



Substance Abuse and Mental Health  
Services Administration

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November 2, 2020

Andrew Brown  
Commissioner  
Behavioral Health Services  
Kansas Department of Aging and Disability Services  
503 S. Kansas Ave.  
Topeka, KS 66603

Dear Mr. Brown:

Enclosed are the final Mental Health Block Grant (MHBG), Substance Abuse Prevention and Treatment Block Grant (SABG), and Substance Abuse Prevention and Synar Monitoring Reports for the State of Kansas. The onsite monitoring visit was conducted from May 22 - 24, 2018, on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The reports were prepared by the onsite monitoring team for your state, led by the federal monitor. The team looked at the requirements of the MHBG, SABG, and SYNAR, its fiscal management, and the accessibility and quality of mental health/behavioral health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The team members were informed by the perspective and interests of stakeholders, such as consumers, advocates, and family members in their evaluation of the level of consumer involvement and the state's progress toward an optimally functioning recovery system.

The reports reflect the team's observations of the state public behavioral health system, focusing on strengths, and current challenges. The reports provide information that may be useful to the state mental health and substance abuse authority, other state entities, provider agencies, consumers, family members, and advocates.

If you have questions or comments please contact:

Mental Health Block Grant

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Substance Abuse Treatment Block Grant

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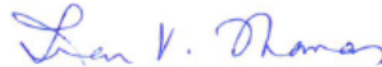
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Sincerely,

A handwritten signature in blue ink that reads "Tison V. Thomas".

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

**Substance Abuse Prevention and Treatment Block Grant  
Compliance Monitoring Review Report**



**Kansas Department for Aging and Disability Services**

**May 22–24, 2018**

**DRAFT**



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**AGENCY NAME:** Department for Aging and Disability Services, Behavioral Health Services

**LOCATION:** Topeka, Kansas

**DIRECTOR:** Susan Fout, RPN, Commissioner, Behavioral Health Services

**REVIEW PERIOD:** May 22–24, 2018

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From left to right:

Charles Bartlett, MH/SAPT SSA and Block Grant Planner; Susan Fout, RPN, Commissioner, Behavioral Health Services; Cissy McKinzie, MH/SAPT SSA and Block Grant Planner

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## DCCCA Women's Recovery Center



Front row, left to right:

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Donna Gorman, LCMFT, LCAC, Clinical Coordinator; Rachal Harper, MS, LCAC, Program Coordinator; Sandra Dixon, LMSW, Director of Behavioral Health Services

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## Substance Abuse Prevention and Treatment Block Grant Background

The Substance Abuse Prevention and Treatment Block Grant (SABG) is authorized in Sections 1921–1935 of the Title XIX, Part B, Subpart II and Sections 1941–1956 of Title XIX, Part B, Subpart III of the Public Health Service Act. The SABG is administered by the Substance Abuse and Mental Health Services Administration (SAMSHA) Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP).

The SABG is a noncompetitive formula grant to provide funding based on specified economic and demographic factors. Its overall goal is to support and expand substance use disorder (SUD) prevention and treatment services while providing maximum flexibility to grantees.<sup>1</sup> Ninety-five percent of the SABG appropriated funds is distributed to the 50 states, the territories and the freely associated states,<sup>2</sup> the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota (referred to collectively as states).<sup>3</sup> The states use the SABG to plan, carry out, and evaluate SUD prevention, treatment, and recovery support services for individuals, families, and communities impacted by substance misuse and SUDs.

The SABG targets the following populations and service areas:

- Pregnant women and women with dependent children;
- Persons who inject drugs;
- Tuberculosis (TB) services;
- Early intervention services (EIS) for human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS); and
- Primary prevention services.

SAMHSA encourages states to use block grant resources to support and not supplant services covered through commercial and public insurer plans.<sup>4</sup> SAMHSA's block grant funds are directed toward four purposes:

- To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;

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<sup>1</sup> Department of Health and Human Services. Fiscal Year 2017. Substance Abuse and Mental Health Services Administration. Justification for Estimates for Appropriations Committees.

<sup>2</sup> U.S. Department of the Interior. Office of Insular Affairs. Territories include Guam, Puerto Rico, the Northern Mariana Islands, U.S. Virgin Islands, and American Samoa. Freely associated states, which have signed Compacts of Free Association with the United States, include the Republic of Palau, Federated States of Micronesia, and Republic of the Marshall Islands. Available at: <http://www.doi.gov/oia/islands/index.cfm>.

<sup>3</sup> SAMHSA 2017 Fiscal Year Cost Justification.

<sup>4</sup> SAMHSA 2017 Fiscal Year Cost Justification.

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- To fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes, supporting recovery, or both;
  - To fund primary prevention for individuals not identified as needing treatment (universal programs that reach everyone in a group being served regardless of risk, selective interventions that serve people at elevated risk of substance misuse or a SUD, and indicated prevention interventions that serve people who exhibit some symptoms of a SUD, but do not yet meet criteria for a diagnosis); and
  - To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.”<sup>5</sup>

SAMHSA also encourages Single State Agencies (SSA) to use their block grants to:

- Allow recovery to be pursued through personal choice and many pathways;
- Encourage providers to assess performance based on outcomes that demonstrate client successes; and
- Expand capacity by increasing the number and types of providers who deliver clinical treatment, recovery support services, or both.<sup>6</sup>

## **Purpose of Substance Abuse Prevention and Treatment Block Grant Compliance Monitoring Review**

SAMHSA, through CSAT and the Office of Financial Resources (OFR), Office of Financial Advisory Services (OFAS), conducts compliance reviews to fulfill its congressional mandate pursuant to 42 U.S. Code § 300x–55 to assess SSA adherence to SABG statutory and regulatory requirements. CSAT and OFAS perform a pre-site desk audit and onsite reviews to accomplish the following:

- Assess the state’s administration of the SABG;
- Inform SAMHSA how SABG regulatory requirements are conveyed and monitored by the SSA and operationalized by sub-recipients;
- Inform SAMHSA about the degree to which funds are expended toward the four purposes directed by SAMHSA;

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<sup>5</sup> SAMHSA 2017 Fiscal Year Cost Justification.

<sup>6</sup> SAMHSA 2017 Fiscal Year Cost Justification.

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- Inform SAMHSA of the progression of the state’s public behavioral health treatment and recovery system;
  - Improve SAMHSA’s understanding of the state’s behavioral health innovations and best practices;
  - Inform SAMHSA regarding the evolution of treatment financing as states modernize health insurance coverage expansions, including the Affordable Care Act;
  - Assess the state’s ability to accurately account for and report on SABG and related non-federal expenditures;
  - Determine if the state has complied with SABG programmatic and fiscal requisites including service provision to priority populations, financial earmarks, maintenance of effort (MOE), restricted expenditures, and sub-recipient monitoring requirements; and
  - Present findings and technical assistance (TA) that will help states better manage and comply with SABG programmatic and fiscal regulatory and statutory requirements; align with SAMHSA priorities; and improve its public behavioral health treatment and recovery system.

## **Limitations**

This report, including findings and corresponding tables, provide a snapshot of SABG compliance by the SSA and participating sub-recipients at the time of the compliance monitoring review. The report does not present efforts the SSA or its sub-recipients have undertaken during or subsequent to the compliance review to enhance compliance.

## **Organization of Appendices**

The report includes the following appendices:

- Appendix A: List of the State and Local Personnel Interviewed During the Compliance Monitoring Review;
- Appendix B: Reference List of Acronyms Relevant to the State of Kansas;
- Appendix C: Examples of Notable Practices and tools;

## **Methodology**

CSAT and OFAS staffs collaborate to complete this report. CSAT staff complete the program section. OFAS completes the financial management section.

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Before the onsite visit, the entire six-person CSAT compliance monitoring team (CMT), comprised of experts in clinical services and data management and administration, completes a comprehensive desk review of documents received from the SSA, and the participating intermediaries (when applicable), and providers. CMT uses a checklist that details each SABG requirement and its subcomponents to identify areas that require additional information, exploration, and validation during the onsite visit.

The CSAT team<sup>7</sup> and the OFAS auditors conducting the onsite review meet with the SAMHSA Regional Administrator (RA) and CSAT State Project Officer (SPO). The meeting allows the review team to become better informed about internal and external factors that impact the state's ability to achieve its organizational mission, comprehensively address the needs of SAMHSA's priority populations, and convey and monitor SABG requirements.

While on site, CMT spends 1 day at the SSA conducting individual and group interviews with senior level and program staff. These interviews provide an opportunity to determine the strategies the SSA uses to convey SABG requirements and monitor sub-recipient compliance. The primary focus is to clarify areas for which documents reviewed during the desk audit did not clearly describe the SSA's conveyance and monitoring processes. The CMT then spends 2 days visiting intermediaries (when applicable) and providers. The intermediaries may be administrative services organizations (ASO), managed care organizations (MCO), or local government units (LGU). The CMT visits providers that target the SABG's priority populations and services: Pregnant women and women with dependent children (PWWDC), persons who inject drugs intravenously (IVDU), and tuberculosis services. Compliance monitoring reviews conducted to HIV-designated states include an additional visit to a SABG-funded program that provides EIS and HIV services.

During the intermediary and provider visits, CMT engages in discussions with executives, supervisors, and front-line staff. These discussions enable the team to retrieve and integrate data from multiple information sources to explore if the SSA has a continuous process of conveying, monitoring, and operationalizing functions that ensure compliance with the SABG requirements. The provider visits include facility tours to observe the security of client records, the security of fax and copy machines, and the general program milieu. The team conducts a retrospective review of a sample of client charts to assess the delivery and timeliness of SABG-required services. While visiting the women's services programs, CMT conducts focus groups with service recipients. It interviews clients receiving services at opioid treatment programs (OTP) and observes the program's dispensing practices.

At the conclusion of the onsite visit, CMT synthesizes the information obtained on site and presented in the pre-site documents provided by the SSA and sub-recipients. The compliance monitoring review results in a written report describing findings, notable practices where present, and recommendations.

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<sup>7</sup> A SABG clinical services specialist and a data management specialist comprise the CSAT onsite team.



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This report documents findings and recommendations for the [Kansas Department for Aging and Disability Services \(KDADS\)](#) and the following intermediaries and service providers:

- [Beacon Health Options, Inc.](#)
- [DCCCA Women's Recovery Center](#)

## **Overall Clinical Findings**

### ***Sub-recipient Monitoring (State)***

KDADS appears to have comprehensive language and processes to convey Substance Abuse Prevention and Treatment Block Grant (SABG) requirements for clinical practices. The requirements are conveyed in its February 24, 2017, contract with Beacon Health Options, Inc. (BHO), and in various KDADS Operational Policies and Procedures, including those effective and approved in September 2011 and October 2011.

The exceptions to full conveyance or monitoring 45 Code of Federal Regulations (CFR) §96.124, §96.131, §96.126, and §96.127 are summarized below:

- 45 CFR §96.124—Certain Allocations: Specialized Services for Pregnant Women and Women with Dependent Children
  - Requirement is conveyed, but not monitored.
- 45 CFR §96.126(a)—Capacity of Treatment for Intravenous Substance Abusers.

Although the contract between KDADS and BHO communicates some of the requirements of 45 CFR §96.126(a), the following requirements for a state capacity management system are not currently fully operationalized or monitored:

- States must require programs that receive funding under the grant and treat individuals for intravenous substance abuse to provide to the state, upon reaching 90 percent of its capacity to admit individuals to the program, a notification of that fact within 7 days (45 CFR §96.126(a)).
- The state shall establish a capacity management program which ensures the maintenance of a continually updated record of all such reports and which makes excess capacity information available to such programs (45 CFR §96.126(a)).
- The state shall require that any program receiving funding from the grant for the purposes of treating injection drug abusers establish wait lists with unique client identifier for each injecting drug abuser seeking treatment including those receiving interim services while awaiting admission to such treatment (45 CFR §96.126(c)).

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- For individuals who cannot be placed in comprehensive treatment within 14 days the state shall ensure that programs—
    - Consult the state’s capacity management system so that clients on wait lists are admitted at the earliest possible time to a program providing such treatment within reasonable geographic area (45 CFR §96.126(c)).
  - 45 CFR §96.127—Requirements Regarding Tuberculosis (TB)
    - The requirements are conveyed via contract, but not completely conveyed in policy language.
    - The requirement is not monitored.
  - 45 CFR §96.131—Treatment services for pregnant women.

45 CFR §96.131(f) requires states to develop effective strategies for monitoring programs’ compliance with 45 CFR §96.131. 45 CFR §75.352 requires pass-through entities to “...impose all requirements to sub-recipients so that Federal awards are used in accordance with Federal statutes, regulations and terms and conditions of the Federal award.” The KDADS contract with BHO includes many but not all of the requirements of 45 CFR §96.131. Specifically, the BHO contract does not include or fully operationalize the following requirements or monitoring mechanisms:

- The state will, in carrying out this provision, publicize the availability to such women of services from the facilities and the fact that pregnant women receive such preference. This may be done by means of street outreach programs, ongoing public service announcements (radio or television), regular advertisements in local or regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers, and social service agencies (45 CFR §96.131(b)).
- The state shall develop effective strategies for monitoring programs’ compliance with this section. States shall report under the requirements of 45 CFR §96.122(g) on the specific strategies to be used to identify compliance problems and corrective actions to be taken to address those problems in 45 CFR §96.131(f).

KDADS receives well-developed, detailed summary reports and data dashboards from BHO. However, it is not clear that these data are currently being used to assess, monitor, and manage the state’s capacity for services and systems for injection drug users.

KDADS submitted pre-site documentation that indicating that it does not currently have a

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mechanism which ensures that the state is notified within 7 days when providers of treatment services to people who inject drugs (PWID) reach 90 percent of capacity. The SSA further noted that it was negotiating with the ASO to provide this monitoring. During onsite interviews, and in the Uniform Block Grant (BG) application (federal fiscal year 2018–2019 [FFY 18–19]), KDADS noted that it is revising the policy pertaining to SABG monitoring. Staff reported that revisions will include language for these (and all other Block Grant) requirements for capacity management of treatment for PWIDs.

As reflected in this report, there are opportunities to improve SABG compliance, including the development and implementation of a monitoring process for all SABG clinical requirements. KDADS can use its foundation of written and conveyed requirements to develop a monitoring strategy and tools to assess sub-recipient compliance with the SABG requirements. KDADS previously had the capability and capacity to use a Block Grant Outcomes Scoring spreadsheet during annual licensing visits conducted by staff from the Survey Certification and Credentialing Commission (SCCC). These visits no longer include the use of the Block Grant Outcomes Scoring spreadsheet. KDADS can revisit the elements and operationalization of the previously utilized Block Grant Outcomes Scoring spreadsheet to crosswalk all required SABG compliance requirements to ensure that monitoring of all SABG requirements occurs.

In the state’s Uniform Block Grant Application for FFY18–19, KDADS noted that the state has a program integrity or quality assurance plan to monitor the administrative services organization (ASO) that oversees and authorizes SABG-funded substance use disorder (SUD) treatment services. The state further noted that these requirements are also included in the ASO’s contract, which is monitored by Behavioral Health Services (BHS) staff. Until recently, per the state’s response in this application, the state’s licensing staff conducted biennial onsite reviews of SABG treatment providers. The results of the reviews were forwarded to the ASO, and the ASO communicated with the providers. If a corrective action plan was required, the ASO and KDADS worked together to ensure that the provider became compliant. Responsibility for Block Grant monitoring was reassigned to KDADS BHS staff when the licensing staff was moved to the SCCC. KDADS is revising BG Policy 404 to outline the new procedure for Block Grant monitoring. The revisions will include that, “...biannually, KDADS will continue to review provider policies and client documentation to ensure that applicable Block Grant requirements are met. Providers found not in compliance will continue to be referred to the ASO for corrective action planning that will enable to provider to become compliant.”

KDADS staff acknowledged the opportunity to improve the state’s monitoring process; noting that monitoring is an organizational “gap” and currently “a work in process.” The agency has experienced reorganization and staffing shortages, and is in the process of interviewing for several key positions. Once additional staff are onboard, it is important that KDADS revisit the monitoring functions and reestablish this essential activity.

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### ***Sub-recipient Monitoring (Intermediary)***

Similar to KDADS, BHO appears to have comprehensive language and processes for SABG-related clinical practices. Its February 24, 2017, contract with KDADS conveys most Block Grant. Exceptions to full conveyance or monitoring of the SABG requirements are as follows:

- 45 CFR §96.124—Certain Allocations: Specialized Services for Pregnant Women and Women with Dependent Children
  - The requirement is conveyed but not monitored.
- 45 CFR §96.131—Treatment Services for Pregnant Women (Admission Preferences)
  - Requirements are partially conveyed and not monitored. The requirements that are not monitored or conveyed are:
    - The state will, in carrying out this provision publicize the availability to such women of services from the facilities and the fact that pregnant women receive such preference. This may be done by means of street outreach programs, ongoing public service announcements (radio or television), regular advertisements in local or regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers, and social service agencies (45 CFR §96.131(b)).<sup>8</sup>
    - The state shall develop effective strategies for monitoring programs compliance with this section. States shall report under the requirements of 45 CFR §96.122(g) on the specific strategies to be used to identify compliance problems and corrective actions to be taken to address those problems (45 CFR §96.131(f)).
- 45 CFR 96.126—Capacity of Treatment for Intravenous Substance Abusers
  - Although there is language in the contract between KDADS and BHO that conveys the requirements of 45 CFR §96.126, the following requirements for a state capacity management system are not fully operationalized or monitored by either the state or BHO:
    - States must require programs that receive funding under the grant and treat individuals for intravenous substance abuse to provide to the state, upon

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<sup>8</sup> KDADS has an admission policy for Block Grant priority populations posted on their website. Additionally, many providers advertise independent of the state. The state reports, in Kansas, the need for services has surpassed available Block Grant funding for many years.

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reaching 90 percent of its capacity to admit individuals to the program, a notification of that fact within 7 days (45 CFR §96.126(a)).

- The state shall establish a capacity management program which ensures the maintenance of a continually updated record of all such reports and which makes excess capacity information available to such programs (45 CFR §96.126(a)).
  - The state shall require that any program receiving funding from the grant for the purposes of treating injection drug abusers establish wait lists with unique client identifier for each injecting drug abuser seeking treatment including those receiving interim services while awaiting admission to such treatment (45 CFR §96.126(c)).
  - For individuals who cannot be placed in comprehensive treatment within 14 days the state shall ensure that programs—
    - Consult the state’s capacity management system so that clients on wait lists are admitted at the earliest possible time to a program providing such treatment within reasonable geographic area (45 CFR §96.126(c)).
- 45 CFR §96.127—Requirements Regarding TB
    - The requirements are conveyed via contract, but not completely conveyed in policy or monitored.

BHO has developed an extensive array of summary reports and data dashboard tools for the state. However, these data sets may not be currently used to their full advantage by KDADS. For example, BHO provides a significant amount of data on SABG required elements, such as wait lists that include Block Grant priority populations, and categories for number of days on wait list by priority population. It is not clear that these reports or the data are currently used to assess, monitor, and manage the state’s capacity for services and systems for injection drug users.

Consistent with state staff comments, BHO staff also indicated that monitoring functions for SABG requirements had previously been conducted by KDADS during the annual licensing visits. BHO staff stated that sub-recipient providers are monitored (though not necessarily for SABG requirements) when there is specific quality of care concerns. BHO staff have occasionally been invited to accompany the consultants conducting the licensing visits when there were issues. BHO also generates a variety of reports to review against contract standards and conducts telephone or onsite reviews with providers to resolve quality improvement issues as necessary. However, BHO staff noted that requests to accompany consultants had not occurred recently. It is not clear if this is due a decrease in quality improvement issues or because SABG requirements are no longer monitored during these licensing visits.

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The contract between KDADS and BHO does not specifically include SABG monitoring functions as a required activity for BHO. Further, BHO staff indicated that while monitoring of SABG requirements is a worthwhile function of the consultants during licensing visits; performing this activity would be a resource issue for BHO.

## **Overall Clinical Recommendations**

To address these overall findings, the CMT recommends that KDADS ensure that all conveyance and monitoring citations, tools, and documents include all SABG requirements. The requirements for which findings were identified have been detailed above, and are summarized below:

- 45 CFR 96.126—Capacity of Treatment for Intravenous Substance Abusers
  - Notify the state of 90 percent capacity within 7 days.
  - Establish a capacity management program to maintain continual updates and make excess capacity information available.
  - Establish wait lists with unique client identifier for wait-listed clients.
  - Use capacity management system to ensure wait-listed individuals are transferred to programs within reasonable geographic location at earliest possible time.
- 45 CFR §96.131—Treatment Services for Pregnant Women
  - Publicize the availability of services for pregnant women and their admission preferences.
  - Develop effective strategies for monitoring program compliance.

The CMT also recommends that KDADS use the foundation provided by the requirements conveyed (via its contract with BHO and various Operational Policies and Procedures) to develop a monitoring process and tool(s) to ensure sub-recipient compliance with all SABG requirements by—

- Utilizing the underpinnings and possibly elements of the model that was previously used to conduct onsite monitoring of providers. It is understood that organizational restructuring and staffing shortages have occurred in recent years. However, it will be important to reinstitute the required monitoring process for SABG requirements in the state. Such a process will also ensure that potential SABG findings are identified and efforts are made to address potential compliance problems to bring providers into compliance quickly.



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- Confer with the CSAT SPO to explore access to other state models for effective SABG monitoring.

### **Overall Data and Administrative Findings**

- The CMT’s review of KDADS revealed that it does not consistently monitor sub-recipient provider compliance with SABG requirements as stipulated by 45 CFR §75.352(d)—Requirements for pass through entities.
- KDADS reported having a process to monitor SABG sub-recipient providers; however, at the time of the compliance monitoring review, the process was being re-evaluated and re-developed.
- In the past, monitoring of SABG sub-recipient providers was conducted during licensing reviews. This is no longer the case as licensing staff focus only on the licensing standards and do not include SABG requirements in their assessment.
- The BG Outcomes Scoring spreadsheet (which was provided to the CMT as part of the pre-site documentation request) is no longer used in the monitoring of SABG sub-recipient providers.
- The intermediary (BHO) visited during the compliance monitoring review does conduct reviews of sub-recipient providers; however, the reviews focus on fraud, abuse, and waste; and adverse incidents.

### **Overall Data and Administrative Recommendations**

- 45 CFR §75.352(d) requires pass-through entities to “...monitor the activities of the sub-recipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved.” Therefore, CMT recommends that KDADS:
  - Revise or develop the SABG monitoring process to adequately assess sub-recipient provider compliance with SABG requirements.
  - Develop policies and procedures (P&Ps) for SABG monitoring functions.
  - Develop and implement requisite training for staff who will be performing SABG monitoring functions and refresher trainings when there are changes in the process.
  - Revise the BG Outcomes Scoring spreadsheet or develop and implement a SABG monitoring instrument to be used by staff performing monitoring functions.

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Ensure that the monitoring instrument includes prompts that comprehensively capture the elements of the SABG and facilitate assessing compliance.<sup>9</sup>

- Conduct a crosswalk of SABG and licensing reports (and reports resulting from independent peer reviews when a process has been developed and implemented). Information resulting from the crosswalk will assist monitoring staff with the identification of recurring findings and trends.

## **45 Code of Federal Regulations §96.121—Early Intervention Services and Human Immunodeficiency Virus Services<sup>10</sup>**

### **Findings**

Not applicable.

### **Recommendations**

Not applicable.

## **45 Code of Federal Regulations §96.124—Certain Allocations: Specialized Services for Pregnant Women and Women with Dependent Children**

### **Findings**

The provider visited by the CMT engaged in or implemented the following activities related to the delivery of specialized services for pregnant women and women with dependent children:

- Treated the family as a unit and admitted both women and their children into treatment services;
- Provided or arranged for primary medical care for women who are receiving SUD services, including prenatal care;
- Provided or arrange for primary pediatric care for the women's children, including immunizations;
- Provided or arranged for gender-specific SUD treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting;

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<sup>9</sup> Sample monitoring tools from three states have been transmitted (e-mail dated May 31, 2018) to KDADS to provide guidance in its development of a monitoring instrument.

<sup>10</sup> Kansas is not a human immunodeficiency virus (HIV)-designated state.

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- Provided or arranged for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect; and
  - Provided or arranged for sufficient case management and transportation services to assure that the women and their children have access to the services provided listed above.

The provider is considered by the state to be a Designated Women's Program (DWP). This designation requires that the provider's services reflect an understanding of women's treatment that extends beyond a focus on abstinence from substances, and incorporates gender-specific interventions that include areas such as:

- Family and significant other relationships;
- Parent interactions, child interactions, and parent education;
- Sexual, physical, and emotional abuse;
- Domestic violence;
- Physical health and wellness; and
- Building healthy community support systems.

In its role as a DWP, the provider also conducts comprehensive assessments and screenings of children who accompany the mothers into residential treatment. Children living in the treatment facility with their mothers are enrolled in the program's licensed day care center or attend a local elementary school.

The provider uses case management services to support the extensive array of support and wrap-around services to women and children—providing services directly or through linkages with community partners. Some of these support services include:

- Transportation;
- Assistance accessing public assistance programs such as Social Security; Medicaid; Supplemental Nutrition Assistance Program; Women, Infants, and Children; Temporary Assistance for Needy Families; and child care subsidies;
- Access to employment training, high school equivalency programs, or higher education;
- Primary health care, including prenatal care and pediatric care;
- Mental health counseling and ongoing recovery support services;
- Housing assistance; and
- Linkages to child care, therapeutic interventions, and other early childhood programs.

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## Recommendations

As detailed earlier in this report, both the state and intermediary convey, but do not monitor, this requirement. The CMT recommends that KDADS and BHO revise their monitoring tools to assess if providers meet the service requirements set forth at 45 CFR §96.124.

### **45 Code of Federal Regulations §96.126(a–e)—Part 96; Interim Final Rule: Capacity of Treatment for Intravenous Substance Abusers**

#### Findings

##### ***Ninety Percent Capacity***

Onsite interviews with KDADS staff and submitted pre-site documentation indicate that the state does not currently have a system in place which ensures that programs notify KDADS within 7 days upon reaching 90 percent of their capacity to admit individuals. Pre-site documentation submitted by KDADS stated: “Kansas does not currently have a mechanism in place to ensure that the state is notified within seven days of a SUD treatment providers to PWIDs has reached 90% of its capacity. We will be negotiating with our ASO, Beacon Health Options, to provide this monitoring.” The state staff also indicated they have plans to revise the language regarding capacity management of treatment for injection substance users.

##### ***Wait List and Capacity Management***

As with findings related to the 90 percent capacity requirement, the CMT onsite interviews with KDADS staff and review of submitted pre-site documents indicated that the state does not currently have a capacity management system in place. The CMT determined the following findings regarding adherence to the SABG wait list requirements:

- BHO has developed a comprehensive policy that details its procedures to maintain and manage a data-driven wait list. These include a Weekly Residential Wait List Report, a Weekly Residential Provider Bed Availability Report for Block Grant funded patients, and delineations for wait list priority populations. However, there does not appear to be a unique client identifier for these reports.
- CMT’s review of submitted pre-site documents found that a spreadsheet entitled “4-month raw data WL/KS SAPT Waitlist” improperly identified clients using protected health information (PHI), including client names and date of birth.
  - While onsite, CMT presented its concerns regarding the sharing of PHI to both state and BHO staff. CMT was informed that an incident report had been filed shortly after the team made the state aware of this situation on the first day of the site visit.

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BHO maintains wait list data for the state, providing a variety of data reports, including the following:

- SAPT Waitlist (by county and total number on wait list); and
- Average Days on Wait List (by gender and member type, and includes injection drug users and pregnant women).

While recognizing that data from these reports is only a snapshot, CMT reviewed reports for a previous 4-month period (October 1, 2017, through January 31, 2018). The review revealed that the average days on the wait list for all member types was 27.51 days, with 308 total clients on the wait list. Seven pregnant women (or 2.27 percent) were on the wait list; 101 (or 32.79 percent) of the wait-listed persons were individuals who inject drugs. The combined percentage of chronic routine and routine was 200 (64.93 percent). Women comprised 113 (36.81 percent) of the wait list, and males comprised 195 (63.19 percent) of the wait list.

