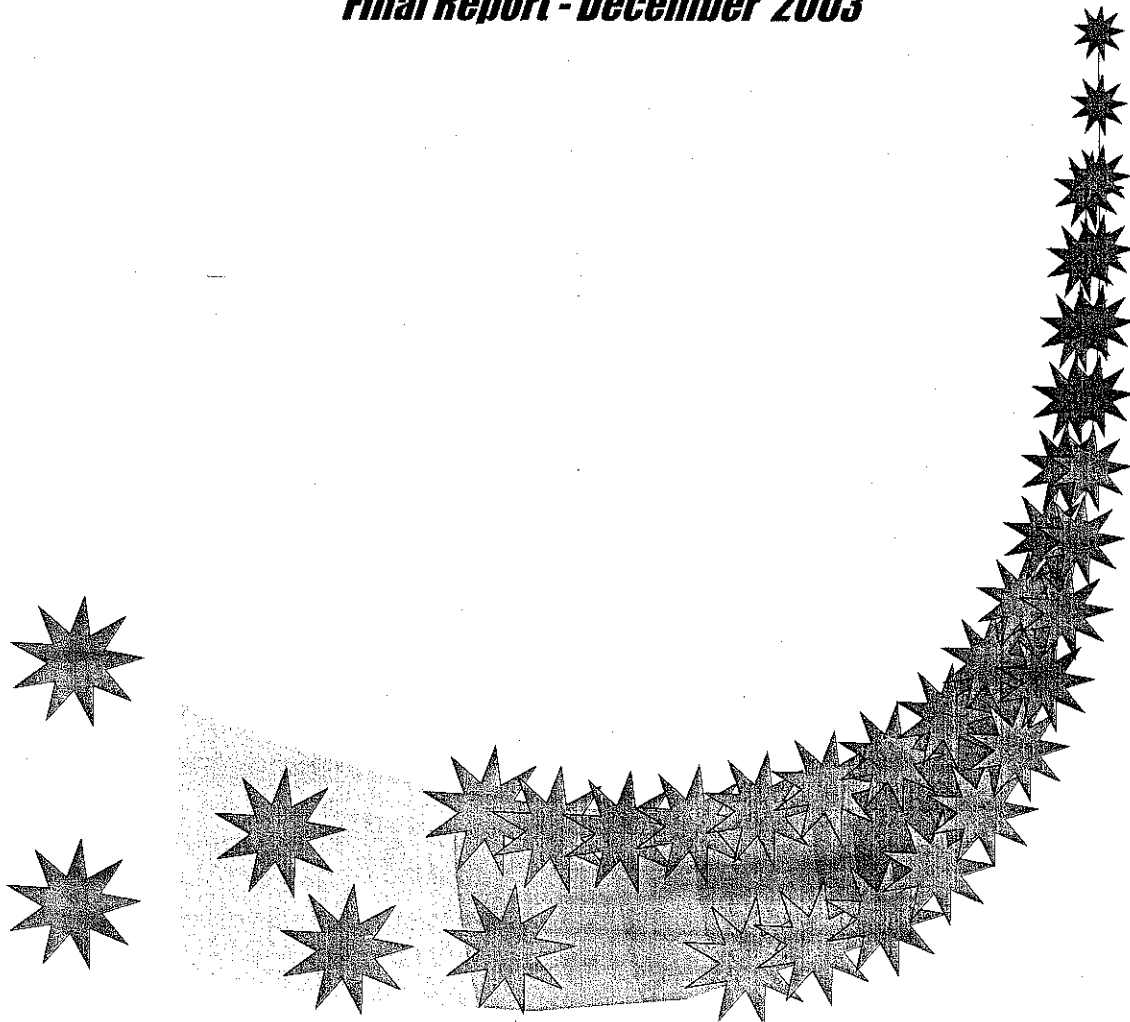
Future of Kansas Mental Health Hospitals

Project Steering Committee Report

Final Report - December 2003



Future of Kansas Mental Health Hospitals
Project Steering Committee Report – Executive Summary

A richly diverse group of Kansas public mental health system stakeholders worked July through November, 2003, to respond to legislative directives, coalesce and build upon prior related work, and develop recommendations and guiding criteria regarding the role and function of state mental health hospitals. Key elements of the committee's report are:

Backdrop

While admissions have dramatically increased and average daily census dramatically decreased, the state mental health hospitals have maintained a barely adequate supply of beds by working in effective collaboration with community mental health centers. Supporting information is detailed in the report, including:

- ❑ The number of people accessing state mental health hospitals has increased by 67% in the past five years (with 3,115 psychiatric admissions in FY 2003).
- ❑ For some 50% of the people admitted, it is their first experience with mental health services.
- ❑ From FY 1990 to FY 2003 the average daily census of Kansas' mental health hospitals decreased from 1283 to 293, a 77% reduction.
- ❑ From FY 1992 to FY 2002, the number of state hospital bed days used by community mental health centers decreased from 145,030 to 21,640, an 85% reduction.
- ❑ Meanwhile, the number of people with the most significant mental illness accessing community-based services continues to increase, up by 60% for youth (15,811 in FY 2003) and up by 14% for adults with serious and persistent mental illness (15,699 in FY 2003) in the last four years.

