

Report of the Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature

CHAIRPERSON: Representative Brenda Landwehr

VICE-CHAIRPERSON: Senator Carolyn McGinn

OTHER MEMBERS: Senators Larry Alley, Dan Kerschen, Pat Pettey, and Mary Jo Taylor; Representatives Tory Marie Arnberger, Barbara Ballard, Elizabeth Bishop, Will Carpenter, Megan Lynn, Adam Smith, and Rui Xu

STUDY TOPIC

The Committee is directed to analyze the state's behavioral health system to ensure that both inpatient and outpatient services are accessible in communities, review the capacity of current behavioral health workforce, study the availability and capacity of crisis centers and substance abuse facilities, assess the impact of recent changes to state policies on the treatment of individuals with behavioral health needs; and make recommendations on steps needed to make Kansas a nationwide leader on behavioral health delivery, specifically focusing on how Kansas should modernize its behavioral health delivery system. The Committee shall solicit input from the following:

- A Judicial Branch Court Services Officer recommended by the Chief Justice of the Supreme Court of Kansas;
- A representative recommended by the Commissioner of Education;
- A Kansas Department for Health and Environment cabinet official recommended by the Governor;
- One sheriff and one chief of police recommended by the Attorney General;

- A Children’s Alliance of Kansas representative;
- A Kansas Association of Addiction Professionals drug and alcohol addiction treatment provider;
- An Association of Community Mental Health Centers of Kansas representative with clinical or medical expertise;
- A Kansas Hospital Association representative with clinical or medical expertise;
- A person with lived experience with mental illness or who has provided assistance to an individual living with a mental illness recommended by the Speaker of the House of Representatives;
- A parent of a child with a mental illness recommended by the President of the Senate;
- A former or current superintendent of a Kansas state mental health hospital;
- A current executive director of a community mental health center recommended by the Association of Community Mental Health Centers of Kansas;
- A health insurance company representative recommended by the Commissioner of Insurance;
- A Kansas County and District Attorneys Association representative;
- A Kansas Health Information Network representative;
- The Medicaid Director for the State of Kansas; and
- The Chairperson of the Governor’s Behavioral Health Services Planning Council.

Special Committee on Kansas Mental Health Modernization and Reform

REPORT

Conclusions and Recommendations

The Special Committee on Kansas Mental Health Modernization and Reforms responded to its charge, meeting at both the committee level and with its members participating in a unique charter relationship with three working groups, a subcommittee, and facilitation support. The Committee submits its own comments and recommendations and includes the report of the working groups and subcommittee, as ratified by the Committee, for consideration by the 2021 Legislature.

Opportunities for Coordination and Collaboration

The Committee recognizes the important recent and ongoing work of commissions, committees, councils, groups, and task forces focused on issues, ideas, and improvements that impact the behavioral health system, its capacity and workforce, and its financing and sustainability. The Committee acknowledges the connections and opportunities to collaborate on common goals and interests associated with the interim work of the Kansas Criminal Justice Reform Commission (KCJRC), the Special Committee on Foster Care Oversight, and the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight. The Committee highlights two areas where coordination and meaningful collaboration occurs – in specialty courts (with the KCJRC) and integrated care (with the Bethell Joint Committee).

- The Committee submits for the record the crosswalk of recommendations serving as the foundation for the review of its three working groups that detailed the relevant recommendations and study considerations submitted by the Child Welfare System Task Force (2017 preliminary, 2018 final reports); the Crossover Youth Working Group (2019 report); the Governor’s Behavioral Health Planning Council and its subcommittees (2018, 2019 reports); the Governor’s Substance Use Disorder Task Force (2018 report); and the Kansas Mental Health Task Force (2018, 2019 reports) ([Appendix pages 6-21](#)).

Contemporary Issues - COVID-19 and Behavioral Health

The discussions of this Committee and its working groups occurred amidst the COVID-19 pandemic. While it is too soon to draw conclusions about the lasting impacts on the behavioral health system in Kansas, the Committee requests state agencies, members of the working group, and the Kansas Legislature continue to assess, monitor, and report on these impacts. The Committee notes early indicators of impressions on the system include suicide rates and prevention efforts, temporarily enhanced reimbursement rates, and significant changes in the accessibility and use of telehealth.

Data as a Decision-Making Tool for Modernization and Reform

The Committee notes the identification of a variety of data sources in the working group report and its committee process and strongly encourages clear, connected data systems and quality reporting to provide decision-makers across the system with measurable and easily tracked results. This will prove essential for the next steps toward implementation and provide measurable outcomes to drive decision-making, particularly for the evaluation of the data reported and financing of system goals and programming.

Distribution of Committee Report

Given the breadth and complexity of the topics associated with mental health and transformation of the system, its capacity and workforce, the policy and treatments options and outcomes for individual's with behavioral health needs, and the sustainability and finance for the delivery of behavioral health services and resources, the Committee requests its complete report be transmitted to the following standing and joint committees of the Kansas Legislature: Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, House Committee on Children and Seniors, House Committee on Corrections and Juvenile Justice, House Committee on Health and Human Services, House Committee on K-12 Education Budget, House Committee on Social Services Budget, Senate Committee on Judiciary, Senate Committee on Public Health and Welfare, and Senate Committee on Ways and Means (agency subcommittees).

- The Committee requests the staff of the Kansas Legislative Research Department compile a new crosswalk to reflect the adopted Committee working group recommendations and the recommendations of other interim groups issuing relevant considerations and recommendations during the 2020 Interim.

Recognition of Participants and Expert Information

The Committee acknowledges and appreciates the unique structure and support needed to conduct its broad review of mental health modernization and reform in Kansas and meet and exceed the charge issued by the Legislative Coordinating Council (LCC). The Committee especially recognizes the support of its Committee staff from the Kansas Legislative Research Department and the Office of the Revisor of Statutes and the working group facilitation support provided by the Kansas Health Institute.

- The Committee commends the work of the roundtable participants and their contributions not only to the work of the Committee, but also to the information, direction, expertise, and passion to the review and formulation of recommendations of the individual working groups.
- The Committee further recognizes meetings occurred under COVID-19 conditions; the public was asked to access its meetings and those of the working groups through audio or video stream.

The Committee encourages all the above entities to continue this spirit of collaboration and welcomes participation and information on these important topics and issues.

Request to Legislative Leaders

The Committee requests the LCC and the Legislature consider formation of a formal standing or joint committee to consider, address, and continue with the effort to address the longer-term goals and strategies incorporated in both this Committee and the adopted working groups' reports. The Committee recognizes that additional time is needed to continue not only this significant discussion but to work towards implementation strategies and longer-term system direction and transformation. The Committee also recommends leadership from each of the identified committees receiving the report commit to planning and discussion on this report and more formal assignment of topics and individual recommendations and priorities for review and consideration by the individual committees.

Strategic Framework for Modernizing the Kansas Behavioral Health System: Working Groups Report to the Special Committee ([Appendix pages 24-115](#))

At its December 11, 2020, meeting, the Committee ratified the Strategic Framework for Modernizing the Kansas Behavioral Health System document, as amended by the Committee, that was created by the working groups and facilitated by the Kansas Health Institute. The Strategic Framework contains 45 high-priority recommendations over a variety of behavioral health topics, categorized for immediate action and strategic importance. Additionally, one separate topic was separately identified as a high-priority item for Committee discussion.

The recommendations were organized by working group and assigned topics within each working group. [Note: Immediate action refers to those recommendations that the working groups believe can be completed in the next two years. Strategic importance refers to those recommendations that should be initiated in the near term but will be completed in the longer term.]

Proposed Legislation: None.

BACKGROUND

The Special Committee on Kansas Mental Health Modernization and Reform (Committee) was created by the Legislative Coordinating Council (LCC) to study the state's behavioral health system and focus on how Kansas can modernize its behavioral health system.

The LCC directed the Committee to study the following topics:

- Analyze the state's behavioral health system to ensure that both inpatient and outpatient services are accessible in communities;
- Review the capacity of current behavioral health workforce;

- Study the availability and capacity of crisis centers and substance abuse facilities;
- Assess the impact of recent changes to state policies on the treatment of individuals with behavioral health needs; and
- Make recommendations on steps needed to make Kansas a nationwide leader on behavioral health delivery, specifically focusing on how Kansas should modernize its behavioral health delivery system.

In addition to the appointed legislative members, the LCC established the following roundtable members and appointing authorities for the Committee to solicit information from:

- A Judicial Branch Court Services Officer recommended by the Chief Justice of the Supreme Court;
 - A representative recommended by the Commissioner of Education;
 - A Kansas Department for Health and Environment cabinet official recommended by the Governor;
 - One sheriff and one chief of police recommended by the Attorney General;
 - A Children's Alliance of Kansas representative;
 - A Kansas Association of Addiction Professionals drug and alcohol addiction treatment provider;
 - An Association of Community Mental Health Centers of Kansas representative with clinical or medical expertise;
 - A Kansas Hospital Association representative with clinical or medical expertise;
 - A person with lived experience with mental illness or who has provided assistance to an individual living with a mental illness recommended by the Speaker of the House of Representatives;
 - A parent of a child with a mental illness recommended by the President of the Senate;
 - A former or current superintendent of a Kansas state mental health hospital;
 - A current Executive Director of a community mental health center recommended by the Association of Community Mental Health Centers of Kansas;
 - A health insurance company representative recommended by the Commissioner of Insurance;
 - A Kansas County and District Attorneys Association representative;
 - A Kansas Health Information Network representative;
 - The Medicaid Director for the State of Kansas; and
 - The Chairperson of the Governor's Behavioral Health Services Planning Council.
- A list of appointed roundtable members can be found on [Appendix pages 108-109](#).
- At the initial meeting of the Committee, it was determined that working groups, consisting of roundtable members and other subject matter experts, would be essential to accomplish the directives for the Committee from the LCC.

STRUCTURE AND ORGANIZATION

Crosswalk. The Kansas Legislative Research Department (KLRD) provided a crosswalk of behavioral health recommendations from five groups, task forces, and committees: the Child Welfare System Task Force, the Governor's Behavioral Health Services Planning Council, the Governor's Substance Use Disorder Task Force, the Mental Health Task Force, and the Crossover Youth Working Group. Recommendations were separated into nine topic areas, with three topic areas assigned to each working group ([Appendix pages 6-21](#)).

The crosswalk served as the baseline for the Committee and working groups to assess prior recommendations and to discuss updating, amending, or creating recommendations based on actions taken to prioritize strategies and implementation of the recommendations.

