ASIST training:

- ASIST is held over two consecutive days for a total of 15 hours.
- ASIST is based on principles of adult learning. It values participants' experiences and contributions and encourages them to share actively in the learning process.
- ASIST workshops always have a minimum of two active ASIST trainers present for the entire two days. If there are more than 30 participants, there will be at least three trainers. Workshops over 45 participants are not recommended and should be split into two separate sessions instead.
- Trainers show two award-winning videos in the course of the workshop. *Cause of Death?* provides a common starting point for the discussion of attitudes about suicide, while two versions of *It Begins with You* illustrate the process of a suicide intervention.
- Some parts of ASIST take place with all participants together, and others take place in a smaller work group. This helps create a balance between safety and challenge. Participants need not disclose personal experiences to the whole group.
- Local resources are provided and their availability in the community is discussed.

- Participant materials include a 20-page workbook, wallet card, and stickers. Participants also receive a certificate upon completing the workshop.

2. Ask 4 Help Suicide Prevention for Youth (Yellow Ribbon)

Information below found at <http://yellowribbon.org/training/youth/>

Ask 4 Help!® Youth Suicide Prevention Training is a peer based training that includes empowering the audience to learn to use this vital life skill. The presentations and trainings are built to increase help seeking behaviors and links between peers and caring adults.

Youth Peer Leaders Training – communities have found that having youth trainers validates the importance of the topic among their peers, increases participation and promotes cultural acceptance around help seeking.

Objectives:

- Increased knowledge of warning signs, risk and protective factors of suicide
- Increased understanding of help-seeking behavior; how to ask for help for themselves and others
- Increased knowledge of resources and crisis contact (locally and nationally) using the simple lifeskill and tool – the Ask 4 Help!® Wallet card – with the step-by-step guide to ask for help and a national resource, 800-273-TALK (8255)
- How to respond to a friend’s cry for help.
- Increased empowerment of their own abilities by knowing the development of the Program and that youth can know how to, and do, make a difference.

Yellow Ribbon Standards for Safe and Effective Messaging for training programs

- Emphasize help-seeking behavior
- Teach Warning Signs, Risk and Protective Factors
- Teach about, and Identify, Resources
- Include appropriate Support Personnel (i.e. counselors, specialists, faith leaders, etc.)
- Don’t present descriptions of methods of suicide
- Don’t glorify or romanticize suicide

3. Be A Link Suicide Prevention Gatekeeper Training (Yellow Ribbon)

Information below found at <http://yellowribbon.org/training/adult/>

Anyone in an organization can potentially be trained in what is known as “suicide prevention gatekeeper training.” (National Action Alliance for Suicide Prevention 2012). Suicide Prevention Trainings are a key step in preparation and readiness for individuals and communities in both prevention and postvention.

Yellow Ribbon’s **Be A Link!® Community Gatekeeper Training** is a community friendly, peer-based, non-clinical training. It teaches simple, effective tools of help between those in need and help resources. It emphasizes the important role parents, school personnel and other trusted adults can play in helping at-risk young people. This core model is appropriate for any adults, professional and non-professional. Yellow Ribbon has feedback

that shows that trusted adults such as school bus drivers, coaches, custodians and scout leaders have been instrumental in helping save lives after receiving the training.

Objectives:

- Increased knowledge of Warning Signs, Risk and Protective Factors
- Increased knowledge of help resources and how to access them
- Increased knowledge of liabilities, policies and procedures for school
- Increased knowledge of how to talk to their own teens about suicide/suicide prevention
- Learn how to respond to a Cry for help
- Learn how to Start the Conversation of help
- Readiness – crisis protocols applicable for your school/site and in your community
-

Additional tracks for specialized groups are available:

- Training for Trainers Workshop (2-Day) – (Can include Youth Leaders (ages 16 & up)
- School Staff (2-1/2 hours) – Educators, staff (certified & classified) and volunteers
- First Responders (EMS or LE) (2-1/2 hours)
Addresses your roles as a professional, colleague and civilian; family, neighbor, friend
- Faith Leaders (2-1/2 hours)
Addresses your roles as a minister/clergy, community leader, colleague and family member/neighbor

Yellow Ribbon Standards for Safe and Effective Messaging for training programs

- Emphasize help-seeking behavior
- Teach Warning Signs, Risk and Protective Factors
- Teach about, and Identify, Resources
- Include appropriate Support Personnel (i.e. counselors, specialists, faith leaders, etc.)
- Don't present descriptions of methods of suicide
- Don't glorify or romanticize suicide

4. Question Persuade Refer (QPR)

Information below found at <http://www.qprinstitute.com/>

(Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention is a 1-2 hour educational program designed to teach "gatekeepers"--those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers)--the warning signs of a suicide crisis and how to respond by following three steps: (1) Question the individual's desire or intent regarding suicide, (2) Persuade the person to seek and accept help, and (3) Refer the person to appropriate resources.

5. More Than Sad

Information below found at MoreThanSad.org

More Than Sad is a 1-2 hour educational program designed to educate high school students about depression, the leading risk factor for suicide in both adults and teens. By presenting vignettes of four teens that were treated for depression, this educational program aims to

teach adolescents to recognize depression in themselves or their friends, and to encourage them to seek help.

More Than Sad teaches the signs and symptoms of depression, encourages teens to seek help for depression from a trusted adult, and demystifies treatment. The program is engaging, based on sound principles, and sensitive to cultural differences. I recommend it highly. —Dr. Ralph E. Cash, President, National Association of School Psychologists

6. Sources of Strength

Information below found at <http://sourcesofstrength.org/>

Sources of Strength is a best practice youth suicide prevention project that utilizes the power of peer social networks to change unhealthy norms and culture and ultimately prevent suicide, bullying and substance abuse. The program is designed to prevent suicide by increasing help-seeking behaviors and connections between peers and caring adults with a focus on Hope, Help and Strength. Sources of Strength takes a different approach in youth suicide prevention by moving beyond a singular focus on risk factors through building multiple sources of support around young individuals so that when times get hard they have strengths to rely on.

7. Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals

Information below found at <http://www.sprc.org/training-institute/amr>

Outpatient behavioral health providers play a crucial role in preventing suicides. Studies have shown that a substantial proportion of people who died by suicide had either been in treatment or had some recent contact with a mental health professional. Yet many providers report that they feel inadequately trained to assess, treat and manage suicidal patients or clients.

Assessing & Managing Suicide Risk: Core Competencies for Mental Health Professionals meets providers' need for research-informed, skills-based training.

AMSR is a one-day training for mental health professionals, including:

- Social workers
- Licensed counselors
- Psychologists
- Psychiatrists

6.5 continuing education credits are available from NASW, NBCC, APA and Continuing Medical Education Credits (CME).

Additional Resources:

Kansas Suicide Prevention Resource Center - www.KansasSuicidePrevention.org

Suicide Prevention Resource Center - www.sprc.org

National Suicide Prevention Lifeline - <http://www.suicidepreventionlifeline.org/>

American Foundation for Suicide Prevention – www.AFSP.org

American Association of Suicidology – www.suicidology.org

National Action Alliance for Suicide Prevention –
www.actionallianceforsuicideprevention.org

Citations

1. Drapeau, C. W., & McIntosh, J.L. (for American Association of Suicidology). (2015). *U.S.A. Suicide 2013: Official final data*. Washington, DC: American Association of Suicidology, dated January 22, 2015, downloaded from <http://www.suicidology.org>.
2. "2013 Annual Summary of Vital Statistics" Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics. <http://www.kdheks.gov/hci/AS2013.htm>
3. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.
4. National Action Alliance: Clinical Care & Intervention Task Force. *Suicide Care in Systems Framework*. Retrieved December 15, 2014, from <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf>
5. Strategic Prevention Framework. (n.d.). Retrieved January 21, 2015, from <http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework>

20. Suicide Prevention

An updated copy of the Kansas *Suicide Prevention State Plan* has been uploaded. This version of the plan was updated during 2014 and finalized in early 2015. Members of the Governor's Behavioral Health Planning Council, Suicide Prevention Sub-Committee working in partnership with KDADAS staff and staff responsible for providing oversight to the Garret Lee Smith Youth Suicide Prevention Grant (GLS) worked collaboratively to update the document.

The *KS Suicide Prevention State Plan* is inclusive of strategies and best practices that are outlined in the National Strategy to Prevent Suicide. In an effort to customize the national strategies to fit the needs of Kansans, several surveys were conducted and meetings were held in 2013 to prioritize and rank suicide prevention efforts. This plan reflects the input from Kansans involved with suicide prevention and local community stakeholders. Based on state specific input five goals from the National Strategy were prioritized and fourteen specific objectives were identified. These goals and objectives encompass an approach based on the SPF framework and will allow our state to assess the strengths needs and to identify target populations that align with the priority populations within the SABG.