KDADS, BHO, and provider staff stated that pregnant women typically remain on the wait list for no more than several days as a result of the DWPs across the state. Consequently, they opined that interim services were not required for these clients. The CMT's review of a small sample of client charts confirmed that one pregnant and one recently postpartum women at the provider site waited 5–6 days to enter treatment. The review of charts for non-pregnant women indicate that there can be long waits to enter residential treatment (up to 434 days and 220 days for residential treatment). Fortunately, these clients were admitted into other treatment modalities while waiting. One woman was admitted to intermediate residential and case management. The other woman was admitted to sobering detox, intermediate residential, housed intensive outpatient, and case management.

## **Recommendations**

### ***Ninety Percent Capacity***

The CMT recommends that KDADS develop a mechanism that allows providers to provide notification within 7 days upon reaching 90 percent of their capacity to admit clients into the program following SABG requirements.

### ***Wait List and Capacity Management Recommendations***

Based on these findings, CMT recommends that KDADS—

- Immediately establish a unique client identifier that does not include clients' PHI.
- Continue current work with BHO to enhance client care coordination to continue decreasing the number of days potential clients are on the wait list to the extent possible. Discussions can be held on ways to enhance the currently performed activities by BHO

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(as provided for in the state’s current contract with BHO).

- As with the 90 percent capacity recommendation above, develop a system to allow for the management of all SABG capacity management elements listed in this report.
- Designate a staff member at the state to periodically conduct deeper analyses and next level inquiries into the detailed and well-developed reports and robust dashboards such as wait list reports and other monthly summary reports provided to the state by BHO. These analysis would seek to determine if there are Block Grant related as well as other quality of service and access concerns or themes.

For example, detailed exploration of the monthly reports summary could be conducted that includes a large variety of reports including the “Designated Women’s Facility Report.” The CMT reviewed this report and noticed that “total pregnant women or women with children (396)” showed the following numbers for women “not treated”:

- Total not recommended for treatment (70);
- Total not recommended for any treatment (58);
- Total recommended for level .5 treatment (12); and
- Total recommended for level IV treatment (0).

Because of these relatively large percentages for pregnant women or women with children (priority populations), it would be useful to follow-up with questions for BHO (after determining medical necessity criteria are met) such as:

- What are the referral sources for these non-treated women?
- What is the disposition for these non-treated women (if data allows that inquiry)? For example, were these women referred to community services?
- Are there other potential factors to consider such as fear of losing custody of children or incarceration or having to travel long distances for services? What is the reputation of treatment services in the community (where women may not accept referrals)?
- Has BHO’s no-show rates improved as a result of following up with no-show clients?
- How does BHO know for which program(s) women were awaiting admission?
- What are the demographics of these non-treated women (for example, age, race and ethnicity, geographic location in state, primary drugs of use)?



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## 45 Code of Federal Regulations §96.127–45—Requirements Regarding Tuberculosis

### Findings

- KDADS conveys the requirements of 45 CFR §96.127 through its contract (dated February 24, 2017) with BHO. The contract includes all requirements regarding TB services (e.g., counseling, testing, medical evaluation, and treatment). This contract also includes language regarding referrals; infection control procedures established by the Kansas Department of Health and Environment (KDHE) for screening and identification, confidentiality requirements, case management; and reporting active cases per state law and federal and state confidentiality requirements.
- The Operational Policy and Procedure (BG 402) approved and effective October 1, 2009, conveys most of the requirements. However, document does not include the exact language from the regulation. Specifically, this document states that “...providers shall provide or arrange for the provision of SAPT interim services if treatment services are not immediately available to clients with high risk of TB”. Although a noteworthy policy to require that interim services are provided if services are not immediately available, this policy does not include the exact language from 45 CFR §96.127(a) (2) requiring the program to refer the individual to another provider of TB services.
- While the contract conveys the requirements of 45 CFR §96.127, it appears that these requirements are currently not routinely or systematically monitored by the state or the intermediary. Further, the state does not appear to conduct monitoring to determine if BHO or providers are referring clients to another provider of TB services when they are denied treatment due to a lack of capacity.
- The staff at the sub-recipient provider visited as part of the compliance monitoring review noted that every client is screened upon admission and receives a TB skin test at the provider site. Staff further indicated that clients who test positive are sent to the Cedric County health department (which has a TB department) for x-rays and additional testing, per the procedures established KDHE. The staff noted there were a few false positives; but no actual TB cases at the provider in the past 5 years.

### Recommendations

Although KDADS and the intermediary convey the requirements (via contract) for 45 CFR §96.127, monitoring of these requirements is not currently in place. To ensure that KDADS, BHO, and its sub-recipients monitor the provision of contractually required SABG services specified in the legislation, the CMT recommends the following:

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- Establish an effective strategy and systemic means for monitoring all Block Grant-funded sub-recipients to ensure that TB services (as defined in 45 CFR §96.127) are being provided.
  - Ensure that Operational Policy and Procedure (BG 402) incorporates all required language for the provision of TB services.

## **45 Code of Federal Regulations §96.131—Treatment Services for Pregnant Women and Women with Dependent Children**

### **Findings**

#### ***Publicize Availability***

KDADS does not include conveyance nor monitoring language regarding the SABG requirement to publicize the availability of services for pregnant women, including the fact that such women receive admission preferences, as required by 45 CFR §96.131(b). The SABG regulation provides examples of strategies that might be used to publicize admission preferences that KDADS may want to consider. These examples include:

- Street outreach;
- Ongoing public service announcements;
- Regular advertisements in local, regional, or both print media;
- Posters placed in targeted areas; and
- Frequent notification of the availability of treatment distributed to networks of community-based organizations, health care providers, and social services agencies.

#### ***Develop Effective Monitoring Strategies***

45 CFR §96.131(f) specifies that the state is required to develop effective strategies for monitoring programs' compliance with providing treatment services for pregnant women. States are required to report under the requirements of 45 CFR §96.122(g) on the specific strategies to be used to identify compliance problems and corrective actions to be taken to address those problems. As noted, since the previous monitoring process was discontinued, monitoring is an opportunity for improvement across all clinical SABG requirements, including those related to treatment services for pregnant women and women with dependent children.

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## **Health Disparities**

During onsite discussions with the provider, CMT inquired about general demographic and other data for the treatment population. The provider presented the following information regarding the percentages of African American and Hispanic or Latino served in FFY18 up to April 30, 2018:

- African American (7 percent); and
- Hispanic or Latino (1 percent).

U.S. census data for 2017, indicated that the state’s population estimate for African Americans was 6.2 percent statewide; and 11.2 percent in Wichita. Similarly, the population estimate for Hispanic or Latino was 11.6 percent statewide; and 16.4 percent in Wichita.<sup>11</sup>

Based on these percentages served and U.S. census data, it appears that the state may have an opportunity to increase its service delivery reach to a larger number of health-disparate populations, particularly in areas of the state where larger percentages of health disparities populations reside (such as Wichita).

Per the Health Disparities narrative in the SABG Uniform Application, FFY18–19, “SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities.” Recognizing that there may be disparities resulting from a variety of reasons (including insurance coverage, language, norms, values, and socioeconomic factors specific to a certain population), to address and ultimately reduce disparities, it is important to collect and analyze information about populations served (and not served) within communities. The SABG Uniform Application Health Disparities plan requires states “to address the potentially disparate impact of their block grant funded efforts”, and “will address access, use and outcomes for subpopulations.”<sup>12</sup>

## **Recommendations**

### **Publicize Availability**

To address the lack of conveyance and monitoring of the publicizing of the availability of services for pregnant women and the admission preferences for this population, CMT recommends the following:

- Ensure that this requirement is included in conveyance and monitoring language for BHO and providers; and

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<sup>11</sup> U.S. Bureau of the Census. Quick Facts: Wichita City, Kansas. Accessed at: <https://www.census.gov/quickfacts/fact/table/wichitacitykansas,KS/PST045217>.

<sup>12</sup> Combined Behavioral Health Assessment and Plan. Environmental Factors and Plan. Health Disparities. Accessed at: <https://bgas.samhsa.gov/Module/BGAS/Application/ApplicationNarrativeXslt?tempsession=585326d6-cac7-4822-8b8a-94e804c70b9a>.

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- Develop a strategy to monitor the outreach efforts of BHO and providers (including a process for monitoring and evaluating outreach efforts).

### ***Develop Effective Monitoring Strategies***

To address the lack of conveyance and monitoring of the requirements to publicize the availability of services for pregnant women and their admission preferences, CMT recommends that KDADS:

- Ensure that this requirement is included in conveyance and monitoring language for BHO and providers.
- Develop an effective strategy or systemic means of routinely monitoring sub-recipients to ensure that all SABG requirements are being met.
  - Using the foundation in place from currently conveyed requirements contained within the contract with BHO; various Operational Policies and Procedures already in place; and components of the previously used onsite monitoring model.
- Confer with the CSAT SPO to explore access to other state models for effective SABG monitoring.

### ***Health Disparities***

The CMT recommends that KDADS consider developing and implementing strategies to conduct outreach and engagement of health disparities populations to increase the number of clients served, particularly in areas of the state where these individuals reside in higher percentages (e.g., Kansas City, Junction City, Leavenworth, and Wichita).

## **42 Code of Federal Regulations §8.12—Federal Opioid Treatment Standards<sup>13</sup>**

### **Findings**

Not applicable.

### **Recommendations**

Not applicable.

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<sup>13</sup> At the time of the compliance monitoring review, Kansas did not have publicly funded opioid treatment programs.

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## 45 Code of Federal Regulations §96.132(a)—Additional Agreements (Level of Care)

### Findings

- In accordance with 45 CFR §75.352(a)(2), KDADS conveys the requirements of 45 CFR §96.132(a) to the intermediary (BHO), and BHO conveys the requirements to sub-recipient providers. The visited sub-recipient provider (DCCCA Women’s Resource Center [WRC]) has operationalized the requirements under 45 CFR §96.132(a) and has P&Ps for referring clients to the most appropriate level of care.
- At the time of the compliance monitoring review, KDADS did not have a mechanism to ensure the state is notified within 7 days of a SUD treatment provider reaching 90 percent of its capacity. The SSA indicated in its pre-site visit documentation that it will be negotiating with BHO to institute this process.
- The Technical Review Report dated January 24, 2012, contained the following recommendation:

*“Strengthen Capacity Management—While AAPS has made progress since the last Technical Review in its ability to document access timelines of clients prioritized under the SAPT Block Grant (e.g., pregnant women and persons who inject drugs) and can now document the intent to provide interim services for those in need, additional opportunities exist to strengthen the AAPS capacity management system for these SAPT Block Grant priority populations.”<sup>14</sup>*

During the May 2018 compliance monitoring review, KDADS staff conveyed that BHO submits wait list management and interim services reports to the SSA, and KDADS has taken steps and made progress to address this recommendation.

- Refer to Overall Data and Administrative Findings earlier in this report.

### Recommendations

- Develop and implement P&Ps for when sub-recipient SUD treatment providers reach 90 percent of their capacity.
- Refer to Overall Data and Administrative Recommendations.

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<sup>14</sup> AAPS (Addiction and Prevention Services) was the name of the SSA at the time of the review (August 2011).

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## 45 Code of Federal Regulations §96.132(b)—Additional Agreements (Continuing Education)

### Findings

- In accordance with 45 CFR §75.352(a)(2), the requirements of 45 CFR §96.132(b) are conveyed by KDADS to BHO, and by BHO to sub-recipient providers. The visited sub-recipient provider, DCCCA WRC, has operationalized the requirements under 45 CFR §96.132(b).
- At the time of the compliance monitoring review, KDADS had three vacancies which included the SABG Coordinator and State Opioid Treatment Authority. The SSA has experienced significant challenges regarding the workforce and succession planning and staff shortages have affected the conduct of SAGB monitoring functions. KDADS staff expressed interest in the workforce development model from the Behavioral Health Education Center of Nebraska (BHECN).
- The 2018–2019 SABG contains strategies developed by a workgroup in 2016 (recruitment and retention recommendations) to address the workforce shortage:
  - “Specifically, they identified recruitment and retention recommendations to: 1) Collect data regarding staff turnover to identify contributing factors; 2) Create a map of where licensed professionals are located across the state; 3) Create incentives for Kansas graduates to remain in Kansas post-graduation; 4) Increase reimbursement rates to keep pace with other disciplines and cost of living; 5) Enforce Mental Health and Addiction Equality Act (parity) law violations (specifically reimbursement rates which are related to starting salaries); 6) Education private insurance companies as to the value added by licensed addiction counselors (return on investment, outcomes); 7) Education for funders as to the importance of measuring behavioral health outcomes along with health outcomes; 8) Review results of pending Mid-America Addiction Technology Center’s workforce study; 9) Identify statutory changes regarding licensure that could enhance reciprocity with other states; and, 10) Dedicate resources toward leadership development, specifically supervisory and business skills.

Continuing education recommendations identified were: 1) Enhance higher education curriculums to include the value of telehealth services; 2) Provide telehealth trainings to current practitioners; 3) Support proposed legislation that defines and promotes the use of telehealth; 4) Make funding available to rural areas to develop broadband to expand the use of telehealth; 5) Offer interdisciplinary training (primary care, mental health and addictions) to current practitioners to improve client outcomes; and, 6) Convene educators of higher learning to discuss ways to prepare students for interdisciplinary practice.”

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At the time of the compliance monitoring review, it appeared the state had not developed timeframes for implementing the workgroup's recommendations.

- BHO staff indicated that the provider network has been professionalized and staff would like to have more resources devoted towards formal continuing education units for practitioners in the field. Staff also conveyed that reduced utilization appears to be related to staff shortages.
- DCCCA WRC expressed a need for women's services-designated training offerings (such trainings used to be offered by the state). Topics of interest include:
  - Impact of opioids on pregnancy,
  - Impact of medication-assisted treatment on pregnancy,
  - Impact of SUDs on children, and
  - New clinical interventions and services for parenting women.

Staff also conveyed that methamphetamine is the primary drug of choice for clients presenting to treatment at their facility, and the need for training on evidence-based practices (EBPs) that are effective in treating this particular client population.

- Refer to Overall Data and Administrative Findings.

## **Recommendations**

- Establish a state peer-to-peer collaboration with BHECN and inquire about options regarding the development and implementation of a workforce model in Kansas similar to BHECN's.
- Develop and implement a workforce development plan that includes succession planning and strategies to:
  - Strengthen the workforce and expand expertise; and
  - Keep institutional knowledge within the organization when vacancies occur through resignations, retirements, or attrition.
- Explore the option of having areas of the state designated as Health Professional Shortage Areas (HPSA) by the Health Resources and Services Administration (HRSA) (since Kansas contains geographic areas that are urban, suburban, rural, and frontier [western part of the state]). Information on HPSAs is available on the HRSA website (<https://bhwhrsa.gov/shortage-designation>).
- The HRSA National Health Service Corps (NHSC) Loan Repayment Program offers student loan repayment opportunities for health professionals providing services in



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communities with limited access to care. The program helps attract new candidates to states and counties and work must be done in a HPSA. Behavioral health professionals can have \$50,000 toward student loan repayments for a 2-year commitment. Physicians and dentists can have \$120,000 toward student loan repayments for a 3-year full-time commitment or 6-year part-time commitment. Information on the NHSC Loan Repayment Program is available on the HRSA website (<https://nhsc.hrsa.gov/loanrepayment/>).

- Explore options for the provision of training offerings to the SUD treatment workforce on evidence-based clinical interventions that are effective in treating client populations being served.
- Refer to Overall Data and Administrative Recommendations.

## **45 Code of Federal Regulations §96.132(c)—Coordination of Prevention and Treatment Activities**

### **Findings**

- The CMT’s review of KDADS, BHO, and DCCCA WRC revealed that 45 CFR §96.132(c) is not conveyed throughout the SUD treatment service delivery system as mandated by 45 CFR §75.352(2)(a). KDADS conveys to BHO the requirement for coordinating of prevention and treatment activities with corrections and criminal justice, social services, and health. Requirements for coordinating of prevention and treatment activities with education, vocational rehabilitation, and employment services are not conveyed. The requirements for developing and implementing memoranda of understanding (MOU) for coordinating activities also is not conveyed.
- 45 CFR §96.132(c) is not conveyed by BHO to the visited sub-recipient provider (DCCCA WRC) as mandated by 45 CFR §75.352(2)(a).
- Although not conveyed to DCCCA WRC, the sub-recipient provider has operationalized the requirements under 45 CFR §96.132(c).
- Refer to Overall Data and Administrative Findings.

### **Recommendations**

- Develop state P&Ps on coordination of prevention and treatment activities that includes the development, implementation, and periodic review of MOUs.
- Ensure that the requirements under 45 CFR §96.132(c) are consistently conveyed from BHO to sub-recipient providers.

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- Refer to Overall Data and Administrative Recommendations.

## **45 Code of Federal Regulations §96.132(e)—Additional Agreements: Confidentiality of Protected Health Information**

### **Findings**

- In accordance with 45 CFR §75.352(a)(2), the requirements of 45 CFR §96.132(e) are conveyed by KDADS to BHO, and by BHO to sub-recipient SABG providers. The visited sub-recipient provider, DCCCA WRC, has operationalized the requirements under 45 CFR §96.132(e).
- KDADS does not have P&Ps on confidentiality or 42 CFR, Part 2. Subsequent to the compliance monitoring review, KDADS provided the CMT with P&Ps on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and information security. However, these P&Ps were not comprehensive.
- All KDADS staff are required to receive HIPAA training and credentialed staff are required to complete refresher training on 42 CFR, Part 2 every 2 years during certification renewals (mandated by licensing standards). There is no mandated continuous training on 42 CFR, Part 2 for non-credentialed staff.
- BHO does not have P&Ps specific to 42 CFR, Part 2.
- As part of the pre-site visit document request, BHO e-mailed a copy of a wait list document to the CMT. The e-mail containing the document was not encrypted and contained client PHI.<sup>15</sup>
- The Authorization for BHO to Release Confidential Information Form does not contain a notice prohibiting the re-disclosure of SUD information (42 CFR, Part 2). The form contains the following sentence: “The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.” This language speaks to HIPAA re-disclosures and violates the requirements of 42 CFR, Part 2.
- At the time of the compliance monitoring review, BHO staff indicated that their business associate agreement (BAA) was under revision and they were working with KDADS to complete the process.
- DCCCA WRC has P&Ps for 42 CFR, Part 2 and HIPAA. However, the P&Ps are outdated.

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<sup>15</sup> During the compliance monitoring review, CMT informed KDADS and BHO of this inappropriate disclosure of client PHI. BHO conveyed to the CMT that an incident report was filed and actions taken to address the inappropriate disclosure.

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- Refer to Overall Data and Administrative Findings.

## Recommendations

- SAMHSA issued a final rule to update and modernize the Confidentiality of Alcohol and Drug Abuse Patient Records (now the Confidentiality of Substance Use Disorder Patient Records) regulations and facilitate information exchange within new health care models while addressing the legitimate privacy concerns of patients seeking treatment for a SUD. The final rule went in effect on March 21, 2017. SAMHSA concurrently issued a supplemental notice of proposed rulemaking (SNPRM) that proposed additional clarifications to the part 2 regulations as amended by the final rule. On January 3, 2018, SAMHSA issued a final rule based on the SNPRM. All states and sub-state entities providing SUD treatment services are required to comply with the new requirements of 42 CFR, Part 2 to ensure the protection and confidentiality of SUD patient records. Therefore, state and sub-state entities must update their policies, practices, consent forms, and other documentation to ensure compliance with the new requirements of 42 CFR, Part 2 and ensure all staff are trained on the new requirements. To assist states and providers of SUD services with understanding the new requirements, SAMHSA issued a webinar giving a broad overview of the Final Rule. The webinar may be viewed online at <https://www.youtube.com/watch?v=DUPTIYwz6fU&feature=youtu.be>.<sup>16</sup>
- Develop and implement P&Ps pertaining to 42 CFR, Part 2 that address:
  - Noncompliance with the requirements;
  - Training and refreshers for all KDADS staff; and
  - Tracking of staff completion of trainings.
- Revise HIPAA P&Ps to include:
  - Comprehensive privacy P&Ps; and
  - Comprehensive information security P&Ps to include:
    - Electronic and physical safeguards;
    - Integrity controls;
    - BAAs;
    - Disciplinary actions for inappropriate disclosures;
    - Notice of Privacy Practices (NOPP);
    - Requirements for authorization to disclose; and
    - Designation of privacy officer.
- Ensure that BHO and sub-recipient SABG providers develop or revise 42 CFR, Part 2 P&Ps to reflect recent changes in the new final rule.

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<sup>16</sup> A summary of the 2017 changes to 42 CFR, Part 2 was e-mailed to KDADS on May 31, 2018.

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- Ensure that informed consents forms and release of information forms are in compliance with 42 CFR, Part 2.
  - Develop and distribute samples of the following forms to BHO and sub-recipient SABG providers (for consistency and internal use):
    - Authorization to disclose;
    - NOPP;
    - BAA; and
    - Notice to Patients of Federal Confidentiality Requirements.
  - Revise the SABG compliance monitoring instrument to include prompts that facilitate the reviewers’ ability to comprehensively ascertain compliance 45 CFR §96.132(e). For example:
    - Privacy P&Ps;
    - Information security P&Ps;
    - Observation of physical safeguards;
    - Observation of electronic safeguards;
    - NOPP;
    - Notice to Patients of Federal Confidentiality Requirements;
    - BAA;
    - Compliant authorization to disclose;
    - Designation of privacy officer;
    - Disciplinary actions for inappropriate disclosures; and
    - Privacy complaint form.
  - Refer to Overall Data and Administrative Findings.

## **45 Code of Federal Regulations §96.133—Statewide Assessment of Needs**

### **Findings**

- KDADS fulfils the requirements under 45 CFR §96.133 and included a statewide assessment of need in its 2018–2019 SABG application.
- KDADS staff interviewed during the compliance monitoring review conveyed that alcohol and methamphetamine are the primary substances used in the state. BHO claims data for April 2018 indicated the following top diagnoses:
  - Amphetamine dependency,
  - Alcohol dependency,
  - Cannabis dependency,

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- Cannabis abuse,
  - Alcohol abuse,
  - Amphetamine abuse,
  - Cocaine dependency,
  - Opioid dependency,
  - Cocaine abuse,
  - Other abuse, and
  - All other diagnoses.

There is a strong need to identify gaps and unmet needs regarding the top substances listed above.

- The statewide assessment of need does not include robust information on the impact of methamphetamine and alcohol use disorders in the state or the gaps and unmet need for services pertaining to these substances. Information from the state's 2018–2019 SABG application indicated the following:
  - Review of youth substance use data indicates that alcohol is by far the most prevalent substance used by students in grades 6, 8, 10, and 12 in Kansas. Alcohol is followed by use of marijuana, e-cigarettes, and misuse of prescription drugs.
  - Kansas reports a much larger percentage of use for methamphetamine. For most substances, Kansas admissions are relatively similar to the national average for treatment admissions per 100,000; however, there is a very large discrepancy for methamphetamine. Kansas has more than double the treatment admissions for methamphetamine than the national average for young adults aged 18–25.
- Staff inquired about EBPs that are most effective in treating methamphetamine use disorders.

## **Recommendations**

- Use the statewide assessment of need to leverage resources to address methamphetamine and alcohol use disorders:
  - Incorporate claims data from BHO into the needs assessment (shows treatment based on diagnoses);
  - Incorporate information on use based on demographics; and
  - Include data that show the incidence and prevalence of alcohol and methamphetamine use in communities and statewide and compare with national data.

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- Forge partnerships with sister agencies and other organizations (as required under 45 CFR §96.132(c)) to collect data on shared client populations (education, vocational rehabilitation, health, social services and child welfare, employment services, corrections and criminal justice, courts, housing, etc.).
    - Develop and implement MOUs or memoranda of agreement and data use or data sharing agreements with new partners for the purposes of accessing and sharing data.
  - Incorporate statewide needs assessment results into the strategic plan for the agency (KDADS).
  - Explore EBPs that are most effective in treating methamphetamine and alcohol use disorders.
  - Explore training opportunities for the workforce on the use of these clinical interventions and maintaining fidelity.
  - The Matrix Model is the most well-known evidence-based intervention for treating methamphetamine use disorders:

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### **The Matrix Model—What It Is**

It is a proven effective, evidence-based protocol that has been used in the treatment of over 6,000 cocaine and 2,500 methamphetamine addicts. It is a ready-made intensive outpatient program that any treatment center can implement.

**The Matrix Model is a comprehensive, multi-format program that covers six key clinical areas:**

- Individual or conjoint therapy,
- Early recovery,
- Relapse prevention,
- Family education,
- Social support, and
- Urine testing.

**It is an integrated therapeutic model incorporating:**

- Cognitive behavioral therapy,
- Motivational enhancement therapy,
- Couples and family therapy,
- Individual supportive or expressive psychotherapy and psychoeducation,
- 12-Step facilitation, and
- Group therapy and social support.

**It is a federally recognized model:**

- CSAT and SAMHSA
- National Institute on Drug Abuse, and
- Office of National Drug Control Policy and Department of Justice (National Synthetic Drugs Action Plan).

The Matrix Model—What It Is. Accessed at: <https://www.hazelden.org/web/public/matrixwhat.page>.

## **Section 505 (a) of the Public Health Service Act (42 US 290aa-4)— Collection of Treatment Episode Data Set**

### **Findings**

- In accordance with 45 CFR §75.352(a)(2), the requirements of Section 505 (a) of the Public Health Service Act (42 US 290aa-4) are conveyed by KDADS to BHO, and by BHO to sub-recipient providers. The visited sub-recipient provider, DCCCA WRC, has operationalized the requirements under Section 505 (a) of the Public Health Service Act (42 US 290aa-4).
- KDADS collects Treatment Episode Data Set (TEDS) information through the Kansas Client Placement Criteria (KCPC) system. KCPC is used by the two regional drug and alcohol assessment centers (RADAC) and SUD treatment facilities for client information and treatment tracking. KCPC is not a web-based application and SSA and provider staffs



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interviewed conveyed limited report functionality within the system. At the time of the compliance monitoring review, KDADS was exploring options for a new data collection system.

- DCCCA WRC staff cannot retrieve data from KCPC and provider-specific reports generated from the system must be requested from KDADS. Staff reported the ability to generate some reports but they are based on episodes of care and are not provider specific. BHO is able to produce reports; however, the data are aggregated.<sup>17</sup>

## Recommendations

- Explore options for using TEDS data to inform programming and decision making.

## 45 Code of Federal Regulations §96.136—Independent Peer Review

### Findings<sup>18</sup>

- The CMT’s review of KDADS, BHO, and DCCCA WRC revealed that 45 CFR §96.136 is not conveyed throughout the SUD treatment service delivery system as mandated by 45 CFR §75.352(2)(a).
- KDADS does not fulfill the requirements under 45 CFR §96.136.
- KDADS has not conducted independent peer reviews (IPR) of SABG sub-recipient providers in several years. The SSA does not have an IPR process and is exploring the possibility of adopting P&Ps similar to those in the state of New York.

## Recommendations

- Develop and implement P&Ps pertaining to 45 CFR §96.136 to include training of individuals performing IPR functions and monitoring of the entity that conducts the IPR (if this requirement is being performed by a contractor).
- Fully convey the requirements under 45 CFR §96.136 to BHO and SABG sub-recipient providers.

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<sup>17</sup> DCCCA WRC staff reported recent collection of National Outcome Measures (NOMs) data for internal organizational purposes. This process commenced approximately 8 months before the compliance monitoring review. NOMs data are collected at admission, during movements through the treatment continuum, and at discharge. These data enable DCCCA WRC to identify trends within their client populations. Staff also reported that NOMs information facilitates identifying clients who have challenges with ancillary services (e.g., housing, employment, etc.) and securing appropriate services for these clients to address the concerns.