Working Group Charter

At its August 28, 2020, meeting, the Committee approved the Working Group Charter (Charter), as developed by the Kansas Health Institute (KHI) in consultation with KLRD and the Office of the Revisor of Statutes ([Appendix pages 22-23](#)). The Charter included the establishment of three working groups, which were created to “achieve the directive by the LCC to the Committee.” Pursuant to the Charter, the Committee is to determine what information from the working groups is to be included in the final product (committee report) and provide leadership to the working groups through the development of guiding vision statements for the final product, identification of key performance indicators to be included in the final product, and input on any criteria that should inform the priorities put forward by the working groups. The Charter outlined the operational process for the working groups and the membership roles of the working groups. All membership in the working groups was voluntary.

Working Group Organization

As the Committee began its planning and organization for meetings, legislators requested the KHI to assist with Committee discussion and recommendations and to facilitate working groups made up of relevant stakeholders and subject matter experts. These working groups reviewed prior recommendations from the groups listed in the KLRD crosswalk.

The primary areas of focus for each of the working groups were:

- **Finance and Sustainability working group (WG1):** The focus of this group was the picture of resources available both monetarily and human. The group examined models and forms of resources that can affect behavioral resources. The related topic areas were workforce, funding and accessibility, and community engagement.
- **Policy and Treatment working group (WG2):** This group looked at how the system can be more effective and what changes might be made. The related topic

areas were prevention and education, treatment and recovery, and special populations.

- **System Capacity and Transformation working group (WG3):** This group considered what the system could look like in the future. The related topic areas were data systems, interactions with the legal system and law enforcement, and system transformation.

Due to social distancing requirements and for public safety during the COVID-19 pandemic, KHI facilitated all working group meetings *via* Zoom. The working groups met twice during the months of September, October, and November and once each during the month of December. Working group members consisted of Committee members, roundtable members, and other relevant subject matter experts that were requested to provide input on individual topics. The working groups selected chairpersons and vice-chairpersons and designated reporters to discuss their work at Committee meetings.

Based on Committee discussion, the Committee decided to create a Telehealth subgroup at its October 30, 2020, meeting that met twice during November. A list of working group members can be found on [Appendix pages 108-111](#).

The working groups reviewed previous recommendations by the Governor’s Substance Use Disorder Task Force, the Governor’s Behavioral Health Services Planning Council, the Crossover Youth Working Group, the Mental Health Task Force, and the Child Welfare System Task Force, utilizing the KLRD crosswalk as its baseline. KHI staff assisted working group members with reviewing and determining whether these previous recommendations should be altered, amended, or removed from consideration. Working group members also proposed new recommendations based on relevant discussion and areas of need that were missing in the previous reports. The working groups then prioritized each recommendation based on ease of implementation and potential for high impact. Based on these measurements, the working groups finalized recommendations by designating

recommendations either for immediate action, those that the working groups believe could be completed in the next two years, or for strategic importance, those that should be initiated in the near term but will be completed in the long term. All recommendations were based on a consensus-based system to allow for the creation of strong recommendations. Below are representative illustrations of two working group recommendations (the former identified as a recommendation for immediate action and the latter is a recommendation of strategic importance):

- **Recommendation 1.3: Provider MAT Training.** Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT. [WG1: Workforce]
- **Recommendation 5.2: Service Array.** Explore options to expand the behavioral health service array, including the expansion of MAT in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured. [WG2: Treatment and Recovery]

The final working group report also includes rationale for the recommendations based on working group discussion. Additionally, each recommendation includes the scoring by the working groups passed on ease of implementation and potential for high impact. Metrics for measuring impact of the recommendation, action leads, and key collaborators are listed for each recommendation. Working group meetings prior to October 12, 2020, may be watched *via* the KHI Youtube channel: <https://www.youtube.com/user/KSHealthInstitute/featured>. All working group meetings after October 12, 2020, are archived on the Legislature's YouTube channel: <https://www.youtube.com/c/KSLegislatureLIVE/videos>.

Strategic Framework for Modernizing the Kansas Behavioral Health System **(Appendix pages 24-115)**

KHI facilitated the creation of the Strategic Framework for Modernizing the Kansas Behavioral Health System (Strategic Framework), the final work product developed by the working groups. Based on the overall work of all three working groups, KHI compiled a draft report that each working group was able to review and make additions or edits to in the December working group meetings.

At the December 10, 2020, Committee meeting, KHI staff presented the Strategic Framework to the Committee. The Committee reviewed the Strategic Framework and recommended additional edits after discussion. At the December 11, 2020, Committee meeting, edits were formalized, and the Strategic Framework was approved, as amended, by the Committee, and staff was directed to attach the Strategic Framework to the Committee report. A list of the edits that were made and approved by the Committee can be found in [Appendix pages 116-124](#).

Definitions. The Strategic Framework adopted the following definition of “Behavioral health system” from the federal Substance Abuse and Mental Health Services Administration (SAMHSA): refers to the system of care that includes the promotion of mental health, resilience and well-being; the prevention, referral, diagnosis, and treatment of mental and substance use disorders; and the support of persons with lived experience in recovery from these conditions, along with their families and communities. See [Appendix pages 2-5](#) for more definitions and an acronym key of common terms in the behavioral health field and in the KLRD crosswalk.

COMMITTEE ACTIVITIES

The LCC approved six meeting days for the Committee. The Committee met on August 27-28,

October 5, October 30, and December 10-11, 2020. The Committee members met in-person with the option for Zoom attendance due to social distancing measures and public safety during the COVID-19 pandemic.

Additional details regarding each of the Committee meetings, minutes, audio recordings, Committee handouts, and written testimony submitted by conferees may be accessed on the Legislature's website on the Committee webpage: http://kslegislature.org/li/b2019_20/committees/ctte_spc_2020_ks_mental_health_modern_1/.

August 27-28, 2020, Meeting

August 27

Informational Briefings on Previous Committees and Task Forces

Representatives from the previous task forces and committees designated in the KLRD crosswalk provided testimony regarding the action and implementation process of their group's previous recommendations.

Governor's Substance Use Disorder Task Force

A representative from the Governor's Substance Use Disorder Task Force (SUD Task Force) provided testimony on the group, established under Governor Colyer's Executive Order 18-09. The SUD Task Force met monthly from April to August 2018. The group focused on five primary topics: provider education, prevention, treatment and recovery; law enforcement; and neonatal abstinence syndrome. An overview was provided on the 34 priority recommendations spanning these topics.

Governor's Behavioral Health Services Planning Council

The Chairperson of the Governor's Behavioral Health Services Planning Council (Council), provided an overview of the Council's focus: to ensure the integration of behavioral health services and meeting the needs of Kansas children and adults who experience mental health, addiction, and co-occurring disorders, as well as supporting their families. The Chairperson stated there are eight active subcommittees, made up of individuals from across the state, that advise the

Council on a variety of issues. He stated the Council was primarily focused on the integration of substance abuse and mental health.

In response to Committee discussion related to frontier and rural access to mental health facilities, the Commissioner of the Behavioral Health Services Commission, Kansas Department for Aging and Disability Services (KDADS), explained the 2019 Legislature appropriated funds to KDADS for a facility in Hays for mental health facilities for children in western Kansas. The Commissioner explained the historical actions regarding mental health facilities in western Kansas and stated that with the closing of the psychiatric residential treatment facility (PRTF) in western Kansas, children in need of services in the area were being directed to Wichita.

Crossover Youth Working Group

A representative from the Crossover Youth Working Group (CY Working Group) provided an overview regarding the second CY Working Group that met from July 2019 to January 2020. The CY Working Group was formed by the Department for Children and Families (DCF) in response to a 2019 budget bill proviso mandating the agency to study the impact of SB 367 (2016) and to study the 16 data elements requested in the proviso. The CY Working Group studied and identified 691 crossover youth that had been placed in the child welfare system and had some involvement with law enforcement or the juvenile justice system as of July 31, 2019. Results from national studies had shown crossover youth are associated with higher risks of mental health challenges, higher rates of recidivism, poor placement stability, and lower permanency outcomes. In addition, 23 percent of crossover youth screened indicated higher levels of anxiety or depression, and nearly 2 in 10 indicated a warning of suicidal ideation.

A point of discussion for the Committee was whether or not Medicaid should be able to cover "parent-only" therapy sessions, even though the Medicaid-covered child is not present during the session. The Committee continued to discuss the importance of accurate and usable data to help inform outcomes to the Legislature and relevant agencies.

Mental Health Task Force (2018 and 2019)

A representative from the Mental Health Task Force (MH Task Force) provided an overview of the MH Task Force reports that were presented to the 2018 and 2019 Legislatures. The first MH Task Force was created by the 2017 Legislature in a proviso in 2017 Senate Sub. for HB 2002 and directed the MH Task Force to study certain mental health topics and submit its findings to the 2018 Legislature. The 2018 Legislature included a similar proviso in 2018 House Sub. for SB 109 to reauthorize the MH Task Force to create a strategic plan to address its previous recommendations, ascertain the total number of psychiatric beds needed to deliver mental health services, and identified where these services would be provided. The report to the 2019 Legislature included a strategic plan detailing 23 recommendations that built on the 2018 Report. A review of the “continuum of care” was provided to explain how the MH Task Force identified and addressed the gaps in the existing system.

Child Welfare System Task Force

A KLRD staff member provided information regarding the Child Welfare System Task Force (CWS Task Force). The CWS Task Force was established as a result of the enactment of 2017 House Sub. for SB 126. The law directed the Secretary for Children and Families to study the child welfare system in Kansas. An overview of the CWS Task Force and the three working groups that assisted the CWS Task Force in studying relevant topics was provided. Staff presented an overview of the recommendations, focusing on those that specifically referenced mental health issues.

Measures Implemented in Response to Recommendations by Agencies

Representatives from KDADS, the Kansas Department for Health and Environment (KDHE), and DCF provided overviews to the Committee on actions taken by the agencies in regard to behavioral health and the relevant recommendations from the previous task forces and committees.

KDADS

The Commissioner of the Behavioral Health Services Commission provided an overview of KDADS’ actions regarding recommendations from the previous task forces and committees. The Commissioner stated KDADS has initiated the following actions:

- KDADS submitted 18 budget enhancements totaling \$74.5 million for fiscal year (FY) 2021, with 15 of those related to fulfilling recommendations within the 2019 MH Task Force report and the Council report. For FY 2021, KDADS received funding associated with lifting the moratorium on admissions at Osawatomie State Hospital (OSH) and with opening a children’s acute care psychiatric hospital in Hays. At the time of the meeting, KDADS was waiting for the request for proposal to process;
- The Commissioner provided the KDADS 2019 Strategic Plan, focusing on eight long-term goals for KDADS during Governor Kelly’s administration, and 50 short-term goals were also listed;
- The Commissioner noted a section in the MH Task Force report provided to the 2019 Legislature regarding seven topic areas and a crosswalk of MH Task Force recommendations with the SUD Task Force recommendations and the CWS Task Force recommendations; and
- The Commissioner described KDADS’s progress in various areas, including system transformation, maximizing federal funding, children’s continuum of care, nursing facilities for mental health, workforce, suicide prevention, and learning across systems.