In an effort to ensure the plan becomes action-oriented and is a document that facilitates both statewide and local level progress toward the reduction of suicide, an annual action plan will be developed. This call to action document will be widely disseminated across the state and offer practical evidence-based strategies and approaches that can be implemented across Kansas communities. These activities will be supported under the new Kansas prevention system that is being designed support all integrated prevention and promotion activities.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

Economic and Employment Services
DCF Administration Building
555 S. Kansas Ave., 4th Floor
Topeka, KS 66603



Phone: (785) 296-3349
Fax: (785) 296-6960
www.dcf.ks.gov

Phyllis Gilmore, Secretary

Sam Brownback, Governor

August 26, 2015

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dr. Mr. Rose:

Kansas Department for Children and Families/Economic Employment Services (DCF/EES) is writing this letter in support of the Kansas Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and its role as the Single State Authority for Mental Health and Substance Use Disorders (SUD) Services.

This agency works in collaboration and partnership with KDADS/BHS and is willing to participate and support the priorities of this agency regarding SUD. Currently, DCF/EES is in partnership with KDADS/BHS as follows:

Interagency Agreement for Solutions *Recovery Care Coordination (SRCC)* services to provide assessment and referrals for mandatory adult recipients of Temporary Assistance to Needy Families (TANF) Work Programs. The purpose in providing SRCC services is to assist TANF recipients with SUD through intensive case management with the goal of obtaining and retaining gainful employment.

Again, DCF supports and understands the importance of TANF recipients receiving quality care for SUD services for prevention, treatment and recovery in order to obtain and retain gainful employment.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Kimmons".

Sandra Kimmons
Economic and Employment Services Director
Kansas Department for Children and Families

Strong Families Make A Strong Kansas



Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

August 26, 2015

To whom it may concern:

The Kansas Department of Health and Environment Tuberculosis Control and Prevention Program is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/or partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS on the following project:

- Ensuring compliance with SAPT BG regulations for TB control

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,

Phil Griffin, BBA, CPM
Bureau of Disease Control and Prevention Deputy Director
Kansas Tuberculosis Controller

New England Building
503 S. Kansas Ave.
Topeka, KS 66603-3404



www.kdads.ks.gov

Sherman "Wes" Cole, Chairperson
Gary Parker, Vice Chairperson

Sam Brownback, Governor

Kari Bruffett, Secretary
Kansas Department for Aging and Disability Services
503 S Kansas Ave.
Topeka, KS 66603

Dear Secretary Bruffett:

In submitting the Kansas Implementation Report for the CMHS Block Grant it is required that a letter from the State Mental Health Planning Council be enclosed as well, containing comments on the report. The Council has been actively involved in the development of the Block Grant, and in reviewing performance indicators for adult, children, and substance use services.

The ongoing work of the subcommittees includes assistance from stakeholders whose expertise enhances the final reports and the scope of information provided. Participants not only include members of the Governor's Behavioral Health Services Planning Council (GBHSPC), but other persons who are invested in improving access to service and recovery outcomes for individuals with behavioral health issues. A behavioral health staff person supports each subcommittee. In addition, the block grant coordinator provides updates to the Council and its executive committee with information on the block grant each quarter. During the month of June, 2015, annual subcommittee reports were presented to you and the Secretaries of the Kansas Department of Health and Environment, the Department of Corrections, and the Department of Children and Families.

During the upcoming year, the GBHSPC subcommittees will be focusing on the following areas:

- Housing and Homelessness
- Children's Services
- Justice Involved Youth and Adults
- Supported Employment/Vocational
- Kansas Citizens' Committee on Alcohol and Other Drugs
- Rural and Frontier
- Veterans
- Prevention
- Suicide Prevention

The subcommittees identify the needs of adults and children who have a severe and persistent mental illness, serious and emotional disturbance, and substance use disorders. Their findings greatly impact our decisions and recommendations. We have again seen an increase in the involvement of adult consumers in program

planning and development as well as in self-advocacy. We continue to see an increase in the participation in the Consumer-Run Organizations (CROs), and youth participating in the Youth Link (Y-Link) activities. Their efforts and activities continue to play an important role in the reintegration of consumers to the community. In addition, the Council has completed integration of substance use and mental health, and has included substance use disorders as a topic, for the Kansas Citizens' Committee and Veterans' Subcommittees in particular.

2016 will bring us new challenges of providing a framework for the integration of physical health, mental health, and substance use services.

We would especially like to thank you and KDADS Behavioral Health Services staff for your continued support of the Governor's Mental Health Services Planning Council in carrying out its responsibilities.

Sincerely,

A handwritten signature in cursive script, appearing to read "S. Cole".

Sherman Wes Cole, Chairman, Governor's Mental Health Services Planning Council

Cc: Bill Rein, Commissioner of Behavioral Health Services
Ted Jester, Assistant Director



714 SW Jackson St, Suite 300
Topeka, KS 66603

Phone: (785) 296-4213
Fax: (785) 296-1412
Email: kdocpub@doc.ks.gov
www.doc.ks.gov

Ray Roberts, Secretary

Sam Brownback, Governor

August 27, 2015

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisory, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Re: Mental Health/Substance Abuse Block Grant

Dear, Mr. Rose:

Kansas Department of Corrections, Division of Juvenile Services (KDOC-JS) supports the Kansas Department for Aging and Disability Services (KDADS) application for continued Mental Health/Substance Abuse Block Grant funding.

This resource from Substance Abuse Mental Health Services Administration (SAMHSA) is an important part of KDADS delivery of mental health (MH) and substance use disorder (SUD) services; which is fundamental to public safety in Kansas. Further, early identification and intervention in behavior health issues for children and adolescents enhances their opportunity to achieve success in school, family, community, and in life.

KDOC-JS is an advocate for behavior health services that are provided timely, consistently accessible, effectively matched to individual needs, and delivered with high quality. When this is achieved, behavior health services contribute to the overall reduction in juvenile crime and subsequent juvenile justice interventions.

KDADS supports collaboration among many stakeholders, including KDOC-JS, through membership and participation on the Governor's Behavior Health Services Planning Council and the Justice Involved Youth and Adults (JIYA) and Children's subcommittees. KDADS staff and service providers are also active in Kansas' current comprehensive examination of our juvenile justice system.

Respectfully,

Randy Bowman,
Director of Community-Based Services



Susan Mosier, MD, Secretary
Michael Randol, Director

Department of Health & Environment

Sam Brownback, Governor

August 28, 2015

Gilbert P. Rose, R.N. M.P.H.
USPHS CAPT
Senior Public Health Advisory, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose,

The Kansas Department of Health and Environment/Division of Health Care Finance (the Medicaid Single State Authority), is writing this letter in support of the Department for Aging and Disability Services/ Behavioral Health Services (KDADS/BHS) in their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration with KDADS/BHS staff and supports the priorities of this agency as it interfaces with the Medicaid program.

This collaboration is demonstrated through several means. A KDHE/DHCF staff member is a member of the Governor's Behavioral Health Services Planning Council. Additionally, we are involved and currently partner with KDADS/BHS on several projects on an as needed basis.

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continuing this support to ensure individuals seeking services for SUD/MH issues are provided appropriate care.

Sincerely,

Michael Randol
Director, Division of Health Care Finance
Kansas Department of Health and Environment

714 SW Jackson, Suite 300
Topeka, KS 66603



Phone: (785) 296-3317
Fax: (785) 296-0014
Email: kdocpub@doc.ks.gov
www.doc.ks.gov

Ray Roberts, Secretary

Sam Brownback, Governor

August 28, 2015

Gilbert P. Rose, R.N., M.P.H.
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State & Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose:

The Kansas Department of Corrections is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and/in partnership with KDADS/BHS and is willing to participate and support the priorities of this agency. Within our incarcerated inmate population, over 38% are mentally ill and 66% are substance abusers. Of the 66% of the population that are substance abusers, 33% are confirmed addicts of their substance abuse. We know that at least 75% of the offenders, who have their parole violated, so they return to prison, are struggling with behavioral health issues, including addiction, misuse of drugs and alcohol, and mental health. We also know that of those offenders who are on probation, and are revoked and sent to prison, well over half are revoked because of behavioral health needs and related behaviors. Therefore, I know only too well the challenges that are faced with this group of individuals.

At this time, we are involved and partner with KDAS/BHS on the following projects:

- Multi agency work group addressing adult continuum of care for behavioral health services.
- Collaboration4Success pilot project to address the behavioral health needs of parolees and probationers in one county.
- Ongoing collaboration to incorporate strategies to address criminal/anti-social thinking in behavioral health services and recovery tools in corrections services.
- Treatment and supervision for DUI offenders.
- Justice Reinvestment Initiative Workgroups.