<sup>18</sup> At the time of the review, the state’s Block Grant position was vacant. Hence, documentation of the state’s compliance with the peer review requirement was not submitted until April 2019. The SABG allows states to satisfy the independent peer review requirement by demonstrating that at least 5 percent of their entities providing services obtained accreditation, during the fiscal year, from a private accreditation body such as the Joint Commission on the Accreditation of Healthcare Organizations, the Commission on the Accreditation of Rehabilitation Facilities, or a similar organization. The state reported nine (9) of 44 providers (20.5 percent) are accredited exceeding the required independent peer review of five (5) percent or 2.2. providers each fiscal year.

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- Ensure IPR protocols incorporate the National Culturally and Linguistically Appropriate Services Standards to evaluate that services are culturally and linguistically appropriate.
  - Use results from IPRs to identify additional training needs and inform statewide training offerings, and to inform overall decision making.
  - Crosswalk results from IPRs, SABG compliance monitoring reviews, and licensing reviews to identify recurring findings and possible trends.

## **42 Code of Federal Regulations §54—Charitable Choice**

### **Findings**

- In accordance with 45 CFR §75.352(a) (2), the requirements of 42 CFR §54 are conveyed by KDADS to BHO, and by BHO to SABG sub-recipient providers. The visited sub-recipient provider, DCCCA WRC, has partially operationalized the requirements under 42 CFR §54.
- KDADS’ P&Ps pertaining to the Charitable Choice provision are outdated.
- KDADS did not provide a copy of a sample notice of an individual’s right to services from an alternative provider.
- KDADS does not have a process or P&Ps for referrals under 42 CFR §54.
- DCCCA WRC stated in its pre-site questionnaire that it is not a faith-based organization; however, the provider has a partnership with Faith Builders (only in Wichita) for respite services. DCCCA WRC completes releases for clients who are receiving services from Faith Builders. The releases do not contain requirements pertaining to the Charitable Choice provision.
- Refer to Overall Data/Administrative Findings.

### **Recommendations**

- Revise P&Ps pertaining to 42 CFR §54.
- Ensure that BHO and sub-recipient SABG providers develop and implement P&Ps pertaining 42 CFR §54 and the P&Ps are reviewed and updated regularly.
- Develop a sample notice of an individual’s right to services from an alternative provider should they object to the faith-based nature of the initial referral, and their right to

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services that reasonably meet the requirements of timeliness, capacity, accessibility, and equivalency.

- Develop a process and P&Ps for referrals made based on the Charitable Choice requirements.
- Ensure that BHO and sub-recipient SABG providers add language regarding 42 CFR §54 to provider manuals and client handbooks.
- DCCCA WRC attach a copy of the requirements outlined under 42 CFR §54 to releases going to organizations that are faith-based to ensure that these entities are aware of the requirements and understand allowable activities in terms of services to clients.
- Refer to Overall Data/Administrative Recommendations.

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**42 Code of Federal Regulations Part 54 and 54A Charitable Choice**

1. If the program is an SABG Block Grant-funded program that is part of a faith-based organization, the program may:
  - a) Retain the authority over its internal governance;
  - b) Retain religious terms in its name;
  - c) Select board members on a religious basis;
  - d) Include religious references in the mission statements and other governing documents; and
  - e) Use space in its facilities to offer Block Grant-funded activities without removing religious art, icons, scriptures, or other symbols.
2. If the program is an SABG Block Grant-funded program that is part of a faith-based organization, the program cannot use SABG Block Grant funds for inherently religious activities such as the following:
  - a) Worship;
  - b) Religious instruction; and
  - c) Proselytization.
3. The program may only engage in religious activities listed under 2 above if both of the following conditions are met:
  - a) The activities are offered separately, in time or location, from Block Grant-funded activities; and
  - b) Participation in the activities is voluntary.
4. In delivering services, including outreach activities, SABG Block Grant-funded religious organizations cannot discriminate against current or prospective program participants based on:
  - a) Religion;
  - b) Religious belief;
  - c) Refusal to hold a religious belief; and
  - d) Refusal to actively participate in a religious practice.
5. If an otherwise eligible client objects to the religious character of the program, the program shall refer the client to an alternative provider within a reasonable period of time of the objection.
6. If the program is a religious organization, the program must:
  - a) Use generally accepted auditing and accounting principles to account for SABG Block Grant funds similar to other nongovernmental organizations;
  - b) Segregate federal funds from non-federal funds;
  - c) Subject federal funds to audits by the government; and
  - d) Apply Charitable Choice requirements to commingled funds when state funds, local funds, or both are commingled with Block Grant funds.

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## Appendix A. List of State and Local Personnel Interviewed During the Compliance Monitoring Review

Name	Agency
Frances Breyne Avery, Director, Provider Relations	Beacon Health Options, Inc.
Charles Bartlett, MH/SAPT SSA and Block Grant Planner	Kansas Department for Aging and Disability Services
Elizabeth Bernasek, Manager, Provider Relations	Beacon Health Options, Inc.
Steve Brazill	Kansas Department for Aging and Disability Services
Sandra Dixon, LMSW, Director of Behavioral Health Services	DCCCA Women's Resource Center
Misty Ford	Kansas Department for Aging and Disability Services
Susan Fout, RPN, Commissioner, Behavioral Health Services	Kansas Department for Aging and Disability Services
Jennifer Gillespie, LPN, Nurse	DCCCA Women's Resource Center
Donna Gorman, LCMFT, LCAC, Clinical Coordinator	DCCCA Women's Resource Center
Rachal Harper, MS, LCAC, Program Coordinator	DCCCA Women's Resource Center
Kasha Himes, Child Care Coordinator	DCCCA Women's Resource Center
Jerlita, Howard, Grievance and Appeals Coordinator	Beacon Health Options, Inc.
Sharon Kearse	Kansas Department for Aging and Disability Services
Janelle Keller	Kansas Department for Aging and Disability Services
April Lee, Office Manager, Provider Relations	Beacon Health Options, Inc.
Cissy McKinzie, MH/SAPT SSA and Block Grant Planner	Kansas Department for Aging and Disability Services
Tamara Moler, Survey, Certification, and Credentialing	Kansas Department for Aging and Disability Services
Glenda Overstreet-Vaughn, Quality and Compliance Manager	Beacon Health Options, Inc.
Rachel Owens, LMSW, LMAC, Therapist	DCCCA Women's Resource Center
Brad Ridley, Commissioner, Financial and Information Systems	Kansas Department for Aging and Disability Services
Toby Scott, Director of Clinical Services	Beacon Health Options, Inc.
Wanda Shaw, LAC, Intake Coordinator	DCCCA Women's Resource Center
Carol Spiker	Kansas Department for Aging and Disability Services
Eric Van Allen, Senior Vice President, Client Partnerships	Beacon Health Options, Inc.
Dorothy Vaughn, CD Technician Supervisor	DCCCA Women's Resource Center

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## Appendix B. Reference List of Acronyms Relevant to the State of Kansas

AAPS	Addiction and Prevention Services
ADIS	Alcohol and Drug Information School
ASO	administrative services organization
BAA	business associate agreement
BHECN	Behavioral Health Education Center of Nebraska
BHO	Beacon Health Options, Inc.
BHS	Behavioral Health Services
CFR	Code of Federal Regulations
CMT	Compliance Monitoring Team
CSAT	Center for Substance Abuse Treatment
DUI	driving under the influence
DWP	Designated Women’s Program
EBPs	evidence-based practices
FFY	federal fiscal year
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	human immunodeficiency virus
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Service Administration
IPR	independent peer review
KCPC	Kansas Client Placement Criteria
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
MOU	memorandum of understanding
NHSC	National Health Service Corps
NOMs	National Outcome Measures
NOPP	Notice of Privacy Practices
P&Ps	policies and procedures
PHI	protected health information
PWID	people who inject drugs

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RADAC	regional drug and alcohol assessment center
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SCCC	Survey Certification and Credentialing Commission
SNPRM	Supplemental Notice of Proposed Rulemaking
SSA	Single State Agency
SUD	substance use disorder
TA	technical assistance
TB	tuberculosis
TEDS	Treatment Episode Data Set
WRC	Women's Resource Center



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## **Appendix C. Examples of Notable Practices and Tools**

### **3rd Time Driving Under the Influence**

In September 2012, KDADS established a formal partnership with the Kansas Department of Corrections in response to implementing provisions under Kansas Statutes Annotated 8-1567 (Driving Under the Influence [DUI] penalties). This partnership resulted in 3rd Time DUI, a diversion program with a multidisciplinary system consisting of the two RADACs, corrections, and the courts. Individuals receiving 3 DUI offenses are diverted to this program.

The 3rd Time DUI program pays for treatment and care coordination for ancillary services (e.g., employment, housing, child support, etc.). Direct care coordination for services is provided for 1 year. The program has a large peer support component and client progress is evaluated. Approximately 600 clients are treated through 3<sup>rd</sup> Time DUI annually and recidivism rates are less than 5 percent.

### **Crisis Centers with Sobering Beds**

Alcohol and methamphetamine are the major substances of choice in Kansas. KDADS has established crisis centers with sobering beds to address the needs of clients with alcohol addiction. Persons in need of services are brought to crisis centers by family members or via crisis intervention team officers. A peer support specialist works closely with a client to get them enrolled in a treatment during program during their stay in the sobering bed. The goal is to enroll the client into social detoxification and other behavioral health services.

### **Alcohol and Drug Information School**

DCCCA WRC created the Alcohol and Drug Information School (ADIS), a 1-day course (8 hours in length) that is held monthly. The course addresses the consequences of alcohol and drug misuse and fulfills the first-time DUI offense requirements for Kansas. Clients are referred to this course for intensive education. Course topics include:

- Substance abuse education,
- State laws and guidelines,
- Blood alcohol content levels, and
- Legal consequences of continued violations.

The course is offered at three locations in Kansas (Pratt, Lawrence, and Pittsburg). Registration fees are an out-of-pocket expense for clients, and prices and the registration process vary by location. Information on ADIS is available on the DCCCA WRC website (<https://www.dccca.org/behavioral-health-services/adis/>).

**Kansas**  
**Substance Abuse Prevention and Synar**  
**Site Visit Report**

**May 22–24, 2018**

**Federal Fiscal Year 2018**

Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Prevention

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## SITE VISIT SUMMARY

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The Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321) enacted by Congress in July 1992 authorized the Substance Abuse Prevention and Treatment Block Grant (SABG) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's Center for Substance Abuse Prevention (CSAP) is charged with providing policy and program guidance to help states<sup>1</sup> use and report on the 20-percent primary prevention set-aside of the SABG. CSAP is committed to providing support that can advance Single State Authority (SSA) and state substance abuse prevention systems. Toward this end, CSAP conducts site visits to 1) understand and document the state's progress in developing and sustaining state prevention infrastructure that can accomplish the state's Substance Abuse Prevention and Treatment Block Grant (SABG) prevention goals; 2) confirm state compliance with prevention and Synar requirements of the SABG; and 3) identify areas for which the state may request CSAP technical assistance (TA) to develop or enhance the state's prevention and Synar program.

This report is a summary of the most recent site visit for Kansas, which was conducted on May 22–24, 2018. The site visit involved discussions with state participants about the state's capacity for using performance management processes to achieve sustainable improvements in the substance misuse indicators and outcomes measured by SAMHSA's National Outcome Measures (NOMs), as well as other state-specific goals and objectives.

This Site Visit Report contains key findings related to state prevention and Synar system strengths and challenges and required followup actions. The Site Visit Report also contains recommendations intended to help Kansas enhance its ability to implement the five steps of the Strategic Prevention Framework (SPF), or an equivalent planning process, to achieve population-level reductions in the incidence and prevalence of substance abuse and related problems and consequences. These findings and recommendations are discussed throughout the report.

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<sup>1</sup> In this document, the word *state* refers to the 50 states and the District of Columbia and to the territories, Pacific jurisdictions, and Native American tribe that receive SABG funds.

## **Prevention System Elements**

### **Prevention System Organization**

#### **SSA Prevention System**

The Kansas Department for Aging and Disability Services (KDADS) is the SSA for the SABG and the State Mental Health Agency for the Community Mental Health Services Block Grant. The agency is the result of a reorganization that merged the former Department on Aging with the Disability, the Behavioral Health Services Division formerly administered by the Department for Social and Rehabilitation Services, and elements of the Health Occupations Credentialing Division formerly administered by the Kansas Department of Health and the Environment (KDHE). KDADS oversees services to older adults; administers behavioral health, addiction, and prevention programs; manages the four state hospitals and institutions; administers the state's home- and community-based services waiver programs under KanCare, the state's Medicaid program; and directs health occupations credentialing.

KDADS was initially organized into an Office of the Secretary and three Commissions: Financial and Information Services, Community Services and Programs, and Aging. In 2015, a new Behavioral Health (BH) Commission was formed to oversee the mental health, addictions-prevention, and treatment programs previously administered by Community Services and Programs as well as the state's two psychiatric hospitals. In 2016, BH Commission staff charged with responsibility for licensing and certifying mental health services and substance abuse treatment providers were moved from the BH Commission to the newly established Survey, Certification, and Credentialing Commission. This move was made to enable BH Commission staff to focus on program planning and management rather than the enforcement of regulations. In 2017, problem gambling was moved from the Prevention Program to another division. An organizational chart is provided in appendix C.

The Director of Behavioral Health Services—who serves as the State Mental Health Agency Director and supervises the majority of BH Commission staff—reports to the Commissioner for Behavioral Health. The Block Grant Manager serves as the SSA Director for substance abuse prevention and treatment. A new Prevention Program Manager—who serves as the state's representative to the National Prevention Network—was hired in December 2017. The Prevention Program Manager oversees three Prevention Consultants who administer substance abuse prevention programs. An additional 5 BH Commission staff oversee substance abuse treatment programs and 11 oversee mental health programs.

In addition to the SABG, Prevention Program staff also administer two 5-year Strategic Prevention Framework Partnerships for Success (SPF-PFS) grants that were awarded by SAMHSA in 2015: one focusing on prescription drugs and the other on underage drinking. KDADS also administers a State Targeted Response to the Opioid Crisis (STR) grant from SAMHSA in which Prevention Program staff are involved.

KDADS is advised by a Governor's Behavioral Health Services Planning Council (GBHSPC), which was formed to fulfill the federal mandate that all SABG recipients have a mental health services planning and advisory council. The Council consults with the Secretary of KDADS on

policies governing behavioral health, advises the Governor, and provides annual reports to the Legislature regarding management and operations of the state community mental health and substance use disorder programs. Members are appointed by the Governor and consist primarily of mental health consumers and practitioners, according to the KDADS website. The council has nine subcommittees, however, that address a range of issues, including prevention, children, housing and homelessness, justice-involved youth and adults, alcohol and other drug abuse, rural and frontier services, suicide prevention, veterans, and vocational rehabilitation.

The SSA contracts out significant statewide functions and responsibilities related to prevention to the following entities which—along with KDADS—are collectively known as the Kansas Prevention Collaborative (KPC):

- **DCCCA, Inc.** for training and technical assistance (T/TA) to community coalitions, community initiatives, and KDADS projects focused on one or more of the following issues: substance abuse prevention, problem gambling awareness and prevention, suicide prevention, and mental health promotion.
- **The Center for Learning Tree Institute, Greenbush (Greenbush)** to provide behavioral health data collection, analysis, and evaluation, including administering the Kansas Communities That Care (KCTC) Student Survey and hosting the online Kansas Behavioral Health Indicators Dashboard (KBHID). Greenbush subcontracts with the University of Kansas Center for Community Health and Development (KU-CCHD) to maintain online systems for data collection and reporting by grantees and subrecipients.
- **Wichita State University Community Engagement Institute (WSU-CEI)** to coordinate monthly PreventionTalks webinars, open to all interested coalitions, and develop and facilitate a statewide prevention coalition (PreventionWorks) that meets quarterly.

KPC forms much of the state's primary prevention infrastructure. In addition to the contractors for substance abuse prevention, KPC also includes two mental health promotion/suicide prevention contractors who are funded through sources other than the SABG. Prevention Program staff noted that they rely on contractors who have the skills and resources needed to help the state implement prevention programs.

KDADS also partners with the Kansas Department of Revenue's (KDOR's) Division of Taxation, which conducts random, unannounced Synar inspections as part of its overarching responsibility for enforcing youth tobacco laws. Prevention Program staff also spoke of efforts to cultivate a relationship with the Kansas Department of Commerce.

### **Behavioral Health Integration and Implementation of the Affordable Care Act**

The PowerPoint (PPT) presentation provided by Prevention Program staff during the site visit stated that they have embraced the integration of substance abuse prevention, mental health promotion, suicide prevention, and problem gambling through a focus on shared risk and protective factors and the KPC. The PPT also noted that the BH Commission is actively working to integrate prevention into other programs, in part through recommendations from the GBHSPC. The PPT reported that integration of behavioral health prevention and primary health care remains a challenge, but the Kansas Prescription Drug and Opioid Advisory Committee—

which is funded by the PFS—has made progress working with prescribers and pharmacists through provider education efforts.

**Prevention System Organization—SSA Prevention System**

**STRENGTHS**

**Prevention Program staff are providing future-oriented leadership for prevention efforts.**

The state’s National Prevention Network representative and other Prevention Program staff are providing stable support for substance abuse prevention efforts during times of significant change and transition. Their knowledge of the state—combined with their interest in innovation and improvement—is instrumental to efforts to build the capacity of the state’s prevention system at all levels. Prevention Program staff have experience managing a diverse portfolio of state and federal discretionary grants and working with at-risk populations and issues that share risk factors with substance abuse, including problem gambling, mental health promotion, and suicide prevention. This wide range of experience complements efforts to enhance wellness and decrease substance abuse-related health disparities across the lifespan.

**KDADS leadership and staff are taking steps to elevate the role and performance of prevention programming across the state.**

KDADS appears to be providing a supportive and encouraging environment for Prevention Program staff to foster communication and build relationships with subrecipients and existing and potential partners. This includes strengthening existing relationships with state agencies such as KDOR, developing new partnerships with other state agencies, and fostering the development of new forums for subrecipients and interagency prevention leadership.

**KDADS’ state-level contracts provide Prevention Program staff with a diverse array of expertise needed to improve prevention outcomes.**

KDADS’ KPC contracts provide Prevention Program staff with external expertise and support in key areas needed to support performance management, such as T/TA, data collection and analysis, and monitoring and evaluation.

**CHALLENGES**

**KDADS’ organizational structure and staffing have been in a state of transition, and there are multiple change initiatives underway with no clear process for prioritizing or coordinating them.**

The Kansas SSA has undergone multiple reorganizations and transitions in leadership and staff since the last CSAP site visit. While the infusion of new staff brings fresh energy and ideas, some Prevention Program staff noted that this has resulted in significant growth in workloads in a short amount of time. At the time of the site visit, there were multiple planning processes and change initiatives either underway or being considered, but no clear process or criteria for identifying those that would be most beneficial for enhancing prevention system development and functioning. There were also no clear processes for coordinating the many different planning and system change efforts, even though they tend to involve the same people and general focus areas.

**Potential Enhancements for Prevention System Organization—SSA Prevention System**

<b>1</b>	<b>Prioritizing steps needed for prevention system development</b>
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<p>Research indicates that while multiple courses of action are always possible for any given problem, on average, 80 percent of outcomes stem from just 20 percent of actions. The challenge is to identify the “vital few” actions that will have the greatest impact. KDADS’ ability to effectively strengthen the state’s prevention system could be enhanced by prioritizing the courses of action to be taken, beginning with those that have the greatest potential for increasing overall effectiveness and are foundational to other capacity development efforts.<sup>2</sup></p>
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KDADS does not appear to have a formal definition of prevention that is used to guide its work. The PPT presentation provided by the state, however, noted that KDADS recognized a need 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. KDADS vision is: “Kansas communities support prevention and recovery throughout the lifespan.” Its mission is “Partnering to promote prevention, treatment, and recovery to ensure Kansans with behavioral health needs live safe, healthy, successful and self-determined lives in their communities.”

State documents note that KDADS embraces the use of the SPF at the state and local levels. Prevention Program staff credit the SPF for the creation of the KPC and an increase in funding for community-led prevention initiatives.

Kansas redesigned its prevention system after the 2014 CSAP site visit and replaced its longstanding system of Regional Prevention Centers (RPCs) with the KPC. At that time, SSA staff spoke of a goal of inverting the funding structure and allocating 85 percent of all SABG funds to community-led prevention initiatives and just 15 percent to supportive contractual infrastructure. (At the time of the 2014 site visit, 88 percent of all SABG funds supported the RPC system and just 12 percent were used to fund the implementation of community-led prevention initiatives.)

During the 2018 site visit, Prevention Program staff noted that the main priorities driving the creation of KPC were to: 1) develop a more integrated approach that would allow the state and communities to address substance use, mental health promotion, suicide prevention, and problem gambling education and awareness; and 2) make the state’s support network more agile and efficient, thus increasing the level of funding for community-led prevention initiatives.

During the site visit, Prevention Program staff noted that they had relied on SAMHSA’s former National Registry of Evidence-Based Programs and Practices (NREPP) as the primary source for selecting prevention strategies. KDADS does not have a state list or registry of evidence-based practices (EBPs) and does not have a functioning Evidence-Based Workgroup to advise it in this area. Prevention Program staff shared a memo that had been sent to coalitions and KPC members to outline the discontinuance of NREPP and assure prevention system members that KDADS would help them locate and navigate other EBP registries.

## Prevention System Organization—SSA Approach to Prevention

<sup>2</sup> The Pareto Principle is a well-established theorem of distribution involving cause and effect, which holds that 80 percent of problems stem from just 20 percent of their causes, while 80 percent of outcomes stem from 20 percent of actions.

**STRENGTHS**

**KDADS’ ongoing adoption of the SPF as its operational framework for prevention reinforces its efforts to implement a results-oriented, performance management approach to prevention.**

Performance management is a process for turning data into actionable information to determine how resources can best be used to produce and sustain desired outcomes, then evaluating those efforts over time. The SPF provides a model for using well-established performance management principles to build effective prevention system infrastructure that can significantly reduce alcohol, tobacco and other drug (ATOD)-related problems. When states and their subrecipients implement all steps of the SPF with fidelity—and pay attention to the interwoven emphases on cultural competence and sustainable outcomes—their efforts are much more likely to result in improvements to the health and well-being of targeted populations.

**CHALLENGES**

**The lack of a common definition and conceptual framework for prevention could lead to misunderstandings about allowable activities under federal SABG regulations.**

In Kansas, as in other states, prevention perspectives, philosophies, and approaches may differ across the state. The lack of a core definition for primary substance abuse prevention could contribute to a lack of clarity among subrecipients as to what activities may be funded through primary prevention set-aside funds. This is a particularly important issue given the multiple behavioral health issue areas under the purview of the Prevention Program. The absence of a common language and understanding of prevention could also inhibit coordination across coalition boundaries and lead to fragmented and isolated efforts that lack the reach, comprehensiveness, and intensity needed to produce intended outcomes.

**KDADS’ reliance on federal registries of evidence-based strategies—without further guidance or criteria—may lead to the selection of prevention strategies that have little documentable impact on priority ATOD-related problems.**

Behavioral and public health research has underscored the importance of implementing a comprehensive array of strategies that have strong evidence of effectiveness and are locally, culturally, and developmentally appropriate. Having providers select from a menu of programs—without applying data and research—can lead them to select strategies that are inexpensive, popular, or easy to implement but are not aligned with their most pressing problems and target populations. This can result in the state investing time and resources in efforts that have little prospect of long-term impact.

**Potential Enhancements for Prevention System Organization—SSA Approach to Prevention**

<b>2</b>	<p><b>Conceptual framework for prevention</b></p> <p>KDADS’ ability to help Kansas’ prevention system reduce ATOD-related problems could be strengthened by the adoption of a clear conceptual framework for primary substance abuse prevention that includes the following components:</p> <ul style="list-style-type: none"> <li>• A written definition of primary prevention that conveys basic intended outcomes and provides parameters to guide how efforts are to be designed and carried out</li> </ul>
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	<ul style="list-style-type: none"> <li>• An operational framework that specifies expectations, processes, and procedures to inform prevention work and a theoretical framework that identifies the science and research that are to be used to design and implement prevention initiatives.</li> </ul>
<p><b>3</b></p>	<p><b>Increased use of evidence-based strategies</b></p> <p>Prevention Program staff identified a need to improve local and state-level access to resources on evidence-based policies and practices in light of the discontinuance of NREPP. KDADS’ ability to increase the degree to which communities select and implement the most effective prevention strategies could be strengthened by expanding current efforts to update guidance on evidence-based strategies. This would involve moving beyond offering a menu of programs to a strategic process for decisionmaking that includes careful consideration of the following information to guide strategy selection:</p> <ul style="list-style-type: none"> <li>• The characteristics of the population(s) for which the strategy has been documented to be effective</li> <li>• The nature and intended reach and scope of the strategy (e.g., population or individual-level behavior change and health improvements)</li> <li>• The geographic settings for which the strategy has been documented to be effective</li> <li>• The domains in which the strategy has proven to be effective (e.g., individual/peer, family, school, community)</li> <li>• The specific intervening variables the strategy has proven successful in addressing</li> <li>• The specific problems and consequences the strategy has proven successful in reducing</li> <li>• The degree to which outcomes achieved can be sustained without ongoing and significant infusions of funding or other resources</li> <li>• The implementation and evaluation requirements associated with the strategy (e.g., staffing patterns and qualifications, required T/TA, activities, required materials and supplies, adaptation or fidelity protocols, evaluation needs)</li> <li>• Additional costs associated with the strategy (e.g., personnel, operating expenses, supplies and materials, contractual services, facility expenses, media).</li> </ul>

**Multiagency/State Prevention System**

The Kansas Legislature has passed some of the strictest alcohol laws in the nation. Kansas prohibited all alcohol manufacturing, sales, and possession from 1881 to 1948, and prohibited bars selling liquor by the drink until 1987. Both the 1948 amendment to the Kansas Constitution that ended alcohol prohibition and a subsequent 1986 amendment that allowed for public bars (called “open saloons”) contain provisions that they only would be in effect in counties that had approved the respective amendments, either during the election over the amendment itself or subsequently. While all counties in Kansas have approved the 1948 amendment, 19 counties have never approved the 1986 amendment and continue to prohibit all sale of liquor by the drink. Another 59 counties—including Johnson County, the largest county in Kansas and part of the Kansas City Metropolitan Area—approved the 1986 amendment with a requirement that establishments must receive 30 percent of its gross revenues from food sales to sell liquor by the

drink. Only 17 counties in Kansas have approved the 1986 amendment without any limitation, allowing liquor to be sold by the drink without any food sales requirement.

Until recently, the only alcoholic beverage that grocery stores and gas stations could sell was beer with no more than 3.2 percent alcohol by weight (“3.2 beer”). While legislation has been passed to allow beer with an alcohol content of up to 6 percent to be sold in stores starting April 1, 2019, all other alcohol sales are allowed solely at state-licensed retail liquor stores. Alcohol sales are prohibited on Christmas and Easter. On the days sales are permitted, package sales are prohibited before 9 a.m. and after 11 p.m., and on-premises consumption is prohibited after 2 a.m. and before 9 a.m. Sunday on-premises sales in the state have been permissible only since 2005. However not all communities that permit off-premises sales allow sales on Sunday. In March 2018, the governor signed into law tougher penalties for repeat offenders who injure or kill someone in a drunk driving crash.

During the site visit, Prevention Program staff also noted that Kansas remains just one of four states that does not allow possession of marijuana for any purpose. While bills to legalize the medical use of marijuana have been proposed, none have passed. The Legislature has, however, recently reduced the penalties for marijuana possession. According to the National Survey on Drug Use and Health (NSDUH), young adults in Kansas report lower rates of past-30-day marijuana use (15.7 percent) than their peers nationally (19.7 percent). The percentage of Kansans who report risk of harm associated with weekly marijuana use, however, has dropped markedly from 2002 to 2014 among both youth (86.1 percent to 70.4 percent) and adults (81.6 percent to 59.9 percent), according to NSDUH data.