The Commissioner also reviewed the CWS Task Force Report and stated KDADS was working with the KDHE on offering Serious Emotional Disturbance (SED) waiver services through KanCare. The managed care organization waitlist for PRTF admissions had 21 foster care youth on it at the time of the meeting, and he

stated KDADS was working to reduce that number.

The Commissioner testified that KDADS was able to increase the community mental health center (CMHC) base funding agreements last year to replace funding lost in the previous decade. He noted KDADS and KDHE vastly expanded the role of telemedicine in behavioral health services in light of the COVID-19 pandemic.

The Commissioner also reviewed the CY Working Group Report and summarized the top finding and stated KDADS continues to work on improving PRTF waiting lists and services. Regarding neonatal abstinence syndrome, the Commissioner stated KDADS has provided support to KDHE utilizing grants from the federal SAMHSA.

In response to Committee discussion about a suicide prevention coordinator, the Commissioner explained the Youth Suicide Prevention Coordinator in the Attorney General's Office is a part-time employee whose focus is on youth suicide. Mr. Brown stated the KDADS recommendation would encourage creation of a suicide coordinator position with expanded focus, including adults and veterans. In response to whether or not this would be a duplication of positions, the Commissioner stated he did not believe this would be a duplication and the coordinators could work together with a lead coordinator in place.

KDHE

The Behavioral Health Consultant, KDHE, provided an overview on KDHE's role within the behavioral health continuum and the programs KDHE has implemented in regard to relevant recommendations from the previous task forces and committees. She noted the importance of data collection with a list of the various reports and systems being monitored. The Behavioral Health Consultant stated prevention is vital to KDHE's efforts, and suicides in Kansas are of great concern. She provided information on the societal and fiscal impact of Adverse Childhood Experiences (ACEs) on the population. She testified strategies had been developed that addressed the needs of children and their families. She also provided information on perinatal

conditions, especially maternal depression, and stated a focus has been universal screening.

The Behavioral Health Consultant also testified the reduction of substance use disorders had shown improvement. She testified drug overdoses, dispensed morphine equivalents, and over abuse of narcotics had seen reductions over the past years and various campaigns had been initiated to assist in these efforts. The SUD Task Force had partnered with organizations to provide training to health care providers to assist with these efforts, and she provided a list of organizations.

The Behavioral Health Consultant provided an overview of the KSKidsMAP Pediatric Mental Health program. She said an important piece of the program is the establishment of a Pediatric Mental Health Care Team that provides a provider consultant line and a TeleECHO Clinic. She provided a map with the locations of enrolled providers, as well as a breakdown of the consultant line calls.

The Committee discussed training for parents and suicide and depression outreach in schools. The Behavioral Health Consultant noted that parent training programs were available for parents with toddlers and young children and resources like social and emotional cards are available. Perinatal screening is also a focus of KDHE. She also explained KDHE was working on grants with the Kansas Department of Agriculture and Kansas Division of Emergency Management to help address suicide and other mental health issues due to the increase of mental illness because of the COVID-19 pandemic.

DCF

The Secretary for Children and Families provided an overview of DCF's responses to the behavioral health recommendations. Regarding delivering crisis and prevention services for children and youth in natural settings, the Secretary noted DCF had issued a bid request to create a mobile response process for crisis intervention. The federal Family First Prevention Services Act (Family First) places an emphasis on in-home parent skill-based programs to keep families intact, and new mental health supports were being provided through this program.

The Secretary stated three Family First grants had been issued to substance abuse disorder treatment providers to assist in sustaining funding sources for prevention associated with drug misuse. She testified DCF had begun to implement the Kansas Parent Management Training Oregon Model to support, encourage, and increase the direct training and support of parents caring for their children. The Secretary noted a high priority within DCF was access to high-quality and consistent health care for Medicaid-eligible high-risk youth and listed the action steps.

The Secretary stated an additional area of focus was creating and expanding safety net and early childhood programs through public services. She noted the Child Care and Development Fund Federal Childhood Grant increased rates from the 45th percentile to the 85th percentile on April 1, 2020. This helped cover costs for the State and children in foster care. DCF was working on increased access to safety net programs such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and child care assistance to at-risk families. She said placement stability was also important and an internal DCF placement stability team had been formed to lead efforts to increase stability for youth.

Overview of Mental Health Intervention Team Program

The Deputy Commissioner of Education, Kansas State Department of Education, provided information on the Mental Health Intervention Program (Program), which has been in existence for two years and approved through provisos each year. The program authorizes school districts to enter into agreements with CMHCs to increase access to mental health services, and the program provides funding for a database for students referred to the program to track progress and outcomes.

The Deputy Commissioner provided a summary of the Program with district breakdowns for school years 2018-2019 through 2020-2021, noting substantial increases in school participation each year. The goal of the Program is to provide greater access to behavioral health services for school-aged students and establish a coherent structure between school districts and mental

health providers to optimize scarce behavioral health resources and workforce. The Deputy Commissioner described the three providers in the program and their duties. He also described the payment structure, with the school district receiving 25 percent of the grant payments.

The Deputy Commissioner described the reporting requirements for the Program, submitted at the end of each semester. School districts are required to complete a Memorandum of Understanding (MOU) each year to participate. He provided a list of all 56 districts that are participating during the 2020-2021 school year.

August 28

Roundtable Discussion: Reflection on Day One and Overview of Working Group Process

KHI staff facilitated a discussion with roundtable members and Committee members. Each participant provided an introduction and commented on their individual background in behavioral health and interests in the topics before the Committee.

Committee members discussed issues that either were not included in the initial first meeting day's discussion or should receive focus at the working group level, including: suicide prevention, telemedicine as a tool to assist people in rural and frontier areas, providing wrap-around services, assisting law enforcement in dealing with people who are experiencing behavioral health issues, and solid data to better manage outcomes.

A KHI Senior Analyst provided an overview of how the working groups would operate and the intent of the working groups. The Committee Chairperson provided an overview of the final product, stating the goal should be the development of a multi-year strategic plan. The Chairperson discussed the importance of collaboration and cooperation between the mental health system and the State and the need to be flexible in expectations.

Committee members provided individual comments on the legislative needs that should be addressed and the associated costs, including: promoting the certified community behavioral health clinic (CCBHC) model; helping children in

schools with early diagnosis in issues; law enforcement interaction with the behavioral health system; and reviewing what data is available and how this data is usable.

The Senior Analyst explained the prioritization criteria for recommendations and how the working groups would use this criteria to focus recommendations for the Committee. She provided various criteria for the Committee to consider: ease of implementation, impact level, consensus level, vulnerability category, existing pilot program, achievability, and category classification.

KHI staff continued the discussion, reviewing the KLRD crosswalk. KHI staff explained the intention for the working groups was to look at these recommendations broadly, to see what details should be updated or changed for the Committee. The Senior Analyst then explained the working group charter and the expectations agreed upon by roundtable members and Committee members. She also explained how the working groups would update the Committee. The Senior Analyst then facilitated assigning roundtable members and Committee members to working groups based on topic interest.

October 5, 2020, Meeting

Follow-up Information

KLRD staff provided information requested from the previous meeting:

- Information regarding KDHE's Sexual Violence Prevention and Education program and the Committee for Children's Second Step, Social and Emotional Learning curriculum;
- Information on the Rural and Frontier Subcommittee Reports;
- ACE information and funding from KDADS; and
- Kansas Department of Agriculture information on mental health supports.

Updates from Working Groups and Roundtable Discussion

The chairpersons and vice-chairpersons of each working group provided updates. Each working group had met twice since the August 27-28, 2020, meeting. The first working group meeting was focused on setting up the process and meeting expectations for each working group and assigning chairpersons and vice-chairpersons to present updates to the Committee.

The working groups' second individual meetings focused on the first assigned topics: WG1 focused on workforce, WG2 focused on prevention and education, and WG3 focused on data systems. The working groups reviewed recommendations as assigned from the crosswalk to the group and determined if certain recommendations should be removed based on agency and task force responses from the previous meetings and discussion during the working group meetings. Working groups also discussed barriers to implementation for past recommendations.

Committee discussion focused on ensuring any recommendations focus on measurable outcomes on whether or not the recommendations are successful and collecting data that is usable for future use by agencies, the Legislature, and the public. Major topics of discussion for the working groups are below:

- **WG1:** Potential reduction in clinical hours for certain professions, and telemedicine and how to utilize this practice for accessing the behavioral health system;
- **WG2:** Suicide prevention, data sharing, and access to telemedicine; and
- **WG3:** information sharing between agencies, law enforcement, and local governments and organizations; and opt-in process for data surveys regarding behavioral health.

The Crossover Youth Practice Model

The Founder and Director Emeritus, Center for Juvenile Justice Reform (CJJR), McCourt School of Public Policy, Georgetown University,

presented on the Crossover Youth Practice Model (Practice Model).

The conferee defined a “crossover youth” as someone who has been abused and neglected and has been involved in delinquent behavior. The individual may or may not have had involvement in the child welfare system and/or the juvenile justice system. He noted the increased likelihood of a crossover youth being female and Black and that a high proportion are individuals who are LGBT/GNCT (lesbian, gay, bisexual, transgender/gender nonconforming and transgender). The conferee reviewed the higher likelihood of suicide, psychosocial issues, and illegal substance use among crossover youth and their higher likelihood of familial history of mental illness. The conferee reviewed the system challenges in improving outcomes for these youth and how the Practice Model recommends three phases of practice to produce systemic change. A list of the states and jurisdictions that have implemented the Practice Model was provided, which included Sedgwick County, Kansas.

Committee discussion focused on different challenges for crossover youth, including medication and potentially over-medicating children. The effect of the changing of placement for crossover youth also was discussed. The conferee stated the data shows that disruptions in placements may cause negative behavior in crossover youth and the fatigue factor for younger people. Foster youth and their overlap with crossover youth was discussed and he noted that foster care youth have a greater risk of entering the juvenile justice system.

The Secretary for Aging and Disability Services commented KDADS has been working with Kansas State Department of Education in creating virtual school for youths to help with access to school for foster care youth and other children who move to different placements.

Kansas Citizen Experience in Kansas Behavioral Health System

A private citizen testified about her experience with trying to assist a child with psychiatric issues in the Kansas behavioral health system. She explained that lack of capacity and coordination contributed to the child waiting a considerable

amount of time for a psychiatric residential treatment facility (PRTF). While the child was sent to several different facilities, the facilities themselves did not communicate with each other regarding the child’s situation.

A KDADS representative testified in regard to the individual’s situation and the difficulty of the current system and the strain on capacity. The representative stated KDADS has been working on a State Institute Alternative Plan to work with private psychiatric hospitals in regions throughout the state that would provide services for patients that had been screened. It was noted the number of acute beds changes daily, but that there are almost 300 psychiatric beds for children licensed in Kansas with a daily census running around 280.