Given the challenges we face within our agency and the overall Kansas public safety community with this specific population, we understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided comprehensive quality care.

Sincerely,


Ray Roberts
Secretary

Rehabilitation Services
555 S Kansas Ave., 3rd Floor
Topeka, KS 66603



Phone: (785) 368-7471
Fax: (785) 368-7467
TDD: (785) 368-7478
www.dcf.ks.gov

Phyllis Gilmore, Secretary

Sam Brownback, Governor

August 28, 2015

Gilbert P. Rose, RN, MPH
USPHS CAPT
Senior Public Health Advisor, Team Lead
HHS/SAMHSA/CSAT/PPGB/Division of State and Community Assistance
1 Choke Cherry Road, Room 5-1067
Rockville, MD 20857

Dear Mr. Rose:

On behalf of Kansas Rehabilitation Services, the state's vocational rehabilitation agency, I am writing to support the application by the Kansas Department for Aging and Disability Services (KDADS) for the Mental Health/Substance Abuse Block Grant. KDADS/Behavioral Health Services (BHS) is the Single State Authority for mental health and substance use disorders.

Our agency works in collaboration with KDADS/BHS. We are committed to our ongoing partnership to support the priorities of this agency and participate in collaborative initiatives. Together with KDADS and three other cabinet-level agencies, we are developing a five-year employment initiative called End-Dependence Kansas. This initiative will focus on the use of evidence-based employment practices to increase work options and outcomes for Kansans with disabilities. End-Dependence Kansas will expand on the use of the Individual Placement Supports model, which is currently a priority for both agencies. We are also represented on the Governor's Behavioral Health Services Planning Council and its vocational sub-committee, which provide additional opportunities for open communication and collaboration.

We also acknowledge the importance of addressing substance use disorder and mental health (SUD/MH) services from the perspectives of prevention, treatment, recovery and employment. We are committed to continuing our support to ensure that individuals seeking services for SUD/MH issues are provided with quality services.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Donnelly".

Michael Donnelly
Director

Strong Families Make A Strong Kansas



Kansas Department of Revenue
Alcoholic Beverage Control Division
Cigarette and Tobacco Enforcement Team
915 S.W. Harrison Street
Topeka, KS 66625-3512
Phone: 785-296-7015 Fax: 785-296-7185

August 31, 2015

To whom it may concern:

Kansas Department of Revenue/Alcoholic Beverage Control is writing this letter in support of the Department for Aging and Disability Services/Behavioral Health Services (KDADS/BHS) and their role as the Single State Authority for Mental Health and Substance Use Disorders Services. Our agency works in collaboration and partnership with KDADS/BHS and is willing to participate and support the priorities of this agency.

We are involved and currently partner with KDADS/BHS in efforts to reduce tobacco consumption by youth and maintain compliance rates for Synar.

We understand the importance of addressing SUD/MH prevention, treatment, and recovery and are committed to continue our support to ensure individuals seeking services for SUD/MH issues are provided quality care.

Sincerely,

Marci Rosencutter
Tobacco Program Coordinator

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is needed related to this section.

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

The Council has been actively involved in the development of the Block Grant, and in reviewing performance indicators for adult and children's services. The ongoing work of the subcommittees includes assistance from stakeholders whose expertise enhances the final reports and the scope of information provided. Participants not only include members of the Governor's Behavioral Health Services Council (GBHSPC) but other persons who are invested in improving access to service and recovery outcomes for individuals with behavioral health issues. A behavioral health staff person supports each committee. The committee members elect chairpersons. Each subcommittee develops a charter which is approved by the executive council and is inclusive of recommendations to the Secretary of KDADS. The charter deals with their implementation projects and focus areas for the upcoming year. During the month of June 2015, annual subcommittee reports were presented to the Secretary of KDADS. These reports are utilized along with other communications through the KDADS liaison to the Council in developing the state plan and the block grant application.

During the year, the GBHSPC subcommittees will be focusing on the following areas:

- Housing and Homelessness
- Children's Services
- Justice Involved Youth and Adults
- Supported Employment/Vocational
- Kansas Citizens' Committee on Alcohol and Other Drugs (KCC)
- Rural and Frontier
- Veteran's
- Prevention
- Suicide Prevention

2. What mechanism does the state use to plan and implement substance abuse services?

The Kansas Citizens' Committee on Alcohol and Other Drugs (KCC) Sub-Committee is under Kansas statute as an advisory committee to the Secretary, and also serves as a subcommittee for the GBHSPC. The KCC was incorporated into the structure of the GBHSPC as part of the integration of SUD and MH services into one Commission of KDADS on Behavioral Health Services. Membership of the subcommittee has representative of consumers, other state agencies, law enforcement, and providers of SUD services, prevention services and general public. The subcommittee makes recommendations to the GBHSPC and to the Secretary of KDADS and other Agency Secretaries such as the Department of Corrections, the Department of

Commerce, and the Department of Health and Environment. Members of the KCC are also encouraged to participate on other GBHSPC subcommittees to advocate and education the need to be inclusive of or SUD services.

The Veterans Subcommittee is currently involved with SAMHSA's Service Members, Veterans, and their Families Technical Assistance Center in working on SUD supports for veterans and also provides recommendation to the Secretary on behavioral health services for persons that have served in the military and their families.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

The Kansas statute has been amended to change the Governors Mental Health Service planning Council to the Governors Behavioral health Service Planning Council and the membership was expanded to include representation of a SUD provider, a prevention provider, person in SUD recovery, family members of persons experiencing substance use disorders, as well as persons that are serving as peer mentors to persons experiencing SUD and MH issues. The council will continue to provide support as the integration progresses and provide insight to facilitate the process. During the year the council continued to sponsor subcommittees to study the needs of adults, children, and issues related to substance use disorders and prevention in the general population. The council has included substance use disorders as a topic for all subcommittees, including the KCC and Veteran's subcommittees in particular.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

The membership is inclusive of the state's population and when vacancies or term limits are available for new membership positions, persons are recruited to apply for appointment to the Council that reflect diversity within the Council as well as geographic representation of the state's population.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The duties of the Council are:

1. To review the Block Grant Plan and to make recommendations;
2. To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance and other individuals with mental illnesses or substance use disorders;
3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of services within the State.

During the year, the council sponsored subcommittees to study the needs of adult and children who have severe and persistent mental illness and a serious emotional disturbance. Their findings greatly impact our decisions and recommendations. We continue to see an increase in the involvement of adult consumers in program planning and development as well as in self-advocacy. We continue to see an increase in the participation in the Consumer-Run Organizations (CROs), and youth participating in the Youth Link (Y-Link) activities. Their efforts and activities continue to play an important role in the reintegration of consumers to the community. The Chair and the Co-Chair and the KDADS liaison of the Council attend the bi-monthly meetings of the state network of Consumer Run Organizations (CROs). The Regional CRO Recovery Centers and the Kansas Consumer Advisory Council (CAC) made presentation and recommendations to the Secretary and the Commissioner of KDADS and will continue to do presentations yearly. The CROs and the CAC are scheduled to provide presentations to the full council later in the year.

GBHSPC meeting, Valeo Behavioral Health Services Crisis Center, Topeka, KS

January 20, 2015

Start at 9:05 am; End at 2:15 pm

Attendance: Wes Cole, Gary Parker, Michael Leeson, Rick Cagan, Guy Steier, Glea Ashley, Fran Seymore-Hunter, Al Dorsey, Sue Schuster, Cheri Bledsoe, Denise Baynham, Jane Adams, Randy Bowman, Peg Spencer

Phone: Teresa Briggs, Sandra Dixon, Walter Hill, Ric Dalke, Roxanne Bollin, Gina Meier-Hummel

Guests: Carla Drescher, Charles Bartlett, Monica Kieffer, Bill Rein

Announcements:

- Rick Cagan announced Mental Health Advocacy Day on March 12th. He said there would also be an advocacy network training event on March 11th.
- Gary Parker said he had been invited to represent consumers with government officials during the President's Lawrence visit to discuss Access to Recovery and Affordable Care Act.
- Wes Cole said the new KDADS website was online and that any updates or changes could be sent to Charles Bartlett.

Presentation – Bill Rein, Director of Hospitals, Chief Counsel for KDADS

- Bill Rein gave a status update of the state hospitals.
- He discussed the new admissions policy, managing involuntary admissions, and central office's involvement with Osawatomie.
- He also gave status updates on other state hospitals.