The Kansas Department of Alcoholic Beverage Control (ABC) licenses and regulates alcoholic beverage retailers and enforces state alcohol laws. It has the power to preempt local laws, but cities may vote to exclude package sales and local governing boards may advise on the issuance of licenses in cities and counties. The ABC’s Enforcement division engages in multiple activities to help liquor licensees stay in compliance with state laws and regulations administered by ABC and KDOR. These include:

- Providing training to liquor licensees to help them understand licensing requirements.
- Conducting investigations and enforcement activities related to possible violations.
- Training local law enforcement officers and agencies on the most effective methods to investigate and enforce liquor laws.
- Working with health organizations, schools, and coalitions on strategies to educate youth on the safety and health dangers related to drinking to reduce underage drinking.

Training for local law enforcement includes a focus on preventing underage drinking. Investigative techniques featured in the training include cops in shops, controlled buy investigations, bar checks, furnishing surveillance, third-party sales, party patrols, working hotels/motels, keg registration investigations, detecting fake IDs, investigation of fake ID rings, and submitting cases to ABC for administrative prosecution against liquor licensees.

The role that agencies such as the Department of Education (KDOE) and KDHE play in substance abuse prevention activities is unknown. KDADS appears to have few prevention

partnerships with other state agencies, but Prevention Program staff noted that expanding partnerships across agencies is a current focus.

There are four federally recognized tribes in Kansas, all of which have reservations in the northeast corner of the state: the Iowa Tribe of Kansas and Nebraska, the Kickapoo Tribe of Indians in Kansas, the Prairie Band Potawatomi Nation, and the Sac and Fox Nation. State documents note that tribal input is secured through representation on the GBHSPC. The SSA also serves on the Steering Committee of Kansas Serves Native American Families, an Administration for Children and Families’ funded project overseen by the Kansas University School of Social Welfare to address substance abuse in the families of the Kansas tribes. The Prevention Program does not have any formal funding or programmatic partnerships with tribes.

The Prevention Subcommittee of the GBHSPC was established in July 2016 to strengthen collaboration and partnership opportunities, ensure alignment of processes and outcomes, and increase the effectiveness of state and local efforts to address prevention issues. The Prevention Subcommittee serves as the advisory council for Kansas behavioral health prevention initiatives addressing a range of health and behavior issues that include suicide prevention, behavioral health promotion, and substance use disorder prevention. The subcommittee comprises 11 members from a variety of backgrounds, including substance abuse prevention, mental health promotion, suicide prevention, and problem gambling prevention, and is currently chaired by DCCCA. Prevention Program staff stated they are looking for ways to consolidate multiple groups and task forces with the same members under the GBHPC Prevention Subcommittee.

The Kansas State Epidemiological Outcomes Workgroup (SEOW) is composed of data experts and prevention stakeholders charged with the following core tasks: 1) identifying, analyzing, profiling, and sharing data from existing state and local sources; 2) creating data-guided products that inform prevention planning and policies; 3) training communities in understanding, using, and presenting data in an effective manner; and 4) building local and state-level monitoring and surveillance systems. Membership includes KDADS, KU-CCHD, DCCCA, WSU-CEI, and Greenbush, which coordinates the SEOW and a KPC Data Project Team.

**Prevention System Organization—Multiagency/State Prevention System**

**STRENGTHS**

**The presence of multiple state agencies with mandates for preventing substance abuse in Kansas creates many opportunities for interdisciplinary coordination and collaboration.**

Prevention is a shared priority and responsibility among multiple state agencies in Kansas, which increases investment and the potential for coordinated action. Each of the agencies tasked with preventing and reducing ATOD-related problems has expertise with data and specialized knowledge, skills, and abilities (KSAs) needed to address many of the factors associated with—and the populations affected by—ATOD-related problems. Were they to coordinate their efforts and use of resources, these agencies could form a comprehensive and effective system of prevention in Kansas.

**The GBHSPC and its Prevention Subcommittee have the potential to strengthen state efforts to prevent ATOD-related problems.**

Single-sector interventions have limited ability to significantly reduce ATOD-related problems, which tend to be driven by a diverse array of intervening variables and conditions across disciplines and sectors. Highly effective prevention initiatives perform three core functions:

1. Identify the key variables and conditions that drive substance abuse
2. Convene the organizations and institutions that have the specialized skills and sector-specific responsibilities for addressing these variables and conditions
3. Target and coordinate efforts across sectors in a seamless fashion.

The GBHSPC and its Prevention Subcommittee have the potential to serve as multiagency coordinating bodies that can leverage and maximize resources across agencies to address the root causes of ATOD abuse in Kansas. KDADS’ inclusion in the former and its facilitation of the latter positions it to play a key role in these efforts. Kansas’ SEOW should also be a significant asset to both interagency endeavors.

**CHALLENGES**

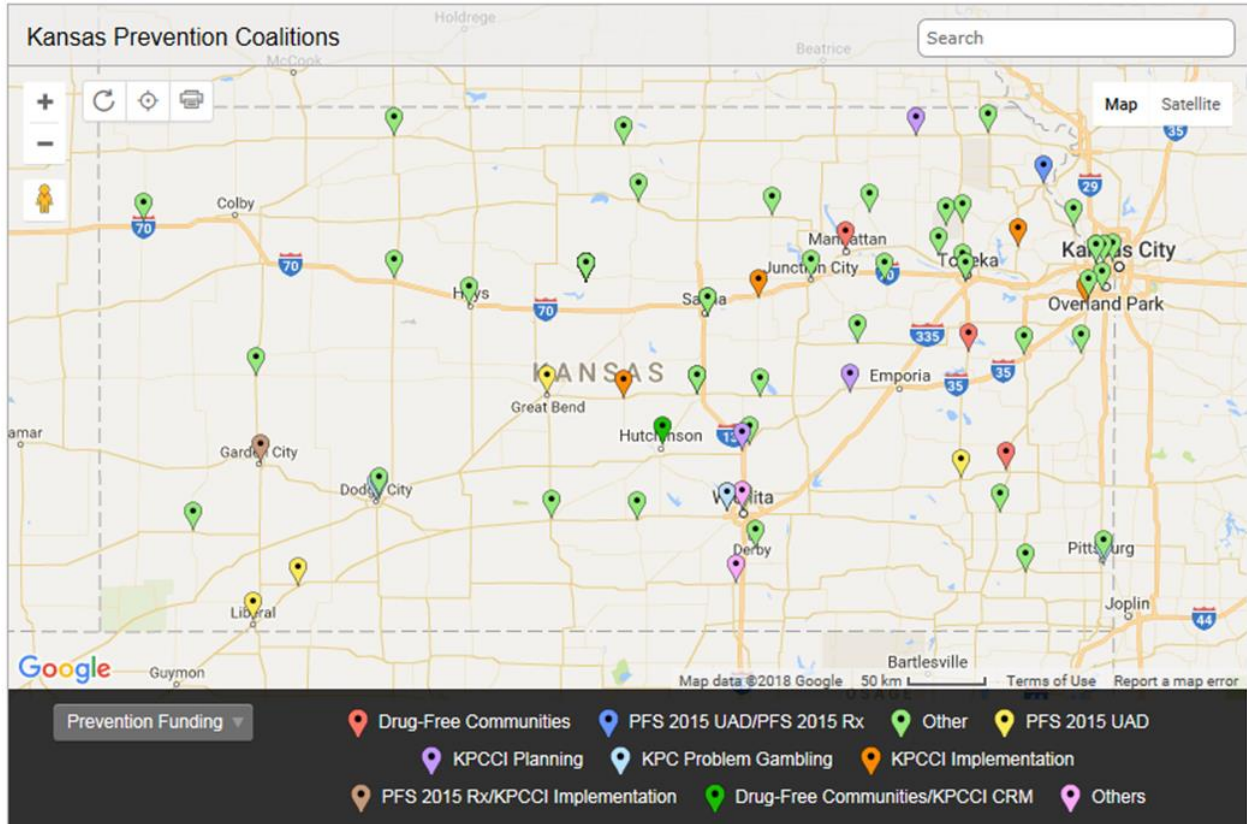
**Prevention efforts carried out by state agencies in Kansas tend to be siloed and uncoordinated.** While several state agencies engage in information sharing and general prevention discussions, they do not currently coordinate the planning, implementation, and evaluation of prevention efforts across state agencies and sectors. KDADS staff noted that increasing coordination and partnership across sectors is a current priority.

**Potential Enhancements for Prevention System Organization—Multiagency/State Prevention System**

<b>4</b>	<p><b>Interagency prevention system development</b></p> <p>KDADS and its partners might consider continuing to clarify the focus and role of the Prevention Subcommittee and strengthen its ability to develop common frameworks and processes that can be used to coordinate efforts and resources across state agencies.</p>
<b>5</b>	<p><b>Increased coordination between KDADS and other state agencies</b></p> <p>KDADS might consider exploring opportunities to work with KDHE, KDOE, ABC, and other state partners that have responsibility for preventing and reducing substance abuse.</p>

**Substate Prevention System**

KDADAS currently funds 13 Kansas Prevention Collaborative Community Initiative (KPCCI) grantee coalitions through SABG funds. Substate infrastructure also includes local health departments that serve all 105 Kansas counties and four Drug Free Community (DFC) grantees, some of which also receive discretionary and SABG prevention funding from KDADS. Prevention Program staff provided the map of Kansas prevention below during the CSAP site visit.



## Prevention System Organization—Substate Prevention System

### STRENGTHS

**KDADS’ support for coalition networking and peer mentoring provides important opportunities for strengthening substate prevention infrastructure.**

The PreventionWorks coalition of coalitions; monthly meetings with coalitions, KDADS, and contractors; and PreventionTalks webinar series all support grassroots knowledge dissemination and sharing of lessons learned.

**Kansas has worked to increase local prevention infrastructure in recent years.**

Community-led prevention is critical to success because effective interventions require a deep understanding of multiple local factors. This includes community history, culture, and values; the relationships between individuals and institutions; the economic and political climate; the demographics of residents and transitory populations; the capacity, readiness, and political will of community members and leaders to define certain behaviors or conditions as problematic and act to address them; and the resources that are available to support action. During the 2014 site visit, Prevention Program staff identified a need to strengthen local prevention infrastructure to achieve population-level outcomes. Since that time, KDADS has restructured its prevention system and increased funding to support community-led prevention initiatives from 12 to 26 percent of all SABG funds.

**Kansas’ DFC grantees provide important resources and expertise that supplement prevention services made available through other funding.**

The number of DFC grantees in the state has increased from two to four since the last site visit, which reverses the downward trend from 2014 when the number had dropped from 10 to 2. This achievement reflects increases in community capacity and new resources for community-led prevention. The DFC program has been a key component of national and local prevention infrastructure since its inception in 1998, and Kansas’ DFC grantees provide valuable expertise that can support community-wide engagement in a comprehensive array of needed strategies.

**Several communities in Kansas have successfully undertaken policy initiatives designed to improve health outcomes.**

These initiatives include successful efforts to raise the legal age for tobacco sales to 21 in some communities.

**CHALLENGES**

**The lack of coordination and limited reach of prevention efforts at the substate level may stretch resources and hinder efforts to reduce ATOD-related problems.**

There are no formal mechanisms to facilitate or require coordination of local prevention efforts, despite common issues and limited resources. In addition, many coalitions appear to spend much of their funding on individual-based prevention programs that reach a small percentage of the population, rather than broader-based approaches targeting entire populations that may be at risk for ATOD-related problems and disparities. Maintaining isolated, uncoordinated, and limited efforts—when problems and the intervening variables that promote them span coalition boundaries and affect individuals across the lifespan—can be resource intensive and spread prevention funding thinly, particularly in rural and underserved areas.

**Potential Enhancements for Prevention System Organization—Substate Prevention System**

**6 Increased coordination across regions**

Kansas’ ability to reduce ATOD-related problems and health disparities could be enhanced by increased planning and coordination between community prevention efforts. Toward that end, KDADS is encouraged to identify incentives or other protocols for increasing coordination at the local level across sectors and disciplines, particularly where funding levels may not be sufficient to achieve desired outcomes or where factors driving ATOD-related problems and consequences cross jurisdictional lines.

**Substance Abuse Needs Assessment**

Kansas uses state and national survey data, along with state archival data, to assess substance abuse needs. In addition to SAMHSA’s NSDUH for individuals aged 12 and older, other national surveys include the U.S. Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS) for adults ages 18 and older, which is administered by KDHE.



State surveys administered by KDADS include the KCTC Student Survey, the Kansas Young Adult Survey, and a Kansas Problem Gambling Survey for adults.

KCTC is a voluntary school-based survey for students in grades 6, 8, 10, and 12 that has been administered annually since 1994–1995. The survey includes a module on depression and suicide that was added at the end of the state’s Garrett Lee Smith Suicide Prevention grant, and has included questions on problem gambling for the past 15 years. The survey is administered by Greenbush in online and paper formats, and results are made available on the KCTC website ([www.kctcdata.org](http://www.kctcdata.org)) by June 1 of each year. Standard reports generated from the KCTC data are updated annually to compare district and/or county data to the state average and trends over time.

In 2015, legislation was passed to require written parental consent for students to participate in the KCTC survey. This has resulted in significant declines in participation data that are not representative of youth at the state level as well as at the local level in many areas. For example, participation in urban counties such as Douglas, Wyandotte, Leavenworth, and Johnson comprised just 25–39 percent of all eligible students, while participation rates in Shawnee County were slightly higher but still too low to be representative at 40–59 percent of eligible students. This issue significantly compromises the usefulness of the data for assessment, planning, and evaluation. Prevention Program staff described efforts to strengthen relationships with KDOE in ways that could promote survey participation. For example, KDADS has added questions to the survey that help KDOE meet its needs for data on social-emotional learning.

The Kansas Young Adult Survey was developed by the SEOW to assess behavioral health among Kansans aged 18–25. It was first administered in February 2017 through SPF-PFS funding. In addition to asking about prescription drug misuse, the survey also addresses ATOD use, major sources of stress, general health, mental health and depression, perceived risk of harm from substance use, knowledge of proper disposal of unused drugs, gambling, and driving safety. The survey used Random Digit Dialing technology and a voter registration list to text young adults invitations to participate and offer an incentive. A total of 996 persons participated statewide and the data were weighted to make them representative of other young adults. Prevention Program staff and contractors reported that the survey had adequate participation in each region to achieve a 95-percent confidence level. There are plans to readminister this survey in 2019 and 2021.

State documents report the following sources of archival data are used to assess ATOD use, ATOD-related consequences, and intervening variables associated with ATOD use:

- **KDHE, Bureau of Epidemiology and Public Health Informatics, Office of Health Assessment**—Data on deaths due to illicit drugs
- **Kansas Department of Transportation**—Data on the number of motor vehicle accidents that involved alcohol, the number of accidents resulting in fatalities, and the age of the drivers involved.
- **Kansas Information for Communities Death Statistics**—Data compiled from death certificates filed with the Bureau of Epidemiology and Public Health Informatics at KDHE.

- **Hospital Discharge Statistics Diagnosis Data**—Data used in Kansas Information for Communities Hospital Discharge queries are provided by the Kansas Hospital Association.
- **KDOE**—Information on school-based offenses and suspensions and expulsions related to ATODs.
- **Kansas Vital Statistics**—Data on risk and protective factors and demographic information at the state and substate levels.

The Kansas Behavioral and Mental Health Profile was released by the SEOW in November 2017 to provide a comprehensive picture of the impact of behavioral health challenges in Kansas. This latest version was expanded to include Kansas data for young adults (ages 18–25) and 2017 Kansas Gambling Survey data.

KBHID was developed by Greenbush in 2018 as a repository that allows users to compare county indicators to state indicators and create county-level reports using a collection of state and national data. County-level indicator sets comprise the following topical areas: Income/Poverty, Crime, Depression/Suicide, Problem Gambling, Family Functioning, and Substance Use. Data sources include KCTC, BRFSS, Kansas Department of Transportation, Kansas Department of Children and Families, Kansas Vital Statistics, and hospital admission data. State documents report that KBHID was developed to help evaluate prevention outcomes in Kansas communities.

Prevention Program staff and contractors described efforts to cross-tabulate data to better identify priority issues and populations and the intervening variables that impact them. These efforts include analyzing marijuana use among African Americans, meth use among young adults, and major depressive disorders among youth ages 12 to 17 years.

In addition to gaps in data for youth due to declining participation on the KCTC survey, the state has also identified gaps in data for young adults, adults, and populations research indicates to be at increased risk for substance abuse. BRFSS data do not provide information for all 105 Kansas counties because the survey requires a minimum denominator of 50 individuals, which is difficult to achieve in some rural and many frontier areas. KDADS also reports data on young adults is largely unavailable at the community level. Prevention Program staff reported being unaware as to whether Kansas colleges and universities are implementing college ATOD surveys among their student populations.

Limited data also exist for minority populations in Kansas, including Hispanics/Latinos who are concentrated in the southwest region of the state and account for up to half of the population in some counties, as well as urban and reservation-based Native Americans. In addition, state documents note that each database in Kansas records the race and ethnicity of individuals differently.

State documents also note that the databases that contain information on the adult and youth offender population are currently not linked to other data collection systems, so the incidence and prevalence of ATOD use and related consequences among this population upon reentry into the community are unknown.

**Substance Abuse Needs Assessment**

**STRENGTHS**

**Kansas has access to a wide array of assessment data and has launched new efforts to assess prevention needs across the lifespan.**

KDADS’ Young Adult Survey appears to be an effective method for collecting data on the ATOD behaviors of a population that research indicates is at higher risk for ATOD use and related problems. The existence of the problem gambling survey and the expansion of the KCTC survey question set also broaden opportunities for cross-tabulating data to better understand the characteristics of populations most at risk, so that prevention initiatives can be more carefully constructed. Indeed, Prevention Program staff described efforts to use demographic data to identify health disparities. Community access to KCTC data appears to have improved since the last CSAP site visit, and Kansas’ prescription drug monitoring system, Kansas Tracking and Reporting of Controlled Substances System, has been credited with keeping the rate of drug overdose deaths in Kansas among the lowest in the nation.

**CHALLENGES**

**A lack of real-time and leading indicator data limits the state’s ability to target SABG resources to the intervening variables and populations most associated with ATOD-related harm.**

Kansas is heavily reliant on survey data. While these data can be useful for tracking trends over time, the long lag time between survey administration and survey results makes such data less useful for assessing and monitoring emerging issues and problems with rapidly growing rates of incidence. The lack of leading indicator data that can predict the likelihood of ATOD abuse before it starts—and real-time data that provide information on issues as they arise—limits the state’s ability to be as proactive as optimal in preventing ATOD-related harm. Inconsistent county- and community-level data in many parts of the state also limit the degree to which assessment can be used to plan, monitor, and evaluate the implementation of prevention initiatives.

**Kansas has gaps in data that compromise the use of data-driven decisionmaking.**

The decline in participation and limited reach of the KCTC mean that the data generated cannot be generalized to the state level and used to set baselines or monitor change in substance abuse behaviors. Communities that do not participate or have insufficient participation also cannot use these data for prevention planning. In general, the lack of data specific to key populations—in addition to the lack of leading indicator and real-time data—also hampers the state’s ability to target prevention resources on the intervening variables and populations most associated with ATOD-related harm. Prevention Program staff reported being unaware of whether Kansas colleges and universities collect data on student ATOD use, and the absence of data on older adult populations, racial/ethnic minorities, and military personnel and families may inhibit efforts to address the needs of these populations.

**Potential Enhancements for Substance Abuse Needs Assessment**

<b>7</b>	<p><b>Expanded data collection and analysis</b></p> <p>KDADS’ ability to strengthen subrecipient use of data could be strengthened by expanding current assessment processes and partnerships. This could include:</p>
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	<ul style="list-style-type: none"> <li>• Working collaboratively with state and substate partners to expand KCTC participation</li> <li>• Increasing access to and use of archival data at the county and local levels</li> <li>• Using consequence data more strategically to plan, guide, and inform prevention activities, particularly where consumption data are difficult to obtain.</li> <li>• Leveraging GBHSPC and SEOW members to serve as goodwill ambassadors within their agencies to create support for collaborative data collection processes that increase access to real-time, multisector data and leading indicators, particularly where those data are linked to priority issues and populations.</li> </ul>
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## Workforce Development and Capacity Building

KDADS’ operational definition of the prevention workforce includes communities and is not limited to substance abuse prevention. While the state has not established minimum requirements for the prevention workforce, it has created a Workforce Development Mission document that aligns prevention-specific job functions with tasks, performance standards, technical knowledge, and skills. The following job functions are listed as necessary for a prevention specialist:

- Promote increased competency and knowledge transfer among community members and staff
- Provide resources, information and referral
- Leverage resources
- Human resource, program, and fiscal management
- Facilitating community processes leading to community change to measurable outcomes
- Social marketing and public relations.

Kansas has a prevention credentialing system that is affiliated with the International Certification and Reciprocity Consortium (IC&RC) and comprises three levels: Certified Prevention Technician; Certified Prevention Specialist; and Certified Prevention Professional. Logistical support for the prevention credentialing process was coordinated by the Kansas Family Partnership, which ceased operation on March 15, 2018. Prevention Program staff reported that 15 people in the state have a prevention credential, about half of whom serve on the credentialing board. KDADS does not provide financial support for credentialing, but Prevention Program staff reported that KDADS is considering making credentialing a state function.

DCCCA provides TA to state staff as well as prevention providers and coalitions regardless of their funding source. DCCCA staff who participated in the site visit described the first 2 years of funding as being very reactive in terms of TA provision, but stated that they are working to develop TA plans with all coalitions receiving services. The plans describe the background of the coalition, and identify progress it had made toward implementing the SPF and potential needs. TA is provided as requested via telephone, email, or in-person contact.

DCCCA has developed standard support materials that are shared with coalitions. These comprise 18 toolkits on a variety of prevention topics, seven e-learning modules, and two live

training options. Toolkits include: Community Mobilizer Toolkit, Effective Coalition Meeting Toolkit, Grant Writing Toolkit, and Vision and Mission Statement Toolkit. In addition to substance abuse prevention, T/TA also addresses suicide prevention and co-occurring disorders. DCCCA also offers regional training on coalition-identified topics such as engaging youth in prevention and coalition development. DCCCA representatives reported that building capacity to implement environmental strategies is a focus area for 2019. According to state documents, DCCCA’s goal is to build the capacity of coalitions to work independently and sustain their initiatives going forward. In addition to DCCCA materials, the KPC website includes 34 e-learning modules on a variety of prevention topics.

<http://kansaspredictioncollaborative.org/resources/e-learning-modules>

WSU-CEI coordinates monthly webinars called PreventionTalks. These include a 15-minute presentation on the topic of the month, sharing of lessons learned and experiences from peers in coalitions throughout Kansas, and time for questions and more discussion.

SABG-funded community coalitions also receive training on KCTC Student Survey data, risk factors, navigation of the KCTC website, and use of the KCTC data through in-person training, webinars, and one-on-one calls. Community coalitions also receive training on use of the new KBHID website and the Community Check Box (CCB) evaluation system.

Prevention Program staff reported that KPC contractors have a Training Team that meets with KDADS on a regular basis to plan and schedule trainings. They noted that a goal is to develop a training calendar that gave people ample notice of mandatory and optional trainings. Another goal is to be more proactive in providing training on coalition deliverables.

Currently, T/TA design is based on anecdotal information and feedback from coalitions, rather than formal assessment of need. KDADS has not identified specialized knowledge, skills and abilities needed to address unique issues and populations in Kansas and does not have a workforce development plan with strategies for recruiting, training, and retaining a highly effective prevention workforce.

## Workforce Development and Capacity Building

### STRENGTHS

**Kansas’ broad conception of the prevention workforce is reflective of—and supports—its commitment to community-based and community-led prevention.**

KDADS’ inclusive conceptual framework of the prevention workforce enables it to leverage diverse skills and abilities from volunteers and paid professionals across a wide variety of disciplines, interest areas, and settings. A diverse workforce that is reflective of the populations being served also promotes community engagement and is well positioned to address the key intervening variables that promote ATOD-related problems at their source. It is also economically effective because it fosters opportunities for promoting volunteerism, service learning, and experiential education, and for leveraging the expertise of professionals in other disciplines that have a vested interest in prevention outcomes, such as law enforcement, education, public health, and public safety.

**KDADS has invested significant resources in a T/TA system for subrecipients.**

KDADS’ approach to T/TA demonstrates an understanding of the importance of a balanced system that supports basic education and training with personalized and ongoing access to TA to help training recipients master and apply new knowledge to real-life situations.

**CHALLENGES**

**KDADS has not established minimum qualifications or specialized competencies for prevention.**

Despite its significant investment in workforce development, KDADS has not identified specialized prevention competencies that may be needed to address priority substance abuse-related problems affecting Kansans across the lifespan, other than the basic ones required for IC&RC credentialing/certification.

**KDADS does not have formal processes for assessing and addressing prevention workforce development needs.**

KDADS does not have processes for formally assessing the degree to which needed KSAs currently exist within the prevention workforce, or a workforce development plan that is based on assessment and includes desired outcomes and associated strategies for recruiting, strengthening, and retaining a diverse and highly competent prevention workforce.

**Substate capacity to implement the SPF remains varied and limited in some areas.**

Despite the significant amount of T/TA and other support that KDADS has historically provided to grantees, their capacity to use data to guide strategic planning, select strategies with the best evidence of effectiveness for local problems and priority populations, and monitor and evaluate progress toward desired outcomes remains uneven and somewhat limited in some areas.

**Potential Enhancements for Workforce Development and Capacity Building**

<b>8</b>	<p><b>Workforce development assessment and planning</b></p> <p>Prevention Program staff expressed interest in identifying and developing additional competencies and specialized KSAs needed to address Kansas ATOD priorities beyond the basic ones contained in the IC&amp;RC framework. KDADS’ ability to maximize workforce development resources and strengthen the prevention workforce across the state might benefit from the following actions:</p> <ul style="list-style-type: none"> <li>• Conducting a formal assessment of prevention workforce needs—based on needed core competencies and specialized KSAs—to inform the scope and intensity of T/TA services needed to help prevention providers use the SPF to select and implement the evidence-based strategies most likely to be effective in addressing local substance abuse needs.</li> <li>• Developing a prevention workforce development plan that uses assessment data to identify specific and measurable outcomes for workforce recruitment, T/TA, and retention, and ensure T/TA services are targeting the most pressing workforce needs.</li> </ul>
<b>9</b>	<p><b>Expanded and targeted TA</b></p> <p>Kansas’ ability to decrease alcohol and illicit drug use could be strengthened by more intensive TA to build workforce capacity to use the SPF. This would include helping coalitions apply knowledge gained through training to address structural and</p>

	<p>organizational issues that impede their ability to: 1) use needs assessment data to identify priority ATOD-related health consequences and the intervening variables and populations most associated with or impacted by them; 2) design and implement prevention initiatives that use the most effective and appropriate evidence-based strategies for those variables and populations; and 3) continually evaluate progress toward outcomes and proactively make midcourse corrections as needed.</p>
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**State Strategic Plan**

Prevention Program staff referenced multiple planning efforts that were in progress at the time of the site visit. These included a draft Kansas Behavioral Health Prevention Comprehensive Plan (Prevention Plan), a KPC Plan, a KPCCI plan, and a Kansas Prescription Drug and Opioid Advisory Committee Plan.

The Prevention Plan was in draft form at the time of the site visit and was not available for review by the CSAP team. An outline provided earlier included placeholders for narrative sections addressing the following: mission, vision, and values statement; goals and priorities; assessment of system strengths and gaps; funding breakdown specific to prevention; populations served; agencies and councils engaged in prevention work; potential strategies based on gaps in services; sustainability; and cultural competence. Prevention Program staff reported that the GBHSPC Prevention Subcommittee reviewed the most current epidemiological data available and identified 25 significant data points, and that the plan prioritizes health disparities and disparities from the national average.