Information Briefings on Remote Mental Health Services

The Executive Director of the Association of Community Mental Health Centers of Kansas testified regarding the success telemedicine has had in rural and frontier areas in Kansas in the past two decades. He explained the gaps in broadband Internet service and technology have been barriers to expansion; however, the use of telephonic services has been a significant addition. The Executive Director also noted the COVID-19 pandemic forced CMHCs to go almost entirely to telehealth services to protect staff and patients.

The Chief Executive Officer for innovaTel Telepsychiatry presented an overview of the services his company provides nationwide. He explained the COVID-19 pandemic’s impact on the increased need for behavioral health services and that one in three individuals could have a behavioral health need in 2021. The conferee explained that due to the pandemic, now 90 percent of patient encounters are occurring in patient homes through telehealth.

The Executive Director for the Central Kansas Mental Health Center (CKMHC) continued the discussion by noting how telehealth has affected her organization. She said initially patients were reluctant to come to the physical facility location, but televisits help assist with this issue with many patients. She also noted that telehealth has also made it easier on the administrative side, working

with managed care organizations, DCF staff, parents in different locations, and case workers.

The Executive Director of the High Plains Mental Health Center (HPMHC) testified on telehealth in northwest Kansas. He stated that HPMHC has used telehealth since 1997, due to the remote locations of many individuals. All HPMHC branch offices are connected, including electronic health records. Barriers include variability in broadband and payer restrictions. This conferee noted 96 percent of patients received remote service in April 2020, but the amount of patients receiving remote services has reduced to 50 percent since then.

The Committee discussed privacy considerations that arise due to telehealth visits. Conferees stated privacy is always a consideration and that patients and staff have to be adaptable. The Committee also discussed discrepancies in staff salaries compared to other states, noting that many states get a higher reimbursement rate due to federal dollars from CCBHC grants.

October 30, 2020, Meeting

Follow-up Information from Previous Meeting

KLRD staff provided follow-up information that was requested at the October 5, 2020, Committee meeting. The information included:

- A breakdown of the number of clinical hours required for licensed clinical social workers in Kansas, Colorado, Missouri, Nebraska, and Oklahoma;
- Web links and a brochure from DCF regarding tracking outcomes for foster care youth and updates on the Family First Prevention Services Act implementation programming in Kansas; and
- A copy of testimony from a member of the Governor's Mental Health Task Force, to the 2019 Senate Subcommittee on Social Services regarding his experiences navigating the Kansas behavioral health system.

Updates from Working Groups

A second Senior Analyst with KHI (KHI analyst) provided a review of the working group process since the last meeting, noting the working groups had met twice and finished reviewing their assigned topics. For each topic, KHI staff led the Committee in a visioning exercise, asking the Committee to discuss whether these issues presented by the working groups should be incorporated into the larger work product due to their importance for a modernized Kansas behavioral health system.

The co-chairperson of WG1 provided an update on WG1 meetings. The working group reviewed the topic of funding and accessibility. Recommendations revolved around reimbursement rates, the CCBHC model, and possible funding streams for different services. A barrier to implement these recommendations included workforce shortages and the level of Medicaid reimbursement rates.

The KHI analyst led the Committee in a visioning exercise, asking the Committee to discuss whether these recommendations should be incorporated for a modernized mental health system in Kansas. The Committee discussed the CMHC model and how it is incorporated between the different levels of government.

The co-chairperson continued his presentation on the topic of community engagement. This topic included recommendations around the Individual Placement and Support employment services, expanding stakeholder engagement in terms of suicide prevention, and a community-based mental health liaison position.

During the visioning exercise, the Committee discussed the need for close collaboration between law enforcement and the community. Another discussion revolved around the collaboration between different organizations in the community to ensure resources were maximized and to lessen duplication of services.

The co-chairperson of WG2 provided an update on WG2 activities. Treatment and recovery was the first topic discussed. Discussion of this topic revolved around recommendations involving expanding the behavioral health service array in

Kansas statewide and ensuring access to PRTFs and supportive housing. Increased access to Medication Assisted Treatment (MAT), particularly in jail settings, was also discussed. The working group determined increased investment in service providers for individuals with intellectual disabilities (I/DD) was crucial.

Discussion during the visioning exercise revolved around gathering data to understand services gaps and to help target the most acute areas.

The co-chairperson reviewed the last topic, special populations. Recommendations centered on neonatal abstinence syndrome supports and services, evidence-based services for non-abuse/neglect situations, and educating women and families on postpartum anxiety and mood disorders. Crossover youth, individuals in the criminal justice system, and the I/DD population were all discussed.

Committee discussion during the visioning exercise revolved around defining special populations versus access to service providers, case management services, and rural and frontier communities.

The WG3 co-chairperson provided an update on WG3 activities. The first topic was interaction with the legal system and law enforcement. Recommendations revolved around benefits reinstatement and suspension of Medicaid, training for correctional employees on substance use, mental health, and trauma-informed response.

The Committee discussed the need for law enforcement training, the possibility and funding for specialty courts, and parole supervision during the visioning exercise.

The co-chairperson discussed the last topic, system transformation. Recommendations considered included integration of behavioral health and primary care, utilizing the Screening, Brief Intervention and Referral to Treatment (SBIRT) service model, and conducting a statewide needs assessment of SUD treatment providers in Kansas.

Committee discussion during the visioning exercise revolved around supportive housing, housing in rural areas, and the importance of accurate and usable data outcomes in the behavioral health area.

Historical Overview of Kansas Mental Health System

KLRD staff provided a historical overview of the Kansas mental health system.

The overview described the transition from institution-based services in Kansas to community-based services. An overview was provided of the state hospitals and the shift to community-based services with the opening of new state agencies and the passage of The Kansas Community Mental Health Centers Assistance Act (1987) and the Mental Health Reform Act (1990). A review of nursing facilities for mental health and the challenges these facilities face and the creation of PRTFs to help fill gaps in the system was provided.

Mental health parity law, a timeline of the system, an explanation of Medicaid waivers related to behavioral health, and an overview of the funding for CMHCs were provided.

Mental Health Collaboration to Improve Outcomes for Youth in the Juvenile Justice System

The Chairperson of the Juvenile Justice Oversight Committee (JJOC) provided testimony regarding the need for collaboration when discussing youth in the juvenile justice system. She gave an overview of the JJOC, its functions, and stated the JJOC is committed to addressing mental health in youth involved in the justice system and working with legislative partners on this issue.

The JJOC chairperson explained some of the challenges youth face in regard to mental health. She also provided an overview of different programs related to mental health that the JJOC was investing in. Committee discussion revolved around the measurable outcomes of these funded programs, the funding stream of the JJOC, and the measurable data being collected from these programs.

Role of CMHCs During Moratorium of Osawatomie State Hospital

The Executive Director for the Labette Center for Mental Health Services, Inc. (Labette Center), provided testimony regarding the impact of the moratorium and changes to admission at the Osawatomie State Hospital (OSH) on CMHCs.

The Labette Center representative stated that mental health reform has brought about needed changes and improvements; however, the moratorium on OSH has changed how mental health reform is understood and implemented. He stated CMHCs have now become a referral source for the state mental health hospitals instead of the single point of admission. He noted the decision to admit patients to a state hospital rests solely with the hospital, with no formal appeals process should the CMHC disagree. For counties like Labette, timely admission to OSH remains a frustration for law enforcement, and at times, involuntary admissions take more than five days.

Committee discussion revolved around discrepancies in the number of people on the waiting list for OSH. A representative from KDADS stated the agency has presented a plan for the lifting the moratorium at OSH and a regional hospital model plan. The representative stated the COVID-19 pandemic had changed some of the capacity at OSH due to following infectious disease protocols.

Role of Law Enforcement in Assisting Individuals with Mental Illness in Rural Areas

The sheriff for Cherokee County testified regarding the frustrations individuals in law enforcement have when dealing with individuals with severe behavioral health issues. The sheriff described a situation his department handled recently, with a woman with no prior mental health issues going into crisis and his department being the only entity capable of dealing with the situation. Involuntary admission to a state hospital was likely necessary; however, space was not available at the time, and the nearest CMHC was still significant miles away.

The Committee discussed the training that police departments receive regarding handling individuals in a mental health crisis and what

would be helpful additions to the system to assist law enforcement. Increased capacity at state hospitals was discussed.

Integrated Care Panel Discussion

The Regional Administrator for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) provided testimony on the need for integrated care for people with mental illness or substance abuse disorders. The Regional Administrator outlined the certified community behavioral health clinic (CCBHC) model under Medicaid. She noted the CCBHC model is possible through enhancing Medicaid reimbursement rates. The Regional Administrator explained how other states had implemented the system, including Missouri, and noted Four County Mental Health Center in Kansas was awarded an expansion grant for the CCBHC model.

The chief executive officer (CEO) for the Four County Mental Health Center provided testimony on the CCBHC expansion grant his company received. He explained the benefits of the integrated system and how dealing with both the medical and behavioral health aspects of individuals in one setting helps meet patient needs and reduce stigma.

A representative of HealthCore Clinic, Inc., provided testimony about the federally qualified health center (FQHC) model. She described how integrating medical, dental, behavioral health, and pharmacy in one location was beneficial to her patients.

Committee discussion revolved around how the state of Missouri implemented their CCBHC model and if SAMHSA would continue to expand this program in the future.

History of Funding and State Grants related to CMHCs

The Executive Director of The Guidance Center provided a history of mental health center funding in Kansas. He explained the history of the Community Mental Health Act of 1963, which established funding for CMHCs. The Executive Director explained the finance structure of CMHCs and the licensing structure to operate

under KDADS. He also addressed the emergence of managed care organizations in Kansas and the work between these entities and CMHCs. The Executive Director continued with an explanation of state funding and the majority of funding received from Medicaid.

Texas Community Behavioral Health Clinic Initiative

The CEO for the Texas Council of Community Centers provided testimony on the efforts Texas has made to make the CCBHC model a reality in that state. She provided an overview of the CMHC network in Texas, noting the high uninsured rate of the state and the lack of ability for mental health and substance abuse patients to receive primary care. The CEO explained the Section 1115 Delivery System Reform Incentive Payment waiver the state pursued under Medicaid to create their new system. She explained the timeline of implementation of the CCBHC initiative and how the state worked with legislative members and agencies to bring everyone on board with the new system.

December 10-11, 2020, Meeting

December 10

Follow-up Information from October 30, 2020, Meeting

KLRD staff provided an update on requested information for the following topics from the October 30, 2020, meeting:

- The number of licensed psychiatrists in Kansas, and of those licensed psychiatrists, how many are currently practicing;
- Information DCF tracks in regard to foster care youth and educational outcomes; and
- A funding overview of the Juvenile Justice Oversight Committee.