KDADS Updates – Carla Drescher and Charles Bartlett (also Gina Meier-Hummel via phone)

- Budget for the agency will be released on Friday, January 23rd.
- There will not be retroactive impact on the block grant due to sequester.
- Workgroup to review ICMS final rules and how they impact waivers.
- Kansas will apply for and pick an appropriate domain for Brass TACS Policy Academy
- The federal site visit related to prevention encouraged a move toward integration. The state will be releasing a request of information (RFI) to gain input on how the system could integrate other areas of behavioral health. A request for proposals (RFP) will follow after the RFI has been reviewed.
- An RFP will be coming out for the work that is currently by ValueOptions related to the block grant.
- Content analysis was being done on Strategic Plan and will be ready to roll out soon.

- KDADS hired a new staff person to work with the adult services and added staff to support block grant monitoring.
- Block grant application was released and is due September 1st. It will be a combined application between mental health and substance use disorders.

Presentation – Gary Parker, Cheri Bledsoe, Denise Baynham

- Information was presented on the work being done by the Consumer Run Organizations (CRO).
- Highlighted they need to be consumer driven and lead.
- Currently 13 funded CROs in 6 regions with 1600 members

CIT Proposal/Future Recommendations Process

- Rick Cagan presented a proposal for the council's support related to a Crisis Intervention Team State Coordinator position from the JIYA subcommittee. The council voted to move forward the CIT recommendation forward.
- The council discussed developing a process for handling requests like this going forward. It was decided that subcommittees could bring forth items for the council's support. The council work to continue develop criteria and a standardized process.

Subcommittee Annual Reports

- It was decided that subcommittees could present to the council its annual reports to the council first, before the presentation to the Secretaries.
- The council could then provide feedback and have discussions with the subcommittees if necessary.
- At that the point, the final version of the summary annual report could be presented to the Secretaries.
- The council agreed this would help provide perspective on the activities that may be overlapping within the subcommittees and how those efforts could be shared.
- The council also discussed creating a grid or chart template to track the recommendations and priorities. This would help have with overlap of efforts and encourage collaboration within the subcommittees.

Rural/Frontier Subcommittee Report

- Cole provided the report for the council's review. He added that they would be looking for the council's support for these items in the future.

Recognition Discussion

- The council discussed the future possibilities of developing a recognition process and collecting historical information related to behavioral health in the state.
- Research was going to be conducted on finding the best format for this.

Vacancies

- Cole called attention to the handout that contained the current vacancies on the council.
- He added that two more positions were also open due to conflicts and job changes.
- He also said that two individuals had been approved but waiting to be appointed.

Subcommittee Chairs Meeting

- Cole would like to have all the subcommittee chairs come together. He will discuss further with the executive committee at a future meeting.

The meeting ended with a tour of the Valeo Crisis Center.

Next Meeting: Tuesday, March 24 – Location: TBD

Respectfully submitted,
Monica Kieffer

GBHSPC Meeting, July 17, 2014, Hays, KS, High Plains Mental Health Center

Present: Wes Cole, Gary J. Parker, Al Dorsey, Guy Steier, Fran Seymour-Hunter, Sue Schuster, Glea Ashley, Kathy McNett, Walt Hill, Ted Jester

Phone: Rick Cagan, Jane Adams, Denise Baynham, Roxanne Bollin, Cherie Bledsoe, Michael _____, Teresa _____,

Guests: Brenda Seemans, Koleen Garrison, Ken _____,

Wes called the meeting to order at 10:10 am.

Announcements:

- Thanks to Walt for hosting the meeting
- Struggling to get meeting with secretary
- Four vacancies on the council. Trying to get interviews
- Good meeting with the KCC. In September, they will have a Recovery Conference, focusing on substance use disorders.
- There will be a proclamation from the Governor's office regarding Recovery month

Walt Hill – Director of High Plains Mental Health Center

- Just celebrated its 50th anniversary
- Had a celebration dinner, with the Lieutenant Governor present.
- 19,000 Square miles, 20 counties
- 2100 video services (approx 10 per day) utilized during the past year.

Brenda Seemans:

- Treat over 5000 people per year
- Travel over one million miles per year
- 6 offices: Goodland, Colby, Norton, Phillipsburg, Osborne, and Hays
- 8 Satellite Offices: Hoxie, Atwood, Oberlin, Quinter, Russell, Hill City, LaCrosse,
- Crisis Services staff available after hours.
- Traditional outpatient services
- Medical services/tele-video services
- Substance use level one services
- Housing services at Woodhaven (Hays) and Colby House Apartments (Colby)
- Schwaller Center (crisis stabilization center) – started in 2002
- Voluntary family foster homes?
- Very strong Mental health first aid program
- Connections for Life – Health Home program

Ken

- Mental Health first aid, 38 trainings, 837 certified
- Youth Mental Health first aid, 5 trainings, over 100 certified
- Worked with KU (Mendenhall) and had some great feedback as a result of the training.
- This program works because of the support received.
- Does not charge for the trainings.
- Work closely with the School district for the youth training
- Have done some trainings with individuals from the CROs

Kathy Shafer

- Screening and referral
- TVC screening in every county via the sheriff's department
- 2/3 of the time, divert someone from being hospital
- "Same Day Access" can be done via call in or walk in (for entry)

Ann Young

- Outpatient therapy
- Supervisors Outpatient Clinical therapists
- Cognitive Behavioral Therapy with kids
- Will do assessment – Do we need to do more services?
- Family Therapy

Mark

- Westside School Program
- Increase the function of the child and the function/support of the family
- Hays, Victoria, Ellis, LaCrosse Co-op
- Review behavior plans
- Review outpatient service availability
- Parents must participate
- Child must meet SED criteria
- Always look at least restrictive environment
- K-12

Walt

- Two medical psychiatrists on staff
- 2 Registered nurses
- 800 patients seen only for med management
- Have created scholarships to send staff back to get graduate degrees
- Utilizes Common Ground through a partnership with KU
- Have a staff of 129

Jennifer Colby

- Developing SUD program
- Kicked off March 1, 2014
- Prescription abuse included
- Seeking Safety – for people with Trauma/substances
- Detox center to be opened

Daphne Brown

- Manager of the new Health Home program at High Plains
- 6 services: Comprehensive Management; Care Coordination; Patient and Family Support; Comprehensive Transitional Care

Lunch

Video

Visit to the Schwaller center

Presentation by High Plains Independence CRO

- Gina Anderson, Director, introduced her members
- Told history and story about the CRO
- Told about the good work that they are doing

CRO Redesign Updates

- 13 CROs have been funded for FY 15
- Technical assistance will be provided to the CROs, as well non-funded consumer groups by the CAC as well as CCSR (WSU)
- CRO Network meetings will be held throughout the year with continued support from KDADS and the Office of Consumer Affairs.

CAC Australia Partnership

- CAC will continue developing a partnership with Consumers in New South Wales
- CAC will host a two day conference in Sydney in May, 2015, on Trauma-informed Care for approximately 200 providers
- CAC will host a three day “train the Trainer” for CRO Specialists in Sydney in May, 2015

We thanked Walt for hosting the meeting.

How could we use technology better to access people better. Create a smart application.

Meeting Adjourned

Next meeting: September 23

Next Exec. Board: August 20

November 18, 2014

Attendance: Guy _____, Rick Cagan, Ted Jester, Ric Dalke, Teresa _____, Wes Cole, Gary J. Parker, Kathy McNett

Phone: Roxanne Bolin, Fran Seymore-Hunter, Sandra Dixon, Al Dorsey, Cherie Bledsoe, Denise Baynham, Walt Hill, Glea Ashley, Sue Schuster

Guests: Dr. Kinlen, Cory Turner, Patient Panel/Staff, Melissa _____, Victor Fitts, Koleen Garrison

Overview of the State hospital

- Recruitment, retention, staff top priorities
- Remodel
- Food contract
- Tele-psychiatry
- 100 anniversary of the state hospital
- Started employee recognition ceremonies quarterly
- Working on the infirmary
- Upgraded security entrances to Isaac Ray building
- Key machine – Employees enter PIN to get work keys each day, and turn in keys at the end of the work day. Keys are never taken home.
- Census Contingency plans are in place
- Safe rooms have been added to the facilities
- IPAD monitoring system is beginning to be implemented

Handout of the overview of the state hospital

- *Fran has requested that a copy of this handout be sent to board members*
- Current policies are being revised for the SPTP
- Staffing issues
 - psychiatry is an issue due to salary, location.
 - Medical staff – very difficult to maintain
 - Frontline staff – had to expand when they were not ready to explain
 - LPNs are an issue. Working with Barton County Community College that hopefully will bring a site to the LSH Campus, so people can get credit for the LPN.
 - Peer specialists – Trying to find funding for an FTE for this. They are in favor for hiring. Just cannot find the position slot to allow this to happen. This is something that the council can advocate to the state for.
 - Pay structure is higher, based on location. There is some flexibility to help with recruitment

Discussion took place, regarding transporting

Panel of Patients

- “More hope”
- “Longer stay worked better for me”
- “Worried about being able to afford meds upon discharge”
- “Hospital has been a great support for me, when I needed it!”