Currently

There is no room presently for any further reduction in the service capacity of the state mental health hospitals. As part of the array of public mental health services, the state hospital resources are essential to meet critical needs of increasing numbers of Kansans in times of intense challenge

Strategies are identified to support and enhance the utilization of state hospital resources in ways that are continuously effective and ensure hospitals are fully integrated parts of the public mental health system, including: improved training for screeners; enhanced community/hospital liaison functions; dynamic cross-system training; and integration of vision, direction and best practices between state hospitals and community mental health providers. Recommendations also address two important issues currently facing the hospitals: customer-friendly steps to support treatment partnership for families of hospital patients; and the increasing number and complexity of forensic service needs for patients also involved in criminal prosecutions.

Looking Forward

Kansans needing to access the public mental health system should have access to and receive a full spectrum of psychiatric services that provide state of the science care, use evidence-based practices, promote timely and durable recovery, build resilience of children and support families The integration of family-centered, community-based and recovery-focused core system principles should be included in future strategic planning and policy implementation.

Any future reduction in the service capacity of state mental health hospitals should occur only with planning input by impacted stakeholders and concurrent implementation of capacity building measures in the impacted communities.

Both short-term and longer-term strategies are identified to help prevent further dissolution of community-based services resources and to explore new public/private partnerships to deliver acute care services consistent with the needs of specific areas. These strategies include:

- ❑ Renewed assessment of the reimbursement system for state-funded inpatient psychiatric services provided outside of state hospitals.
- ❑ Increased outreach to inform families having youth with mental health needs about CMHC services.
- ❑ Enhanced crisis service plan development and implementation by CMHCs.
- ❑ Additional inpatient service availability regionally, with implementation in FY 2005 of a regional model for inpatient psychiatric services for children.
- ❑ Continued exploration of alternative models of state hospital inpatient service delivery.

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Table of Contents

	Page
Committee's Message	1
Message Context: The Guiding Mission of Kansas' Public Mental Health System	1
Committee's Background & Work	2
How This Report Should be Used	3
Kansas' Current State Hospitals	3
Recommendations	5
A. The state mental health hospital resource, as part of the array of mental health services, is essential to meet critical needs of increasing numbers of Kansans in times of intense challenge, and to help them achieve timely and durable recovery, build resilience of children and support families	5
B. The role of our state mental health hospitals is changing, varies from one hospital to another, and reflects unique community and individual needs. Any additional decrease in state hospital services should occur with both (a) a consensus plan developed with input by representatives of all stakeholders impacted by such a change and (b) prior or concurrent implementation of capacity building strategies to meet the needs of people accessing the impacted state hospital services	7
C. Community-based services and community psychiatric inpatient services must be supported to prevent further dissolution of resources for patients near their homes	8
D. Work must continue to ensure that our state mental health hospitals are continuously effective and fully integrated parts of Kansas' public mental health system	10

Attachments:

1: "Leadership Team Charter for: The Future of State Mental Health Hospitals Project Steering Committee," with membership list

2: "Project Steering Committee – Resource List"

Future of State Mental Health Hospitals
Project Steering Committee Report

Committee's Message

To the citizens of Kansas who do, have or will access public mental health services; and to the citizens of Kansas who shape, lead, implement, manage, fund and guide public mental health services, we offer this message for the future:

- The state mental health hospital resource, as part of the array of mental health services, is essential to meet critical needs of increasing numbers of Kansans in times of intense challenge, and to help them achieve timely and durable recovery, build resilience of children and support families.

- The role of our state mental health hospitals is changing, varies from one hospital to another, and reflects unique community and individual needs. Any additional decrease in state hospital services should occur with both (a) a consensus plan developed with input by representatives of all stakeholders impacted by such a change and (b) prior or concurrent implementation of capacity building strategies to meet the needs of people accessing the impacted state hospital services.

- Community-based services and community psychiatric inpatient services must be supported to prevent further dissolution of resources for patients near their homes.

- Work must continue to ensure that our state mental health hospitals are continuously effective and fully integrated parts of Kansas' public mental health system.

Message Context: The Guiding Mission of Kansas' Public Mental Health System

Individuals with mental health needs should have access to and receive a full spectrum of psychiatric care and services that provide state of the science care, implement evidence-based practices, promote timely and durable recovery, build resilience of children and support families. Kansas' public mental health care system, which includes the state mental health hospitals, should provide a full spectrum of services to individuals with mental health needs. This system should be family-centered, community-based, recovery-focused, and guided by the following principles:

- Every Kansan with mental illness has the right to make informed choices about his/her life based on individual preferences.
- Active partnerships of mental health professionals, consumers, family members and peers, are essential and directive to treatment planning, and promote durable recovery and building resilience.
- Kansans with mental illness deserve effective state of the science treatment.
- Psychiatric treatment must be respectful of and empowering to the individual.
- With effective psychiatric treatment and services, Kansans can experience a personal process of recovery from mental illness.
- Psychiatric services must be provided in the most natural, safe, flexible and accessible environment with a focus on community-based supports.

The integration of these principles should specifically be included in future strategic planning and policy implementation.