The Committee discussed whether there was a more-comprehensive report of DCF information to review, whether DCF tracks foster care students who have not completed the twelfth grade, and more insight into different programs funded by the

JJOC and changes in requested funds for certain programs.

Review of the Strategic Framework for Modernizing the Kansas Behavioral Health System

KHI staff provided the Committee a review of the process of the working groups and the compilation of work done by each entity, culminating in the Strategic Framework for Modernizing the Kansas Behavioral Health System (Strategic Framework) ([Appendix pages 24-115](#)).

KHI staff noted the working definition of behavioral health and the importance of agreed-upon definitions of different programs moving forward. KHI staff presented the Committee the vision statements that were developed for each of the topic areas and how these vision statements summarize the key points of the working group discussion.

The format of the recommendations of the Strategic Framework were discussed and how recommendations were sorted into high-priority for the Committee, based on the discussion of the working groups and the prioritization process. Within these high-priority recommendations, the working groups sorted each recommendation into an “immediate action” category and “strategic importance” category. Immediate action meant recommendations the working groups believed can be completed in the next two years. Strategic importance meant those recommendations the working groups believed should be initiated in the near term but would be completed in the longer term. Notable parts of the Strategic Framework that were discussed by KHI were:

- A summary of the high-priority recommendations ([Appendix pages 31-39](#));
- Recommendations that were not deemed high priority but were still maintained in the Strategic Framework ([Appendix pages 96-102](#));
- A copy of the recommendation rubric that the working groups used to finalize their

recommendations ([Appendix pages 104-105](#));

- Tables for the high-priority recommendations by topic, which could be used as checklists for implementation ([Appendix pages 106-107](#)); and
- Working groups membership list ([Appendix pages 108-111](#)).

KHI staff reviewed the Data Profile section of the Strategic Framework ([Appendix pages 43-45](#)). KHI staff noted that data points were filled in with assistance from state agency staff, including: KDADS, KDHE, DCF, the Kansas Department of Corrections, the Kansas State Department of Education, and the Office of the Attorney General.

The section included a review of the Mental Health in America rankings of the 50 states by report year and different outcomes reported. The Committee discussed these data points, noting the difference in the point “adults with mental illness who report unmet needs,” where Kansas was ranked last in the nation. The Committee requested the links to the reports and a summary of these reports, the data used, and the different metrics used to develop the rankings.

Certain data boxes were left blank, due to more time needed for agencies to gather or collect this information. The Committee requested this information be compiled once the information becomes available.

Committee members discussed the importance of terminology and acceptance of common terms. One term included the definition for crisis intervention center and the difference between this term and crisis stabilization units. The Committee requested more information on the distinction between these two terms.

The Committee discussed adding language to the rationale section of Recommendation 10.2 Reimbursement Codes. This language was submitted by a representative from Blue Cross Blue Shield of Kansas. The language and Committee discussion centered on ensuring the recommendation did not propose to incentivize

providers at a higher rate to provide telehealth services than in-person services. During discussion, additional clarifying language was added by a representative from the Association of Community Mental Health Centers.

KHI staff facilitated the rest of the discussion by introducing the co-chairs of each working group. These individuals reviewed each of the high-priority recommendations by the working groups and explained the rationale for each of the recommendations. Following these presentations for each recommendation, the Committee had the opportunity to discuss these recommendations, pose questions to relevant working group members and subject matter experts, and propose any additional edits for the Strategic Framework.

Related to the discussion on reimbursement rates, the Medicaid Director provided data on the top 6 behavioral health codes utilized in KanCare by claim count and amount ([Appendix pages 125-126](#)).

December 11

Follow-up Questions on Strategic Framework and Review of Special Committee Edits

KLRD staff facilitated a Committee discussion on any follow-up information from the December 10, 2020, meeting and any information the Committee would like researched and provided in the upcoming legislative session.

KLRD staff presented a handout to the Committee that showed the edits and changes to the Strategic Framework the Committee discussed at the December 11, 2020, meeting ([Appendix pages 116-124](#)). This included minor changes to certain recommendations and additional language added to the rationale section of Recommendation 10.2 Reimbursement Codes.

After this information was presented and discussed, the Committee approved the Strategic Framework report, as edited by the Committee, and KLRD staff were directed to advance the Strategic Framework as an attachment to the Special Committee report.

KLRD staff reviewed additional recommendations. The Committee approved the

additional recommendations and considerations: opportunities for coordination and collaboration, COVID-19 and behavioral health contemporary issues, data as a decision-making tool for modernization and reform, distribution of the Special Committee Report, recognition of participants and expert information, and request to legislative leaders for a joint standing committee.

CONCLUSIONS AND RECOMMENDATIONS

Special Committee Recommendations

At its December 11, 2020, meeting, the Committee discussed and approved the following recommendations based on Committee and working groups discussion.

Opportunities for Coordination and Collaboration

The Committee recognizes the important recent and ongoing work of commissions, committees, councils, groups, and task forces focused on issues, ideas, and improvements that impact the behavioral health system, its capacity and workforce, and its financing and sustainability. The Committee acknowledges the connections and opportunities to collaborate on common goals and interests associated with the interim work of the Kansas Criminal Justice Reform Commission (the KCJRC), the Special Committee on Foster Care Oversight, and the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight. The Committee highlights two areas where coordination and meaningful collaboration occurs – in specialty courts (with the KCJRC) and integrated care (with the Bethell Joint Committee).

- The Committee submits for the record the crosswalk of recommendations serving as the foundation for the review of its three working groups that detailed the relevant recommendations and study considerations submitted by the Child Welfare System Task Force (2017 preliminary, 2018 final reports), the Crossover Youth Working Group (2019 report), the Governor’s Behavioral Health Planning Council and its subcommittees (2018, 2019 reports), the Governor’s Substance Use Disorder Task Force (2018

report), and the Kansas Mental Health Task Force (2018, 2019 reports).

Contemporary Issues - COVID-19 Pandemic and Behavioral Health

The discussions of this Committee and its working groups occurred amidst the COVID-19 pandemic. While it is too soon to draw conclusions about the lasting impacts on the behavioral health system in Kansas, the Committee requests state agencies, members of the working group, and the Kansas Legislature continue to assess, monitor, and report on these impacts. The Committee notes early indicators of impressions on the system including suicide rates and prevention efforts, temporarily enhanced reimbursement rates, and significant changes in the accessibility and use of telehealth.

Data as a Decision-Making Tool for Modernization and Reform

The Committee notes the identification of a variety of data sources in the working group report and its committee process and strongly encourages clear, connected data systems and quality reporting to provide decision-makers across the system with measurable and easily tracked results. This will prove essential for the next steps toward implementation and provide measurable outcomes to drive decision-making, particularly for the evaluation of the data reported and financing of system goals and programming.

Distribution of Committee Report

Given the breadth and complexity of the topics associated with mental health and transformation of the system, its capacity and workforce, the policy and treatments options and outcomes for individuals with behavioral health needs, and the sustainability and finance for the delivery of behavioral health services and resources, the Committee requests its complete report be transmitted to the following standing and joint committees of the Kansas Legislature: Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, House Committee on Children and Seniors, House Committee on Corrections and Juvenile Justice, House Committee on Health and Human Services, House Committee on K-12

Education Budget, House Committee on Social Services Budget, Senate Committee on Judiciary, Senate Committee on Public Health and Welfare, and Senate Committee on Ways and Means (agency subcommittees).

- The Committee requests KLRD staff compile a new crosswalk to reflect the adopted Committee working group recommendations and recommendations of the other interim groups issuing relevant considerations and recommendations during the 2020 Interim.

Recognition of Participants and Expert Information

The Committee acknowledges and appreciates the unique structure and support needed to conduct its broad review of mental health modernization and reform in Kansas and meet and exceed the charge issued by the Legislative Coordinating Council (LCC). The Committee especially recognizes the support of its Committee staff from KLRD and the Office of the Revisor of Statutes and the working group facilitation support provided by the Kansas Health Institute.

- The Committee commends the work of the roundtable participants and their contributions, not only to the work of the Committee, but also to the information, direction, expertise, and passion to the review and formulation of recommendations of the individual working groups.
- The Committee further recognizes meetings occurred under COVID-19 pandemic conditions; the public was asked to access its meetings and those of the working groups through audio or video stream.

The Committee encourages all the above entities to continue this spirit of collaboration and welcomes participation and information on these important topics and issues.

Request to Legislative Leaders

The Committee requests the LCC and the Legislature consider formation of a formal standing or joint committee to consider, address, and continue with the effort to address the longer-term goals and strategies incorporated in both this Committee and the adopted working groups' reports. The Committee recognizes that additional time is needed to continue not only this significant discussion but to work towards implementation strategies and longer-term system direction and transformation. The Committee also recommends leadership from each of the identified committees receiving the report commit to planning and discussion on this report and more formal assignment of topics and individual recommendations and priorities for review and consideration by the individual committees.

Strategic Framework for Modernizing the Behavioral Health System; Working Groups Recommendations

At its December 10, 2020, meeting, the Committee adopted the recommendations of the Strategic Framework developed by the working groups. The Strategic Framework ([Appendix Pages 24-115](#)) lists the rationale behind each recommendation and other measures for implementation.

[*Note:* The notation “IA” denotes an immediate action recommendation, and “SI” denotes a strategic importance recommendation.]

Workforce Recommendations ***(Appendix pages 46-50)***

- **1.1 Clinical Supervision Hours (IA):** Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers.
- **1.2 Access to Psychiatry Services (IA):** Require a study to be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses.
[*Note:* The Committee requests

consideration be given to education institutions, regardless of size, that can provide this expertise and assistance.]

- **1.3 Provider MAT Training (IA):** Increase capacity and access to medication assisted treatment (MAT) in Kansas through provider training on MAT.
- **1.4 Workforce Investment Plan (SI):** The State of Kansas should 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. Specific steps include: develop a career ladder for clinicians, such as through the development of an associate's-level practitioner role; and take action to increase workforce diversity, including diversity related to race/ethnicity and LGBTQ identity, and the ability to work with those with limited English proficiency.
- **1.5 Family Engagement Practices (SI):** Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnerships with families.

Funding and Accessibility Recommendations (Appendix pages 50-55)

- **2.1 Certified Community Behavioral Health Clinic Model (IA):** Support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinical (CCBHC) model.
- **2.2 Addressing Inpatient Capacity (IA):** Implement and fund a comprehensive plan

to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.