- “I plan on going back to school”
- “Peer support while in the hospital has been very vital to my treatment”
- “Staff is doing well”
- “more technology would be greatly appreciated – computers, etc., for patients to use”
- “cold food on the unit ATC West should be addressed”

Special Announcements

- National Federation of Families
 - Heroes and Pioneers – recognized Jane Adams as one of the 25. To be recognized November 22.

Block Grant

- Have invested \$75,000 for the law enforcement for TIC training.
 - This will increase trainings from 2 to 3. Also developing a video training.
 - Developing a series of six one day trainings
 - Developing a TOT – Training of Trainers – for Mental Health First Aid
- Working on the report for the 2014/2015 combined block grant application
- Indicators have changed since the last application.
- KDADS has made a proposal on what the indicators should be, and are waiting for SAMHSAs approval.
- The 2017 grant application due date is April 1, 2015.
 - SAMHSA is down to six strategies
 - Prevention
 - Healthcare
 - Trauma and justice
 - Health Information Technology
 - Recovery supports
 - Workforce Development
- Executive Committee will be looking at these various strategies.

KCC (Kansas Citizens Community) Presentation

- Made up of a variety of people from many different areas.
- Was part of the Recovery Month initiative (Recovery Idol) in Sedgwick County.
 - Brought approx 450 people.
 - This year, 600 participants at Century II.
 - Recorded, Video
- How do we encourage developing community resources in the state? i.e. Churches,
- Promote Public Safety components
 - Evidence based programs
- Supporting expanding Medicaid
- Identifying gaps in treatment
 - Competitive salaries
 - Working with educators in the various programs/making recommendations to them
- *Kathy McNett – Does the Foster Care system know about you?*
- How do we get the plan going, then make the appropriate recommendations/strategies?

Announcements:

- Laura Howard has resigned from SAMHSA
- Dailyn Schmidt has resigned
- Citizens Advisory Committee at OSH spoke with legislators. They seemed to be very supportive for mental health issues.
- Alternative Sentencing court has been established in Topeka.
- Chris Howell – Tribal issue, has resigned his position, so we will be working with a new person
- December 10 – meeting (NFMH) in Topeka at the Library from 10 – Noon
- Meeting dates have been set for the following year, and has been sent out to members
 - The council needs to get its house in order
 - Bylaws
 - Membership
 - Etc.
 - Executive committee to start doing some strategic thinking on how we present issues and how to move forward. Use new approaches.
 - Ex-officio members may be added in order to fulfill SAMHSA requirements. This includes a tribal person.
- Meeting of the chairs – *Guy—how do we become part of the process? Who is driving the bus?*

GBHSPC Council Meeting, September 23, 2014

DCCCA. Lawrence, KS

Attendance: Roxanne Bolin, Sandra Dixon, Cherie Bledsoe, Wes Cole, Gary J. Parker, Ted Jester, Rick Cagan, Bailey Reed, Michael Leeson, Jane Adams, Glea Ashley, Catherine Ramshaw, Guy Steier, Viola Riggins

Phone: Walt Hill, Al Dorsey, Fran Seymore-Hunter

Excused: Kathy McNett,

Guests: Sarah Fischer, Doug Wallace

Meeting Began at 9:07 am

Announcements

- New Assistant Mental Health Director – Ted Jester. Ted will remain as liaison to the council
- Subcommittee reports were given to the Secretary, as well as to the Commissioner. Given over three days. Each subcommittee will have the opportunity to present to the council during the year.
- Invitation to a grand opening of a new hospital facility (crisis stabilization) on the KCMO
- Aging Subcommittee has been folded over into the Aging Coalition.
- Hospital and Home work group is no longer. The work of this group will be merged into the council. Originally started as Service Delivery Subcommittee, which really defined services. All subcommittees will be asked to look at the services that fit for the work that they do. What are the barriers? Discussion concerning how to move forward, and which groups would be looking at issues followed.
 - Publication from SAMHSA
 - Secretary has announced a \$million project
 - Tribal representation for the council in an ex-officio position is being worked on.
 - Block grant site review will be taking place soon. No specific date was given, but stated it would be for a two -3 day meeting.
 - Executive board will be meeting on November 5 to discuss the retreat for the council. Will be held the first of the year.

Prevention Subcommittee (Sarah Fischer)

- Charter distributed
- Receives federal discretionary funds (grants), which requires an advisory council
- SAMHSA recommendation from
- Has representation through Suicide Prevention and other subcommittees
- Want to allow people “self-direction” in the direction that the group goes
- Brings people together (behavioral health prevention programs)
- *Walt would like a copy of the charter and requirements for this group from SAMHSA*
- *Jane will send contact information to Sarah regarding the Librarian who spoke in May*
- Assessments – how can they be better streamlined?
- Wes – The council will support and approve and make this a subcommittee of the council.

Block Grant Review and Update

- Mini-application was due September 1, 2014
- New strategic Initiatives include the following:
 - Prevention of Substance Abuse and Mental Illness
 - Trauma and Justice
 - Workforce development
 - Health Information Technology
 - Recovery Support
 - Health Care and Health Systems Integration
- BHS will submit a report on performance indicators, data, and fiscal info on December 1. An update will be given to the Council of the indicators at the next meeting
- BHS plans to submit the 2016/2017 combined block grant application on April 1, 2015. This will be the new deadline in the future.
- BHS staff plans to meet with Wes to go over the work plans which includes plan for communication to and from the Council.
- Ted – Will try to get the budget to the council, so that the council will actually know how the money is being spent.
- How do we start getting back to being able to have consistency, so the Council can adequately review the block grant
- What have done in the past that worked, that maybe we need to look at, so that we can fall back to doing that again?
- Things that they ask
 - What planning mechanism does the state use to plan and implement substance abuse services?
 - How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
 - Was the council actively involved in developing the State BG Plan? If so, please describe how it was involved.
 - Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
 - Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
 - Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Housing and Homeless Subcommittee

- Vision – Our vision is that all Kansans experiencing a severe and persistent mental illness, serious emotional disturbance and/or co-occurring disorders have access to safe, decent affordable, and permanent housing.
- Recommendations:
 - Continue supporting the provision of training for SOAR case managers.

GBHSPC meeting, Kansas Association of School Boards, Topeka, KS March 24, 2015

Start at 9:12 am; End at 2:59 pm

Attendance: Wes Cole, Rick Cagan, Guy Steier, Fran Seymour-Hunter, Sue Schuster, Cheri Bledsoe, Denise Baynham, Jane Adams, Sandra Dixon, Ric Dalke, Roxanne Bollin, Gina Meier-Hummel, Charles Bartlett, Jim Castello, Ted Jester, Monica Kieffer, Kirk Schottler, Kathy McNett, Randy Bowman

Phone: Walter Hill

Guests: John Calbeck, Rev. Dave Fulton, Panel Presenters

KDADS Update:

- Gina Meier-Hummel announced her resignation and she will become the Executive Director at The Shelter in Lawrence. Her last day at KDADS is May 1st.
- She also stated that there will be an RFP for assessment done by CMHC. CMS preferred that those doing the assessment and providing service not be the same. She was not clear on if the RFP would be separate or would be rolled into existing contract.
- There is a new proposed law around mental health medication. It was passed to House and went to Senate. It has since been sent to a subcommittee. There would be an advisory committee/panel and changes in the formulary for KanCare/Medicaid would go through the panel.
- Plan on continuing to use waiver programs. Have extended waivers at this time and conversations with CMS are tied into what is going on with DOL. State has verbally been told to expect some extensions related to this.
- Additionally active discussion of grants we did not fund. The legislature continues to discuss what they will and will not fund. Conversations are ongoing on what will be restored. Grants are slated to not be funded unless the legislature says otherwise. The planned RFP for integrated prevention programming process is moving forward. The state expects the RFP for these grants to be posted by Department of Administration within the next week or so and will be open for 30 days. The contracts will be awarded by the end of May with a start date of July 1st.
- The state hospital census is a priority. KDADS is actively engaged in staffing issues. They are creating alternative options and approaches. At the time of the meeting, Osawatomie was down below census at 193. Census is 206.
- KU Medical Center has purchased the building that is currently housing RSI in Kansas City. RSI is actively working on moving forward. The monies from the purchase will go specifically to building community support programs.
- RSI continues to be successful program. One of the new things is they can take direct admits from field paramedics. Johnson County paramedics can direct to RSI without having to go to emergency room or jail if they assess mental health or substance use issues only. The state is working towards something similar to be operating in three major metro Kansas areas. There be a celebration and public discussion for the anniversary of RSI.

- Charles Bartlett said that efforts on ongoing to train as many as possible in Mental Health First Aid. They are trying to especially train people who work within diversion from jails and state hospitals.