Committee's Background & Work

This report of the Future of State Mental Health Hospitals Project Steering Committee is an effort to coalesce work efforts by hundreds of mental health system stakeholders. Beginning in December 1999, when SRS Secretary Janet Schalansky charged the Hospital Stakeholder Task Force to assess the guiding vision for public mental health services and the role of hospitals in that vision, to September 2003 when the Statewide Children's Hospital Committee issued its recommendations, many consumers, family members, advocacy groups, community providers, the Governor's Mental Health Services Planning Council and state staff have dedicated compassionate energy in work on this subject which has greatly informed this committee.

Last April, SRS initiated this project to be responsive to requests and direction from the Kansas Legislature, to honor the related work efforts that had been completed or were underway, and to comprehensively coalesce the significant interests of the many diverse stakeholders toward a united vision as to the role of State Mental Health Hospitals – both now and in our shared preferred future – in the array of services for Kansans seeking mental health treatment, recovery and resilience.

In order to ensure the Project committee would not duplicate previous work, a Leadership Charter describing the activity and responsibility of the committee was developed to bring focus and boundary to the work. The committee believed this document would assist in creating realistic expectations as well as describing the process for observers. In addition, the Project Committee of stakeholders, consumers and professionals, included individuals who have been a part of previous initiatives, studies and efforts looking at some aspect or dimension of the mental health system. The purpose of this committee was: "To identify the role and function of state hospitals. The committee will develop a template or set of criteria that will guide current decisions, recommendations and action plans now and in the future." (See "Leadership Team Charter for: The Future of State Mental Health Hospitals Project Steering Committee," with membership list, attached.)

The Committee reached agreement on recommendations through a consensus process and spent time framing the issues, conducting discussions, identifying data, and generating options and ideas around the role state hospitals do or could play in the mental health service system. For clarity and focus, the committee created a framework that they used in assessing the various issues related to state hospital roles. Specifically, the activity of the committee fell into three categories of service:

- ❑ Front end services: What are the issues related to the state hospital's role prior to admission?
- ❑ While in service: What role does the hospital play and what services are provided while the individual is in the hospital?
- ❑ Back end services: What services and support are provided by the state hospital as an individual is transitioned to the community?

The full group self-assigned to sub groups based on these categories. Each group focused on, relative to their particular category, <u>the current role of state hospitals, what role they could or should play and how do we get there?</u> Meetings were held through August, September, October and November of 2003 with regular progress communication to key stakeholders between meetings. Summaries of all meetings were recorded and serve as background documentation for this report.

This project, supported in part by the National Technical Assistance Center for State Mental Health Planning, culminated in this Project Steering Committee's work. Our report gives recommendations that are the results of a thoughtful and facilitated consensus building process with stakeholders, consumers and professionals. It concludes that state hospital services must remain an integral part of the mental health system. Because the availability of appropriate medical follow-up, case management, housing and other supportive services varies from community to community, the type and duration of the services provided by state hospitals will vary from patient to patient.

How This Report Should Be Used

This report is meant to be a guide for all Kansas mental health system stakeholders in determining effective utilization of state hospital resources. Consequently, we believe this report can be used to:

- ❑ build a common agenda around priorities for this state system;
- ❑ educate local decision makers;
- ❑ inform legislators;
- ❑ assist in asking critical questions before decisions are made regarding level of service; and
- ❑ craft public policy relative to the role of state hospitals.

This report provides a template that should be used to guide current and future decisions about the role of state hospitals in the continuum of mental health services for Kansans. It should be used as a comprehensive decision-making tool for **all** interested people as we chart the course to our future.

Kansas' Current State Hospitals

Kansas currently has three state mental health hospitals, all of which are JCAHO accredited and CMS certified. In state fiscal year 2003, 3115 people were admitted for psychiatric inpatient services (including 221 adolescent or children admissions) at these three hospitals, and 107,782 days of inpatient service were provided. The primary basis for inpatient hospitalization in a state psychiatric hospital is that the individual is a danger to self or others. Children and adolescents who are hospitalized have been found to be a danger to themselves and others and generally exhibit behaviors which community providers have been unable to deal with successfully, such as extreme self abuse or violence toward others. Adults, likewise, have been found to be dangerous to themselves or others, and have psychiatric illnesses with uncontrolled symptoms, such as manic episodes, delusions, and severe depression.

Some brief historical and current practice information about each hospital follows:

Larned State Hospital (LSH) was first opened for patients in 1914 to provide care and treatment for people with mental illness and continues in it's role as the only state mental health hospital in western Kansas with a total capacity of 326. The organization continues to evolve in response to the changing needs of Kansas citizens for high quality and affordable psychiatric care. Currently, Larned State Hospital consists of three formal treatment programs and one support services program that deliver services to both internal and external customers.

The *Psychiatric Services Program (PSP)* provides psychiatric treatment to Kansas citizens who range in age from 5 to 85, and who come to the hospital from 59 counties in western Kansas. LSH's catchment area's population is 608,188 and covers 51,693 square miles. There is presently a budgeted capacity of 104 beds, which includes an admission unit with 15 psychiatric beds and 3

chemical detox beds, two 30-bed adult treatment units, and a youth services wing with 15 adolescent beds and 10 beds for children.

Other treatment programs at LSH include: The *State Security Program (SSP)* opened in 1939 and provides a secure setting for forensic evaluations and psychiatric treatment for persons referred from the courts or the Department of Corrections, from across the entire state. The *Sexual Predator Treatment Program (SPTP)*, which provides treatment for convicted sex offenders who have completed their prison sentences, but who have been civilly committed under Kansas' Sexual Predator Law, opened in 1994. The *Finance and Support Program* works to ensure that LSH and two other agencies on campus receive high quality goods and services from a long list of options that include: laundry, dietary, engineering, grounds keeping, supply, water, security, etc.

Related to acute psychiatric services at LSH: In FY98, 30% of admissions were due to risk of suicide. In FY03 this increased to 37%. In FY98, 17% of admissions presented with thought disorders like schizophrenia. This increased to 32% in FY03. In FY98, 23% of the admissions presented with mood disorders but this, as a primary presenting problem, dropped to 9% in FY03. It appears that a greater proportion of persons with severe disorders like schizophrenia, as opposed to severe mood disorders like bipolar illness, are presenting for hospital treatment. Substance abuse, as a primary presenting problem, dropped from 22% in FY98, to 10% in FY03. This likely reflects a reality that a greater proportion of persons coming to the hospital have a mental illness that is seen as more primary than their substance abuse. Between 60% and 70% of LSH patients with mental illness have a co-occurring substance abuse/dependence issue that requires treatment.

Osawatomie State Hospital (OSH) serves adult consumers of mental health services in the 46 easternmost counties of Kansas. In 1866, the Kansas Insane Asylum was established by the legislature and located in Osawatomie, Kansas, as a reward for the role that city had played in the Civil War. In 1901, the facility was renamed Osawatomie State Hospital, its name since then. OSH's catchment area has a total population of over 2,000,000 people and includes Kansas City, Johnson County, Topeka and Wichita. The population served also includes an average of 30 individuals who have been committed under the criminal statutes due to a judicial finding of either not guilty by reason of insanity or incompetency to stand trial.

During FY 2003 over two thirds (72%) of all admissions were involuntary and for 50% of the individuals admitted it was their first admission to OSH. On June 30, 2003 of the 141 individuals being served at OSH, 64% were diagnosed with schizophrenia or other psychoses and 26% with affective disorders. These percentages have held relatively consistent over the last five (5) years. As with LSH, 60% to 70% of individuals served have co-existing substance abuse problems.

Rainbow Mental Health Facility (RMHF) was opened in 1973 as a low security unit of Osawatomie State Hospital (OSH), with a Program Director who reported to the OSH Superintendent. The doors were initially opened to partial hospital patients, who were primarily people with long term psychiatric histories who were transferred from OSH. Rainbow began admitting inpatients at the beginning of 1974, with 30 beds for children and adolescents, and 30 adult beds. A 10 bed adult unit evolved to become a Substance Abuse Unit. The partial hospital adult program served up to 20 adults per 10 bed inpatient unit; the three 10 bed child/adolescent units each served up to an additional 10 to 15 partial hospital patients. During the 1980s a paradigm shift occurred, and community mental health centers initiated community support programs which led to phasing out adult partial hospital programs by the end of the 1980s. The partial hospital program for children/adolescents continued for several more years, but was also closed in the early 1990s as community based service capacity for youth was built.

Rainbow currently serves people of all ages and covers all major psychiatric disorders. Rainbow's catchment area includes 10 counties in the Kansas City metropolitan area for adult admissions. Youth admissions come from the 46 easternmost counties of Kansas, covering a total population of 2,000,000, including Topeka and Wichita. Presently, Rainbow operates a 50 bed facility, with 20 beds for youth and 30 beds for adults. Johnson County Mental Health Center's Adult Detox Unit temporarily rents the remaining 10 bed unit, pending construction of a new facility.

Nearly 600 people (421 adults, 114 adolescents and 53 children) were served in FY 03, an increase of 15% over the previous year. During FY03, 68% of all admissions were voluntary and 22% were involuntary; 60% of all admissions were first time admissions. Of those served in FY03, 51% were diagnosed with schizophrenia or other psychoses and 31% with affective disorders such as schizoaffective, bipolar and anxiety disorders. On June 30, 2003, of the 42 individuals served at Rainbow Mental Health Facility, 53% were diagnosed with schizophrenia or other psychoses and 38% were diagnosed with affective disorders. These percentages have been relatively consistent over the last five (5) years. Consistent with the other state hospitals, at least 70% of individuals served have co-occurring substance abuse issues.

Recommendations

A. THE STATE MENTAL HEALTH HOSPITAL RESOURCE, AS PART OF THE ARRAY OF MENTAL HEALTH SERVICES, IS ESSENTIAL TO MEET CRITICAL NEEDS OF INCREASING NUMBERS OF KANSANS IN TIMES OF INTENSE CHALLENGE, AND TO HELP THEM ACHIEVE TIMELY AND DURABLE RECOVERY, BUILD RESILIENCE OF CHILDREN AND SUPPORT FAMILIES.

Rationale and Supporting Data

1. Mental Health Reform initiated an ongoing systemwide dialog regarding the appropriate number of state hospital beds that should be maintained, with the result being a major reduction in beds since 1991. From FY 1992 to FY 2002, the number of state hospital bed days used by community mental health centers (CMHCs) decreased from 145,030 to 21,640 – an 85% reduction.

   In addition to the dramatic reduction in available beds and bed days used, the average daily census for state mental health hospitals has steadily declined. The average daily census decreased from 1,283 in FY 1990 to 293 in FY 2003, a 77% reduction.

2. Also during this period, while considerable change has occurred in the use of remaining hospital beds – due to the natural impact of shifting access and demand (such as increased severity of presenting symptoms, increased co-occurring needs and criminal court involvement) and the *de facto* impact of funding reductions – no planned agreement has developed about how to determine the appropriate number of state hospital beds. <u>We now recommend that the right means for determining that appropriate number is one which is responsive to real-time consumer need and flexible to adjust to varying public mental health system needs.</u>

3. <u>The contemporary nature of service needs for people accessing our state hospitals are dramatically different from the stereotypical notions of institutional care.</u>

- State hospital services are needed to provide increasingly fast-paced, safe, secure, nimble, and technologically complex services for people with intense psychiatric illness. These services include:
  - Acute crisis and emergency care
  - Comprehensive diagnostic assessment
  - Comprehensive psychopharmacological treatment
  - Psychiatric rehabilitation
  - Specialized treatment when needed, for issues such as traumatic brain injury, severe violence, refractive psychiatric symptoms, fire setting, etc.
  - Skillful nursing and attendant care
  - Vocational and educational assessment and programming
  - Post-discharge planning for continued care and treatment in the community
- Increasingly, state hospital services are needed to provide complex services in a safe and secure environment for people who have multiple service needs. This includes people – both adults and youth – who are violent, people involved in criminal cases (forensic service needs), people with sex offending behaviors, people who have been victims of sexual abuse, and people with co-occurring disorders (substance abuse, developmental disabilities).

4. With admissions increasing at a rate of 10% and more per year, state hospitals have maintained an adequate supply of beds by working in effective collaboration with community mental health centers to shorten lengths of stay.

5. In state fiscal year 2003 the three existing state mental health hospitals were accessed for inpatient psychiatric care extensively:
   - 3,115 people were admitted to state mental health hospitals
   - 2,136 of those people were involuntarily committed
   - The average length of stay was 64 days (LSH), 63 days (OSH) and 24 days (RMHF)
   - The median length of stay was 14 days (LSH), 20 days (OSH) and 17 days (RMHF)
   - The average daily census was 91 (LSH), 168 (OSH) and 37 (RMHF)
   - There were 221 children and adolescent admissions

6. In contrast, inpatient psychiatric care provided just five years ago in state fiscal year 1998:
   - 1,859 people were admitted to state mental health hospitals
   - 1,295 of those people were involuntarily committed
   - The average length of stay was 116 (LSH), 100 (OSH) and 34 (RMHF)
   - The median length of stay was 18 (LSH), 29 (OSH) and 23 (RMHF)
   - The average daily census was 107 (LSH), 154 (OSH) and 36 (RMHF)
   - There were 261 children and adolescent admissions

7.
   - In state fiscal year 2002, the state hospitals provided 117,710 days of inpatient psychiatric service.
   - In state fiscal year 2003, the state hospitals provided 107,782 days of inpatient psychiatric service.

8. While the number of admissions to state hospitals has increased 67% (from 1,859 to 3,115) in the past five years, the average length of stay has decreased by 30% (at RMHF), 37% (at OSH) and 45% (at LSH). The median length of stay has decreased by 26% (at RMHF), 31% (at OSH) and 22% (at LSH). In addition, the recidivism rates (that proportion of people who are readmitted within 30 days of discharge) of our state mental health hospitals

for FY03, at 5.8% (RMHF), 7.9% (OSH) and 6.3% (LSH) were all below the national average of 9.3%.

9. State hospital services are an important part of the array of care for Kansans seeking mental health services. They should be – in fact and in perception – a viable and valuable, state of the science, functional, therapeutic, effective stop along the journey of recovery for each Kansan whose needs are addressed there. Because of the intensity and complexity of service needs that are addressed at state hospitals, they represent an important part of an integrated system of expertise and state of the science service delivery available to Kansans having acute care needs. During a psychiatric emergency, state hospitals are the safety net for patients without access to inpatient psychiatric services – because those services are not found in their community and/or because they are uninsured or unable to afford those services.

10. For approximately 50% of the people accessing state hospital services, this is their first experience with mental health services, and the hospital connects them as the "front door" to community mental health services. Accordingly, it is critical for these people that thorough assessment of current needs, historical information accounting, treatment planning, service provision and CMHC connection occurs at the state hospital.

11. Even while community-based screening processes connect people to community-based services when appropriate, and the number of bed days used at state hospitals has dramatically decreased, the number of people accessing state hospital services continues to increase, and the number of people with the most significant mental illness accessing community-based services continues to increase.

- In FY 2003, the 3,115 people screened by community mental health centers for admission to state mental health hospitals was only about one-third of the nearly 8,200 people seeking such admission. Across the year, up to 64% of adults and up to 70% of children were appropriately triaged and returned to least restrictive community-based services to meet their needs.
- The number of adults with serious and persistent mental illness accessing community based services increased 14% from FY 1999 (13,808 adults) to FY 2003 (15,699). Likewise, the number of youth with serious emotional disturbance accessing community based services increased 60% from FY 1999 (9,909 youth) to FY 2003 (15,811 youth).
- According to federal prevalence standards (designed to anticipate the number of adults and youth who may need to access public mental health services), nearly three-fourths of Kansans who may need such services are not yet accessing them. At this time, the Kansas public mental health system anticipates serving 27% of the potential population of people predicted to need services this year.

B. THE ROLE OF OUR STATE MENTAL HEALTH HOSPITALS IS CHANGING, VARIES FROM ONE HOSPITAL TO ANOTHER, AND REFLECTS UNIQUE COMMUNITY AND INDIVIDUAL NEEDS. ANY ADDITIONAL DECREASE IN STATE HOSPITAL SERVICES SHOULD OCCUR WITH BOTH (A) A CONSENSUS PLAN DEVELOPED WITH INPUT BY REPRESENTATIVES OF ALL STAKEHOLDERS IMPACTED BY SUCH A CHANGE AND (B) PRIOR OR CONCURRENT IMPLEMENTATION OF CAPACITY BUILDING STRATEGIES TO MEET THE NEEDS OF PEOPLE ACCESSING THE IMPACTED STATE HOSPITAL SERVICES.

Rationale and Supporting Data

1. State hospital services cannot be considered as a single type of service or a "one size fits all" service. The services they provide to any given person or community depend upon the needs of the person and the availability of community services. The services sought from the hospitals, as well as the communities referring people to the hospitals, are diverse. As part of the overall array of mental health services, the specific role and function of the state hospitals should be flexible, interactive with other system stakeholders, and responsive to changing needs.

2. Community mental health center screeners, who have front line knowledge about community dynamics (population turnover, crisis housing, transportation), service options (type and availability of community mental health service providers), short- or long-term service gaps, and the community's capacity for the person's dangerousness, must and do make the decision about the ability to meet the person's needs with community-based services or the need to access state hospital services.

3. Valid decisions about the role of state hospitals cannot be made without specifically factoring in these types of issues:

   - ❑ Demographics and geography of a given area
   - ❑ Nature of the person's current illness and acuity, as well as level of violence or dangerousness to self or others
   - ❑ Current capacity of the community to meet the person's needs
   - ❑ A service type or model that works well in one community may not be appropriate for another (such as urban/rural differences, economic status, cultural distinctions, availability of professional service practitioners)
   - ❑ The reality that before a service is eliminated, plans for service replacement must be clearly developed and implementation must be prior or simultaneous.

C. COMMUNITY-BASED SERVICES AND COMMUNITY PSYCHIATRIC INPATIENT SERVICES MUST BE SUPPORTED TO PREVENT FURTHER DISSOLUTION OF RESOURCES FOR PATIENTS NEAR THEIR HOMES.

Rationale and Supporting Data

1. The ability of communities – due to size, resources, rural nature, and otherwise – to meet crisis service needs of its members varies widely. Although psychiatric services at any level of intensity are more preferably provided in or near one's community, in reality that option does not always exist and alternative options must be available.

2.
   - ❑ In state fiscal year 2002, Medicaid-billed inpatient services provided by community psychiatric hospitals were provided for 22,950 days to 3,785 people.
   - ❑ In state fiscal year 2003, Medicaid-billed inpatient services provided by community psychiatric hospitals were provided for 25,820 days to 3,227 people.

3. Kansas continues to experience the closure of community inpatient psychiatric service settings. Just this fall, 2003, two additional community inpatient psychiatric service settings (at Lawrence Memorial Hospital and Overland Park Regional Medical Center) have closed, and in those two settings over 130 Kansans had accessed Medicaid-funded inpatient

psychiatric services during the prior year. The reimbursement system for state-funded inpatient psychiatric services provided outside of state hospitals should have a renewed assessment to determine if any adjustments can be made to more effectively support people in or near their communities. This should include specific examination of the Diagnostic Related Group (DRG) payment system, and should address ways to effectively support access to adequate funded service days for youth and others needing inpatient psychiatric care.

4. Children are more likely to be admitted to a state hospital if they are not known to their CMHC. Thus, additional outreach effort should be made to increase knowledge about and access to CMHC services for families having youth with mental health service needs. This includes enhanced partnership between community psychiatric hospitals and CMHCs to collaborate about youth with private insurance accessing inpatient psychiatric services.

5. CMHCs have developed crisis service plans and should be supported to continue to enhance and implement those plans. The committee strongly recommends that the state increase its application of meaningful and measurable performance standards connected to CMHC crisis service plans. The state should monitor to ensure that those plans are effectively identifying community gaps and needs, that the plans give particular attention to the needs of children/adolescents and service issues unique to them, and that CMHCs are accountably implementing their crisis service plans.

6. The use of new public/private partnerships to deliver acute care services should receive ongoing consideration consistent with the needs of specific areas.