Kansas’ 2018 SABG Behavioral Health Assessment and Plan (BHAP) includes two goals specific to substance abuse prevention: reduce underage drinking and increase perceived harm of underage marijuana use. Performance indicators for both involve increasing the use of EBPs and education, media, and information dissemination strategies. A third goal for behavioral health prevention and promotion seeks to increase the number of collaborative partnerships to address risk and protective factors, develop a charter for the GBHSPC Prevention Subcommittee, and increase the number of education, media, and information dissemination strategies.

Prevention Program staff reported they have just started a strategic planning process for the future of KPC as well as a strategic planning process with WSU-CEI to identify a future path for the KPCCI. They noted that they are also working with other partners to develop a separate Prescription Drug and Opioid Plan. Although the planning processes tend to involve the same people, there was little evidence that the planning processes are integrated, formally linked, or coordinated.

**State Strategic Plan**

**CHALLENGES**

**KDADS does not currently have a strategic plan that can inform and/or guide prevention efforts.** While KDADS’ participation in multiple planning efforts reflects the collaborative thinking of deeply invested professionals, there does not appear to be a common, structured process for using data and theories of change to develop measurable goals, objectives, and targeted outcomes, or for coordinating the multiple planning processes. This could limit the feasibility of the resulting plans and limit the monitoring and evaluation of progress toward outcomes.

**Potential Enhancements for State Strategic Plan**

<b>10</b>	<p><b>Comprehensive strategic prevention plan</b></p> <p>KDADS’ ability to reduce or prevent ATOD-related problems and strengthen its prevention system would be enhanced by ensuring that its new strategic prevention plan is based on a formal needs assessment and includes the following components:</p> <ul style="list-style-type: none"> <li>• Clear goals related to priority substance abuse behaviors, related problems and consequences, and desired changes in prevention system functioning</li> <li>• Specific objectives related to key intervening variables that are logically linked to priority substance abuse behaviors and related problems and consequences</li> <li>• Targeted outcomes that represent measurable progress over time toward desired goals and objectives for priority populations</li> <li>• State-level strategies and activities that are logically linked to desired goals, objectives, and outcomes</li> <li>• An implementation plan with clearly defined roles, responsibilities, and timelines</li> <li>• An evaluation plan sufficient to monitor progress toward outcomes and provide information for midcourse adjustments as needed.</li> </ul>
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**SABG Compliance**

At the time of the 2018 CSAP site visit, Kansas’ federal fiscal year (FFY) 2017 SABG application was approved; accordingly, the compliance year used for the 2018 site visit was FFY 2014.

**Primary Prevention Set-Aside**

Kansas reported meeting the 20-percent prevention set-aside requirement of the SABG. In its FFY 2017 SABG Report, Kansas reported primary prevention expenditures of \$2,363,417 out of a total SABG allocation of \$11,815,442, or 20 percent.

**Six CSAP Prevention Strategies**

The state reported expenditures in all six CSAP strategies for FFY 2014. The state reported that \$2,164,748 in SABG funds supported the six CSAP strategies and no SABG funds were used for Section 1926-tobacco activities.



**Public Review and Comment on SABG Application**

KDADS posts the SABG application on their website, along with comments and feedback. The state also solicits feedback via emails to their providers.

**National Outcome Measures**

Kansas reported all required NOMs in the 2017 SABG.

Kansas’ 2017 SABG Report notes that program data were collected through participant baseline and exit surveys using the Kansas University Online Documentation and Support System, now called CCB. Entries include a brief description of the event or activity being recorded, allocation of a primary code, and the completion of several codes that make the “Analysis of Contribution.” A footnote to Table 32 reported that KDADS believes the numbers reported served were lower than those actually served due to issues with documentation. In order to obtain more accurate measurement, CCB was updated to support the NOMs requirements to report demographic data of persons served including gender, age, and race of those served by population programs.

<b>SABG Compliance</b>
<p><b>Compliance Statement</b></p> <p>Kansas was found to be in compliance with all requirements of the primary prevention set-aside.</p>
<p><b>Potential Enhancements for SABG Compliance</b></p> <p>None noted.</p>

**Implementation**

**Prevention Budget and Allocation Processes for SABG Funds**

According to Kansas’ FFY 2018 BHAP, KDADS’ planned substance abuse prevention budget for FFY 2018 is \$4,046,910, which consists of \$2,380,203 in SABG funds (Tables 2 and 4 of the BHAP), \$885,000 from other federal funds (i.e., SPF PFS), and \$781,707 in state funds. Kansas’ STR grant provides an additional \$3,114,402 per year for prevention and treatment.

Federal and state funding are supplemented at the local level by four DFC coalitions, which receive an additional \$500,000 per year for substance abuse prevention, and a 4-year Sober Truth on Preventing Underage Drinking Act grant of \$47,145 per year.

The state distributes primary prevention funds through competitive request for proposals (RFP) processes. Prevention Program staff reported that initial KPCCI grantees budgets were based on applicant requests in order to spend down all SABG Primary Prevention set-aside funds. Each year thereafter, funding amounts have been reduced in order to fund new grants. This amounted to a 10-percent decrease in 2017 and a 20-percent decrease in 2018. Prevention Program staff noted that funding for the initial KPCCI cohort will have to be reduced significantly in 2019 to fund new grantees. Information on how the state determines funding amounts for KPC contractors—who receive the majority of SABG funding—was not provided.

**Implementation—Prevention Budget and Funding Allocation Processes**

**STRENGTHS**

**Kansas has been successful in acquiring state and federal funding for prevention.**

Kansas has a relatively robust overall budget for prevention, given its relatively small population. The state continues to invest general revenue funds in prevention despite budget deficits, and KDADS and community coalitions have been successful in competing for federal discretionary prevention funding.

**CHALLENGES**

**State budget deficits have reduced the amount of state support available for prevention.**

Kansas’ economic growth and employment have lagged behind the country as a whole, with economic outputs up only 0.02 percent in 2016 compared to 1.50 percent nationally. Prevention Program staff reported that state budget deficits have left prevention programs underfunded.

**Allocating funding on a preset and uniform basis—without consideration of needs and circumstances—may contribute to inequities in access to needed services in both rural and urban areas.**

The use of preset, uniform allocation amounts may result in funding levels that are insufficient to reduce ATOD-related problems. While KDADS’ interest in encouraging grantee sustainability and self-sufficiency is commendable, the absence of a more significant initial investment in community efforts may lead to the use of approaches that are chosen for low cost or ease of implementation rather than their ability to effectively target priority issues and populations. This practice may also limit the ability of coalitions to implement a comprehensive approach, and lead to a lack of outcomes, which can discourage coalition members and limit their ability to attract other funders.

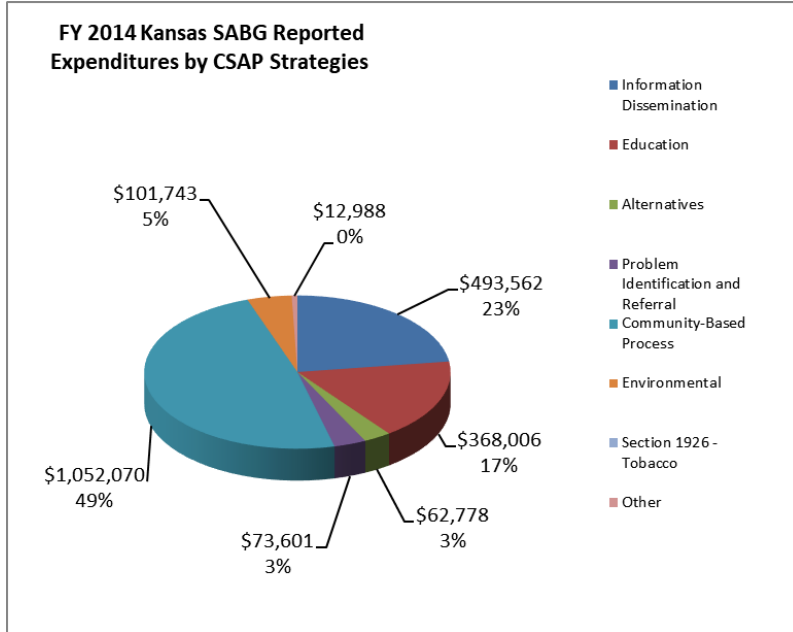
**Potential Enhancements for Implementation—Prevention Budget and Funding**

<b>11</b>	<p><b>Financial support for community-based prevention</b></p> <p>KDADS might consider how it can ensure that funded coalitions have adequate access to the resources needed to support an outcome-based approach to prevention. This would include adequate funding and other resources to use all five steps of the SPF and select, implement, and evaluate the evidence-based programs, policies, and practices with the best documentation of effectiveness for local priority populations and problems.</p>
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**Prevention Expenditures and Allocations**

***SABG Prevention Expenditures for Compliance Year 2014***

As depicted in the pie chart **below**, Kansas reported the largest expenditures of SABG funds in compliance year 2014 were for community-based process, followed by information dissemination, education, environmental strategies, problem identification and referral,



alternative activities, and other strategies. This allocation pattern was largely consistent for all prevention expenditures (i.e., SABG plus other federal and state funds), with the exception of slightly less funding for community-based process (41 percent), information dissemination (19 percent), education (15 percent), environmental (4 percent), and alternative activities (2 percent); slightly more for other strategies (1 percent); and the addition of funding for Section 1926-tobacco (15 percent).

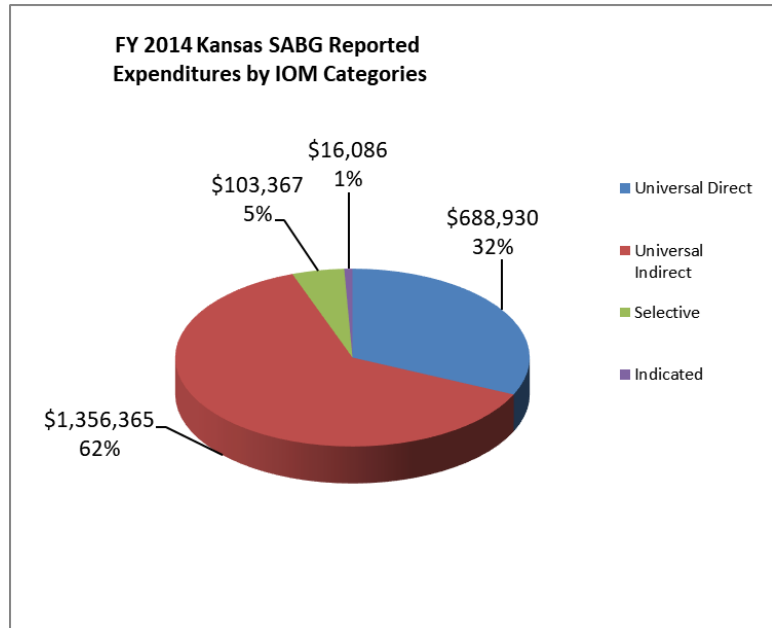
Kansas also reported expenditures by Institutes of Medicine (IOM) categories for compliance year 2014. As depicted in the pie chart below, Kansas reported the largest expenditures of SABG funds were for strategies for universal indirect populations, followed by strategies for universal direct, selective, and indicated populations. Kansas reported the same percentages by IOM category for all prevention expenditures.

KDADS reported funding the following under each CSAP strategy during compliance year 2014.

**Education**—Parenting and family management, ongoing classroom and/or small-group sessions, education programs for youth groups

**Information Dissemination**—Clearinghouse/information resource centers, resource directories, media campaigns, brochures, radio and TV public service announcements, speaking engagements, health fairs and other health promotion

**Community-based Process**—Community and volunteer training, systematic planning, multiagency coordination and collaboration/coalition, community team-building, accessing services and funding



**Alternatives**—Youth/adult leadership activities, community service activities

**Problem Identification and Referral**—Student assistance programs, driving while under the influence/driving while intoxicated education programs

**Environmental**—Promoting the establishment or review of ATOD use policies in schools; guidance and TA on monitoring enforcement governing availability and distribution of ATODs; retailer education.

Kansas reported that 100 percent of all prevention programs and strategies funded in compliance year 2014 were evidence based, with all of them targeted at universal direct and universal indirect populations.

***Persons Served in Compliance Year 2014 with SABG Funds***

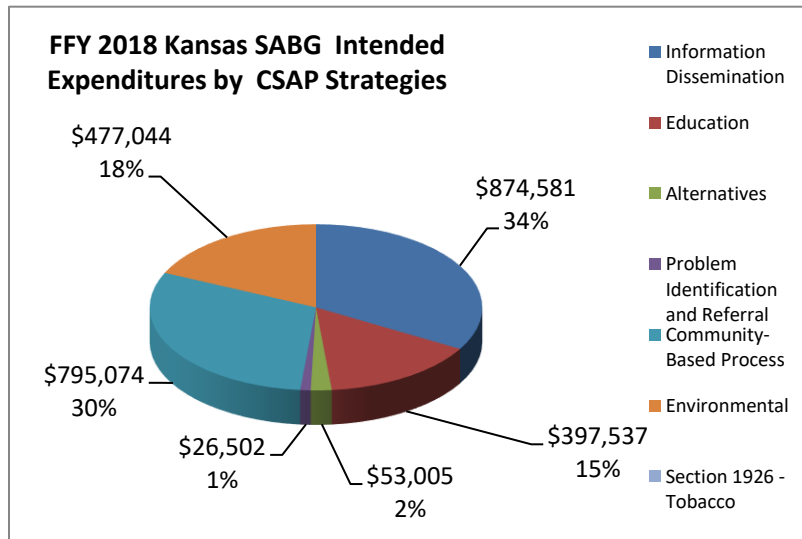
Kansas reported serving 1,764 persons through individual-based strategies and 655,752 through population-based strategies in compliance year 2014. These numbers represent 0.06 and 22.6 percent of the state’s population, respectively.

Kansas noted in its 2017 SABG application that numbers served during 2014 were lower than previous years because of the transition in 2015 to increase the funding awarded to communities to implement prevention strategies. The note stated that Kansas anticipates that the numbers of persons served will increase in the future.

***SABG-Funded Prevention Activities for Current Year FFY 2018***

Kansas reported intending to allocate \$2,494,164 of its entire SABG allocation of \$11,876,972 in FFY 2018 to primary prevention, or 20.9 percent.

As depicted in the pie chart below, Kansas’ FFY 2018 SABG application reported intent to allocate the largest percentage of SABG funds in FY 2018 for information dissemination,



followed by community-based process, environmental strategies, education, alternative activities, and problem identification and referral. Kansas reported exactly the same allocation percentages per CSAP strategy for all prevention funds (SABG funds plus state and other federal funds).

SABG funding allocation patterns in Kansas by the six CSAP strategies changed between 2014 and 2018.

Funding was increased for information dissemination and environmental strategies, and reduced for education, alternative activities, problem identification and referral, and community-based processes. Kansas did not report intended allocations by IOM categories for FFY 2018.

Budget figures provided by KDAD reported the following categories of intended SABG prevention funding for FY2018:

- KPC contracts
  - DCCCA—\$699,606 (SABG) plus \$50,000 (state funds)
  - WSU-CEI—\$479,347 (SABG) plus \$199,150 (state funds)
  - Greenbush—\$563,843
- KPCCI Planning and Implementation Grantees—\$602,000 (SABG).

The initial KPCCI grants awarded in state fiscal year 2016 focused on the planning step of the SPF. Currently, there are three capacity building grants, four planning grants, and six implementation grants. Prevention Program staff reported that they plan to fund 10 KPCCI implementation grants at \$50,000 each next year, 4 planning grants at \$15,000 each, and no capacity building grants. Expenditures for coalitions constituted 26 percent of all SABG funds in 2017, up from 12 percent in 2014. Prevention Program staff reported that coalition grants are limited to small amounts to encourage sustainability.

In 2018, KDADS also allocated \$436,782 in state funds to KDOR for Synar and County Alcohol and Tobacco Enforcement and \$923,932 in other federal funds to support SPF-PFS grantees.

The KPCCI grantees that attended the site visit were an energetic, engaged, and accomplished group:

- Reno County Community That Cares—This coalition was one of the original Communities That Care coalitions dating back to 2003. It is currently in its fifth year of DFC funding and is also a SPF-PFS grantee. The coalition has engaged youth leaders and successfully passed policies limiting tobacco smoking to restricted areas at the Hutchinson County Fair and amending the Clean Air Act in Hutchinson to include e-cigarettes.
- Mirror—One of the largest treatment providers in Kansas that formerly housed an RPC, Mirror has also focused on cultivating youth leadership and has established prevention teams in each town it serves.
- Garden City Coalition—This coalition, located in the southwest corner of Kansas, serves a transient, minority-majority population drawn there by the beef industry. It has taken as its motto “The world grows here.” The coalition formed to address a teen pregnancy rate that was the third highest in the state, and subsequently branched out into efforts to reduce other substance abuse-related problems. A recent policy success for the coalition was achieving passage of an ordinance to raise the minimum legal age to purchase tobacco to 21.

## Implementation—Prevention Expenditures and Allocations

### **STRENGTHS**

**Kansas’ increased support for community-based prevention provides an important foundation for effectively preventing and reducing ATOD-related problems where they occur.**

The belief that local people solve local problems best and that people support what they help create have been long-standing philosophies in the field of prevention. As noted previously

and documented by research, community engagement and leadership are critical for mobilizing the support and political will needed to acknowledge the existence of ATOD-related problems and take needed action—especially with regard to making necessary changes in the shared environment related to laws and policies, access, and enforcement. State support for community-led prevention—which instills confidence that even the most complex and entrenched problems can be solved and provides adequate funding to help implement solutions—is critical for community success.

## CHALLENGES

### **Kansas is experiencing a number of challenges associated with preventing and reducing substance abuse-related problems.**

Data indicate significant disparities in ATOD use by race, ethnicity, age, and gender. Data also point to an increase in meth use across the state. While opioid use/misuse prevalence remains low in Kansas, the incidence of opioid misuse and related mortality/morbidity is increasing substantially. This indicates both a need and an opportunity to proactively respond before an opioid crisis occurs. Prevention Program staff cited a number of other challenges, including the largely rural nature of much of the state, its interstate highway system which is conducive to drug trafficking, permissive drug laws in neighboring states, diverse populations with an array of issues in metropolitan areas, and its large geographic size and sparse population density in many areas which makes even coverage of prevention services challenging.

### **KDADS data indicate that a small percentage of Kansas' population is being reached by funded prevention initiatives.**

In compliance year 2014, KDADS reported reaching just 0.06 percent of the state's population through individual-based strategies, and 22.6 percent through population-based strategies. The majority of those reached were youth, although state data indicate significant substance abuse issues among adults. Research has also documented numerous other populations that are at increased risk for ATOD-related problems, including women, racial/ethnic minorities, individuals with lower educational levels and family income, and older adults. Regarding the latter, national data reflect substantial and unprecedented increases in high-risk drinking and alcohol use disorders—and related disability, morbidity, and mortality—among adults ages 55 and older. Researchers warn that—even if rates remain stable—the projected doubling of this population from 2010 to 2030 could produce a public health crisis if the issue is not addressed.<sup>3</sup> Given the much higher prevalence of substance abuse-related problems compared to numbers reached by prevention efforts, it could be difficult for KDADS to reduce substance abuse prevalence, incidence, and related problems if its approach to prevention is not broadened to include an array of needed strategies for populations across the lifespan.

### **KDADS' prevention expenditures and allocations do not appear to reflect a comprehensive approach.**

Despite its increased funding for community-led efforts, KDADS still allocates the majority of SABG funding (86 percent) to statewide contracts that support a small number of community coalitions. Nearly half of all reported intended allocations for 2018 are for education and

<sup>3</sup> “Prevalence of 12-month alcohol use, high-risk drinking, and DSM-IV Alcohol Use Disorder in the United States 2001-2002 to 2012-2013: Results from the National Epidemiologic Survey on Alcohol and Related Conditions,” *JAMA Psychiatry* 74, no. 9 (2017): 911-923.

information dissemination, although prevention research indicates that education is most effective when implemented in support of a comprehensive approach that includes changes in the environmental factors that promote substance abuse. The use of environmental strategies, however, remains low in Kansas. In addition, efforts to develop culturally specific prevention strategies and offer prevention services and materials in languages other than English continue to be limited in some parts of the state, despite significant Hispanic/Latino populations in many counties and diverse populations in metropolitan areas.

**Despite KDADS' efforts to increase the use of data to guide decisionmaking, some funded community coalitions appear to select strategies that are popular or easy to implement, as opposed to ones that are indicated by data.**

During the site visit, Prevention Program staff noted the need to support and increase subrecipient use of data to carefully select those evidence-based strategies that are most aligned with the intervening variables that promote ATOD-related problems and the associated target populations in the communities they serve.

**Potential Enhancements for Implementation—Prevention Expenditures and Allocations**

<b>12</b>	<p><b>More comprehensive approaches to prevention</b></p> <p>Adopting a more inclusive approach to prevention could help Kansas reduce problems among all populations that are at increased risk of ATOD-related harm. Toward this end, KDADS might consider increasing financial support for community-based prevention efforts that can considerably extend the reach of prevention services to priority populations across the lifespan. KDADS is also encouraged to increase the use of strategies that address the intervening variables that promote ATOD-related problems within the shared environment. These shifts in practice could help KDADS significantly enhance the health and well-being of all Kansans in ways that are economically effective and sustainable without significant dependence on continuing resources.</p>
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**SABG Funding Requirements**

KPCCI planning grantees are required to implement the first three steps of the SPF process and submit a community plan that contains the following components:

- A needs assessment that identifies and prioritizes at least one or two local prevalence outcomes and two to five targeted local risk and protective factors
- Capacity and readiness assessments and plans
- A strategy plan that includes a logic model/theory of change and action plans for each primary evidence-based strategy
- An evaluation framework outlining key process and outcome indicators and corresponding data collection needs for all funded strategies
- A cultural competency assessment and plan
- A sustainability plan.

Grantees must also try to recruit 60 percent of all students in the 6th, 8th, 10th, and 12th grades to participate in the KCTC each year of the award. They must also participate in face-to-face, virtual, and phone conference T/TA and learning opportunities.

KPCCI planning grantees are awarded 3 years of implementation funding based on fidelity to the SPF process and submission of deliverables associated with each of the steps within the planning phase. KDADS staff and Evaluation Team members review the deliverables to ensure accuracy, comprehensiveness, and appropriateness of all proposed strategies and request any needed revisions.

KPCCI implementation grantees are required to implement all five steps of the SPF process and encourage local participation in the KCTC survey. Implementation strategies are to focus on underage drinking, binge drinking, increasing perception of harm of marijuana use, and associated risk and protective factors. The Notice of Grant Award requires the use of evidence-based strategies, but environmental strategies are not specifically required. Grantees must complete an evidence-based services program fidelity checklist halfway through program completion and are evaluated with an environmental strategy fidelity checklist each quarter.

**Implementation—SABG Funding Requirements**

**STRENGTHS**

**KDADS has implemented a competitive RFP process for community coalitions that requires the use of the SPF.**

KDADS’ requirement that subrecipients use the SPF to design and carry out their prevention efforts is a key component of its transition toward needs-driven and outcome-based prevention. As data challenges are resolved and local capacity to fully implement the SPF is strengthened, the requirements spelled out in KDADS’ funding application processes should help subrecipients fully maximize the use of performance-based processes and prevention research to significantly reduce ATOD-related problems in Kansas.

**CHALLENGES**

**Despite requiring the use of performance-based processes, Kansas’ prevention system remains in a state of transition with regard to full implementation of the SPF.**

KDADS’ transition toward needs-driven and outcome-based prevention has been challenged by gaps in data as well as slow adoption of data-driven, population-based, and environmental approaches to prevention. Despite significant T/TA supports, subrecipient efforts do not reflect full use of the SPF in that they tend not to be based on data and do not consistently reflect the use of strategies that have the highest evidence of effectiveness for local problems and priority populations. As noted previously, local data are insufficient for planning in many areas, and it has been difficult to move communities from a historical reliance on education and information dissemination to more comprehensive and targeted approaches.

**Potential Enhancements for Implementation—SABG Funding Requirements**

**13 Strengthened use of the SPF by subrecipients**

Many of the recommendations in this report address issues related to building subrecipient capacity to fully use the SPF or similar performance management processes—particularly with regard to expanded data collection and analysis. KDADS might consider working with its partners, contractors, and subrecipients to design and



	implement systematic processes for building subrecipient capacity to implement all steps of the SPF.
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**Evaluation**

**SABG Subrecipient Evaluation**

KDADS and its contractors have developed processes to proactively identify grant recipient fiscal and program deficiencies and to provide the T/TA necessary to help grantees correct issues before further action is necessary. This system of early identification relies on regular site visits, semiannual reports, telephone and email conversations, and other input to identify and respond to challenges experienced by grantees. KDADS and contractors meet monthly and as needed to review the status of grant recipients on high-risk status, or who are deemed to be at risk of being placed on high-risk status, suspended, or terminated.

KPCCI grantees are required to submit weekly documentation, monthly financial reports, and quarterly progress reports in CCB. KU-CCHD staff then review, validate, and sort the entries, and Prevention Program staff review the monthly reports. KPCCI planning grantees must develop an evaluation plan by the end of the grant period. KPCCI implementation grantees must develop an evaluation plan and collect and report relevant NOMs, comply with federal and community-level evaluation requirements, and participate in at least one KDADS site visit during the implementation grant.

**SSA/State Evaluation of SABG Funding**

KDADS’ Evaluation Team consists of Greenbush and its subcontractor KU-CCHD. As noted previously, Greenbush administers behavioral health outcome data collection through the KCTC Student Survey and KBHID, while KU-CCHD administers the collection of process and implementation data through the CCB and the Community WorkStations.

<b>Evaluation</b>
<p><b>STRENGTHS</b></p> <p><b>KDADS monitors grantees’ programmatic operations on a regular basis.</b>                      KDADS’ detailed fiscal and programmatic monitoring protocols and systems—such as Data Dashboard and CCB—require subrecipients to track process data and monitor progress toward completion of activities.</p> <p><b>KDADS’ investment in state-level evaluation underscores a commitment to results-oriented prevention.</b>                      The ability to monitor and evaluate progress toward desired outcomes—and use evaluation data to make interim adjustments as needed—is a hallmark of an outcome-based orientation. At the aggregate level, KDADS is supporting efforts to establish baselines and monitor general progress toward desired outcomes.</p>

**CHALLENGES**

**Inaccuracies in program data, if unresolved, could limit the ability of KDADS and its subrecipients to evaluate and monitor the scope and reach of prevention strategies.**

Process evaluation relies on program data to monitor the implementation of prevention initiatives, including the degree to which activities are occurring as planned. Program data on the numbers and characteristics of persons served are extremely important indicators of the degree to which initiatives are reaching the intended target populations at the penetration levels needed. Continued inaccuracies in provider reporting on persons served—such as occurred for compliance year 2014—could leave KDADS and its subrecipients unable to determine the degree to which funded prevention initiatives are reaching intended populations and those most in need.

**KDADS is not currently able to monitor the individual effectiveness of all prevention initiatives funded through the primary prevention set-aside.**

Although KDADS tracks process outcomes, it does not have a comprehensive evaluation system that can monitor intermediate or long-term subrecipient outcomes and tie those outcomes back to funded prevention strategies. In addition, KDADS’ extremely detailed collection and use of subrecipient process data appears to be very labor and resource intensive, with sometimes questionable utility for evaluation purposes and the potential to artificially inflate the perception of outcomes. For example, grantees are required to extensively log all activities, which are then reviewed by multiple contract and state staff. This includes telephone calls and emails. If the contact is between a coalition member and someone they have not contacted previously, it is logged as a “community change.” These types of measures do not measure the degree to which the implementation of a strategy or activity and its associated outputs are achieving desired changes in priority risk behaviors and/or associated problems and intervening variables. Further, this level of detail devoted to process measures and limited attention to outcome evaluation precludes subrecipients from fully using the SPF to make informed decisions about the degree to which the strategies they are implementing are achieving desired changes in priority risk behaviors and associated problems and intervening variables.