Announcements:

- Sue Schuster is working with NMFH group. Currently they are in the planning and formation phase.
- Rick Cagan provided NAMI Advocacy Day update. He said they don't have an exact count of number of participants but participants were able to have a lot of contact with legislators. Sec. Bruffett made a presentation.
- Randy Bowman talked about the work of Kansas Juvenile Services. He has been invited to work with councils of state governments and public safety issues in the fall. The work will be data-driven and qualitative. They will be looking at screenings and way that services are disconnected. They will also be looking at things that can be done on the corrections side to help that are within the power of the Secretary.

Appointment and GBHSPC New Business:

- Wes Cole said a tribal appointee has been added by the legislature. No one is currently in this position. The person of interest for that position is now out-of-state.
- Current vacancies were discussed. Members suggested contacts be made with the Kansas Department of Education and the KCC subcommittee for suggestions.
- Some members expressed barriers that have prevented some applying and some completing the application process.
- Cole stated that if a person of interest is identified, the council needs to work with that person on the application process and see it to completion.
- Future meeting dates were outlined. Next full council meeting is May 1st. This meeting will be to hear subcommittee reports and provide suggestions and feedback on the reports. There will also be an upcoming full council meeting focused on children's issues. These meetings will meet the deadline for the block grant.

Faith in Community Presentation – KCC Subcommittee: John Calbeck, Chair and Rev. Dave Fulton, Citizen Member

- Faith in Community is a partnership initiative that has the support of the KCC Subcommittee. Rev. Fulton is a pastor from Wichita and Calbeck is the executive director of Prevention and Recovery Services in Topeka.
- The vision is "a sustainable statewide organization which uses faith partners to accomplish drug and alcohol prevention and recovery."
- The mission is "We will provide effective prevention and recovery strategies through faith communities and other partners so that Kansas citizens, families, youth, and children will experience health and well-being."
- The guiding principles will be faith-centered, non-denominational, non-evangelistic, and community-driven. Evidence based practices for prevention and recovery would be provided

that utilize community-based processes, information dissemination, prevention education, and support for recovering individuals.

- Partners will include but not limited to congregations, faith groups, service organizations, prevention professionals, and the KCC. The initiative will target families, children and youth, adults, government policy makers, organization decision makers, and service organizations.
- The 3 components would be:
 - *The schoolhouse* is where training in the approach will take place. I see KLC as the schoolhouse.
 - *The tools* are the programs we offer, including leadership training, Youth Corps, Partners for Wichita training (how to be a faith based action center), Safe streets training (how to mobilize the community), training in prevention science, etc.
 - *Action Centers* are locations in the communities where we engage with FIC. The action center in the community then becomes the place where resources are mobilized to implement programs in the community, or, to use the tools in the tool box. Orientation to the model, training and consultation would happen at the school house.
- Comments included:
 - Making sure that mental health and substance use disorders are both used or that overall behavioral health is addressed.
 - Review work of interfaith groups in Douglas and Shawnee counties.
 - Will promote community engagement on behavioral health issues and hopefully help reduce stigma.

Integrated Services at CMHC's Panel – Ric Dalke

- Prairie View - Karla Roth, LCSW and Ronda Tammen, RN, BSN
 - Synergy: Accessible
 - Physical and Structural: BH office, Nurses Station, Exam Rooms
 - Bridge: RN Behavioral and Mental
 - Screens
 - System change from Mental to Behavioral
 - Buy-In with Providers, Staff, and Patients
 - Behavioral Interventions to Support Primary Care
 - "If you take *Behavior* out of the equation, how would you lose weight?"
 - Changed Behaviors Improved Clinical Outcomes
 - Providers Changed
 - Patients Changed
- Horizons Mental Health Center - Beth Akins, M.S.W.
 - Created a new department that is focusing on health homes
 - They are called in for about 20-30 minute consultations and providers will ask them back if follow-up is needed.
 - All clinical staff is LCSAC level
 - Part of her job is to educate provider to provide some perspective on smaller goals
 - Hard to get primary care to focus on smaller goals because of limitations mental health issues can play on a patient's capacity

- Heartland Community Health Center/Bert Nash Center - Karin Denes-Collar, LCSW
 - Integration started through Sunflower Foundation grant in 2011
 - Started with Behavioral Health Consultant part time then full time and initially worked on bidirectional integration
 - Behavioral Health Consultant: Key member of team and have close coordination with primary care providers and Bert Nash providers
 - Any patient of the clinic, a potential BHC patient
 - Office in the middle of exam rooms: Currently - Brief visits, average 30 minutes
 - Warm handoffs whenever possible, assessments, screening, education
 - Brief treatment of depression, anxiety, insomnia, ADHD and SBIRT
 - Smoking cessation, Weight management and Diabetes/health behavior change
 - Modalities used: Motivational interviewing, Solution focused therapy, Mindfulness skills, Cognitive-behavior therapy/DBT
 - AmeriCorps Health Coaches - Grant through United Way
 - Utilized prior to start of BHC integration
 - Now fit in our PCMH model and paired with a PCP
 - Variety of roles, including: Smoking cessation, health behavior change, medication adherence and track patients need for follow up
 - Psychiatry
 - Bert Nash Center APRN at Heartland .2 FTE
 - Patients referred by PCP for consultation and monitoring and shared patients seen at Heartland by APRN for closer coordination
 - Bi-directional curbside consults
 - One challenge is Billing: Not every visit is billable and phone time not billable, helping patients adjust to different model of care and primary care at Bert Nash
 - Successes: Close partnership with CMHC: staff knew the BHC and collaboration nearly seamless and Early screening and treatment: very low no show rate, smoking cessation, lifestyle changes

- The council discussed a need for more work on integration not only between mental health and primary care but also substance use disorders. They also discussed how braided funding will lead to more integration. There was also discussion in relationship to the move towards integration and the block grant dollars.

Subcommittee's 2015 Reporting Process

- Cole would like to have all the subcommittee chairs come together. He will discuss further with the executive committee at a future meeting. He said work would continue on developing the process and how the council will handle the reports going forward.

Next Meeting: Friday, May 1 – Location: KDADS; New England Building

Respectfully submitted,
Monica Kieffer

GBHSPC meeting, Valeo Behavioral Health Services Crisis Center, Topeka, KS

January 20, 2015

Start at 9:05 am; End at 2:15 pm

Attendance: Wes Cole, Gary Parker, Michael Leeson, Rick Cagan, Guy Steier, Glea Ashley, Fran Seymore-Hunter, Al Dorsey, Sue Schuster, Cheri Bledsoe, Denise Baynham, Jane Adams, Randy Bowman, Peg Spencer

Phone: Teresa Briggs, Sandra Dixon, Walter Hill, Ric Dalke, Roxanne Bollin, Gina Meier-Hummel

Guests: Carla Drescher, Charles Bartlett, Monica Kieffer, Bill Rein

Announcements:

- Rick Cagan announced Mental Health Advocacy Day on March 12th. He said there would also be an advocacy network training event on March 11th.
- Gary Parker said he had been invited to represent consumers with government officials during the President's Lawrence visit to discuss Access to Recovery and Affordable Care Act.
- Wes Cole said the new KDADS website was online and that any updates or changes could be sent to Charles Bartlett.

Presentation – Bill Rein, Director of Hospitals, Chief Counsel for KDADS

- Bill Rein gave a status update of the state hospitals.
- He discussed the new admissions policy, managing involuntary admissions, and central office's involvement with Osawatomie.
- He also gave status updates on other state hospitals.

KDADS Updates – Carla Drescher and Charles Bartlett (also Gina Meier-Hummel via phone)

- Budget for the agency will be released on Friday, January 23rd.
- There will not be retroactive impact on the block grant due to sequester.
- Workgroup to review ICMS final rules and how they impact waivers.
- Kansas will apply for and pick an appropriate domain for Brass TACS Policy Academy
- The federal site visit related to prevention encouraged a move toward integration. The state will be releasing a request of information (RFI) to gain input on how the system could integrate other areas of behavioral health. A request for proposals (RFP) will follow after the RFI has been reviewed.
- An RFP will be coming out for the work that is currently by ValueOptions related to the block grant.
- Content analysis was being done on Strategic Plan and will be ready to roll out soon.

- KDADS hired a new staff person to work with the adult services and added staff to support block grant monitoring.
- Block grant application was released and is due September 1st. It will be a combined application between mental health and substance use disorders.