- **2.3 Reimbursement Rate Increase and Review (IA):** Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a working group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population.
- **2.4 Suicide Prevention (IA):** Allocate resources to prioritized areas of need through data-driven decision-making. Assist local suicide prevention efforts and promote local support groups in fundraising efforts, building capacity, and increasing availability for survivors of suicide loss. Dedicate resources and funding for suicide prevention.
- **2.5 Problem Gambling and Other Addictions Fund (IA):** Recommend the State continue to incrementally increase the proportion of money in the Problem Gambling and Other Addictions Grant Fund (PGOAF) that is applied to treatment over the next several years until the full funding is being applied as intended.

Community Engagement Recommendations (Appendix pages 56-60)

- **3.1 Crisis Intervention Centers (IA):** Utilize state funds to support the expansion of Crisis Intervention Centers, as defined by state statute, around the state.
- **3.2 IPS Community Engagement (IA):** Increase engagement of stakeholders, consumers, families, and employers through KDHE or KDADS by requiring agencies implementing the Individual Placement and Support (IPS) program, an evidence-based supported employment program, to create opportunities for

assertive outreach and engagement for consumers and families.

- **3.3 Foster Homes (SI):** The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support youth experiencing serious emotional disturbance (SED).
- **3.4 Community-Based Liaison (SI):** Fund and improve resources for a community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon reentry as a component of pre-release planning and services for justice system-involved adults and youth with substance use disorder (SUD) and co-occurring conditions.

Prevention and Education Recommendations ***(Appendix pages 60-65)***

- **4.1 988 Suicide Prevention Lifeline Funding (IA):** Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees *via* phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources.
- **4.2 Early Intervention (IA):** Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment, and treatment.
- **4.3 Centralized Authority (IA):** Centralize coordination of behavioral health, including substance use disorder and mental health, policy, and provider coordination in a cabinet-level position.
- **4.4 Behavioral Health Prevention (SI):** Increase state funds for behavioral health

prevention efforts (e.g., substance use disorder prevention and suicide prevention).

Treatment and Recovery Recommendations ***(Appendix Pages 65-69)***

- **5.1 Psychiatric Residential Treatment Facilities (IA):** Monitor ongoing work to improve care delivery and expand capacity at psychiatric residential treatment facilities (PRTFs) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools.
- **5.2 Service Array (SI):** Explore options to expand the behavioral health service array, including the expansion of MAT in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance, and the uninsured.
- **5.3 Frontline Capacity (SI):** Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.
- **5.4 Housing (SI):** Expand and advance the Supported Housing program and the SSI/SSDI Outreach, Access, and Recovery (SOAR) program, including additional training regarding youth benefits.

Special Populations Recommendations ***(Appendix pages 69-74)***

- **6.1 Domestic Violence Survivors (IA):** Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies, and community providers serving individuals impacted by domestic violence.

- **6.2 Parent Peer Support (IA):** Increase access to parent peer support for caregivers and families of youth in the behavioral health system, including ensuring appropriate supports for fathers of dependent children.
- **6.3 Crossover Youth (SI):** Continue to develop linkages between the behavioral health system, juvenile justice system, and the child welfare system to increase understanding of treatment options to youth externalizing traumas in the crossover youth population as current treatment options are not meeting the needs of this population. Then develop specialty services to meet the needs of this population.
- **6.4 I/DD Waiver Expansion (SI):** Fully fund the intellectual and developmental disabilities (I/DD) waiver and expand I/DD waiver services. Increase reimbursement rates for I/DD services to support workforce expansion.
- **6.5 Family Treatment Centers (SI):** Increase the number and capacity of designated family SUD treatment centers, as well as outpatient treatment programs across the state.

Data Systems Recommendations ***(Appendix pages 74-79)***

- **7.1 State Hospital EHR (IA):** The new state hospital electronic health record (EHR) system should be interoperable with other data systems in the state. Interoperability should include the ability to automate the current process to reinstate Medicaid benefits following discharge.
- **7.2 Data and Survey Informed Opt-Out (IA):** Collect, analyze, use, and disseminate surveillance data to inform prevention. Change legislation regarding public health and behavioral health state surveys, including changing the Kansas Communities That Care (KCTC) and Youth Risk Behavior Surveillance System

(YRBS) surveys from an opt-in consent to an informed opt-out consent, to allow for meaningful data collection.

- **7.3 Information Sharing (IA):** Utilize Medicaid funds to incentivize participation in health information exchanges (e.g., Kansas Health Information Network [KHIN] or Lewis and Clark Information Exchange [LACIE]). Explore health information exchanges as an information source on demographic characteristics, such as primary language and geography for crossover youth and other high-priority populations.
- **7.4 Needs Assessment (IA):** Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers, and specific policies to effectively utilize, integrate, and expand SUD treatment resources.
- **7.5 Cross-Agency Data (SI):** Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.

Interactions with Legal System and Law Enforcement Recommendations ***(Appendix pages 79-83)***

- **8.1 Correctional Employees (IA):** Expand training provided in correctional facilities to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services.
- **8.2 Criminal Justice Reform Commission Recommendations (IA):** Implement recommendations developed by the Kansas Criminal Justice Reform Commission (KCJRC) related to specialty courts (e.g., drug courts) and develop a

process for regular reporting on implementation status and outcomes.

- **8.3 Law Enforcement Referrals (IA):** Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to services for this population.
- **8.4 Defining Crossover Youth Population (SI):** Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population.

System Transformation Recommendations ***(Appendix pages 83-88)***

- **9.1 Regional Model (IA):** Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas.
- **9.2 Long-Term Care Access and Reform (IA):** Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within the continuum of care. Increase access to long-term care (LTC) facilities, particularly for individuals with past involvement with the criminal justice system or those with a history of sexual violence.
- **9.3 Integration (IA):** Increase integration, linkage, and collaboration and identify care transition best practices among mental health, substance abuse, primary care, and emergency departments across

the state. Adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions.

- **9.4 Evidence-Based Practices (SI):** Kansas should continue and expand support for use of evidence-based practices (EBP) in the state, including for housing and supported employment. Coordinate EBP utilization across systems (e.g., law enforcement, SUD, mental health care) with a goal of implementing programs with fidelity, when possible.
- **9.5 Family Psychotherapy (SI):** Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility.

Telehealth Recommendations ***(Appendix pages 88-94)***

- **10.1 Quality Assurance (IA):** Develop standards to ensure high-quality telehealth services are provided, including: establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies, implementing standard provider education and training, ensuring patient privacy, educating patients on privacy-related issues, allowing telehealth supervision hours to be consistently counted toward licensure requirements, and allowing services to be provided flexibly when broadband access is limited.
- **10.2 Reimbursement Codes (IA):** Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.

- **10.3 Telehealth for Crisis Services (IA):** Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities.
- **10.4 Originating and Distant Sites (SI):** The following items should be addressed to ensure that individuals receive - and providers offer - telehealth in the most appropriate locations: adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act; allow

staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met; and examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts.

- **10.5 Child Welfare System and Telehealth (SI):** Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Consider how the unique needs of parents of children in the child welfare system can be met *via* telehealth.

Appendix

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Working Definitions for Mental Health Modernization and Reform

Behavioral health system: Refers to the system of care that includes the promotion of mental health, resilience and well-being; the prevention, referral, diagnosis, and treatment of mental and substance use disorder; and the support of persons with lived experience in recovery from these conditions, along with their families and communities. (Adopted from the “Strategic Framework for Modernizing the Kansas Behavioral Health System: Working Groups Report to the Special Committee on Kansas Mental Health Modernization and Reform,” December 2020)

Certified Community Behavioral Health Clinic (CCBHC): Under Section 223 of the Protecting Access to Medicare Act of 2014, Congress required the U.S. Department of Health and Human Services (HHS) to establish a process for certification of CCBHCs as part of a two-year demonstration project under Medicaid. Per statute, entities under the CCBHC Medicaid Demonstration must provide a comprehensive set of services that respond to local needs by using integrated care. The demonstration project allows CCBHCs to have a reimbursement model that enhances the coverage of provider costs and allows for a full set of statutorily required services to be offered. In October 2015, HHS awarded planning grants to 24 states to help prepare to participate in the two-year demonstration project. The demonstration phase began in July 2017. Additional expansion grants (CCBHC-E) were awarded beginning in May 2018.

Crisis Intervention Center: Any entity licensed by the Kansas Department for Aging and Disability Services (KDADS) that is open 24 hours a day, 365 days a year, equipped to serve voluntary and involuntary individuals in crisis due to mental illness, substance abuse or a co-occurring condition, and that uses certified peer specialists. [KSA 59-29c02(e)]

Integrated Care: A systematic coordination of general and behavioral health care. (See Recommendation 9.3 Integration in the Strategic Framework for Modernizing the Kansas Behavioral Health System).

Psychiatric Residential Treatment Facility: Any non-hospital facility with a provider agreement with the licensing agency to provide inpatient services for individuals under the age of 21 who will receive highly structured, intensive treatment for which the licensee meets the requirements as set forth by regulations created and adopted by the Secretary for Aging and Disability Services. [KSA 39-2002(m)]

Telemedicine: Including “telehealth”, means the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient’s healthcare. “Telemedicine” does not include communication between healthcare providers that consist solely of a telephone voice-only conversation, email or facsimile transmission; or a physician and a patient that consists solely of a telephone voice-only conversation, email or facsimile transmission. [KSA 40-2,211(5)]

Acronym Key		
ACE	Adverse Childhood Experiences	
ACM	Administrative Case Management	
ADA	Americans with Disabilities Act	
CARES	Coronavirus Aid, Relief, and Economic Security Act	
CCBHC	Certified Community Behavioral Health Clinic	
CMA	Certified Medication Aide	
CMHC	Community Mental Health Center	
CMS	Centers for Medicare and Medicaid Services	
CNA	Certified Nurse Aide	
DCF	Kansas Department for Children and Families	
CIC	Crisis Intervention Center	
CSU	Crisis Stabilization Unit	
EBP	Evidence Based Practices	
EMHA	Excellence in Mental Health Act	
EO	Executive Order	
FEMA	Federal Emergency Management Agency	
FMAP	Federal Medical Assistance Program	
FMS	Financial Management Services	
FPL	Federal Poverty Level	
HCBS	Home and Community Based Services	
	AU	Autism
	BI	Brain Injury
	FE	Frail Elderly
	I/DD	Intellectual and Developmental Disability
	PD	Physical Disability
	SED	Serious Emotional Disturbance
	TA	Technology Assisted
HHS	U.S. Department of Health and Human Services	
HRSA	Health Resources and Services Administration (HHS agency)	
ICF	Intermediate Care Facility	
IPS	Individual Placement and Support	
ISP	Individual Service Plan	
JJOC	Juvenile Justice Oversight Committee	
KAR	Kansas Administrative Regulations	
KCJRC	Kansas Criminal Justice Reform Commission	
KCTC	Kansas Communities That Care	
KDADS	Kansas Department for Aging and Disability Services	
KDHE	Kansas Department of Health and Environment	
KHA	Kansas Hospital Association	
KHI	Kansas Health Institute	
KHIN	Kansas Health Information Network	
KLRD	Kansas Legislative Research Department	
KMAP	Kansas Medical Assistance Program	