**Potential Enhancements for Evaluation**

**14 Strengthened subrecipient evaluation requirements**

KDADS is encouraged to work with its partners, contractors, and subrecipients to design and implement evaluation processes that align with and support more outcome-oriented ways to measure the true impacts of community prevention initiatives. This includes requiring subrecipients to identify and monitor progress toward desired reductions in ATOD-related problems and consequences, consumption (where data are available), and intervening variables.

**Summary and Technical Assistance Themes**

The Kansas SSA has undergone numerous organizational and staffing transitions since the 2014 CSAP site visit. These include broadening its approach to prevention to better support community-led initiatives that can promote health and wellness across the lifespan. Toward that end, KDADS replaced its long-standing system of RPCs with several statewide professional and

technical support contracts collectively called the KPC. While this transition has resulted in slightly more funding for community coalitions (from 12 to 26 percent of all primary prevention funds), it falls short of the 85 percent that was envisioned in 2014.

Prevention Program staff are working to increase the use of the SPF and strengthen the performance of prevention programming across the state and have launched or are considering multiple planning and system change initiatives. KDADS' ability to achieve its ambitious agenda for prevention may be limited, however, by its current capacity and a lack of prioritization or coordination of multiple courses of action which compete for time and resources.

The presence of multiple state agencies and interagency groups with mandates for preventing ATOD-related problems in Kansas creates many opportunities for coordination, and the GBHSPC and its Prevention Subcommittee are important venues for facilitating this. Plans for how the latter will operate, however, are still evolving, and prevention efforts carried out by state agencies remain largely siloed and uncoordinated.

KDADS has been working to enhance the representativeness and reliability of KCTC data and has added questions to identify populations at higher risk for a spectrum of behavioral health-related problems. It has also launched a new Young Adult Survey that is providing representative data for this high-risk population. Assessment efforts are limited, however, by a number of lingering gaps, such as community-level and real-time data, as well as leading indicator data that can predict the likelihood of ATOD abuse before it starts.

KDADS has historically invested a significant amount of its prevention funding in T/TA that is based on universal prevention competencies. The state has not identified any specialized KSAs needed by its prevention workforce, conducted a formal assessment of workforce development needs, or developed assessment-driven strategies to address recruitment, T/TA, and retention issues. KDADS also does not currently have a strategic plan for prevention that can be used to guide its efforts, but—as noted above—Prevention Program staff report that multiple strategic planning processes are underway or planned.

KDADS has been very successful in leveraging state and federal funding for prevention and has implemented a competitive RFP process for grantees that requires the use of the SPF. Inconsistent access to local data and data on some high-risk populations, however, limits state and local ability to fully align funding with needs.

Grantees remain varied in their capacity to implement the SPF and other performance management processes, particularly with regard to using data to select, implement, and evaluate prevention strategies. In some cases, they appear to select strategies that are popular or easy to implement, as opposed to ones that are indicated by data. In addition, prevention expenditures remain skewed toward education and information dissemination, although KDADS staff noted that increasing local capacity for environmental prevention will be a focus in the coming year.

The CSAP team provided KDADS with recommendations for strengthening Kansas' prevention system, including the following:

- Prioritize the many actions currently identified for strengthening the state's prevention system

- Strengthen guidance for selecting evidence-based prevention strategies
- Increase coordination across agencies and grantees
- Expand current assessment processes to address data gaps
- Develop formalized processes to assess, plan for, and address workforce development needs
- Ensure that strategic planning processes are based on data and include targeted goals and objectives and measurable outcomes
- Strengthen outcome evaluation capacity and require subrecipients to evaluate progress toward desired reductions in ATOD-related problems, consumption, and intervening variables.

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# Synar Program Development, Organization, Compliance, and Support

## Synar Program Development and Organization

The Kansas Department for Aging and Disability Services (KDADS) has primary oversight of the state's Synar program, including Synar planning, coordination with partners, oversight of the Synar Advisory Group (SAG), and posting the Annual Synar Report (ASR) for public comment.

KDADS has a contract with the Kansas Prevention Network's Learning Tree Institute at Greenbush (Greenbush). Under this contract, Greenbush draws the Synar sample, conducts Synar data analysis, trains Synar adult inspectors, conducts coverage studies, and completes the ASR.

Additionally, KDADS has a contract with the Kansas Department of Revenue (DOR) pursuant to which DOR provides the list of licensed tobacco retailers from which the Synar sample is drawn, conducts Synar inspections, conducts non-Synar state enforcement inspections known as Cigarette and Tobacco Enforcement (CATE) inspections, and provides merchant education to tobacco retailers. DOR is also responsible for conducting FDA inspections. Synar and FDA inspections are conducted separately.

The SAG meets twice a year to discuss Synar and CATE activities and results. KDADS is in the process of updating SAG's membership to expand and facilitate more active participation. Current SAG members include:

- KDADS
- Kansas Department of Health and Environment (KDHE)
- Tobacco Free Kansas Coalition (TFKC)
- Greenbush
- Petroleum Marketers and Convenience Store Association of Kansas

KDHE is responsible state tobacco prevention efforts funded by the CDC Tobacco Control Program and oversees and funds TFKC, which seeks to eliminate tobacco use through advocacy, education, and policy change. KDADS and KDHE have an informal partnership and conduct joint planning activities.

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## SYNAR PROGRAM DEVELOPMENT AND ORGANIZATION

### STRENGTHS

**KDADS has well established and effective relationships with Greenbush and DOR.**

KDADS's contractual relationships with Greenbush and DOR are well established. KDADS staff indicated that both contractors complete their statements of work (SOWs) effectively and consistently.

### CHALLENGES

**KDADS staff indicated they would like to be more fully engaged with Synar contractor activities.**

KDADS staff indicated a desire to improve their ability to monitor the agency's contracts with Greenbush and DOR by increasing the staff's knowledge of the specific tasks completed by each contractor. The state does not currently have a policies and procedures manual for the Synar program.

**According to state staff, the SAG has not reached its full potential.**

KDADS staff noted that SAG membership does not include the full array of agencies and other organizations that play a role in tobacco control and prevention in the state. They also indicated that not all current members actively participate in the SAG.

### Potential Enhancements

**1 KDADS might consider ways in which it could enhance its monitoring of Synar contracts.**

KDADS staff might consider working with the CSAP State Project Officer (SPO) to enhance their knowledge of Synar program requirements. Greater knowledge of these requirements and how they relate to contractor activities could improve the staff's ability to monitor and interact with the contractors to ensure compliance. The state might also consider developing a Synar program policies and procedures manual. Although KDADS staff and contractors effectively complete their Synar related activities, their institutional knowledge may be lost or compromised if future staffing changes should occur. Documenting policies, procedures, and tasks in a manual could both enhance and sustain the ability of state staff to ensure compliance by Synar contractors.

**2 KDADS might continue to explore opportunities to expand SAG membership and encourage more active participation.**

KDADS staff identified the need to increase the number of stakeholders represented in the SAG and to encourage more active participation by SAG members. Continuing to seek opportunities to effect these changes could help the state promote a comprehensive approach to tobacco control and prevention, including youth access prevention, across state agencies and other partnering organizations.

## Description of Trends in the Kansas Retailer Violation Rate and Other Tobacco Outcomes

Retailer Violation Rates for Federal Fiscal Years 1997–2018 (in percent)																						
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Target	–	50	38	30	27	25	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Reported	63	47	35	29.3	22.7	21.1	20.6	22.1	38	19.2	19.9	12.9	15.9	8.3	7.8	7.6	3.1	8.5	12.1	11	8.4	11.5

With a retailer violation rate (RVR) of 11.5 percent in FFY 2018 (see table), Kansas is in compliance with the Synar target rate requirement. In FFY 1997, the state’s RVR was 63 percent, and Kansas reported its next highest RVR of 47 percent in FFY 1998. The state’s RVR exceeded 20 percent every year from the first year of the Synar program to FFY 2005 when SAMHSA found Kansas to be out of compliance with the target rate requirement due to the state’s 38 percent RVR. From FFY 2006 to FFY 2009, the RVR ranged from 12.9 percent (FFY 2008) to 19.9 (FFY 2007). Since FFY 2010, however, Kansas’s RVR has been consistently below 15 percent. In these years, with the exception of FFY 2013 when Kansas reported its lowest RVR of 3.1 percent, the RVR has ranged from 7.6 percent (FFY 2012) to 12.1 percent (FFY 2015).

According to the National Survey on Drug Use and Health (NSDUH), the percentage of 12-17 year olds in Kansas that report using cigarettes in the last 30 days decreased markedly between FFY 2002–2003 (13 percent) and FFY 2013–2014 (5.7 percent). The percentage of youth using tobacco products other than cigarettes also decreased between FFY 2002-2003 (6.5 percent) and FFY 2013–2014 (5.2 percent). However, the percentage of Kansas 12-17 year olds who perceived moderate or great risk of harm from smoking one or more packs of cigarettes per day decreased between FFY 2002–2003 (92.4 percent) and FFY 2013–2014 (89.7 percent).

RETAILER VIOLATION RATE AND OTHER TOBACCO OUTCOMES
<p><b>Compliance Statement</b></p> <p>Kansas is in compliance with the retailer violation rate element of the Synar Regulation.</p>
<p><b>STRENGTHS</b></p> <p><b>Past-month cigarette use by 12-17 year olds has decreased.</b></p> <p>The percentage of Kansas 12- to 17-year-olds that report using cigarettes in the last 30 days decreased from 13 percent in FFY 2002–2003 to 5.7 percent in FFY 2013–2014. This represents a 56.2 percent decrease in past 30-day cigarette use reported by this age group.</p>
<p><b>CHALLENGES</b></p> <p><b>The percentage of youth perceiving moderate or great risk of harm from smoking has decreased in recent years.</b></p> <p>The percentage of Kansas youth who perceived moderate or great risk of harm from smoking one or more packs of cigarettes per day decreased by 2.9 percent between FFY 2002–2003 and FFY 2013–2014. Although the rate remains relatively high at 89.7 percent, it has largely trended downward after reaching a high of 95.7 percent in FFY 2006-2007.</p>

<b>Potential Enhancements</b>	
<b>3</b>	<p><b>KDADS might consider monitoring trends in risk perception among youth regarding tobacco use.</b></p> <p>The state might consider monitoring youth perception of risk with respect to tobacco to determine whether the recent trend is sustained. In the event that the trend continues, KDADS might consider how the state could address decreased perception of risk as part of a comprehensive tobacco control and prevention strategy.</p>

## **Summary of Synar Program**

### **State Synar Program Compliance**

#### ***Youth Access Law***

DOR is responsible for enforcing the State’s youth tobacco access law, which prohibits the sale or distribution of cigarettes, electronic cigarettes, or tobacco products to persons under the age of 18. The law includes a youth possession provision, but also provides for minor immunity for controlled buys of tobacco products. Because the statute does not include a preemption provision, local communities can enact laws and ordinances further restricting youth tobacco access.

Under Kansas’s youth tobacco access law, the sale of cigarettes, electronic cigarettes, or tobacco products to a person under 18 is punishable as a Class B misdemeanor subject to a minimum fine of \$200. The fine may be imposed on a person who directly sells, furnishes, or distributes the product to a minor and/or an outlet owner who has actual knowledge of the sale, furnishing, or distribution of the product to a minor. The law provides for an affirmative defense if the seller reasonably believed the purchaser was over the age of 18 and the purchaser provided identification indicating this was the case.

In addition to or in lieu of the \$200 minimum fine described above, Kansas’s law empowers DOR to impose a fine of no more than \$1,000 on the tobacco licensee for each violation of the state youth tobacco access law. The law provides for an affirmative defense from this penalty if the licensee’s employee completed a training program to avoid the sale of cigarettes and tobacco products to minors. The law also authorizes DOR, after a hearing, to suspend or revoke for up to one year the tobacco license of any person the Director of Taxation has reason to believe is in violation of the state’s youth tobacco access law.

State staff reported that while DOR assesses sales to minors violations as administrative citations to the outlet owner’s tobacco license, it also provides violation information to county attorneys. The county attorneys in turn can pursue and assess the penalty against the clerk and/or owner for the misdemeanor of violating the state youth tobacco access law. State staff noted that fines against clerks may be reduced if the clerk agrees to receive merchant education.



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## YOUTH ACCESS LAW

### Compliance Statement

Kansas is in compliance with the youth access law element of the Synar Regulation.

### STRENGTHS

#### **Tobacco retailers who violate youth access laws receive an administrative citation.**

DOR issues administrative citations to tobacco licensees that violate the state youth access law during Synar and CATE inspections. In addition, DOR also provides the sales information to the county attorneys for imposing misdemeanor penalties on the clerk and/or owner. The combination of these penalties may enhance the deterrent effect of Kansas's enforcement activities.

### CHALLENGES

None noted.

### Potential Enhancements

None noted.
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### *Enforcement*

Enforcement is always combined with the state's Synar survey. As noted previously, DOR also conducts CATE controlled-buy inspections. These non-Synar inspections are conducted on all licensed tobacco retailers annually. Synar inspections include purchase attempts of cigarettes only while CATE inspections may include electronic nicotine delivery systems (ENDS) products. DOR conducted 2,689 inspections in FFY 2017, including 318 Synar inspections. DOR also conducts follow-up inspections of outlets that previously violated during CATE inspections. DOR revisits these outlets every quarter until a violation does not occur. Local law enforcement agencies can also conduct compliance inspections, which may include DOR participation.

As reported in the FFY 2018 ASR, Kansas issued a total of 394 citations for violations of youth tobacco access laws in FFY 2017 with 197 issued to store owners and 197 to sales clerks. In addition, 197 fines were assessed against owners and an unknown number of fines were assessed against clerks. No tobacco licenses were suspended or revoked during the reporting period.

## ENFORCEMENT

### Compliance Statement

Kansas is in compliance with the enforcement element of the Synar Regulation.

### STRENGTHS

#### **All licensed tobacco retailers annually receive at least one inspection.**

In addition to tobacco retailers randomly selected for Synar inspections, which can result in enforcement actions, DOR conducts annual non-Synar CATE inspections of every tobacco

licensee in the state. Moreover, retailers that violate youth access laws during CATE inspections receive follow-up inspections during the following quarter. This signals the state's strong commitment to the prevention of youth tobacco access as well as Kansas's recognition of the crucial role of enforcement in a comprehensive tobacco prevention and control strategy.

**CHALLENGES**

None noted.

**Potential Enhancements**

None noted.

***Random, Unannounced Inspections and Valid Probability Sample***

DOR is responsible for issuing tobacco licenses. The license fee is \$25 for each location, and licenses must be renewed every 2 years. The tobacco license list includes retailers of cigarettes, smokeless tobacco, and ENDS products. The Synar list frame is derived from DOR's list of tobacco licenses and includes 2,347 over-the-counter and vending machine outlets. Retailers that only sell ENDS are removed from the Synar list frame prior to random selection. List cleaning by DOR and Greenbush has resulted in a highly accurate Synar list frame. The state reported a weighted accuracy rate of 96.8 percent in FFY 2018.

Greenbush draws the Synar sample using a stratified simple random sample. Strata are defined as urban (two counties), quasi-urban (six counties), medium-sized rural (28 counties), and sparsely populated rural (69 counties). The state uses optimum allocation to assign the sample size within the four strata. The sampling design as described onsite is consistent with the description provided in Appendix B of Kansas's FFY 2018 ASR.

Kansas conducted a coverage study in 2017 using a sampling design based on the same four strata. Areas in the sparsely populated rural stratum were defined as counties while areas in the other strata were defined as zip codes, clusters of zip codes, or portions of zip codes. Sampled areas were canvassed, and the state reported a weighted coverage rate of 99.3%. The state's next coverage study is scheduled for 2022.

Synar inspections are assigned to adult inspectors by region and were conducted from June 1, 2017 to September 30, 2017. DOR uses the same protocol for the Synar survey and CATE inspections except that cigarettes are the only products requested during Synar checks. The inspection team consists of one to two adult inspectors and one to two youth inspectors. DOR recruits adult inspectors through the state's hiring website. Adult inspectors complete a 1- to 2-month training led by DOR and Greenbush. In addition, DOR and Greenbush conducted a Synar protocol refresher course for all adult inspectors in May 2017 to review Synar protocols and procedures. Adult inspectors also participate in a 2-week follow-up training if deemed necessary by their supervisors. DOR is responsible for the recruitment and training of youth inspectors. DOR staff recruit youth inspectors via personal contacts as well as from other sources such as schools and youth organizations. Adult inspectors train youth inspectors on inspection protocols and safety issues and provide youth with the Kansas Cigarette and Tobacco Underage Cooperating Individual Handbook.

The Synar survey is conducted using a consummated buy protocol. Youth inspectors are required to carry identification and are instructed to answer all questions truthfully except if asked if they are working with law enforcement in which case the youth is instructed to answer “no.” DOR issues citations against the license immediately after a violation. As noted previously, DOR provides inspection information to the County Attorneys for enforcing the misdemeanor violations against the clerk and/or owner. DOR monitors County Attorney activities to verify whether misdemeanor citations were issued to the clerk and/or owner. The inspection protocol as described onsite is consistent with the description provided in Appendix C of the state’s FFY 2018 ASR.

Adult inspectors complete a DOR Compliance Inspection Controlled Buy Inspection Report following each Synar inspection. Within 24 hours, the adult inspector must enter the inspection data into the state’s Alcohol and Beverage Control Controlled Buy data system. The data system generates real-time summary reports, which track key data such as RVR and youth inspector age and gender. After uploading the inspection data into the system, the inspector delivers the inspection forms to DOR. Upon receipt of the inspection forms, DOR staff conduct quality control checks on every inspection form to ensure inspection data were correctly entered into the data system.

After all Synar inspections are completed, DOR provides an electronic file containing all Synar inspection data to Greenbush, which is responsible for entering the data into the Synar Survey Estimation System (SSES). Greenbush randomly selects a portion of the inspections and requests the corresponding hard-copy Compliance Inspection Controlled Buy Inspection Report forms from DOR. This allows Greenbush to conduct a second quality control check before completing the SSES analysis.

The CSAP State Project Officer (SPO) pulled a random sample (10 percent) of the completed inspection sheets, reviewed them for completeness, and then compared them with SSES raw data submitted in the state’s FFY 2018 ASR to verify data accuracy. The SPO’s review found no errors.

The SPO also observed five mock Synar inspections conducted by DOR. No sales were made during these inspections. All five observed inspections followed the approved protocol.

<b>RANDOM, UNANNOUNCED INSPECTIONS AND VALID PROBABILITY SAMPLE</b>
<p><b>Compliance Statement</b></p> <p>Kansas is in compliance with this element of the Synar Regulation.</p>
<p><b>STRENGTHS</b></p> <p><b>The Synar list frame’s accuracy rate is consistently high.</b></p> <p>Despite a two-year tobacco licensing format and low license fee amount, cleaning of the Synar list frame by DOR and Greenbush has resulted in consistently high accuracy rates of over 93 percent since FFY 2013. This benefits the state by reducing costs associated with traveling to ineligible outlets.</p>

**DOR's tracking of citations results in accurate measurement of statewide enforcement outcomes.**

DOR diligently monitors County Attorney efforts to adjudicate sales to minors violations. This often includes repeated follow-up calls to the County Attorneys until DOR obtains the needed information. Such monitoring can reveal counties where violations are not being adjudicated, which can inform state outreach efforts to County Attorneys on the key role of enforcement in preventing youth access to tobacco products.

**DOR's inspection database provides real time information.**

Because DOR inspectors are required to upload inspection data within 24 hours of completing a Synar inspection, DOR's inspection database provides real time information to the state. This allows variables such as the minor's age and gender to be monitored throughout the Synar cycle and thus assists the state in ensuring age and gender balance in its Synar inspections.

**Two levels of quality control are performed on the DOR database to ensure inspection data are accurately recorded.**

DOR performs quality control checks on the database to ensure that information from each inspection form is correctly recorded in the database. Greenbush provides additional quality control by comparing database entries for randomly selected inspections to the original inspection forms prior to SSES analysis. These quality control measures help ensure the accuracy of the Synar data the state reports to SAMHSA.

**CHALLENGES**

None noted.

**Potential Enhancements**

None noted.

**Reporting**

The FFY 2018 ASR was completed and submitted on time on December 19, 2017, and was made available for public comment before submission to SAMHSA, as required.

REPORTING	
<b>Compliance Statement</b>	
Kansas is in compliance with the reporting element of the Synar Regulation.	
<b>STRENGTHS</b>	
None noted.	
<b>CHALLENGES</b>	
None noted.	
<b>Potential Enhancements</b>	
None noted.	

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## State Synar Program Support

### *Synar Budget and Funding*

In its FFY 2017 SABG Report, Kansas reports that no FFY 2014 SABG award funds were used to support the Synar program. According to the state’s FFY 2018 SABG Behavioral Health Assessment and Plan, Kansas does not intend to expend any FFY 2018 SABG award funds for Synar activities. KDADS’s contract with DOR allocates \$400,000 in state funds for providing the license list, conducting the Synar and CATE inspections, and merchant education. KDADS’s contract with Greenbush is also supported entirely by state funds as are all other Synar activities in Kansas.

SYNAR BUDGET AND FUNDING	
<b>STRENGTHS</b>	
<b>Despite decreasing state revenues, Kansas continues to fund annual inspections of all licensed tobacco retailers.</b>	
In spite of challenges posed by decreasing state revenues, budgets cuts, and staffing shortages, DOR has been able to conduct annual inspections of all licensed outlets in the state. State staff indicated that DOR will continue to do so for the foreseeable future. As noted previously, the high level of enforcement in the state demonstrates Kansas’s commitment to preventing youth tobacco access. The state’s plans to continue these efforts indicate that this commitment will be sustained.	
<b>CHALLENGES</b>	
None noted.	
<b>Potential Enhancements</b>	
	None noted.

### *Strategic Planning*

TFKC developed the Kansas Tobacco Control Strategic Plan, 2016–2020, which outlines four goals. Goal 1 is to prevent the initiation of tobacco use among youth and young adults and includes the objective of reducing the percentage of high school students who use cigarettes, e-cigarettes, and any tobacco products by 5 percentage points. However, the plan makes no specific reference to youth tobacco access from retail sources apart from endorsing the adoption of Tobacco 21 legislation and does not address efforts to enforce or educate merchants or the public on the state’s current youth tobacco access law.

Also with respect to planning, Greenbush analyzes data obtained from the DOR inspection database and provides its analysis to KDADS to inform Synar planning, monitoring, and evaluation. Greenbush used information from the inspection database to develop the report titled “Supplemental Analysis Kansas Synar and CATE Tobacco Retail Violations FFY2017/Calendar Year 2016.” This report is developed following each annual Synar cycle. However, the report does not compare data across years. Greenbush analyzes annual violation data to determine RVRs by county. A hot spot map is included in the report, as are past-30-day smoking rates among middle and high school students disaggregated by county and demographic information

on clerks. Based on report findings, the SAG identified the need to sustain enforcement efforts and to work with clerks on the importance of properly reading and consistently checking identification. State review of supplemental report findings also helped spur the addition of several youth tobacco-related use questions to the Kansas Communities That Care (KCTC) Student Survey, which currently includes ten such questions. State staff noted that, based on KCTC trend data for the period 2007–2017, Children’s Mercy Hospital and the KU Medical Center are conducting an evaluation study to assess the impact of the adoption of Tobacco 21 legislation by local governments on youth use of tobacco products.

**STRATEGIC PLANNING**

**STRENGTHS**

**Greenbush provides supplemental Synar analysis beyond the SSES tables.**

In addition to completing the SSES analysis, Greenbush also conducts further analysis using Synar inspection data. This analysis has informed state decisions regarding merchant education, enforcement, and data collection.

**CHALLENGES**

**The Kansas Tobacco Control Strategic Plan does not address retail access to tobacco products by youth under 18.**

While Synar and CATE inspection data were provided to TFKC during the development of the Kansas Tobacco Control Strategic Plan, the plan does not include strategies or key activities to address retail access to tobacco products by youth under 18. In addition, the state Synar team was not consulted in the development of the plan.

**The development and use of Greenbush’s supplemental Synar analysis appears to have not reached its full potential.**

While Greenbush provides inspection data analysis to the state beyond the tables generated by SSES, some of the analysis might not be as beneficial as it could be. For example, a chart indicating the number of violations per county tends to align with county population and does not present per capita data. In addition, the annual supplemental analysis report does not compare data from year to year to detect any positive or negative trends.

**Potential Enhancements**

**4 The Synar team might seek opportunities to participate more actively in state strategic planning on tobacco control and prevention.**

By providing Synar and CATE inspection data to TFKC, the state Synar team indicated its interest in the development of the Kansas Tobacco Control Strategic Plan. The Synar team might build on this outreach by identifying opportunities to participate in efforts to update the plan. Taking advantage of such opportunities to integrate Synar activities into the plan may help the state ensure the comprehensiveness of its tobacco control and prevention efforts.

<b>5</b>	<p><b>KDADS might consider ways to expand and optimize the usefulness of the additional analysis provided by Greenbush.</b></p> <p>The state might consider how additional data points and options for analysis might enhance and focus the state’s planning and evaluation efforts with respect to youth tobacco access. For example, Greenbush might expand its analysis of county level data to include violations per capita. Future supplemental data reports might also include longitudinal data and trend analysis at the state and county level. Moreover, the state might consider expanding the reports to include comparisons of data from CATE inspections to Synar data. Because CATE inspections would provide data on all retailers in the state, comparisons to Synar data may provide a more complete picture of youth tobacco access in the state to inform state planning and evaluation.</p>
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***Policy Development and Education***

KDADS staff indicated that proposed state legislation to increase the minimum tobacco purchasing age to 21 was stalled in committee during the most recent legislative session. However, the bill remains active and may be reported out of committee in the next session. If the bill is not passed in the next session, it must be reintroduced in a subsequent session to be considered. At the local level, Tobacco 21 legislation has been enacted in 19 cities in the state, including Topeka and Kansas City.

Also with regard to policy development and education, state staff reported that TFKC has successfully advocated for multiple cigarette tax increases, local and statewide clean indoor air policies, and enactment of local Tobacco 21 ordinances in three cities. At the time of the CSAP site visit, five additional local governments were considering the adoption of such ordinances.

<b>POLICY DEVELOPMENT AND EDUCATION</b>	
<b>STRENGTHS</b>	
None noted.	
<b>CHALLENGES</b>	
None noted.	
<b>Potential Enhancements</b>	
	None noted.

***State Youth Tobacco Access Support Strategies***

CATE inspectors provide merchant education during annual license inspections of all tobacco outlets on the DOR license list. The inspectors request that managers sign the DOR merchant

education checklist at the end of the visit, and inspectors leave a business card for the licensee to request additional retailer training. Inspectors also inform retailers that the CATE team is conducting controlled buys on an ongoing basis.

State staff indicated that supplies of printed merchant education materials are very low. Moreover, state staff reported that, due to a lack of funds, there is currently no plan to produce additional materials.

Also with respect to merchant education, in its FFY 2018 ASR, Kansas reported that language barriers present a challenge in providing merchant education to retailers in ethnically and culturally diverse communities. The state indicated that it is challenged to provide linguistically and culturally appropriate materials. Merchant education materials are currently available only in English.

<b>STATE YOUTH TOBACCO ACCESS SUPPORT STRATEGIES</b>	
<b>STRENGTHS</b>	
<b>The high accuracy of Kansas’s list frame benefits its merchant education activities.</b>	
In addition to its value to the state’s Synar survey, the accuracy of the Kansas list frame also helps minimize the time and other resources CATE inspectors might expend visiting outlets that do not sell tobacco products.	
<b>CHALLENGES</b>	
<b>DOR’s supply of printed merchant education materials is severely depleted.</b>	
Although the state continues to provide in-person merchant education, DOR’s supply of printed materials is very low, and there are currently no plans to replenish these supplies.	
<b>Merchant education materials are available only in English.</b>	
KDADS and DOR merchant education materials are available in English only and state staff indicate that materials in other languages are needed.	
<b>Potential Enhancements</b>	
<b>6</b>	<b>The state might consider potential funding sources for replenishing supplies of merchant education materials.</b> State staff might consider the feasibility of using funding sources such as SABG, TCP, or state funds to produce additional printed merchant education materials.
<b>7</b>	<b>Producing merchant education materials in multiple languages may enhance the effectiveness of Kansas’s youth tobacco access prevention efforts in all of its communities.</b> Merchant education is more effective when it is linguistically and culturally appropriate. The availability and use of materials in languages in addition to English could strengthen Kansas’s Synar efforts by ensuring that merchant education messages address the specific language and cultural needs of retailers. Merchant education materials in multiple languages could assist retailers in diverse communities to become active partners in youth tobacco access prevention in the state.



## APPENDIX A

### Participant List From the Site Visit

Name	Title	Organization
<b>State Participants</b>		
Mende Barnett	Synar Coordinator	KDADS
Sandra Borth	Executive Director	Reno County CTC
Andrew Brown	Prevention Program Manager	KDADS
Chris Bush	Prevention Consultant	KDADS
Lisa Chaney	Director of Research and Evaluation	Greenbush
Chad Childs	Prevention Systems Project Coordinator	WSU-CEI
Dola Gabriel	Senior Research Assistant	KU-CCHD
Kimi Gardner	Prevention Consultant	KDADS
D. Matens	Director of Prevention	Mirror, Inc.
Chrissy Mayer	Director of Prevention and Leadership	DCCCA
Marci Rosencutter	Cigarette and Tobacco Manager	DOR
Troy Unruh	Consultant – Special Projects	LiveWell Family Coalition
<b>CSAP Team</b>		
John O'Donnell	State Project Officer	SAMHSA/CSAP
Laurie Barger Sutter	Prevention Consultant	SAMHSA's State TA Project
Jeff Barr	Synar Consultant	SAMHSA's State TA Project

## APPENDIX B

### Sources of Information Reviewed

The following tables list the sources of information consulted during the system review process for the Kansas system and Synar program (e.g., reports, websites, state documents).

<b>Sources of Prevention Information</b>	
2017 Combined Behavioral Health Assessment and Plan 2018-19 Combined Behavioral Health Assessment and Plan	2017 SABG Behavioral Health Report
Substance Abuse Prevention and Synar Site Visit Report Kansas Federal Fiscal Year 2014 March 19–21, 2014	Kansas Substance Abuse Prevention and Synar System Review Report August 4–6, 2009 Fiscal Year 2009
Kansas State and County Quick Facts	KS 2014-42STA SIR Response Kansas SIR response Kanas TA Report - KS-P-7-15-08-2 KS-P-07-15-2008-1 TA Report
Kansas Behavioral Health Barometer 2017	Kansas State Contacts Directory Page
Kansas State Information Wikipedia	FY 2017 Kansas Grant Awards Summaries FY 2017 Kansas Grant Award in Detail FY-2017-DFC-New-Awards
Governor Orders in Lists	Understanding the Economy: State-by-State Snapshots
Kansas Behavioral Health Profile April 2015	Kansas Substance Abuse Epidemiological Indicators Profile 2004
KDADS Organizational Chart	Commissions and Organizational Chart of KDADS
Governor’s Behavioral Health Services Planning Council	Governor’s Behavioral Health Services Planning Council By Laws
Statutes 39-1605. Governor's behavioral health services planning council; composition of council; chairperson; terms of members; vacancies; vice-chairperson; compensation.	Kansas Prevention Collaborative
Kansas Strategic Prevention Framework State Incentive Grant: Final Evaluation Report	SPF Success II Initiative
KDADS Senior Leadership Staff Organizational Chart	KDADS Behavioral Services
KDADS Key Partner Agencies & Relationships Relationship to Key Partner Agencies	Substate System for SABG and MHBG Organizational Chart
Tribal Involvement	KDADS Prevention Program Quality Assurance & Performance Improvement Plan
Information About Kansas Data Systems	Site Visit Protocols—Onsite Training Outline
PFS Grants To Reduce Underage Drinking Year 1—Implementation Phase—Site Visit	A Guide to Conducting an Onsite Visit
Executive Reorganization Order No. 41	Kansas Statutes Annotated. 75-5375

	Drug abuse treatment and prevention duties of secretary for aging and disability services
KDADS Mission and Vision	Prevention Mission & Vision
Information about state data systems	Workforce Development Mission: To Recruit, Train And Retain A Competent Prevention Workforce
Workforce Development Planning Committee February – October 2016 Summary and Recommendations	Workforce Development Planning Committee 2016–2017
Kansas Prevention Workforce Survey Report	Automated Information Management System
Addiction And Prevention Services Integrated Data System	State SAPT Block Grant Monitoring and Independent Peer Review
Progressive Grant Program Discipline and Appeal Processes	Funds for Infrastructure
Kansas MH/SAPT Updates	Kansas Behavioral Health Prevention Comprehensive Plan—DRAFT
Cultural Competence and Sustainability PowerPoint	Kansas Prevention Collaborative Cultural Competence Plan
KDADS BHS Acronyms	Fiscal Management Tables 1–11
Management of SABG and MHBG Awards	Policies and Procedures of SABG Awards
Protocol for Onsite BHS Funded Provider Performance Reviews	FY 2018 Kansas State Block Grant Plan Priority Area and Annual Performance Indicators
FY18–19 Block Grant Planning—Prevention Language	KPCCI Community Logic Model
State of Kansas Governor’s Behavioral Health Services Planning Council By Laws	Kansas City Metro Methadone Program Summary Report
Kansas Behavioral & Mental Health Profile November 2017	Kansas SEOW
KPC Training Events to Date 02.14.2018	DCCCA Module Summaries
KPC Toolkits Description	Workforce Development System Development Work Team Action Plan to be completed by August 21, 2009
Enhancing, Supporting, and Sustaining the Kansas Prevention Workforce: Strategic Recommendations for Comprehensive Workforce Development	Workforce Development Subcommittee Recommendations
DCCCA Contract Award	CPS Certification Requirements
DCCCA TA Description	KPC KCTC Participation Action Plan Template
KPC Membership Roster Template	KPC Sustainability Action Plan Template
KPCCI Community Logic Model Template	KPCCI Quarterly Report Template Form
KPCCI Strategy Action Plan	Vendor List for BH Training and Technical Assistance RFP
Prevention & Problem Gambling Team Strategic Plan	Governors Behavioral Health Service Planning Council Minutes for January 17, 2018
Governors Behavioral Health Service Planning Council Minutes for August 16, 2017	Governors Behavioral Health Service Planning Council Minutes for October 18, 2017
Checklist of Policy Indicators for Alcohol, Tobacco, and Other Drugs	Sustainability Plan Template Coalition Core Essentials

KDADS Prevention Program Quality Assurance & Performance Improvement Plan	EBS Program Fidelity Checklist
Environmental Strategy Fidelity Checklist—Quarter 1	Kansas Prevention Collaborative Community Initiative 2017–2018
Chase County Notice of Grant Award	Narrative that describe how performance standards are set
Narrative that describes how subrecipients are monitored and provided	Narrative that describes how the state takes corrective action to address sub-recipient implementation and performance issues
Protocol for Onsite BHS Funded Provider Performance Reviews	Quality of Life Coalition, Inc. Notice of Grant Award
Finney County Notice of Grant Award	Haysville Healthy Habits Coalition Notice of Grant Award
Jefferson County Health Department Notice of Grant Award	Prevention Presentation to CSAP
Mirror, Inc. Notice of Grant Award	Four County Mental Health Center, Inc Notice of Grant Award
United 4 Youth Countywide, Inc. Notice of Grant Award	Olathe Communities That Care Coalition Notice of Grant Award
Shawnee Regional Prevention and Recovery Services Notice of Grant Award	Reno County Communities That Care Notice of Grant Award
Rice County Coalition for Children and Families Notice of Grant Award	Partners for Wichita, Inc. Notice of Grant Award
Behavioral Health Education Contract Award	

<b>Sources of Synar Information</b>	
Annual Synar Report FFY 2018	Synar Survey Sampling Plan and Inspection Protocol Review Final Version
SSES Tables 1–4	Kansas FFY 2018 Synar Inspection Form Kansas FFY 2018 Synar Inspection Protocol
Substance Abuse Prevention and Synar Site Visit Report Kansas Federal Fiscal Year 2014 March 19–21, 2014 (e-format)	Kansas Substance Abuse Prevention and Synar System Review Report August 4–6, 2009 Fiscal Year 2009
Kansas SLATI	Supplemental Analysis Kansas Synar & CATE Tobacco Retail Violations FFY2017/Calendar Year 2016
Compliance Inspection – Controlled Buy Investigation Report	Compliance Inspection—Controlled Buy (Vending Machine) Investigation Report
Synar Controlled Buys (June-September 2017)	Synar Advisory Group Member List 2017
Kansas Department of Revenue Cigarette and Tobacco System	Cigarette and Tobacco Underage Cooperating Individual Handbook
Kansas Synar Merchant Education	Kansas Tobacco Control Strategic Plan, 2016–2020
Budget and Justification Worksheet	Retailer Training
Synar Inspections agreement	Learning Tree Institute at Greenbush: FFY2018 Synar Deliverables/Tasks

APPENDIX B: SOURCES OF INFORMATION REVIEWED

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Agreement: Kansas Department of Revenue, Cigarette and Tobacco Enforcement	Q1 (July 1–Sept 30, 2016) CATE Controlled Buys
Cigarette hotspot map	Q3 (Jan 1–March 31, 2107) CATE Controlled Buys
Youth Tobacco-Related Data: Prevalence, Availability & Enforcement	Q4 (April 1–June 30, 2017) CATE Controlled Buys
Approved Synar Expenses	Q2 (October 1–December 31, 2016) CATE Controlled Buys

## APPENDIX C

### SSA Organizational Charts and Key Partnerships



**APPENDIX D**

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**Abbreviations**

ABC	Alcoholic Beverage Control
ASR	Annual Synar Report
ATOD	alcohol, tobacco and other drug
BHAP	Behavioral Health Assessment and Plan
BRFSS	Behavioral Risk Factor Surveillance System
CATE	Cigarette and Tobacco Enforcement
CCB	Community Check Box
CDC	Centers for Disease Control and Prevention
CSAP	Center for Substance Abuse Prevention
DFC	Drug Free Community
DOR	Department of Revenue
EBPs	evidence-based practices
ENDS	electronic nicotine delivery systems
FDA	Food and Drug Administration
FFY	Federal Fiscal Year
GBHSPC	Governor’s Behavioral Health Services Planning Council
Greenbush	Learning Tree Institute at Greenbush
IC&RC	International Certification and Reciprocity Consortium
IOM	Institute of Medicine
KBHID	Kansas Behavioral Health Indicators Dashboard
KCTC	Kansas Communities That Care
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KDOE	Kansas Department of Education
KPC	Kansas Prevention Collaborative

KPCCI	Kansas Prevention Collaborative Community Initiative
KSAs	knowledge, skills, and abilities
KU	University of Kansas
KU-CCHD	University of Kansas Center for Community Health and Development
MDS	Minimum Data Set
MIS	management information system
NOMs	National Outcome Measures
NREPP	National Registry of Evidence-Based Programs and Practices
NSDUH	National Survey on Drug Use and Health
PPT	PowerPoint
RFP	request for proposals
RPCs	Regional Prevention Centers
RVR	retailer violation rate
SABG	Substance Abuse Prevention and Treatment Block Grant
SAG	Synar Advisory Group
SAMHSA	Substance Abuse and Mental Health Services Administration
SEOW	State Epidemiological Outcomes Workgroup
SFY	State Fiscal Year
SIG	State Incentive Grant
SOW	statement of work
SPF	Strategic Prevention Framework
SPF PFS	Strategic Prevention Framework Partnerships for Success
SPF SIG	Strategic Prevention Framework State Incentive Grant
SPO	State Project Officer
SSA	Single State Authority
SSES	Synar Survey Estimation System
STR	State Targeted Response to the Opioid Crisis
T/TA	training and technical assistance
TA	technical assistance
TFKC	Tobacco Free Kansas Coalition



UCI	Underage Cooperating Individual
WSU-CEI	Wichita State University Community Engagement Institute
YRBS	Youth Risk Behavior Survey

# Mental Health Block Grant On-Site Monitoring Visit Report



**Kansas**

**May 22 - 25, 2018**



Susan Fout  
Commissioner  
State Mental Health Authority  
Kansas Department of Aging and Disability Services  
Behavioral Health Services Commission

### **Overview Statement and Purpose of Visit**

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a joint monitoring visit of Kansas on May 22 - May 25, 2018. The investigation is authorized by section 1945(g) of Title XIX, Part B, Subpart III of the Public Health Service Act [42 U.S.C. 300x-56(g)]. The monitoring team represents SAMHSA's Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, and the Office of Financial Advisory Services. The outcome of all monitoring visits is an objective, assessment of the state's behavioral health department's compliance and performance status. Specifically:

1. Assess the state's administration of its Community Mental Health Services Block Grant (MHBG);
2. Inform SAMHSA about mental health and substance use disorder treatment system development including, prevention infrastructure strengths and opportunities for improvement;
3. Identify areas in which targeted technical assistance (TA) may help Kansas manage and improve its public behavioral health delivery systems and prevention infrastructure;
4. Assess the state's ability to accurately account for, and report on, MHBG and related non-federal expenditures; and
5. Determine if the state and its sub-recipients has complied with MHBG fiscal requirements including earmarks, maintenance of effort, restricted expenditures, sub-recipient monitoring and performance requirements.

In an effort to provide the outcome of the monitoring visit, and provide feedback to the state in a timely and precise manner, the CMHS monitoring report was restructured in May 2016. The revised CMHS monitoring report includes, an executive summary of the monitoring visit, an evaluation of each regulatory requirement, an evaluation of SAMHSA and state programmatic priorities, the state's strengths and innovative practices and a list of those in attendance during the monitoring visit.

If you have any questions regarding the following monitoring report, please contact Kim Harris, Lead Monitor, SAMHSA, Division of State and Community Systems Development at [kim.harris@samhsa.hhs.gov](mailto:kim.harris@samhsa.hhs.gov) or (240) 276-0360.

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## Executive Summary

The designated public Mental Health Authority in Kansas is the Kansas Behavioral Health Services Commission, located in the Department of Aging and Disability Services (KDADS). State law designates KDADS as the department responsible for planning, administering, and managing the delivery of Kansas' public mental health services. This responsibility includes supporting, managing, overseeing, monitoring, and funding a full array of providers and stakeholders to provide quality, effective, and efficient mental health services. In addition, it oversees addiction and prevention service programs for the State of Kansas, including targeted workforce development initiatives. The commission works in close collaboration with the Governor's Behavioral Health Services Planning Council. The commission is also charged with overseeing the state's two psychiatric hospitals, Larned State Hospital and Osawatomie State Hospital.

Community Mental Health Centers (CMHCs) by are designated by counties, according to statute, to provide the community-based public mental health services safety net. Many counties joined together to designate a single CMHC to cover multiple counties, resulting in 26 CMHCs statewide. The centers are required to serve all persons needing community mental health services, regardless of the ability to pay. The CMHCs provide a wide range of services designed to meet each person's individual need for mental health services. Services include outpatient mental health therapy and psychiatric medication management. The centers also provide Community Support Services (CSS) to adults with serious and persistent mental illness (SPMI) and Community Based Services (CBS) to children with serious emotional disturbance (SED) and their families. The CSS and CBS include mental health rehabilitation and support services and are provided in the community where the person lives. Targeted case management and 24-hour emergency crisis services are also provided. The CMHCs determine the appropriateness of an admission to the State psychiatric hospital, Nursing Facilities for Mental Health (NFMH), Psychiatric Residential Treatment Facility (PRTF), and community inpatient psychiatric hospitals.

Kansas administers the vast majority of Medicaid-funded community mental health services through a community-based mental health managed care program approved by the Centers for Medicare and Medicaid Services. Services administered through the managed care organizations (MCO's) under contract with KDADS, include all community mental health state Medicaid plan services, the SED Waiver services, and the PRTF Community Based Alternative grant services. The MCO's do not limit the provider network and contracts, allowing any qualified and willing outpatient provider to deliver services that support mental health recovery and improve quality of life.

A significant challenge noted by the monitoring team are numerous leadership changes, retirement of individuals with extensive historical knowledge, state staffing shortages, and insufficient allocation to CMHC's. These experiences have had a negative impact on the access and quality of services as well as the state's ability to perform needed strategic planning to improve the system of care.

## **Overall Areas of Strength 2018**

The MHBG Monitoring Team identified the following areas of strength in Kansas:

- KDADS leadership and staff resiliency and unwavering commitment to the populations served through a strong focus on innovation and evidence-based services;
- Strong working relationship with the SAMHSA Regional Administrator for collaboration, support and guidance;
- Comprehensive approaches and commitment from KDADS to address homelessness for individuals with SMI or SED and their families;
- Governor's Behavioral Health Services Planning Council (GBHSPC), its' leadership for KDADS, and the state's behavioral health system of care;
- Disaster behavioral health responses for SMI and SED populations, emergency responders and community mental health first aid;
- Youth leadership initiatives along with a SAMHSA system of care grant for children and youth with SED; and
- Use of tele-psychiatry and collaboration with Federally Qualified Health Centers (FQHCs) in rural areas to address access to care issues.

## **Areas of Opportunity from Consumers, Family Members and the Kansas Governor's Behavioral Health Services Planning Council Input 2018**

Through interviews with the GBHSPC, consumers, and family members, the following areas of concern emerged:

- Limited psychiatrists for both adults and children;
- Lack of services for transition-age youth from both the child welfare system and the mental health system;
- Insufficient available inpatient and inconsistent community-based services for adults, children, and youth;
- Limited services for children, youth and adults who have a co-occurring substance use and mental health condition;
- Discharge practices from inpatient, emergency departments, and jails to the community. Specifically, it was reported that individuals can be discharged into homelessness and given a list of shelters in the area;
- Underutilized peer and family peer services along the system of care and in policy and planning;
- Insufficient permanent, affordable, safe housing and transitional housing for families and individuals with SED or SMI, which includes transition-age youth populations;
- Overall workforce shortages and retention for mental health services for both adults and children;
- Lack of transportation to access services for both children and adults in rural and suburban areas;

- Lack of available diversion services for adults, children, and youth;
- Lack of comprehensive behavioral health services for individuals who are uninsured and underinsured;
- Lack of services for children, youth, and adults who have co-occurring mental health and substance use conditions;
- Lack of access to permanent, safe and affordable housing, including transitional housing;
- Lack of resources for children and youth mental health and specialty care services; and
- Inconsistent treatment from law enforcement when individuals and their families are in crisis.

### **Overall Recommendations based on 2018 Monitoring Visit**

- Stabilization of KDADS leadership and staff;
- Create an updated Olmstead Plan that includes the NFMH's;
- Create a KDADS Cultural Competency Plan which includes implementing CLAS standards;
- Create an updated Suicide Prevention Plan;
- Standardized discharge planning from inpatient, emergency departments and corrections;
- Require standardized re-entry services, data collection and mental health treatment when individuals with SMI or SED are incarcerated in state prisons or county jails;
- Expand data collection areas to include more demographics, First Episode Psychosis (FEP) Initiative, outcomes for individuals with co-occurring mental health and substance use conditions, integration with gender specific and responsive primary care services, and reasons for discharge from community mental health treatment;
- Increase the availability of inpatient psychiatric, tiered services and child specific services statewide;
- Increase diversion for individuals with SMI at all points of entry in the criminal justice systems;
- Improve access to care issues for all SED and SMI individuals with co-occurring mental health and substance use conditions and individuals living in rural areas;
- Increase peer and family peer services along the system of care and in policy and planning;
- In addition to state law requirements related to cultural competency within contracts, the state needs to operationalize comprehensive cultural responsiveness and partner with the state Office of Minority Health to address the ongoing disparities that minorities and Lesbian, Gay, Bisexual, Transgender, Queer, Two Spirit (LGBTQ2S) experience;
- Expand tele-psychiatry services to key access point areas and improve data collection efforts related to the current tele-psychiatry initiative; and

- Increase equitable allocation of resources based on county needs assessments for mental health and co-occurring substance use and mental health services statewide for individuals and their families with SED or SMI to address access to comprehensive clinically determined services.

**Technical Assistance:**

- Strategic planning in collaboration with KDADS for the system of care; and
- Leadership with addressing disparities and cultural responsiveness for the system of care.

## Programmatic Review

### Statutory Requirements

The MHBG program's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services. The MHBG program is authorized by section 1911 of Title XIX, Part B, Subpart I and III of the Public Health Service (PHS) Act.

#### Purpose of Grants [42 U.S.C. § 300X (b)]

A funding agreement for a grant under subsection (a) of this section is that, subject to section 300x-5 of this title, the State involved will expend the grant only for the purpose of-

- (1) carrying out the plan submitted under section 300x-1(a) of this title by the State for the fiscal year involved;
- (2) evaluating programs and services carried out under the plan; and
- (3) planning, administration, and educational activities related to providing services under the plan.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: Kansas has submitted a comprehensive plan for evaluating programs and services in the MHBG application. The plan has been reviewed and approved by the SAMHSA State Project Officer. Kansas utilized the MHBG to provide increased access to mental health care and evidenced-based mental health treatment to individuals with SMI or SED. The MHBG application and plan were comprehensive and appropriate.

#### Comprehensive Community-based Mental Health Systems [42 U.S.C. § 300X-1(b) (1)]

The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include, health and mental health services, rehabilitation services, employment services, housing services, educational services, substance use services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the

Individuals with Disabilities Education Act [20 U.S.C. 1400 et seq.]. The plan shall include a separate description of case management services and provide for activities leading to reduction of hospitalization.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The plan is comprehensive and includes contracted community mental health centers throughout the state. There is a continued need for a full array of services and supports in order to maintain and enhance the quality of life of adults with SMI or children and youth with SED. Adult consumers with SMI can access the State's system of care through several avenues. They can gain access through hospital emergency rooms, 24/7 hotlines, CMHCs, community-based mobile crisis intervention units, and warm lines staffed by NAMI Kansas and other Consumer Run Organizations (CROs). Consumers can access the system's suicide prevention services through local Suicide Prevention hotlines statewide.

The public mental health system providers deliver all of the core service standards including: assessment, case management/service coordination, inpatient treatment, public education, evidence-based practices for adults with mental illnesses - including outreach, engagement and treatment Assertive Community Treatment (ACT), housing (Permanent Supportive Housing), employment (Individual Placement Services), recovery (Wellness Recovery Action Planning), and the implementation and measurement of evidence-informed practices with child-serving agencies. Kansas has received several federal System of Care grants. Based on recent collaborative efforts on behalf of children and adolescents, Kansas is committed to creating, state-of-the-art services for children and families based on System of Care values, principles, and practices.

Ancillary mental health services include respite care, drop-in centers, peer counseling and support services, recovery initiatives, ACT, home-based and other evidence-based services, warm lines, early intervention services, supported housing services, prevention services, supportive and competitive employment, and Medicaid reimbursed peer services.

**Area of Concern:**

- Services for both youth and adults with co-occurring mental health and substance use conditions are not integrated consistently statewide, which has caused some access to care issues and created disparities for these populations.

**Recommendations:**

- It is recommended that the KDADS and county authorities collaborate with substance use agencies to ensure uniform access and quality integrated behavioral health services that are based clinically on the needs of the person and their family, regardless of where they reside in the state; and
- Consider licensing and regulation reform that require all licensed CMHC's provide mental health and substance use treatment along the continuum of care.

Mental Health System Data and Epidemiology [42 U.S.C. § 300X-1(b) (2)]

The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The state is committed to performance measures outcomes in the entire system of care for both children and adults. KDADS works to assure accountability within the system and in the eyes of the public. By supporting proven methodologies and evidence based practices, the State works to ensure high quality services and allows consumers a voice in the services they receive. KDADS uses data systems to capture consumer-level registry, status, outcomes, and service utilization data, while remaining committed to transforming data into meaningful information to guide effective decision making.

KDADS conducts annual surveys to measure client satisfaction with children's mental health services at all CMHCs in Kansas. The Kansas Family Satisfaction Survey and the Kansas Youth Satisfaction Survey give families and youth a forum to provide feedback regarding services at the CMHC. However, due to staffing shortages and numerous leadership changes, KDADS staff have not made policy changes based on the results of the consumer satisfaction surveys for the past eight years.

The monitoring team **recommends** expanding data collection areas to include:

- Standardized data collection with all the CMHC's to eliminate inconsistencies;
- FEP initiatives that apply to all access points of services for this population, including post-partum depression;
- Services and outcomes for individuals with co-occurring mental health and substance use conditions;
- LGBTQ2S and other non-binary gender expressions;
- Corrections entry and re-entry to community which includes jails;
- Juvenile Dispositions of youth with SED and additionally in the areas of race, ethnicity, and LGBTQ2S;
- Law enforcement training evaluations, that measure the experiences from the consumers and families perspective;
- Gender specific and gender responsive (i.e. gynecological appointments, cervical, breast, ovarian or testicular screenings), including post-partum depression;
- Physical health categories and wellness;
- Homeless, Runaway, and Transitioning youth from the children's mental health system to adult mental health system;

- Implement new data collection practices or systems that relate to sexual and domestic violence and the associated risk and protective factors. Create surveillance systems rather than “one time” data collection intimate partner violence, sexual assault, and human trafficking;
- Reasons for discharge from community mental health treatment after the initial engagement and along the system of care; and
- Integrating the consumer satisfaction surveys from the tele-psychiatry program with the consumer satisfaction surveys. Additionally, monitor the contractor more vigorously to ensure standard survey protocols.

Children’s Services [42 U.S.C. § 300X-1(b) (3)]

In the case of children with serious emotional disturbance, the plan—

- (A) subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance use services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act [20 U.S.C. 1400 et seq.]);
- (B) provides that the grant under section 300x of this title for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and
- (C) provides for the establishment of a defined geographic area for the provision of the services of such system.

Met Requirement:  YES  NO  Technical Assistance Recommendation  Other

Summary: The community-based mental health managed care program provides services for children and families, which includes a full range of treatment options. Parents and children are actively involved in planning for all treatment services, with the goal of keeping children and youth in their homes, schools, and communities.

Services for children and families provided through the community-based mental health managed care program includes a full range of treatment options:

- Outpatient therapy;
- Outpatient medical services;
- Rehabilitation services;
- Targeted case management;
- SED Waiver services;



- PRTF community-based alternative services; and
- 1915(b) (3) services (attendant care and case consultation).

Rehabilitation services include community psychiatric support and treatment, psychosocial rehabilitation, peer support, and crisis intervention. Targeted case management ensures that children with emotional disturbance have the supports and services needed for success in all parts of their lives. Mental health services are also provided to youth with both SED and developmental disabilities. If a child/youth meets the definition of SED and the criteria for community-based services, appropriate services are provided. If the child/youth does not meet the definition of SED, the client and family are offered appropriate outpatient services.

The Children's SED Waiver provides services to children and youth with SED who are at risk of inpatient hospitalization. The SED Waiver provides intensive support services that allow children and youth to remain in their homes and communities. A Psychiatric Residential Treatment Facility Community Based Alternative grant provides services to children and youth at risk of admission into a psychiatric residential treatment program. Services include all those identified in the SED Waivers, employment preparation, and community transition services. Parent Support Services, recognized as a Promising Practice Program, offers training and support to parents of children with SED to help maintain their child in their home.

Kansas' Systems of Care for Mental Health Services to Children and Their Families (Kansas SOC) is the partnership of the KDADS, Community Engagement Institute, and four local jurisdictions/ CMHC's across the state. Kansas SOC has created, expanded, and sustained trauma-informed care, family-driven, and youth-guided SOC approaches for addressing the needs of children and youth with SED and their families. Of fourteen counties (eight are frontier with less than 6 persons per square mile, five are rural, the largest county, and the poorest county in the state) have seen growth in mental health systems of care for their youth and families through capacity building activities focused in trauma-informed care, trauma-informed systems of care, family-driven, and youth-guided practices. Other children and youth focused stakeholders have been engaged to enhance these practices across the state. In addition, the Kansas SOC Advisory Council has worked on State level programmatic and finance policy changes.

Kansas has the Youth Leaders in Kansas (YLinK) Program. YLinK offers youth throughout the state the opportunity to develop community youth leadership sites for youth ages 12-18 with a SED with the support and guidance of their primary caregiver(s). YLinK provides youth with information, education, and development of individual and group leadership skills in their community, statewide, and nationally. The program provides an array of services: improving family and peer relationships, community engagement, knowledge and training for employment and vocational education, and self-advocacy skills.

Kansas has a 2014 outdated suicide prevention plan, which needs to be updated. The current suicide prevention plan is comprehensive and has targeted emphasis on populations the data revealed as the most vulnerable to suicide and suicidal ideation.

An unmet need was identified in the service array for CROs for adolescents, to support them as they transition into adulthood. A consumer advisory committee is currently assisting CROs for adults in becoming more self-sufficient and is aware of this unmet need.

#### Targeted Services to Rural and Homeless Populations [42 U.S.C. § 300X-1(b) (4)]

The plan describes the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

Met Requirement:  YES  NO  Technical Assistance Recommendation  Other

Summary: Access to services by individuals with SMI or SED residing in rural areas is hampered by shortages of skilled clinicians and longer traveling distances. Resources are needed to provide all mental health services in rural Kansas, including traditional clinic-based services, as well as community-based crisis and in-home services. Kansas aims to increase the quality and availability of services in rural areas by prioritizing and advancing the use of interactive communication technology, such as tele-medicine strategies.

The increased numbers of homeless adults in Kansas discharged from inpatient facilities and prisoners with mental health issues released from jails and prisons (along with existing gaps in the availability of housing) further stretch the State's housing resources. This challenge is an opportunity for Kansas to establish a more comprehensive continuum of housing options for adults beyond the current, transitional, and interim housing, and assisted living homes.

Kansas continues to have gaps in statewide resources for different types of housing, including transitional, supported, and interim, especially in rural and frontier areas. Additionally, except for the three urban areas of the state, Kansas has either little or no public transportation in many of its small cities and towns, especially in rural or frontier areas. A basic unmet need exists in transportation, in spite of several short-term efforts. However, some CMHCs provide transportation for consumers' medication management and medical appointments. A transportation contractor funded by the State provides discharged Medicaid consumers with same-day transportation from the State hospital to their first post-discharge medication appointments.

Kansas has an extensive history of working with individuals and families who are experiencing homelessness. Over the years, Kansas providers have developed an array of services that include case management, crisis intervention services, a day center/drop-in-program, and mobile assessment units across the state. Allocations for the PATH program have fluctuated in recent years, and providers have diligently continued to use funds to expand and enhance services to homeless persons with mental illness. KDADS contracts with nine CMHC's to provide PATH services. While most of the PATH programs provide services to all PATH eligible adults ages 18 and over, some focus on transition-age youth and forensic populations that meet the PATH eligibility criteria.

Management Systems [42 U.S.C. § 300X-1(b) (5)]

The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 300x of this title for the fiscal year involved.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: KDADS is committed to providing an expanded array of curricula assigned to build capacity and improve the System of Care in state, local, and community-based organizations.

KDADS continues to support numerous statewide trainings to improve the system of care and service delivery in the following areas: ACT Teams, Cognitive Behavior Therapy, Mental Health First Aid, Family Psychoeducation, Motivational Interviewing, Person Centered Planning, Individual Placement and Support, Recovery Support Specialist, Family Partnership Professional Certifications, Supported Housing, Trauma Focused and Informed Training, Co-Occurring Treatment and Assessment, Wellness Recovery Action Plan, First Episode Psychosis, Evidence Informed Practice, Suicide Prevention, and CIT trainings for law enforcement statewide.

**Please see Office of Fiscal Review report for further details.**

Criteria for Mental Health Centers [42 U.S.C. § 300x-2(c)]

The criteria referred to in subsection (b)(2) of this section regarding community mental health centers are as follows:

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

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

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The community mental health centers are strategically located throughout the state and are comprehensive in nature, which include screening services, crisis intervention, early intervention, intensive outpatient services, medication management, family support services, recovery oriented services, residential services, evidence-based treatment, and trauma-informed care. There is a clear commitment from leadership and throughout the system of care in providing timely care, communicated in their mission, vision, and strategic plans as reflected in their policies and procedures. However, there are shortages of available private inpatient services for individuals with SMI, SED and co-occurring mental health and substance use conditions, step down and step up tiered services, and crisis stabilization to prevent hospitalization.

KDADS currently has a request for proposal that establishes mobile crisis services in an effort to increase crisis stabilization and divert individuals from inpatient services.

Community Mental Health Center Access [42 U.S.C. § 300x-2(c) (2)]

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

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: Kansas uses MHBG funds to supplement care for individuals and their families with SMI or SED who are not eligible for Medicaid or private insurance or underinsured for services. Community Mental Health Centers are located throughout the state and prioritize treatment based on acuity, with a commitment to providing timely access and care to consumers with SMI and SED.

Kansas expanded its use of tele-psychiatry and tele-medicine to help address access to care issues and workforce shortages for psychiatric services to children, youth, adults and older adults living in communities with limited access to board certified psychiatrists. Even though these efforts are in place to minimize access to care, transportation continues to be the most significant issue related to access to care.

**Recommendations:**

- Increase implementation of Kansas’s tele-psychiatry and include clinical supervision as a reimbursable service;
- Negotiate with insurance companies to include parity reimbursement for behavioral health services via tele-psychiatry;
- KDADS leadership meet with leaders at the Kansas Department of Transportation and Medicaid to address and find solutions to the transportation issues in rural and frontier areas; and
- Expand and improve data collection efforts and related to the current tele-psychiatry services.

Community Mental Health Center Quality Care [42 U.S.C. § 300x-2(c) (3)]

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

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The quality of care in Kansas is comprehensive and evidence based for children, youth, and adults. However, based on the interviews with Kansas staff, planning council members, and the consumer/family focus groups it was stated that significant access to care challenges continue to exist for individuals with SED and SMI due to the decreases allocation of state and county funds, resources, transportation and workforce shortages.

The state has a continuous quality assurance process in place to ensure that services are accessible, comprehensive, quality driven, and evidenced-based for improved outcomes.

State Mental Health Planning Council: Membership [42 U.S.C. § 300x-3]

(c) Membership  
(1) In general

A condition under subsection (a) of this section for a Council is that the Council be composed of residents of the State, including representatives of—

(A) the principal State agencies with respect to—

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.];

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

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

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

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The GBHSPC currently in compliance with the required membership statute ratios, which includes consumers, family members, state employees representing principal state agencies with respect to mental health, education, substance use, criminal justice, vocational rehabilitation, housing, and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with SMI and SED.

The GBHSPC has a tribal representative who was appointed by the Governor. Currently he is working with Council to establish communication and consultations with Kansas Tribes. In addition, this past year, the Prairie Band Pottawatomi Nation became a licensed SAT provider, and SABG block grant funding was allocated to pay for services that they provided.

The GBHSPC and its Subcommittees meet at least quarterly. All Subcommittees have representative liaisons from the GBHSPC, as well as designated staff from KDADS. Subcommittees provide feedback to the GBHSPC via their liaisons, as well as through annual reports that are presented to the Secretary of KDADS, the Governor, and other State Officials.

Subcommittees have educated themselves about the Kansas behavioral health system through inviting speakers to their meetings. They have also toured community service providers, as well as more restrictive settings, such as Psychiatric Residential Treatment Facilities and State Mental Health Hospitals, where they interact with staff and consumers informally and through presentations. This past year, the Continuum of Care task force has focused upon identifying service strengths and gaps in the adult mental health system, and has made recommendations to the GBHSPC and the KDADS Secretary. In the coming year, the task force will conduct similar assessments of the children's behavioral health system and the SAT system.

In addition, in 2017, the GBHSPC hosted a Public Comment Session in which members and attendees provided feedback about a communication protocol that KDADS would follow to gather input into the MHBG. They recommended that KDADS provide

education to the GBHSPC about: MHBG requirements, Kansas requirements of how MHBG funding is distributed, data about potential gaps in geographic access and other possible service barriers, data about the availability of services and any delays in accessing services, and trends in provider quality. One suggestion was to reinstate multi day, facilitated planning sessions with the entire GBHSPC to assist KDADS in preparing the block grant.

**Recommendation:**

- Create a subcommittee that focuses on integration of physical health and behavioral health.

State Mental Health Planning Council: Ratios [42 U.S.C. § 300x-3]

(2) Certain requirements

A condition under subsection (a) of this section for a Council is that—

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
- (B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The GBHSPC advises the KDADS on mental health issues. The GBHSPC currently in compliance with the required statute ratios, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with SMI and SED. The Governor recognizes the importance of the consumer voice and appoints two youth and several family members to the GBHSPC and its subcommittees. Youth Leaders in Kansas (Youth Link) is sponsored by a State grant and offers to youth ages 8-18 opportunities for involvement in leadership development, reduction of stigma, and relationship building on community, statewide, and national levels.

Members of the GBHSPC view their role as unique among other planning councils within the State because members are appointed by the Governor. The Council reports directly to the Governor and to the Secretary of KDADS on a regular basis. The Council also reports to the State legislature and to different legislative committees, based on the policy issues being addressed at any given time. Legislators are invited to Council meetings to discuss the initiatives and the mental health priorities the Council supports. One of the greatest strengths in Kansas is the leadership and innovation of the GBHSPC.

**Technical Assistance:**

- Strategic planning in collaboration KDADS for the system of care; and
- Addressing disparities and cultural responsiveness for the system of care. In addition, the GBHSPC recognizes the need for more racial and ethnic diversity and LGBTQ2S representation on the GBHSPC.

Review of State Plan by State Mental Health Planning Council [42 U.S.C. § 300x-4]

(a) Review of State plan by mental health planning council

The Secretary may make a grant under section 300x of this title to a State only if—

- (1) the plan submitted under section 300x-1(a) of this title with respect to the grant and the report of the State under section 300x-52(a) of this title concerning the preceding fiscal year has been reviewed by the State mental health planning council under section 300x-3 of this title; and
- (2) the State submits to the Secretary any recommendations received by the State from such council for modifications to the plan (without regard to whether the State has made the recommended modifications) and any comments concerning the annual report.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: GBHSPC reported a strong working relationship with the State, with opportunities to influence and enhance the Kansas mental health system. The State provides a range of supports for participation by consumers, family members, and Council members. The Council's active subcommittees are instrumental in structuring a process of regular reports and recommendations to KDADS, the legislature, and the Governor and many Council recommendations have been implemented by the State.

The GBHSPC's subcommittee structure contributes to its ability to influence the system's future directions. Subcommittees address Aging, Service Delivery, Children and Youth, Transformation, Suicide Prevention, Veterans, Justice Involved Youth and Adults, Rural and Frontier, Housing and Homelessness, Vocational, and Co-Occurring Mental Health and Substance Use conditions. The subcommittees include individuals who are not Council members in order to broaden the range of voices and perspectives involved in the planning process.

Council members noted they take their role in fulfilling the three federally mandated duties seriously. The members, for example, are involved in the State Plan's development, they review and comment on performance indicators for adult and children's services, and they solicit input on the Plan from stakeholders statewide.

The monitoring team met with the GBHSPC and the following are the consensus areas to improve the mental health system of care:



- Overall workforce shortages and retention for mental health services for both adults and children;
- Insufficient reimbursement rates for behavioral healthcare staff and services;
- Expand the use of tele-psychiatry to reduce health disparities for individuals with SED and SMI;
- Lack of transportation to access services for both children and adults in rural and suburban areas;
- Lack of available diversion services for adults, children, and youth;
- Discharge practices from inpatient, emergency department, and jails to the community. Specifically, it was reported that many individuals get discharged into homelessness with no transition planning;
- Lack of comprehensive behavioral health services for individuals who are uninsured and underinsured;
- Lack of services for children, youth, and adults who have a co-occurring mental health and substance use conditions;
- Lack of access to permanent, safe and affordable housing, including transitional housing;
- Lack of resources for children and youth mental health and specialty care services;
- Inconsistent treatment from law enforcement when individuals and their families are in crisis;
- Inconsistent application of standards of care for both child and adults systems statewide;
- Insufficient crisis stabilization services for children, youth, and adults with SED or SMI; and
- Increase use of technology at all points in the system of care and with data.

**Recommendation:**

- Ensure the GBHSPC reviews the MHBG expenditures at the beginning for planning and on an ongoing basis so they can have input to improve the system of care.

**Mandatory 10 Percent Set-aside First Episode Psychosis**

SAMHSA is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the MHBG allocation for each state to support evidence-based programs that provide treatment for those with early SMI and a FEP – an increase from the previous 5 percent 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".*

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: Kansas has two mental health service providers that have developed specialized teams to provide services and supports to individuals with an early serious mental illness (ESMI). Eligible individuals are those with early psychotic disorders, specifically first episode psychosis, between the ages of 15 to 25. This project includes the use of multiple EBPs, among them: “Recovery After First Schizophrenia Episode” (RAISE), NAVIGATE, and Cognitive Behavioral Therapy for Psychotic Disorders (CBTp).

RAISE involves coordinated specialty care (CSC) treatments for people experiencing first episode psychosis. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual’s needs and preferences. The client and teamwork together to make treatment decisions that involve family members as much as possible.

The team includes: a Program Director, who educates the community, recruits individuals who have begun to experience psychosis, and leads the team; a Prescriber, trained in using low doses of medications and addressing special issues of clients with first episode psychosis; an Individual Resiliency Trainer (IRT); a Family Education (FE) Clinician; a Supported Employment and Education (SEE) Specialist; and, Case Management, provided either by a separate case manager or by a specified NAVIGATE team member. Education by the two funded programs for mental health professionals across the state is the highest priority, as it should increase the number of providers who are offering similar interventions. Over the next two years, providers will present at State conferences, as well as the GBHSPC. These two programs also provide education and outreach in their communities via: hospitals, schools, colleges, and a large social media campaign.

Currently, the programs collect treatment data monthly, and report quarterly. Reports include achievements, outcomes, and goal progress for each individual. Agencies also provide narrative on overall performance of the program, achievements, barriers, and plans for the next quarter’s report.

The monitoring team visited one of the FEP sites. Onsite technical assistance was given to improve demographic ratios related to the binary gender imbalances with individuals enrolled in the program, which are mostly male versus female. Their clinical approaches met fidelity with the evidence-based programs they were implementing for the population. The monitoring team promoted the principles of early identification, innovative clinical interventions, increased peer recovery implementation, family engagement, gender specific and responsive medical services (including reproductive and family planning), and, finally, strategic partnerships and collaborations with local public health entities and social services to ensure access equity for race, ethnicity, sexual orientation, and non-binary gender minorities.

**Recommendation:**

- Currently, the team has Spanish speaking clients and family members and no information translated into Spanish and no Spanish speaking staff on the FEP Team. DSCSD recommends the translation of information into Spanish and to hire staff who can speak Spanish. Additionally, the staffing demographics of the Wyndot Center does not reflect the demographics of the area they serve which is predominantly African American and Hispanic.

### Tribal Consultation

SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#) to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan. Describe current activities between the state, tribes and tribal populations <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Met Requirement:  YES  NO  Technical Assistance Recommendation  Not applicable:  Other

Summary: There are four federally recognized tribes in Kansas with reservations: the Iowa Tribe of Kansas and Nebraska, the Kickapoo Tribe in Kansas, the Prairie Band Potawatomi Nation, and the Sac and Fox Nation of Missouri in Kansas and Nebraska. Lawrence is home to Haskell Indian Nations University, which has an average of over 1,000 students enrolled each semester. Haskell students represent federally recognized tribes from throughout the United States (Haskell Indian Nations University).

The monitoring team attempted to conduct a confidential call with the above listed tribes to discuss any meaningful consultation and collaboration with tribe officials in the development of federal policies that have tribal implications but none of the tribes called in.

### Additional Requirements [42 U.S.C. § 300x53 (a)]

A funding agreement for a grant under section 300x or 300x–21 of this title is that the State involved will -

- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
- (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities)

*States may satisfy the independent peer review requirement by demonstrating that at least 5 percent of their entities providing services obtained accreditation, during their fiscal year, from a private accreditation body such as the Joint Commission on the*

*Accreditation of Healthcare Organizations, the Commission on the Accreditation of Rehabilitation Facilities, or a similar organization.*

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: At least 5 percent of state entities providing services are accredited by Joint Commission Accreditation Health Care Certification or Commission on Accreditation of Rehabilitation Facilities and other entities as applicable. Due to shortages in state workforce, the State is reviewing options for independent peer review.

## SAMHSA & State Priorities

### Access to Care

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. According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises:

"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."

Met Requirement:  YES  NO  Technical Assistance Recommendation  Other

Summary: Of significant concern is the over utilization of jails for young adults and adults with SMI. Kansas does support expansion of diversion services and the sequential intercept model to decrease the over criminalization of individuals with mental illness. The state does an excellent job with re-entry from the state prison system back into the community but this is not the case statewide for individuals who are involved in county jails.

#### Area of Concern:

- In discussions with KDADS staff, GBHSPC and the focus group, racism and discrimination against LGBTQ2S were identified as significant impediments and influences on positive outcomes for these SED and SMI populations.

#### Recommendations:

- Collect, analyze, and utilize data from the courts, county, and state levels about youth with SED and adults with SMI to improve the system of care and outcomes;
- Implement liaison care coordinators for individuals transitioning out of jails;
- Increase diversion efforts at all points of the criminal justice system;

- Partner and collaborate with all state HHS Agencies to develop a strategic plan to address and eliminate disparities and inequities specific to racial, ethnic, gender, and sexual orientation minorities; and
- Add racism, sexism and heterosexism concepts to CIT training for law enforcement to decrease the over representation of racial, ethnic, and sexual minorities of our populations in the correction system.

### Integration of Systems (1) Mental Health/Substance Use (2) Primary Care/Mental Health

It is vital that SMHAs' and Single State Agencies 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.

Has the state integrated mental health and substance use service delivery? Yes No

Has the state integrated primary care and mental health service delivery for both adults and children/youth? Yes No

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The importance of the integration of mental health and substance use services with primary health care has continued to be supported and advocated by KDADS. However, Kansas at the state, county and local levels are not integrated with mental health and substance use services. While there are pockets of excellence in this areas a majority of the state struggles with care coordination or with providing comprehensive co-occurring mental health and substance use services statewide.

### Workforce Challenges & Response

How is the state meeting workforce demands? Brief description of plan to address gaps

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: Kansas recognizes gaps in workforce development, particularly for prescribers in rural areas. The state is committed to ongoing expansion of tele-psychiatry and tele-medicine to help address these needs. Other recommendations include aggressive recruitment efforts for mid-level practitioners, training of primary care physicians in mental health, and increased investment in certified peer supports.

## Recovery and Consumer/Family Driven Treatment

Recovery encompasses the spectrum of individual needs related to those with mental disorders 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 health or substance use disorder.

Does the state follow a recovery model that allows consumers to drive their treatment decisions?  Yes  No

Met Requirement:  YES  NO  Technical Assistance Recommendation  Other

Summary: Kansas has a strong reputation for supporting and involving mental health consumers and families in developing and implementing mental health services throughout the State. Consumers and family members serve on many State committees and initiatives. Recovery and consumer groups in the state are very vocal advocates and have established a strong network, including an active NAMI chapter. The state is committed to promoting recovery and enhancing employment opportunities for consumers in the state.

A Consumer Leaders' Group currently helps to ensure that consumers involved in State planning and policy development vary from committee to committee and that involved consumers represent all geographical areas of the State. In addition, some outreach meetings are scheduled regionally to increase consumer and family participation. Those meetings provide updates on mental health system policies and elicit input from the participants about their concerns and needs.

Kansas involves representatives of CROs in opportunities to influence the mental health system. For example, the National Alliance on Mental Illness (NAMI) Kansas has a representative on the State's EBPs Committee and on the GBHSPC. The State has plans and initiatives that ensure consumers and family members have the knowledge, skill development, supports, and resources they need to contribute meaningfully to the system. Kansas funds CRO programs that provide supports to consumers and family members, such as the Family-to-Family support program sponsored by NAMI Kansas. Several CMHCs have State funding for classes that train consumers and family members how to advocate for themselves.

SAMHSA awarded funds for the Enhancing Supported Employment in Kansas (ESEK) will convene a state level Supported Employment Coordinating Committee of stakeholders and establish IPS services in two Kansas communities - Sedgwick County, a population dense, urban county, and Southwest Kansas, a diverse and rural area of the state. ESEK will build upon the existing supported employment efforts in Kansas, including the Vocational Sub-Committee, under the GBHSPC.

## Peer Supports

States are 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:

- Peer-delivered motivational interviewing,
- Peer specialist/Promotors,
- Peer-run respite services,
- Person-centered planning,
- Self-care and wellness approaches, and
- Peer-run crisis diversion services.

Met Requirement:  YES  NO  Technical Assistance Recommendation  Other

Summary: The state and county supports efforts to enhance the meaningful contributions of consumers regarding policies and services and to ensure consumers have the knowledge, skill development, access, resources, support, and time to contribute meaningfully to system change. Consumers are also afforded meaningful opportunities to influence the service delivery system by serving on Boards of Directors, Advisory and Planning Councils, and committees.

In addition, Kansas has a network of CROs dedicated to improving the lives of adults with SPMI using Peer Support as the cornerstone of its programs and services. CROs are legally incorporated nonprofit consumer governed and operated organizations using a peer recovery model built on self-direction, empowerment, peer support, and hope for restoring individuals to a life that is integrated and meaningful according to each person's own terms. CROs provide an array of services to its members which include: one on one peer support, peer support groups, self-help groups, employment support, life skills training, health and wellness activities; act as bridge supports from state institutions to life in the community, and education about Medicaid and other community resources to connect members to services. The Kansas network of CROs also utilizes Wellness Recovery Action Plan (WRAP) with their members.

The monitoring team met in person with a statewide cross section of consumers and family members in person for three hours. The following are the areas of concern and strengths they identified:

### **Consumer and Family Focus Group Recommendations:**



- Increase inpatient treatment for both adults and children and expand crisis stabilization to prevent hospitalization;
- Increase the number of psychiatrists, specialty services, and co-occurring mental health and substance use services for both adults and children;
- Address gaps in the system of care specifically discharge practices from inpatient, emergency departments, jails and individuals with co-occurring substance use and mental health conditions;
- Improve communication with identified family members when in individuals go into and are discharged from inpatient, emergency departments, and incarceration;
- Implement a comprehensive cultural responsiveness plan and require more training to help eliminate disparities against racial, ethnic, gender, and sexual orientation minorities;
- Increase access to transitional housing and permanent safe and affordable housing;
- Implement of Person-Centered Services throughout the system of care;
- Improve training of law enforcement in CIT to include racism, sexism, heterosexism, and individuals with co-occurring mental health and substance use conditions;
- Improve trauma informed care along the continuum of care especially in crisis, diversion placements and incarceration;
- Increase and integrate more peers into the entire system of care for individuals with SED or SMI and their families;
- Increase advocacy, recovery, and family leadership within the continuum of care;
- Increase peer integration in all aspects of crisis services and along the continuum of care;
- Increase public awareness about mental health conditions in racial and ethnic minority communities to reduce stigma and establish greater trust of the mental health system of care;
- Require a peer or social worker accompany the law enforcement officer to assist with the mental health crisis;
- Decrease the number of individuals with SED or SMI incarcerated, expand diversion initiatives and if they are incarcerated, improve their mental health treatment in a trauma informed manner and implement standardized re-entry and family centered practices for individuals and their families involved in the county jail system; and
- Increase public education about peer services and employment for consumers and families.

### Health Disparities & Cultural Competency

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, *Healthy People, 2020*, *National Stakeholder Strategy for Achieving Health Equity*, 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.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The state has the Kansas Commission for the Deaf and Hard of Hearing (KCDHH), which is a state agency that is authorized to develop and implement program of information, referral, advocacy, public education, and direct services. KCDHH works with agencies and organizations throughout Kansas to assure availability and coordination of services for people who are deaf and hard of hearing, including communication access. Additionally, KCDHH assists state agencies, hospital, law enforcement organizations, courts, and businesses to locate professional interpreters.

**Recommendations:**

- Implement CLAS Standards statewide for mental health services; and
- Create a Cultural Competency Plan for KDADS and
- Require contractual compliance from the CMHC's with the cultural competency plan that is developed.

Quality Assurance and Continuous Quality Improvement (CQI)

These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the National Behavioral Health Quality Framework, 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 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.

Met Requirement: YES NO Technical Assistance Recommendation Other

Summary: The contract between CMHCs and KDADS Centers provide monthly Consumer Status Report (CSR) updates for adults and children/adolescents to DBHS. Each Center develops a quality improvement plan to improve service delivery, and submits quarterly updates to MH. In addition, centers develop performance improvement plans (PIPs) when indicated and include information in the quarterly updates.

KDADS Centers also report on the use of State mental hospitals, noteworthy activities and recent accomplishments, results of consumer and family interviews, and any observations indicated during the quarter requires the centers to have a continuous quality improvement plan, participate in the development of measures of performance and collecting, report baseline data on identified performance indicators, and develop and implement improvement plans. In addition, CMHC regulations require centers to develop and maintain agency-wide continuous quality improvement programs as part of the CMHC's normal operations.

Field staff conduct qualitative interviews face-to-face, addressing 15 subject areas. An annual consumer satisfaction survey, based on the Mental Health Statistics Improvement Program data elements, generates information that is provided to the University of Kansas, which extracts and analyzes the data and provides recommendations and reports. After a review of survey results and recommendations, CMHC's submit a plan describing how they will use survey feedback to improve the quality of service delivery. Additional quality assurance processes include licensing, annual contract monitoring, and following up on consumer and stakeholder complaints. Peer reviews are conducted through chart review and the utilization of services.

The state tracks grievances filed by Medicaid consumers through a weekly account log that is coordinated with staff in the Ombudsman's Office. A bimonthly meeting between State administrators and the Ombudsman and the account log are used to review the State's progress in addressing grievances. Quality improvement staff use charted and trended data to identify patterns in performance indicators and patterns in the types and number of grievances filed across CMHCs.

**Recommendation:**

- Create an updated Olmstead Plan that includes the NFMH's.

## Appendix

### List of CMHS Federal and other Attendees

Name	Position	Agency
Kim Harris, MSW, LCSW	CMHS, Lead Monitor	SAMHSA (LEAD)
Members of the MHBG Planning Council		
Statewide Representation of Consumers and Family Members (Focus Group)		
Statewide Representation of CMHC Leadership		

### KANSAS SMHA INTERVIEWEE LIST

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## APPENDIX A. KANSAS NPN/SYNAR/SSA INTERVIEWEE LIST

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APPENDIX B. – KANSAS BEHAVIORAL HEALTH SERVICES (BHS) COMMISSION COMMENTS

1. Areas of Opportunity from Consumers, Family Members and the Kansas Governor’s Behavioral Health Services Planning Council Input 2018
  - a. Lack of services for transition-age youth from both the child welfare system and the mental health system;

KDADS Response

Kansas continues to work towards access to care. Last year, the BHS Commissioner and Children’s Director went on a western Kansas listening tour to hear from stakeholders about rural access issues related primarily to Acute Psych for youth. For residential psych PRTF, Kansas currently has 50 beds in Hays and there are plans in the works for an additional 12 beds in Newton for females.

2. Integration of Systems (1) Mental Health/Substance Use (2) Primary Care/Mental Health  
It is vital that SMHAs' and Single State Agencies 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.  
Has the state integrated mental health and substance use service delivery? Yes No  
Has the state integrated primary care and mental health service delivery for both adults and children/youth? Yes No

KDADS Response

Kansas still has more work to do but has made progress towards integration of BH and Physical Health. Examples include: Almost all CMHCs are also Substance Use Disorder providers. The State has a project in progress to integrate substance use disorder providers with health clinics. Kansas also has implemented a Health Homes program in Medicaid. Target populations include those with paranoid schizophrenia and severe bipolar disorder, as well as, those with asthma who are at risk of developing a behavioral health disorder. Please see OneCare Kansas: <https://www.kancare.ks.gov/home>