Presentation – Gary Parker, Cheri Bledsoe, Denise Baynham

- Information was presented on the work being done by the Consumer Run Organizations (CRO).
- Highlighted they need to be consumer driven and lead.
- Currently 13 funded CROs in 6 regions with 1600 members

CIT Proposal/Future Recommendations Process

- Rick Cagan presented a proposal for the council’s support related to a Crisis Intervention Team State Coordinator position from the JIYA subcommittee. The council voted to move forward the CIT recommendation forward.
- The council discussed developing a process for handling requests like this going forward. It was decided that subcommittees could bring forth items for the council’s support. The council work to continue develop criteria and a standardized process.

Subcommittee Annual Reports

- It was decided that subcommittees could present to the council its annual reports to the council first, before the presentation to the Secretaries.
- The council could then provide feedback and have discussions with the subcommittees if necessary.
- At that the point, the final version of the summary annual report could be presented to the Secretaries.
- The council agreed this would help provide perspective on the activities that may be overlapping within the subcommittees and how those efforts could be shared.
- The council also discussed creating a grid or chart template to track the recommendations and priorities. This would help have with overlap of efforts and encourage collaboration within the subcommittees.

Rural/Frontier Subcommittee Report

- Cole provided the report for the council’s review. He added that they would be looking for the council’s support for these items in the future.

Recognition Discussion

- The council discussed the future possibilities of developing a recognition process and collecting historical information related to behavioral health in the state.
- Research was going to be conducted on finding the best format for this.

Vacancies

- Cole called attention to the handout that contained the current vacancies on the council.
- He added that two more positions were also open due to conflicts and job changes.
- He also said that two individuals had been approved but waiting to be appointed.

Subcommittee Chairs Meeting

- Cole would like to have all the subcommittee chairs come together. He will discuss further with the executive committee at a future meeting.

The meeting ended with a tour of the Valeo Crisis Center.

Next Meeting: Tuesday, March 24 – Location: TBD

Respectfully submitted,
Monica Kieffer

GBHSPC Executive meeting, KDADS; New England Building, Topeka, KS July 21, 2015

Start at 10:05 am; End at 11:30 am

Attendance: Wes Cole, Charles Bartlett, Monica Kieffer, Gary Parker, Stacy Chamberlain, Sandra Dixon (phone)

Welcome and Announcements

- Continuum of Care group is looking at number of beds. They are setting up a task force with two co-chairs.
- Grid is in process. Waiting to get all together to review how it should be put together.
- Justice Involved Youth and Adults subcommittee is concerned about the CIT coordinator position.
- CROs are trying to revise budgets.
- All contracts out for CROs.

KDADS Update

- Reorganization of agency will be released on KDADS website.
- Agency is planning for a Recovery Rally on September 25th at the Capital.
- Gary Parker has been appointed by SAMHSA as the Kansas representative for Recovery Month.
- Stacy Chamberlain said that she has posted for field positions with KDADS.
- Grants for the year are mostly out. Prevention grants are in the process. Some are still processing through Dept. of Administration.

Block Grant update - Stacy Chamberlin

- Some initiatives have not been approved. Writing in requested initiatives in addition to those that are required.
- Handed out requirements information, grid for who is writing what sections, and council specific questions.
- Will be including information on council members when that portion of application is available.
- Site visit is not planned yet.
- Suggested Stacy Chamberlain attend the subcommittees presentations to the Secretaries going forward. This will help provide additional insight on how the block grant is being used.
- KCC will be contacted to help identify gaps
- Need to complete additional assessment, an overview of the entire system at state level and identify stakeholders and providers. Some of these were missed in the past.
- RFP for cost analysis of Mental Health services.

Review of last Meeting/ Where do we go from here?

- Children's Meeting
 - Cole thought it was a good meeting. He said it identified things going on in the state that people need to be aware of including the Housing and Children's subcommittees.
 - Jane Adams has since joined the Children's subcommittee and will report back to the council.
 - Bartlett added it was well received. He felt like more could have been discussed related to families and substance use disorders.
 - Bartlett said more time for discussion would be needed if the event happens again. He also said the presentations could be shortened to get this time back.

- Dixon said the meeting needed to include finding intended objectives and more statewide data. She also felt like more identification of current capacity.
- Subcommittee chairs will need to be present to speak to how the issues relate to the work of their subcommittees.
- Needs a formal set of recommendations completed by end of meeting.
- Agreed to conduct this meeting again next year under the guidance of the Children's subcommittee.

Review of New Members/Orientation

- New members added are Robbin Cole replacing Walt Hill and Margaret Manning replacing Rick Cagan.
- Will have orientation with KDADS leadership on July 23rd.
- Will have orientation with new members in the near future.
- Will need new executive committee representation since Rick is no longer on the council.
- Cole would like to consider Guy Steier.

Planning Session

- August 20th meeting will be in Emporia at the Mental Health Center of East Central Kansas. Bill Persinger will discuss some of their new projects.
- September 29th meeting will be in Wichita at Wichita State University. There will be a presentation from prevention providers on the new system.
- Prevention subcommittee has a charter. Sarah Fischer told prevention contractors that she has a list of names and is waiting on the council. Cole will follow-up with her.
- Expectations of members will be reviewed at the next meeting.

Review of SAMHSA Strategic Plan 2015 to 2017

- Bartlett wants all subcommittees to review the document.
- SAMHSA Strategic plan for 2015 -2018," Leading Change 2.0: Advancing the Behavioral Health of the Nation". <http://www.samhsa.gov/about-us/strategic-initiatives>

Next Meeting: August 4th - KDADS; New England Building, Topeka, KS

Respectfully submitted,
Monica Kieffer

GBHSPC meeting, KDADS; New England Building, Topeka, KS May 1, 2015

Start at 9:04 am; End at 3:25 pm

Attendance: Wes Cole, Jim Costello, Megan Bollinger, Alison Allen, Fran Seymour-Hunter, Gary Parker, Sandra Dixon, Al Dorsey, Randy Bowman, Rick Cagan, Cherie Bledsoe, Denise Baynham, Jane Adams, Charles Bartlett, Chris Bush, Doug Wallace, Kyle Kessler, Ric Dalke (phone)

Minutes: The minutes from the previous meeting were approved.

KDADS Update:

- Bill Rein is the new commissioner at KDADS.
- Kim Brown is the new SAMHSA rep for the 7th district.
- Budget is still in committee. Savings have been realized due to bed closures at Osawatomie. Have been able to purchase other beds for people who would have gone there. The state cannot go over 146 patients during the renovations.
- Working on the mental health and substance use disorder integration.

GBHSPC Updates:

- Suicide subcommittee will continue.
- Prevention subcommittee will start after the end of the session and be all encompassing.
- Work on developing a grid from the subcommittee reports so the council can see where there are intersects and gaps in the recommendations.

Subcommittee's 2015 Reports

- The council reviewed the charter and draft report for the Kansas Citizen's Committee on Alcohol and Other Drugs. Charles Bartlett is the liaison.
 - Highlights from the report included:
 - Incorporating substance use disorder awareness into the work of the other subcommittees
 - Community education through advocacy and the Faith in Communities project
 - Need for increased and expanded service
 - Workforce Challenges
 - Feedback/Questions:
 - Need more defined recommendations
 - If KCC has audience with Secretary, the council may want to preview what is being presented beforehand
 - Get information from KAAP related to workforce issues
 - Council Executive Committee could engage KCC in gaining insight that can help guide what is put in the block grant.
- The council reviewed the charter and draft report for the Veteran's Subcommittee. Charles Bartlett is the liaison.
 - Highlights from the report included:
 - Part of the Policy Academy

- Focused on employment and peer development as well as supports for mental health and substance use disorders
 - Identified different veterans cultures and made stigma reduction a goal
 - Focusing on families and children, impact on rural areas and impact on households with both parents deployed
 - Feedback/Questions:
 - Continue discussion with Wichita State in regards to their pilot program related to peer support
 - Could advocate for a more specialized staff person to work with the population
 - Continue to read out to the reserves and national guard.
- The council reviewed the charter and draft report for the Justice Involved Youth and Adults subcommittee. Charles Bartlett is the liaison.
 - Highlights from the report included:
 - Working to build work groups within the subcommittee
 - Expand CIT and Mental Health First Aid trainings
 - Evaluated need for specialty courts
 - Warm handoffs and seeking services while incarcerated to help with transition after release
 - Feedback/Questions:
 - Review methods to braid funding for services
 - Work to establish relationships at a more localized level to divert from corrections and get into services
 - Continue to build recommendations for the council to review.
- The council reviewed the charter and draft report for the Housing and Homelessness Subcommittee. Doug Wallace is the liaison.
 - Highlights from the report included:
 - Housing includes permanent and 24 hour care approach
 - Develop resources for multiple needs
 - Often hard to track population
 - Feedback/Questions:
 - Review methods to braid funding for services
 - Work to establish relationships at a more localized level to divert from corrections and get into services
 - Continue to build recommendations for the council to review.
 - Better ways to track data and be able to use it
 - Consistent systems that work with each other may be needed
- The council reviewed the charter and draft report for the Suicide subcommittee. Chris Bush is the liaison.
 - Highlights from the report included:
 - A suicide prevention website has been created.
 - A retreat was held in January.
 - Feedback/Questions:
 - In the process of applying for additional funding.
 - Working towards integrating the subcommittees work with the other subcommittees.
- The council reviewed the charter and draft report for the Vocational subcommittee. Doug Wallace is the liaison.
 - Highlights from the report included:
 - Feedback/Questions:
 - Local steering committees to come up with resources.