KNI	Kansas Neurological Institute
KSDE	Kansas State Department of Education
LSH	Larned State Hospital
LACIE	Lewis and Clark Information Exchange
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MDS	Minimum Data Set
MFP	Money Follows the Person
OSH	Osawatomie State Hospital
NF	Nursing Facility
NSPL	National Suicide Prevention Lifeline
PIL	Protected Income Level
PPE	Personal Protective Equipment
PRF	Provider Relief Fund
PRTF	Psychiatric Residential Treatment Facility
PSHTC	Parsons State Hospital and Training Center
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SGF	State General Fund
SMC	Specialized Medical Care
SNF	Skilled Nursing Facility
SPARK	Strengthening People and Revitalizing Kansas Taskforce
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
YRBSS	Youth Risk Behavior Surveillance System

KLRD Crosswalk Acronym Key	
CAODA	Committee on Alcohol and Other Drug Abuse
CASA	Court Appointed Special Advocates
CWSTF	Child Welfare System Task Force
CYWG	Crossover Youth Working Group
GBHSPC	Governor's Behavioral Health Services Planning Council
HAHS	Housing and Homelessness Subcommittee
JIYAS	Justice Involved Youth and Adult Subcommittee
SUDTF	Governor's Substance Use Disorders TF
MHTF	Mental Health Task Force
PS	Prevention Subcommittee
RFS	Rural and Frontier Subcommittee

SPW	Suicide Prevention Workgroup
VOS	Vocational Subcommittee
VS	Veterans Subcommittee

Kansas Legislative Research Department

Special Committee on Mental Health Modernization and Reform, August 2020 Recent Behavioral Health and Mental Health Committees and Task Forces' Recommendations - KLRD Crosswalk				
Work Group 1: Finance and Sustainability				
Topic 1. Workforce				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier One Recommendation: Workforce. The State of Kansas should invest in the child welfare system workforce by increasing funding for recruitment, retention, and support to effectively attract and retain high-quality staff.</p> <p>Tier Three Recommendation: Front-End Staffing. The Department for Children and Families (DCF) should employ highly skilled and experienced front-end child welfare staff.</p>	<p>Committee on Alcohol and Other Drug Abuse (CAODA) Counseling Recommendations. Support initiatives that provide tuition reimbursement for addiction counselors equal to those provided to other behavioral health professionals. Support better funding for agencies so the agencies may provide compensation and benefits sufficient to encourage prospective professionals to seek training and licensure.</p>	<p>TR19. Workforce Development. Implement workforce development programs to increase capacity of addiction professions.</p>	<p>Recommendation 5.1 Workforce Study (2019). Initiate a comprehensive workforce study statewide to examine challenges experienced by employers in reaching optimal staffing levels to provide services.</p> <p>Recommendation 5.2 Peer Support (2019). Encourage integration of peer support services and Kansas-certified peer mentoring services (substance use disorder [SUD]) into multiple levels of service, including employment services at community mental health centers (CMHCs), hospitalization, discharge, and transition back to the community.</p> <p>Recommendation 5.3 State Loan Repayment Program (2019). Require a report on increasing the number of psychiatrists and psychiatric nurses.</p>	<p>No relevant considerations.</p>

Topic 2. Funding and Accessibility				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier One Recommendation: Access to Care. The State of Kansas should require access to high-quality and consistent medical and behavioral health care for Medicaid-eligible high-risk youth through the state Medicaid state plan or other appropriate sources of funding.</p> <p>Tier Two Recommendation: Service Setting. The State of Kansas should prioritize delivering services for children and youth in natural settings, such as, but not limited to, homes, schools, and primary care offices, in the child's community when possible. The needs of the child and family should be the most important factor when determining the settings where services are delivered.</p>	<p>Suicide Prevention Workgroup (SPW) Recommendation. Assist local suicide prevention efforts and promote local support groups in fund-raising efforts, building capacity, and increasing availability for survivors of suicide loss.</p> <p>Prevention Subcommittee (PS) Recommendations: Allocate resources to prioritized areas of need through data-driven decision-making. Increase access and availability of behavioral health services by restoring funding for CMHCs and supporting efforts to recruit students to enter the behavioral health services community. Dedicate resources and funding for suicide prevention.</p> <p>Vocational Subcommittee (VOS) Recommendations. Actively seek out and provide grants to CMHCs from the State General Fund to offset costs initiating and implementing Individual Placement and Support (IPS) Supported Employment model.</p>	<p>TR3. Prior Authorizations. Remove prior authorization requirements for MAT (medication-assisted treatment).</p> <p>TR5. Opioid Addiction Project ECHO. Identify funding for Opioid Addiction Project ECHO telementoring.</p> <p>TR10. Mental Health Parity. Review procedures for mental health parity laws to ensure compliance.</p> <p>TR11. IMD Waiver. Explore waiver of Medicaid Institutions for Mental Diseases (IMD) exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment.</p>	<p>Recommendation 1.1 Addressing Capacity (2019). Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.</p> <p>Recommendation 1.2 Regional Community Crisis Center Locations (2019). Develop regional community crisis centers across the state including co-located or integrated SUD services.</p> <p>Recommendation 2.4 IMD Waiver (2019): Seek revocation or waiver of the federal IMD exclusion rule to allow federal Medicaid funds for both SUD and psychiatric inpatient treatment.</p>	<p>No relevant considerations.</p>

<p>Tier Three Recommendation:</p> <p>Maximizing Federal Funding. The State of Kansas should conduct an audit of potential funding streams by program area to ensure the State is maximizing federal benefits.</p> <p>Tier Three Recommendation:</p> <p>Resources and Accountability. The State of Kansas and DCF should provide services that are in the best interest of children in their care by supporting a system that is accountable and resourced well enough to provide the needed services. Considerations should include, but not be limited to, the awarding of funds based upon qualifications and not financial factors, improving workforce morale and tenure, and providing technology to improve efficiencies.</p>	<p>CAODA Recommendation. Facilitate a pursuit of grant funding. Recommend creating a new state-level grant-support position to work directly with agencies to help secure and maintain these opioid-related funds as well as other addiction prevention and treatment opportunities. A state-level coordinator could provide the grant-specific expertise. Recommend the State continue to incrementally increase the proportion of money to the Problem Gambling and Other Addictions [Grant] Fund.</p>	<p>TR13. KanCare. Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans.</p> <p>TR15. Senate Bill 123. Assure adequate funding for SB 123 (2003) [provides certified SUD treatment for offenders convicted of drug possession who are nonviolent with no prior convictions] to allow appropriate provision of medically necessary treatment services and allow for an expanded list of qualifying offenses.</p> <p>TR17. Addiction Treatment. Create additional services for the treatment of addiction as well as any co-occurring mental health diagnoses.</p> <p>TR18. Sober Housing. Study the efficacy of sober housing and strategies for success from other states including funding mechanisms.</p>	<p>Recommendation 2.3 Excellence in Mental Health (2019). Support expansion of the federal Excellence in Mental Health Act and then pursue participation.</p> <p>Recommendation 2.5 Medicaid Expansion (2019). Adopt Medicaid expansion to cover adults under the age of 65 with income up to 138 percent of the federal poverty level (FPL) to pursue solutions for serving the uninsured and underinsured, which will improve access to behavioral health services.</p>	
		<p>PE6. K-TRACS Funding. K-TRACS should be sustainably funded by the State General Fund after any available grant funding is exhausted.</p>	<p>Recommendation 2.4 Funding for Crisis Stabilization Centers (2018). If Crisis Stabilization Centers are to be part of the state safety net system, the State must provide ongoing base funding for these services. The structure of Medicaid should be robust enough to sustain these services. Make sure that services are available to the uninsured and underinsured.</p>	

			Recommendation 3.2 Number of Beds. Develop a plan to add more than 300 additional hospital beds, or create and expand alternatives that would reduce the number of new beds needed. The Kansas Department for Aging and Disability Services (KDADS) should execute a study to determine a Kansas-specific estimate of beds needed, while simultaneously moving forward with implementing other recommendations included in this report to provide a functioning safety net to eliminate the waiting list at Osawatomie State Hospital.	
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Topic 3. Community Engagement				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier Two Recommendation: Reintegration Support. The State of Kansas should provide consistent, individualized, evidence-based support throughout reintegration for children in need of care and caregivers, including, but not limited to, parents and foster parents.</p> <p>Tier Two Recommendation: Foster Homes. The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training and providing additional financial incentives that support older youth, high-needs children, and birth families, as well as modifying licensing requirements.</p>	<p>Veterans Subcommittee (VS) Recommendation. Increase engagement of stakeholders, consumers, families, and employers through the Kansas Department of Health and Environment (KDHE) or KDADS by requiring agencies implementing IPS to create opportunities for assertive outreach and engagement for consumers and families.</p> <p>Justice Involved Youth and Adult Subcommittee (JIYAS) Recommendations. Engage community partners using three pilot communities that the workgroup identified, which would involve a coordinated effort between the Kansas Department of Corrections (KDOC), CMHCs, and SUD providers.</p> <p>SPW Recommendations. Encourage the development of new local coalitions and enrichment of collaborating existing local coalitions each bringing unique perspectives and resources for effective suicide prevention initiatives. Support and increase availability of support groups for survivors of suicide loss.</p>	<p>Prev4. Community Collaboration. Increase collaboration with community partners to enhance their capacity to develop and implement local-level prevention efforts for prescription drug, illicit opioid, methamphetamine, and other drug misuse and overdose.</p> <p>TR12. Treatment Navigator. Develop a statewide treatment navigator.</p> <p>LE1. Community-Based Liaison. Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for those [justice-involved individuals] with SUD and co-occurring conditions .</p>	No relevant recommendations.	No relevant considerations.