    - Our neighbors to the east in Missouri have developed a public/private partnership to serve acute care needs of people who would otherwise have been admitted to a state mental health hospital in and around St. Joseph, Missouri. This service arrangement, known to some as the "St. Joseph model," serves only those patients who need acute care (no more than 30 days, and if more than 30 days are needed the person is transferred to a state hospital) and only those who are not sent in connection with a criminal case, in an 18-bed acute care unit of Heartland Health. Services are provided in accordance with a contract between the State of Missouri and Heartland.
    - Our neighbors to the north in Nebraska are working on a plan to create "a center for excellence" in Omaha by partnering with Nebraska's two medical schools to develop a facility that provides professional training, scientific research, crisis medical care and statewide outreach services for people experiencing mental illness.
    - The recommendations in the Report from the Rainbow Redesign Task Force concerning alternative service approaches at the Rainbow Mental Health Facility should be supported and implemented as soon as feasible. This includes such partnership elements as co-location of CMHC 24-hour services at RMHF; using RMHF as a site for Consumers As Providers internships; use of Consumer Run Organization staff to facilitate training for staff, patients, families; and use of RMHF to provide technical assistance to other Kansas communities to replicate aspects of a recovery and wellness center. Similarly, activities such as Larned State Hospital's hiring of consumer representatives to serve as patient advocates and represent consumer interests in programming decisions, as well as parent advocacy and mentoring activities, are commended and encouraged for further consideration.

7. Consideration should be given to making additional inpatient psychiatric services available in more regions of the state. The number of children up to age 12 served by state hospitals continues to decline. RMHF and LSH admitted only 81 children in FY 2003. The average daily census for the two children's programs combined in FY2003 was less than 9 children. This level of utilization for children's services is far below the current capacity of eighteen (18), and is a utilization level that can serve as a starting place for a regionalization model. We recommend that, without closing access to state hospital beds when needed, the state develop a regional model to deliver acute inpatient psychiatric services for children up to age 12 to be implemented in FY 2005.

D. WORK MUST CONTINUE TO ENSURE THAT OUR STATE MENTAL HEALTH HOSPITALS ARE CONTINUOUSLY EFFECTIVE AND FULLY INTEGRATED PARTS OF KANSAS' PUBLIC MENTAL HEALTH SYSTEM.

Rationale and Supporting Data

1. To help assure optimum and consistent performance by persons performing the screening role, the state should develop and implement a mandatory, standardized, statewide training curriculum for all screeners. The curriculum content should be refreshed periodically and include content on the core service principles and processes, the importance of collaborating with the family and local community service providers, and how to mobilize community-based alternatives to hospitalization. Particular care must be given to ensure good training and performance of screening decisions made regarding children/adolescents and screening decisions made during irregular hours.

2. In the absence of more state hospital services available geographically close to all areas of the state, the state should implement some mitigating measures to facilitate full treatment partnership and visitation by families of people accessing state hospital services. This may include financial assistance with phone conferencing, travel and lodging expenses (such as free housing for families slated to open at Larned State Hospital in December), toll-free phone access for families and friends, expanded video conferencing access in partnership with CMHCs, and family-friendly visitation environments and practices.

3. Because the CMHC liaison role is critical to effective discharge planning and implementation, the CMHCs and state hospitals should collaborate to ensure that the liaisons are involved at significant times, and support their active partnership with hospital staff. People filling that role should be skilled in effective partnership practices and collaborative working strategies; have ongoing solid working knowledge about community services – including those for children/adolescents and their families – and be able to facilitate access to them; and partner actively with community psychiatric, NFMH, foster care and other relevant service providers in their area to the fullest extent feasible.

4. Because both community services and state hospital services are critical elements of the overall mental health service array, training for key staff members involved in each system should be ongoing to ensure that there is good mutual understanding of state of the science service issues, community service availability, state hospital services, and the active connections between them. Shared values around core service issues – such as individualized wraparound service planning and implementation, recovery and wellness service focus, building the resilience of children and supporting families, etc – should be the subject of mutually-developed, dynamic, refreshed, ongoing, and accessible training.

Consideration should be given to the use of technology in sharing these training opportunities, and to including adults and youth accessing services as well as their families in this training both as teachers and learners.

5. Because the presence of people needing forensic services is increasing in number and complexity, the activities and recommendations of the Governor's Mental Health Services Planning Council Forensic Subcommittee should be supported and implemented. This includes a comprehensive study of the forensic population in Kansas' jails; a review of criminal mental health statutes and processes for evaluation and treatment; support the growth of the state mental health forensic program; and cross training between mental health/law enforcement/substance abuse systems and impacted families.

6. SRS should consider ways to help integrate the vision, direction, best practice and collaboration between state hospitals and community mental health providers. The SRS/Health Care Policy Mental Health Director should conduct ongoing interactive meetings with mental health system stakeholders to receive and respond to input about service issues and related data development, management, and system decision making.

LEADERSHIP TEAM CHARTER FOR:

The Future of State Mental Health Hospitals
PROJECT STEERING COMMITTEE

Requested by: SRS Health Care Policy
Date: April 2003

Charter Process: As a result of a request by the 2003 Legislature regarding issues related to serving individuals in the state hospital system, SRS Health Care Policy has convened this Project Steering Committee. Composed of a diverse group of system stakeholders, this team is designed for a specific purpose and a time certain. The product of this committee will be a report outlining recommendations and a template to guide current and future decisions about the future role of state hospitals. SRS/HCP will complete the final report after receiving recommendations and input through this process.

Team Purpose: To identify the role and function of state hospitals. The committee will develop a template or set of criteria that will guide current decisions, recommendations and action plans now and in the future.

Boundaries/Expectations

1. Where possible use existing data relative to the current status of state institutions
2. Work within exiting resources (people and dollars) relative to this committee process
3. Maintain focus on state institutions and their role as part of the mental health delivery system

Ground Rules

1. Decisions made by the committee will be based on a consensus-building model. In the event the committee cannot reach agreement by this method on recommendations, the committee will develop an alternative method of agreement.
2. If a committee member cannot attend a meeting, he or she will be given the opportunity to provide input prior to and following a scheduled meeting.
3. Committee work will be completed by the end of November 2003.
4. Committee members will assist in the management and communication of information by distributing information to constituents or other stakeholder populations

Tasks

1. Review data and information about the current role of the state hospitals within the mental health system as it relates to each key arena..
2. Use the following areas as areas of strategic focus in analyzing, reviewing data, and as a framework for making recommendations: Front end services; Services received while in the state hospital setting; Services received when exiting the hospital system..
3. Review current, and pertinent reports on aspects of the mental health system, including task force, consultant and committee recommendations. Identify recommendations in these reports that should be considered as the committee develops recommendations on the state hospital future.
4. Identify who is currently being served; what services are provided by state hospitals unique to that setting in each of the areas of strategic focus

5. Make recommendations relative to the role of state hospitals that are:
    a. Immediate
    b. Mid-range
    c. Long-range

(define the period of time for each)

6. Develop as part of the committee process, a method of ensuring ongoing stakeholder input.

Key Resources

1. Reports provided to the Project Committee from state task forces, Governor's Committees, and consultant reports.
2. Stakeholder input
3. 2003 legislative directives

Committee Members

Name	***Organization Representing***
Karen Ford Manza	NAMI Kansas
Jane Adams	KEYS for Networking
Wes Cole	Governor's Mental Health Svcs Planning Council
Judy Thompson	Sunshine Connections
Gary Parker	Governor's Mental Health Svcs Planning Council
Dr. Roy Menninger	Mental Health Coalition
Rocky Nichols	Kansas Advocacy & Protective Services
Anne Roberts	KVC Behavioral HealthCare
Mary Vilmer	Oakleaf
Chris Petr	University of Kansas-School of Social Welfare
Bruce Linhos	Children's Alliance
Laurie Loughry	Gatewood Care Center
Ron Denney	Four County Mental Health Center/CMHC Assn
Pete Zevenbergen	Wyandot Center for Comm. Beh. Healthcare, Inc.
Jim Karlan	Southwest Guidance Center
Mel Goering	Prairie View, Inc./CMHC Assn
Sanford E. Pomerantz, M.D.	Kansas Psychiatric Society
Julie DeJean	Stormont Vail Medical Center
Fred Zang	Shawnee Mission Medical Center
Maggie Rassette	Mercy Regional Health Center
Dr. Garry Porter	Via Christi Regional Medical Ctr
Dr. Brad Grinage	Univ.of Ks. School of Medicine-Dept of Psychiatry
Dr. Mark Schutter	Larned State Hospital
Don Jordan	Osawatomie State Hospital
Laura Howard	SRS/Health Care Policy
Kathy Harmon/Gary Harbison	SRS/Health Care Policy/Mental Health
Rick Shults	SRS/Health Care Policy/Management Operations

Charting the Future for State Mental Health Hospitals & Acute Care Resources

Project Steering Committee – Resource List

October 2003

The following is a list of resource items provided to project steering committee members for consideration as part of their work on this project:

Document	Date
Hospital Stakeholder Task Force Report	March 2001
Report from the Rainbow Re-Design Task Force	October 2002
Statewide Children's Hospital Committee Draft Interim Report Draft Report	 May 2003 September 2003
The President's New Freedom Commission on Mental Health – *Achieving the Promise: Transforming Mental Health Care in America* – Final Report	July 2003
Responsive Comments to "Achieving the Promise: ..." by the Bazelon Center, NAMI, NASMHPD and NMHA	July 2003
"*A Review and Analysis of the Future of Kansas State Mental Health Institutions*" Submitted by Garry A. Toerber, Ph.D.	July 2003
Special Report: *Medicaid Financing of State and County Psychiatric Hospitals*; U.S. Department of Health and Human Services; SAMHSA	Printed 2003
Draft of Governor's Mental Health Services Planning Council *Forensic Subcommittee Report*	September 2003
SRS Reports Distributed to Project Steering Committee	August 2003

~ FY03 service data pertaining to Larned State Hospital
~ FY03 service data pertaining to Osawatomie State Hospital
~ FY03 service data pertaining to Rainbow Mental Health Facility
~ "Mental Health Funding History" document which summarizes key funding facts for entire mental health system, from state fiscal year 1990 to state fiscal year 2004
~ "State Mental Health Hospitals: General Background/Information" document which compiles general agency information about each of the three state facilities
~ Information About Medicaid-Billed Services Under "Mental Diseases and Disorders" - FY02 (Revised/Corrected 10/03)
~ Information About Medicaid-Billed Services Under "Mental Diseases and Disorders" - FY03 (Revised/Corrected 10/03)