- Add younger audiences that may not have access to this information.
- Pam McDiffett not present to review the Rural and Frontier subcommittee report or the Children's subcommittee report.

Presentation: Kyle Kessler

- Kyle Kessler with the Association of Community Mental Health Centers of Kansas gave an update to the council.
 - He stated there are effective and competent systems in Kansas.
 - There is an opportunity for Kansas to apply for a state planning grant. This would be a collaboration between several partners, including KDADS.
 - Wes Cole stated the council could provide a letter of support for the application.

Orientation: An orientation was conducted for new members after the conclusion of the meeting.

Next Meeting: June 5th – Children's Meeting

Respectfully submitted,
Monica Kieffer

Please describe the steps taken by the state to make public aware of the plan and allow for public comment.

In the past KDADS/BHS has always posted the block grant, once approved for review, we are now planning how this can be accomplished prior to submission and final approval. Although the plan was not posted prior to submission for public comment, significant public input was gathered and utilized in the development and creation of our plan.

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

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

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

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

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

Activities of the Council

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

- To serve as coordinator of recommendations which may be brought forth by stakeholders, consumers, mental health service providers, SUD service providers and community service providers and others, and based thereon, to make any appropriate recommendations to the Governor; and
- To work with the State's Mental Health Authority/ State's SUD authority as well as other State departments, to improve and refine the State Behavioral Health Strategic Plan, and to also develop strategies to improve the behavioral health service system across all systems of state departments.

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

This report includes an overview of the work completed and recommendations. The recommendations are reviewed by the council and shared with KDADS as the block grant is developed for submission.

Subcommittees of the Council are:

- Housing & Homelessness
- Children
- Supported Employment
- Suicide Prevention
- Rural and Frontier
- Justice Involved Youth and Adults
- The Kansas Citizens Committee on Alcohol and Drug Abuse
- Prevention
- Veterans
- Vocational

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Dr. Jane Adams	Others (Not State employees or providers)	Keys for networking	3926 SE 6th St Topeka, KS 66607 PH: 785-233-8732	jadams@keys.org
Wes Cole	Others (Not State employees or providers)		937 Walnut Osawatomie, KS 66064 PH: 913-731-3193	scole@micoks.net
Guy Steier	Others (Not State employees or providers)	12th Judicial District	636 Grand Ave Clyda, KS 66938 PH: 785-243-8130	judges@12jd.org
Al Dorsey	Others (Not State employees or providers)	Kansas Housing Corporation	611 S. Kansas Ave., Suite 300 Topeka, KS 66603 PH: 785-217-2043	ADorsey@kshousingcorp.org
Margaret Manning	Others (Not State employees or providers)		13225 Kimberly Cr. Olathe, KS 66061	manmarg48@gmail.com
Fran Seymour-Hunter	State Employees	Kansas Health and Environment	900 SW Jackson, Suite 900 Topeka, KS 66612 PH: 785-296-2212	fseymour-hunter@kdheks.gov
Peg Spencer	State Employees	Kansas Department of Children and Families	555 South Kansas Avenue Topeka, KS 66603 PH: 785-368-8214	Peg.Spencer@dcf.ks.gov
Susan Gile	State Employees	Kansas Department of Children and Families	555 S. Kansas Avenue Topeka, KS 66603 PH: 785-296-5254	Susan.Gile@dcf.ks.gov
Viola Riggins	State Employees	Kansas Department of Corrections	714 SW Jackson, Suite 300 Topeka, KS 66603 PH: 785-296-3317	violar@doc.ks.gov
Randall Bowman	State Employees	Kansas Department of Corrections	4031 SE 29th St. Topeka, KS 66605 PH: 785-296-5656	Randall.Bowman@doc.ks.gov
Ted Jester	State Employees	Kansas Department for Aging and Disability Services	503 S. Kansas Avenue Topeka, KS 66603 -3404 PH: 785-296-6495	Ted.Jester@kdads.ks.gov
Sue Schuster	State Employees	Kansas Department for Aging and Disability Services	503 S. Kansas Ave. Topeka, KS 66603 PH: 785-368-7323	sue.schuster@kdads.ks.gov
Dr. Michael Leeson	Providers	Colmery-O'Neil Veterans Affairs	534 S Kansas Ave Ste 510 Topeka, KS 66603 PH: 785-291-9100	mleeson@khs-hs.org

Teresa Briggs Providers

10933 W 333rd
St.
Reading, KS

66868
PH: 620-481-1197

Ric Dalke	Providers	Compass CMHC	901 Lyle Ave Garden City, KS 67846 PH: 620-276-6470	rdalke@compassbh.org
Sandra Dixon	Providers	DCCCA	1808 Golden Rain Dr. Lawrence, KS 66044 PH: 785-843-5756	sdixon@dcca.org
Robbin Cole	Providers	Pawnee Mental Health Services	2500 Meade Circle Manhattan, KS 66502 PH: 785-587-4300	robbin.cole@pawnee.org
Mark Dodd	Federally Recognized Tribe Representatives	Kansas Racing and Gaming Commission	3519 SW MacVicar Topeka, KS 66611 PH: 785-368-6203	doddmark1@gmail.com
Denise Baynham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7701 Armstrong Ave Kansas City, KS 66112 PH: 913-287-3092	baynhamdenise@yahoo.com
Cheri Bledsoe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Kansas Consumer Advisory Council for Adult Mental Health, Inc.	7528 Troupe Ave Kansas City, KS 66102 PH: 913-787-3507	cheriebledsoe.cac@gmail.com
Rick Cagan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Executive Director, NAMI KY	Post Office Box 675 Topeka, KS 66601 PH: 785-233-0755	rcagan@nami.org
Kathy McNett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2201 28th Great Bend, KS 67530	imokrightnow@yahoo.com
Gary Parker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Advisory Council	PO Box 485 Colby, KS 67701 PH: 785-432-0412	garyjparker@kansascac.org
Megan Bollinger	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2184 Road K Emporia, KS 66801 PH: 620-343-0982	mbollinger88@gmail.com
Molly Brace	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2229 SW Jewell Topeka, KS 66611 PH: 785-233-8732	mbrace@k-state.edu
Kirk Schottler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		17991 R Road Mayetta, KS 66509	kschott54@hotmail.com
Roxanne Bollin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		109 N Hospital Drive Paola, KS 66071 PH: 913-731-1508	rbollin@headsuponline.org
Bailey Reed	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1301 Kentrucky Street Lawrence, KS 66044	bayreed@ku.edu
Dr. James Costello	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1717 SW Stone Crest Drive Topeka, KS 66615 PH: 785-273-1495	jcstell@emporia.edu
Rhonda Moreland	Parents of children with SED		PO Box 369 Lebo, KS 66856	moreland.rhonda@yahoo.com

Catherine Ramshaw	Parents of children with SED	1421 SW Hodges Topeka, KS 66615	cramshaw1989@yahoo.com
Alison Allen	Parents of children with SED	15111 West 55th Terrace Shawnee, KS 66217 PH: 913-268-3079	alisonallen@aol.com
Lee Flamick	Parents of children with SED	1104 E Florence Rush Center, KS 67575 PH: 785-372-4369	flawmik@gbta.com

Footnotes:

Peg Spencer works for Vocational Rehabilitation Services.
 Susan Gile works for the Social Services Agency which is now called the Department for Children and Families.
 Ted Jester is the Director of Mental Health Services for KDADS/Behavioral Health Services.
 The State Education Agency position is open and we are currently attempting to recruit.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	36	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	<input type="text" value="3"/>	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	23	63.89%
State Employees	7	
Providers	5	
Federally Recognized Tribe Representatives	1	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	13	36.11%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="6"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="12"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

JUL 7 2015

Mr. Ted Jester
Kansas Department for Aging
and Disability Services
503 S. Kansas Avenue
Topeka, KS 66603

Dear Mr. Jester:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

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Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

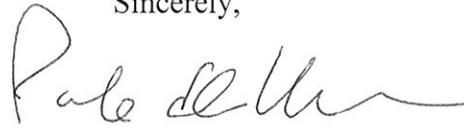
Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

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Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a long horizontal stroke at the end.

Paolo del Vecchio, M.S.W.

Director

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

cc: Stacy Chamberlain
Sherman Cole

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory