Topic: **Populations – maternal mental health**

Background on topic: The Special Committee discussed challenges related to behavioral health outcomes and services for several populations. Population-specific recommendations could be developed, or considerations for populations could be addressed, in other recommendations that would have a disproportionate effect on one or more of the noted populations.

Maternal Mental Health: Mental health conditions contributed to around 20% of Kansas' pregnancy-associated deaths in 2016-2018 (KMMRC). Maternal depression screening and treatment are critical preventive care tools.

Among Kansas women with a live birth in 2017-2019, the prevalence of self-reported postpartum depressive symptoms was 13.5%. Prevalence of not getting treatment or counseling for postpartum depression, despite a perceived need, as reported by Kansas women with a live birth in 2017-2018 was 15.2%. Reasons for not getting treatment or counseling include:

- It seemed too difficult or overwhelming (68.4%)
- Worried about the cost or could not afford it (56.9%)
- Did not have time because of a job, childcare, or another commitment (49.7%)
- Had trouble finding a provider she liked (22.2%)

A woman's physical and mental health, as well as the social conditions in which she lives, have a direct impact on the early and long-term health of her child. It has been found that children whose mothers are depressed while pregnant are at an increased risk for being born preterm and at a low birth weight, increasing the odds of developmental delays. Studies show that nurturing parent-child relationships and environments where the family's social needs are met, make it more likely that children will succeed in school and the workforce, and experience lower rates of chronic disease.

A KanCare Maternal Depression Screening policy became effective on January 1, 2021. The policy supports reimbursement for up to three screenings during the prenatal period under the mother's Medicaid ID and up to five screenings during the 12-month postpartum period under the child's Medicaid ID. This aligns with best-practice recommendations of routine screening until 12-months postpartum. However, **Medicaid cannot pay for for subsequent treatment, when indicated by a positive screening result,** under the child's Medicaid ID. A mother's Medicaid plan would cover her mental health treatment services, but Medicaid benefits for the Pregnant Women eligibility group currently terminate at 60-days postpartum.

Extension of Medicaid coverage from 60-days postpartum to 12-months postpartum would help reduce barriers to care while improving maternal health and child development. A postpartum coverage extension will provide for the continuity of care and resources that are central to a woman's physical and mental wellbeing following

pregnancy. Continued access to important services will impact health outcomes far beyond the postpartum period for both mother and child.

Further, a provision in the American Rescue Plan Act of 2021 gives states a new, streamlined option to extend Medicaid postpartum coverage to 12-months via a state plan amendment instead of the more cumbersome 1115 waiver process. This new option takes effect on April 1, 2022 and is available to states for five years. This topic is therefore extremely timely.

Supporting Materials:

- Rural Mental Health (Rural Health Information Hub)
- Disparities within Serious Mental Illness (AHRQ, 2016)
- SAMHSA Office of Behavioral Health Equity Learning Page
- Kansas Perinatal Behavioral Health Program: Screening, Referral and Treatment Support for Maternal Depression, Anxiety and Substance Use (KDHE, 2021)
- *2021 Governor's Behavioral Health Services Planning Council Veterans Subcommittee report (draft distributed in Sept. 28 Special Committee meeting)*

WORKSHEET:

1. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to one or more of the populations noted above.

   Extend the Medicaid postpartum coverage period to 12-months postpartum. This supports access to behavioral health treatment and other preventive care, thus improving health outcomes for both the mother and child.

2. Identify any research used to craft this recommendation.

   - Kansas Pregnancy Risk Assessment Monitoring System (PRAMS) Annual Reports (KDHE, 2017, 2018, 2019)
     - *Insights into Access to Treatment for Postpartum Depression – Kansas PRAMS 2017-2018*
   - *Kansas Maternal Morbidity & Mortality Report, 2020*
   - *Postpartum Support International Screening Recommendations*
   - *Medicaid Postpartum Coverage Extension Tracker*

3. Identify additional research or information needed to clarify or discuss this recommendation.

   A fiscal impact report of extending the Medicaid postpartum coverage period from 60-days to 12-months is needed.

4. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

   Medicaid
   - Sarah Fertig, State Medicaid Director

   Maternal Mental Health & Impact on Child Development
   - Rick Gaskill, CEO Sumner County Mental Health Center

   Maternal Mental Health Treatment
   - Melissa Hoffman, DNP, APRN, PMHNP-BC and current President of Postpartum Support International (PSI) Kansas Chapter
   - Erin Bider, MD – Perinatal Psychiatrist at University of Kansas Health System

5. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

   Medicaid State Plan Amendment; fiscal impact

Topic: **Access to Psychiatry Services/Workforce Investment Plan/Frontline Provider Capacity**

Background on topic: The 2020 report included recommendations to: 1) conduct a study to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses; 2) make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff; and 3) increase capacity of frontline healthcare providers to identify and provide services to those with behavioral health needs.

With rising behavioral health concerns across all population groups, and shortage of mental health professionals in Kansas, more individuals are seeking treatment in primary care, obstetric, and emergency department settings. One factor contributing to the gap between behavioral health disorder identification and service provision is the lack of growth in the workforce for psychiatrists, specifically child and adolescent and peripartum specialists. Often, primary care and obstetric practitioners are the first responders in behavioral health disorder identification and service provision. The training of pediatricians, family physicians, and obstetrician-gynecologists includes some education on evaluating and treatment of behavioral health conditions. However, their expertise is limited, and many do not feel confident, particularly in the evaluation and management of more complex clinical presentations.

To address this issue, psychiatric access programs are being implemented across the country. To date, 46 states have established pediatric psychiatry access programs and 25 states and organizations have established perinatal psychiatric access programs. Kansas currently receives federal grant funding that supports both a pediatric psychiatry program, KSKidsMAP, and a perinatal program, Kansas Connecting Communities (KCC). These programs build the capacity of frontline healthcare providers to address behavioral health concerns by providing:

- **Education**: Trainings and toolkits for practitioners and staff on evidence-based guidelines for screening, triage, and referral; risks and benefits of treatment; and discussion of screening results and treatment options.
- **Consultation**: Psychiatric consultation between a healthcare provider and the respective clinical grant team (KCC team includes a peripartum psychiatrist, and KSKidsMAP includes a child and adolescent psychiatrist, child and adolescent psychologist, pediatrician, and social worker).
- **Resource and referral support**: Linkages with community-based mental health resources including individual and group therapy, support groups, and other resources to support health and wellness.

These support services contribute to healthcare providers reporting increased knowledge, skills, and comfort to address behavioral health concerns, not only in the patients about whom they consult, but also in encounters with other patients in their own practices. By empowering healthcare practitioners to provide care in their own clinic while receiving treatment guidance and mentorship from highly trained professionals,

access to high quality evidence-based and trauma informed psychiatric care increases across the state. Further, psychiatric access programs, like KSKidsMAP and KCC, enhance integrated behavioral health care models, which have been shown to improve health outcomes and patient experience, while reducing unnecessary costs in time, money, and delays and stigma associated with accessing behavioral health treatment.

Federal funding for KSKidsMAP and KCC concludes in July and September 2023, respectively. **Kansas should leverage infrastructure developed through these grant programs to establish one statewide psychiatric access program.** The centralized access program should include highly trained specialty experts functioning as interdisciplinary teams and providing education, case consultation, and resource and referral services for primary healthcare providers. The expert team should include existing pediatric and perinatal professionals but also be expanded to address other identified workforce shortage and treatment service gaps, such as autism, intellectual and developmental disabilities, and adults with serious mental illness.

WORKSHEET:

1. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART)

   Fully fund a statewide psychiatric access program that includes linked specialty teams with high levels of expertise (e.g., psychiatrists, child and adolescent psychiatrists, peripartum psychiatrists, child psychologists, pediatricians, resource specialists, and patient and family advocates) to provide multi-disciplinary consultations to healthcare providers across the lifespan, including pediatrics and perinatal. Full program funding should be secured by July 2023.

2. Identify any research used to craft this recommendation.

   - Kansas Pediatric Mental Health Care Access Program, KSKidsMAP, draft project impact paper; included in the Children's Subcommittee Annual Report (p. 25-32)
   - *Addressing Perinatal Mental Health by Building Medical Provider Capacity Through Perinatal Psychiatry Access Programs*
   - Integrated Behavioral Health Care
   - KSKidsMAP
   - Kansas Connecting Communities (KCC)

3. Identify additional research or information needed to clarify or discuss this recommendation.

   N/A

4. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

- Dr. Rachel Brown, Board-Certified Child & Adolescent Psychiatrist; KSKidsMAP
- Dr. Kari Harris, Board-Certified Pediatrician; KSKidsMAP Medical Director
- Dr. Erin Bider, Peripartum Psychiatrist; Kansas Connecting Communities (KCC)

5. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

Funding

MHMR – Services and Workforce Working Group For the Meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Trauma-Informed Care**

Background on topic: The Special Committee discussed the importance of trauma-informed care and strategies to prevent trauma and adverse childhood experiences.

Supporting Materials:

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)
- 10 Key Ingredients for Trauma-Informed Care (Center for Health Care Strategies, 2017)
- State of Kansas Child Maltreatment Prevention Plan, 2019-2023

WORKSHEET:

1. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to trauma or trauma-informed care.
   First, determine the desired level or intervention of trauma informed care practice. There are EBP for the treatment of trauma within children and adults and there are models for addressing organizational trauma within staff. These are not mutually exclusive but potentially require different approaches and different levels of buy-in. I recommend the organizational focus as that sets the tone and the culture under which specific practices occur.
   Launch pilot projects with select behavioral health providers to increase their understanding and adoption of trauma informed practices. Take the lessons learned from these pilots and conduct a feasibility study as to the strategies needed to take it state-wide.

2. Identify any research used to craft this recommendation.
   The public sector social service industry is seeing an unprecedented number of people leave and go to private practice. If we hope to retain staff, we have to do a better job of addressing their secondary trauma and burnout.

3. Identify additional research or information needed to clarify or discuss this recommendation.
   It would be helpful to know what other states have done to incentivize provider adoption of trauma informed practices. The workgroup would need to be very clear on what the desired outcome is.

4. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

It would be important to invite agencies to the discussion who have adopted these practices at an organizational level. They could share what the benefits and challenges have been.

5. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?
   Funding for pilot projects which would either come through legislative action or current state budgets. Technical assistance from the federal government or other entity would be helpful.

MHMR – Services and Workforce Working Group For the Meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Social Isolation**

Background on topic: The Special Committee discussed social isolation, particularly as experienced by older adults, people of color, and rural residents, both before and during the pandemic.

Supporting Materials:

- Loneliness and Social Isolation Linked to Serious Health Conditions (CDC, 2021)
- Disrupting Disparities in Kansas: A Review of Social Isolation Among Older Adults (KHI, 2020) and the related Social Isolation in the Time of COVID-19

WORKSHEET:

1. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to social isolation.

   Treat social isolation similar to other public health issues. Create strategies to disseminate the importance of social isolation on health through public service announcements (with suggestions on where to go), educate providers on this issue and encourage adoption of a screening tool. For each group, identify primary places that are frequented and target strategies for each. For example, if older adults tend to seek out medical care, run data to see which providers tend to see the most older people and target those providers. If people of color tend to visit a local community center, provide education seminars (with food provided) in their native language.

2. Identify any research used to craft this recommendation.

   The populations listed here are broad and the reasons for the isolation are varied. Many of the solutions will be individualized but starts with an identification of the problem and creating a sense of urgency about it.

3. Identify additional research or information needed to clarify or discuss this recommendation.

   Inclusion of the people we are trying to help will be critical. Selecting 1 or 2 priority populations as a start will be important.

4. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

   Agencies who already have these groups as their target population.

5. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

Likely legislative action. A lead agency would have to identified.

MHMR – Services and Workforce Working Group For the Meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Strategies to Address Stigma**

Background on topic: The Special Committee raised the issue of stigma related to mental illness and its impact on access to behavioral health services.

Supporting Materials:

- Stigma, Prejudice and Discrimination Against People with Mental Illness (American Psychiatric Association, 2020)
- Reducing Stigma (in relation to COVID-19; CDC, 2021)

WORKSHEET:

1. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to strategies to address stigma.
   Normalize mental health care by reducing barriers for the uninsured to receive care. Mental Health care in Kansas should be easy to get, low cost and located near one's home or work.
   Publicize help lines-encourage people to get help before they are suicidal or in crisis.
   Increase access to therapy and medications for the uninsured.
   Find success stories and promote them publicly.

2. Identify any research used to craft this recommendation.

   It is difficult to find low cost therapy for people, even when you work in the field. The help lines we promote tend to focus on those who are suicidal or in crisis. We need to encourage people to get help before they are at that stage.

3. Identify additional research or information needed to clarify or discuss this recommendation.

   An environmental scan needs to be conducted to identify where are greatest gaps are and identify strategies to address those first. Those strategies should distinguish between rural and urban settings.

4. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.
   Recipients of services, providers of services who can speak to gaps in their area

5. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

   A study would need to be funded by the legislature or by a department within existing resources.

MHMR – Services and Workforce Working Group For the Meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Suicide Prevention (Added Focus for Rural/Other Populations)**

Background on topic: The 2020 report of the working groups of the Special Committee on Mental Health Modernization and Reform included two recommendations related to suicide prevention. The 2021 Special Committee indicated a special interest in suicide prevention in rural communities, as well as among people of color.

Supporting Materials:

- The State of State, Territorial, and Tribal Suicide Prevention (CDC, 2021)
- Preventing Suicide: A Technical Package of Policy, Programs and Practices (CDC, 2017)
- Kansas Suicide Prevention Plan, 2021-2025
- Urban-Rural Differences in Suicide Rates and Leading Means in Kansas (KHI, 2021) and the related Rural Suicide Rates are Rising in Kansas and Solutions Won't Come Easy (High Plains Public Radio, 2021)

WORKSHEET:

1. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to suicide prevention.
   Invest in substance use disorder treatment. The intersection between substance use and suicide is clear yet the investment for SUD services remains low in comparison to mental health.
   Conduct a Kansas SUD needs assessment to determine the extent of the gap. Identify a source to provide for sustainable funding to address this gap.
   Work to remove the current regulatory barriers to providing integrated MH and SUD care.

2. Identify any research used to craft this recommendation.
   Data shows that at least 20% of all suicides are completed by someone with an alcohol or drug problem.

3. Identify additional research or information needed to clarify or discuss this recommendation.
   It would be helpful to know what other states have done to successfully address this gap.

4. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.
   Providers of SUD and MH and recipients of services and the barriers they face.

5. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

Improving the SUD service delivery in Kansas has to become a priority by the legislature, KDADS and KDHE. A source of sustainable funding needs to be found such as the Problem Gambling and Addiction Fund. The co-morbidity of problem gambling and suicide is also well known.

MHMR – Services and Workforce Working Group For the Meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Trauma-Informed Care**

Background on topic: The Special Committee discussed the importance of trauma-informed care and strategies to prevent trauma and adverse childhood experiences.

Supporting Materials:

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)
- 10 Key Ingredients for Trauma-Informed Care (Center for Health Care Strategies, 2017)
- State of Kansas Child Maltreatment Prevention Plan, 2019-2023

WORKSHEET:

6. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to trauma or trauma-informed care.

   S: All KDADS funded agencies will train all staff in the basics of TIF – KDADS can work collaboratively with CMHC's or utilize curriculum from SAMHSA to disseminate to the funded agencies. Training upon hire and annual updates
   M: Annual Reporting of compliance – # trained versus # employed. Goal of 90% compliance
   A: All social services and licensed agencies have required trainings so adding one as important as this is achievable.
   R: The number of people how have experienced trauma or who have a high ACES score is astronomical for those receiving mental health or substance abuse tx, those incarcerated, those placed in foster care. This awareness and trauma sensitivity is vital
   T: Within 30-60 days of hire + annual refresher. Implement in FY 2023 or before

7. Identify any research used to craft this recommendation.
   The 3 articles already attached would support this plus:
   https://www.cdc.gov/violenceprevention/aces/index.html
   https://en.wikipedia.org/wiki/Adverse_childhood_experiences
   https://www.acf.hhs.gov/trauma-toolkit

8. Identify additional research or information needed to clarify or discuss this recommendation.

   Nothing more to add

9. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

   Nothing more to add – CDC, SAMHSA

10. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)

    Contract revision

MHMR – Services and Workforce Working Group For the Meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Social Isolation**

Background on topic: The Special Committee discussed social isolation, particularly as experienced by older adults, people of color, and rural residents, both before and during the pandemic.

Supporting Materials:

- Loneliness and Social Isolation Linked to Serious Health Conditions (CDC, 2021)
- Disrupting Disparities in Kansas: A Review of Social Isolation Among Older Adults (KHI, 2020) and the related Social Isolation in the Time of COVID-19

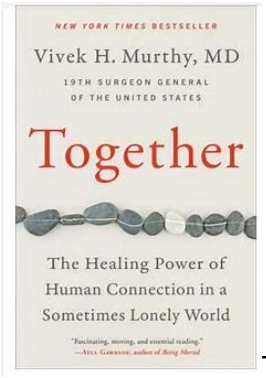
WORKSHEET:

6. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to social isolation.
   S: We have to have open conversations about loneliness and its impact on physical health, mental health and the potential for suicide. This needs to be community wide. Perhaps look at social media/media campaign to address.
   M: Because so global, hard to measure and yet the more we can get this out in the public, the more likely we will see less tragedy, perhaps unemployment will go down as people will leave their homes and go back to work
   A: Increasing awareness via mass media should be achievable – what we will no know for sure is how many people we impact
   R: We know loneliness and isolation creates health issues and given the extreme exposure to loneliness and isolation we ALL faced and MANY still face, tackling this in some way is a must
   T: We need to start now – this is a growing problem and without intervention and education this will not heal itself

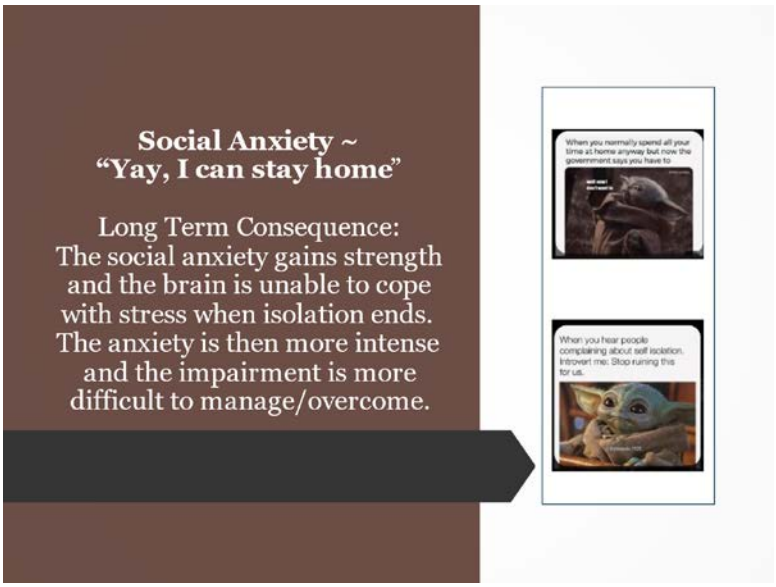
7. Identify any research used to craft this recommendation.

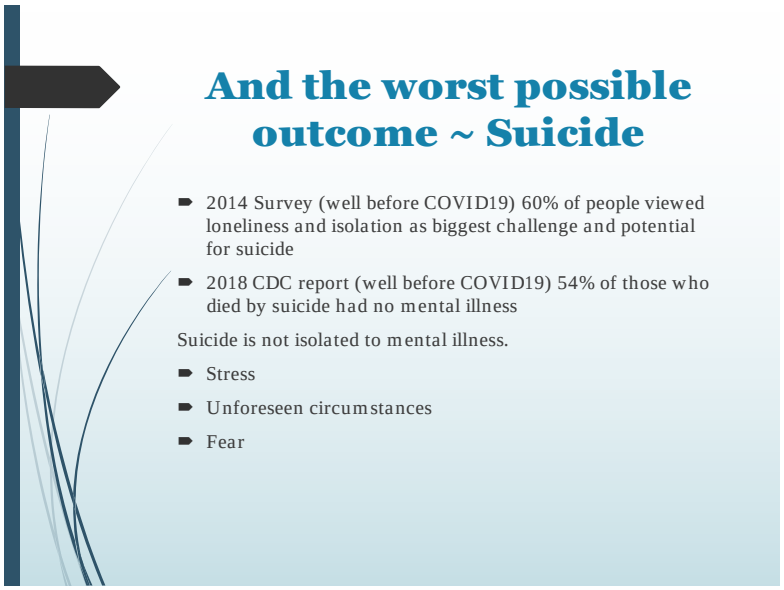
   Articles above already mentioned plus:
   Research studies and personal stories outlined in Dr. Murthy's book <see below>
   https://pubmed.ncbi.nlm.nih.gov/34256632/
   https://www.psychologytoday.com/us/blog/the-fallible-mind/202010/5-types-loneliness-during-the-covid-pandemic
   https://www.cnn.com/2021/04/17/us/loneliness-epidemic-covid-wellness-trnd/index.html

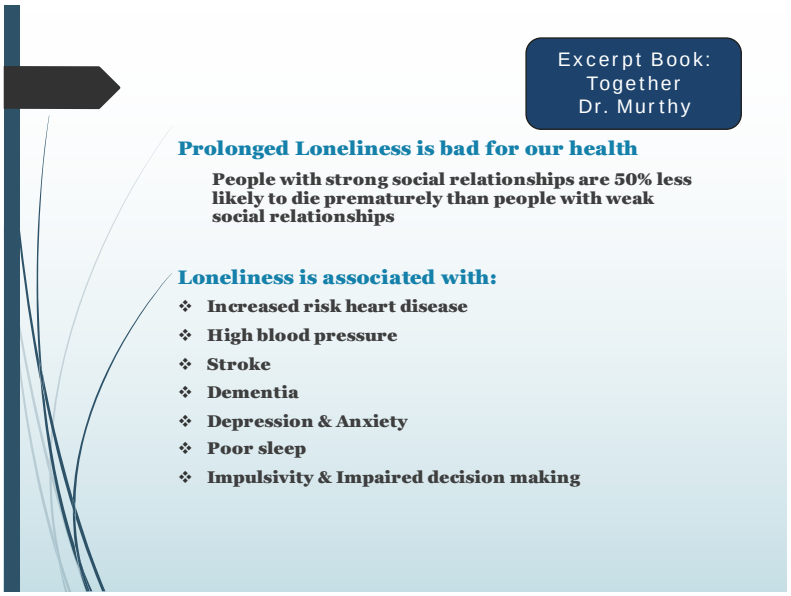
8. Identify additional research or information needed to clarify or discuss this recommendation.

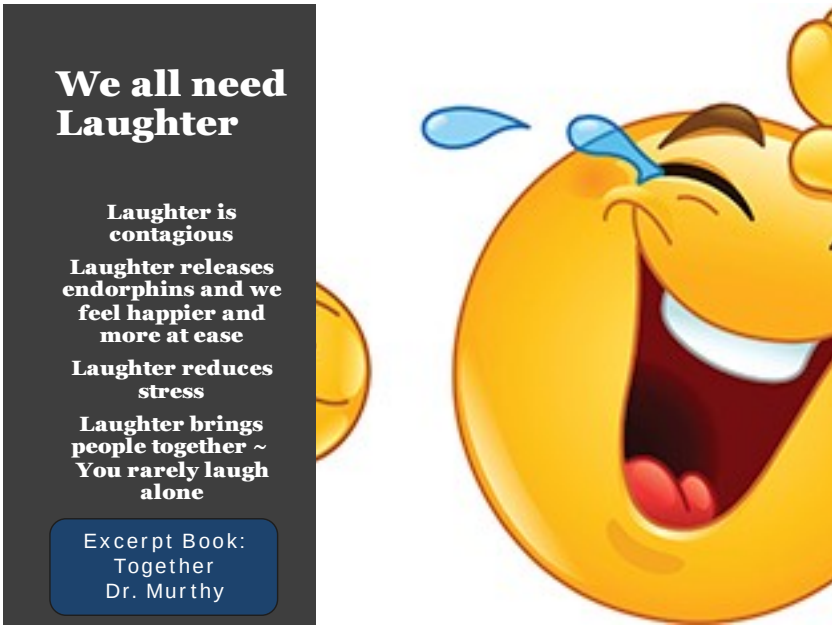


This book by Dr Vivek Murthy, our current (and a former) US Surgeon General was written pre-COVID and release right at the onset of COVID. It is so pertinent to what has been faced by so many with COVID. The loneliness and isolation was life altering to the point that some people continue the isolation that COVID created. At times, I wonder if some people we will ever become social again.




And the worst possible outcome ~ Suicide
2014 Survey (well before COVID19) 60% of people viewed loneliness and isolation as biggest challenge and potential for suicide
2018 CDC report (well before COVID19) 54% of those who died by suicide had no mental illness
Suicide is not isolated to mental illness.
Stress
Unforeseen circumstances
Fear


Excerpt Book: Together Dr. Murthy
Prolonged Loneliness is bad for our health
People with strong social relationships are 50% less likely to die prematurely than people with weak social relationships
Loneliness is associated with:
Increased risk heart disease
High blood pressure
Stroke
Dementia
Depression & Anxiety
Poor sleep
Impulsivity & Impaired decision making



9. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

   Nothing to add at this time

10. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

    Grants – if there are COVID dollars still available, put our RFP to give dollars to tackle this issue in all 105 Counties.

MHMR – Services and Workforce Working Group For the meeting of Nov. 3, 2021
New Recommendation Worksheet

Topic: **Strategies to Address Stigma**

Background on topic: The Special Committee raised the issue of stigma related to mental illness and its impact on access to behavioral health services.

Supporting Materials:

- Stigma, Prejudice and Discrimination Against People with Mental Illness (American Psychiatric Association, 2020)
- Reducing Stigma (in relation to COVID-19; CDC, 2021)

WORKSHEET:

6. Suggest a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) recommendation related to strategies to address stigma.

   S: Just talk about mental health. Honestly, in my opinion, every time we use the words Stigma and Mental Health together we promote this. I cringe when I am asked to address this and simply say "Let's talk about Health. Let's talk about Behavioral and Mental Health" and not even bring up the word stigma. This seems to better open the door to conversation. If we continue to say this topic is stigmatizing it reinforces it.

   With all the MHIS work we are doing, we are creating a generation that will be ok talking about their mental health, of being ok that their peers "saw them go in the room with the mental health provider" and of being comfortable asking for and receiving help. For them it is not stigmatizing so we have to quit using this term.

   We need to talk as freely about mental health as we do about physical health. For some, having a physical illness creates shame or stigma and we don't preface those open discussions with the use of the word "stigma"

   The Center for Workplace Mental Health suggests organizations strive to **"create a culture in which mention of depression, anxiety, post-trauma, and other common illnesses become as mentionable as diabetes, hypertension, and migraines."**
   https://www.psychiatry.org/patients-families/stigma-and-discrimination

   Or what would happen if we stopped separating mental health from physical health? Maybe great things ! Dr. Brown said on 10/28 that they are just so close.

   I am unsure at this time how to formulate **M A R T**

7. Identify any research used to craft this recommendation.

Focusing on the term “health” versus “illness” is less stigmatizing and suggests learning about and promoting health versus discussing illness. Rarely do people want to talk about any illness they have (physical or mental) – it stirs or negative emotions.

> **Mental health** is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.[1]
>
> **Mental illness** is a recognized, medically diagnosable illness that results in the significant impairment of an individual’s cognitive, affective or relational abilities. Mental disorders result from biological, developmental and/or psychosocial factors and can be managed using approaches comparable to those applied to physical disease (i.e., prevention, diagnosis, treatment and rehabilitation).[2]

8. Identify additional research or information needed to clarify or discuss this recommendation.

   http://wmhp.cmhaontario.ca/workplace-mental-health-core-concepts-issues/what-is-mental-health-and-mental-illness

9. Indicate people or groups (i.e., supplemental experts) who could discuss this recommendation.

   Nothing more to add

10. What kind of action or resources would be necessary to implement the recommendation (see rubric on last page)?

    Unsure