Tier Three Recommendation: Court Appointed Special Advocates (CASAs). The Legislature shall fund CASAs to ensure the availability of CASA volunteers in all jurisdictions, without disrupting the current funding CASAs receive from the State of Kansas.				
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Work Group 2: Policy and Treatment				
Topic 4. Prevention and Education				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier Two Recommendation: Safety Net, Early Childhood Programs, and Early Intervention. The State of Kansas should fully fund, strengthen, and expand safety net and early childhood programs through public services (DCF, mental health, substance abuse, and education) and community-based partner programs, and reduce barriers for families needing to access concrete supports. The State of Kansas should ensure availability and adequate access to early childhood behavioral health services statewide. the Task Force recommends consideration of related Mental Health Task Force recommendations 1.2 (Medicaid Expansion Models), 1.3 (Housing), 3.1 (Regional Model), and 6.4 (Early Intervention).</p>	<p>SPW Recommendations. Write, distribute, and promote op-eds, and disseminate information about safe messaging covering suicide, and urge the development of effective materials including through local media outlets. Increase number of trainings and workshops to promote and support application of best practices and evidence-based approaches in the field of suicidology among Behavioral Sciences Regulatory Board (BSRB) licensed behavioral health practitioners and community gatekeepers when working to prevent suicides.</p> <p>PS Recommendations. Form an evidence-based practices workgroup (EBW) for behavioral health promotion. An EBW could promote more use of evidence-based strategies to better integrate promotion, prevention, treatment, and recovery services. Priority areas for initial EBW focus include marijuana, opioids, and strategies to help 18-25 year olds.</p> <p>CAODA Recommendation. Work to publicize the availability of prevention tools that may be used by community groups, schools, and families at www.kansaspreventioncollaborative.org.</p>	<p>PE 1. Centralized Authority. Centralize coordination of substance use disorder policy and provider education.</p> <p>PE2. Provider Training. Provide training and continuing education programs for healthcare professionals. Healthcare programs should include in curricula additional education on opioid prescribing, addictions, MAT, pain management and risk identification.</p> <p>PE3. K-TRACS Education. Develop and disseminate materials on K-TRACS and U.S. Centers for Disease Control and Prevention (CDC) guidelines to healthcare providers and students.</p>	<p>Recommendation 6.4 Early Intervention (2018). Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment, and treatment. Ensure children and caregivers are screened and assessed at regular intervals in early childhood programs. Based on the screening results, work in collaboration with partners to address adverse childhood experiences (ACEs) and sources of toxic stress.</p> <p>Recommendation 2.2 Care Management Program (2019). Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt into a health home to have access to activities that help coordinate care.</p>	<p>No relevant considerations.</p>

		<p>PE 10. Coroner Letters. Explore the feasibility of and consider a pilot program for coroners or medical examiners sending educational letters to prescribing providers upon their own patient's death from prescription drug or other illicit substance overdose.</p> <p>PE12. Provider MAT Training. Increase capacity and access to MAT in Kansas through provider training on MAT.</p> <p>Prev1. Promote Safety. Promote safe use, storage, and disposal of prescription medications, including opioids, to prevent misuse and illicit acquisition and distribution.</p>		
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		<p>Prev2. Disposal Sites. Expand medication disposal sites in gap areas to ensure that there is a minimum of one medication disposal site in each Kansas county.</p> <p>Prev3. Awareness. Develop and disseminate educational materials for both professional and non-professional audiences on the issues of prescription drug, opioid, methamphetamines, and other drugs misuse, abuse, overdose, and mitigation strategies.</p> <p>Prev4. Fund Prevention. Establish and sustain permanent funding sources for primary, secondary, and tertiary prevention associated with prescription drugs, opioids, alcohol, methamphetamines, and other drug misuse for all ages.</p>		
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Topic 5. Treatment and Recovery				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier Two Recommendation: Foster Care Re-entry and Transitional Services. The State of Kansas should provide young adults age 18-21 with the option to seamlessly re-enter the child welfare system, and ensure continuity in medical, behavioral health, and support services for youth who have exited the custody of DCF.</p> <p>Tier Three Recommendation: Immediate Response. The State of Kansas should provide immediate response 24/7 to hotline calls and dedicated immediate response investigators to be dispatched and warranted.</p>	<p>Housing and Homelessness Subcommittee (HAHS) Recommendation. Expand and advance SSI/SSDI Outreach, Access, and Recovery (SOAR) program, which is a federal program designed to help states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and have a mental illness or other co-occurring disorders.</p>	<p>TR1. Expand MAT. Expand Access and utilization of MAT.</p> <p>TR2. Buprenorphine Prescribers. Increase the number of buprenorphine-waivered prescribers practicing in Kansas and incentivize buprenorphine training for providers.</p>	<p>Recommendation 1.3 Warm Hand-Off (2019). Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model.</p> <p>Recommendation 3.2 Intensive Outpatient Services (2019). Expand community-based options such as intensive outpatient services.</p> <p>Recommendation 3.3 Psychiatric Residential Treatment Facility (PRTF) (2019). Re-establish the purpose of PRTFs.</p> <p>Recommendation 6.3 Quality of Care (2018). Managed care organizations (MCOs) contracts should incentivize PRTF readmissions instead of reduced lengths of stay.</p>	<p>Services for Crossover Youth. The Working Group's limited scope of review could not speak to the cost per crossover youth and any claims denied for reimbursement for a child's behavior problems. The Working Group further suggests researching the effect of therapeutic environment on care of youth with higher levels of aggression in a PRTF and the impact of such youth on other youth in care settings.</p>
			<p>Recommendation 4.2 Presumptive Approval of Medicaid (2019). Coordinate with KDHE and determine if a policy could be developed or revised that facilitates presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs.</p> <p>Recommendation 6.1 Suicide Prevention (2019). Place a focus on reversing negative suicide trends for youth and adults.</p>	

Topic 6. Special Populations				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier Two Recommendation: Non-Abuse Neglect. The State of Kansas should provide differential responses for newborns and refer them to evidence-based services.</p> <p>Tier Three Recommendation: Serious Injury Review. The State of Kansas, in accordance with federal and state confidentiality laws, should formalize a Serious Injury Review Team to establish and conduct a review process both internally and externally for an immediate and necessary response when a child dies or suffers serious bodily injury after having previous contacts with DCF Protection and Prevention Services concerning prior abuse and neglect.</p>	<p>Rural and Frontier Subcommittee (RFS) Recommendation. Increase funding for crisis beds for the non-insured and underinsured to fill the gap in rural and frontier areas of the state.</p> <p>VS Recommendation. Expand the three-day crisis intervention training across the state for police and first responders concerning veterans in a mental health crisis.</p>	<p>NAS1. Educate and Intervene. (Neonatal Abstinence Syndrome [NAS]). Provide education, screening, intervention, and support to substance-using women to reduce the number of infants born substance-exposed, while expanding coverage for family planning services, preconception services, and a variety of contraceptives, including long-acting reversible contraceptives.</p> <p>NAS2. Standardize Care. Provide education on best practices to reduce stigma and promote standardized care regarding NAS cases, develop a standardized reporting process for NAS cases across the state, and offer universal training and continuing education through the Vermont Oxford Network NAS Universal Training Program to Kansas birthing centers.</p> <p>NAS3. Women and Family Treatment Centers. Increase the number and capacity of designated women and family treatment centers across the state.</p> <p>NAS4. MAT in Pregnancy. Increase access to MAT for pregnant women.</p>	<p>Recommendation 3.1 Access to Effective Practices and Support (2019). Deliver crisis, clinical, and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.</p> <p>Recommendation 3.5 Transition Age Youth (2019). Request a formal joint report to Legislature by corrections, education, and health and human services agencies on programs, coordinated efforts, and any collective recommendations for populations identified in 2016 SB 367.</p>	<p>Child Welfare Placements. The working group suggests exploring what supports/services are lacking and prevent permanency from being achieved regarding placement stability of crossover youth placed in foster care.</p>

Work Group 3: System Capacity and Transformation

Topic 7. Data Systems

Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier One Recommendation: Data Infrastructure. The State of Kansas should create a single, cross-system, web-based, integrated case management and data reporting system that can be used by DCF and all relevant agencies and stakeholders to efficiently and effectively share information (e.g., education, dental, medical, behavioral).</p> <p>Tier Two Recommendation: Information Sharing. The State of Kansas should establish a multi-disciplinary approach and share information across and among stakeholders, irrespective of state borders, in accordance with federal and state laws.</p>	<p>PS Recommendations. Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment. Integrate and utilize the guidance of a state epidemiological workgroup. Enhance data collection procedures— change legislation regarding public behavioral/health youth surveys (e.g., the Kansas Communities That Care (KCTC) Student Survey and the Youth Risk Behavior Surveillance System (YRBSS) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection and availability of data decision making.</p> <p>AODA Recommendations. Reverse the active consent policy that currently requires active parent consent on the KCTC. Explore options to report county data about substance use, treatment access, and outcomes to agencies in order to aid in strategizing local and state response to addiction.</p>	<p>Prev5. Data. Collect, analyze, use, and disseminate surveillance data to inform prevention efforts and monitor trends in at-risk populations.</p> <p>Prev6. Survey Opt-Out. Change legislation regarding public health and behavioral health state surveys (KCTC and YRBSS) from an opt-in consent, to an informed opt-out consent to allow for meaningful data collection).</p> <p>TR4. Needs Assessment. Conduct a statewide needs assessment to identify gaps in funding, access to SUD treatment providers and identify specific policies to effectively utilize and integrate existing SUD treatment resources.</p>	<p>Recommendation 2.1 Reimbursement Rates (2019). Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.</p>	<p>Demographics: Potential future topics to study regarding demographic characteristics were to include primary language and geographic distribution amongst crossover youth across Kansas.</p> <p>Child Welfare Placements: Based upon findings by the working group, the working group proposes future efforts to study strategies for engaging relatives to care for crossover youth, collecting data on outcomes for youth placed in group residential homes, and understanding whether youth who might have been detained prior to SB 367 are now being placed in the child welfare system.</p>

Topic 8. Interaction with the Legal System and Law Enforcement				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier Two Recommendation: Code of Care of Children. The Judicial Council should review the Code for Care of Children (CINC Code), especially with regard to: a) the way DCF's definition of "non abuse neglect" relates to cases under the CINC Code, and b) modifications to meet the child's ongoing best interests for permanency.</p>	<p>JIYAS Recommendations: Endorse and focus on the issue of high behavioral health acuity releases from KDOC and any other jail entity. Primary issues include integration of services from incarcerated status to community; focus on high acuity need individuals who may be difficult to house with sexual offenders and offenders with poor impulse control; offenders who have been screened for civil commitment and alternatives commitment; and substance use treatment upon release.</p>	<p>LE2. Benefits Reinstatement. Develop reinstatement policies or procedures to increase the ability of offenders to access Medicaid benefits upon release, such as suspending benefits rather than termination upon incarceration.</p> <p>LE3. Diversion Sobriety and Treatment. Expand pre-charge and post-charge diversion sobriety and treatment options for first time, non-violent simple drug possession charges.</p> <p>LE4. Naloxone. Promote Naloxone education and use for first responders and pursue all available funding.</p>	<p>Recommendation 1.5 Suspension of Medicaid (2019). Implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care.</p>	<p>Demographics: Future efforts should focus on operationalizing a definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population.</p> <p>Law Enforcement Agency Administrative Survey: A future study consideration stated the survey that the Working Group administered did not assess individual behaviors by law enforcement officers responding to juvenile incidents. In addition, potential future topics to study include age at first arrest, number of arrests while in the custody of the state, and differences in criminal charges in arrest records compared to final criminal charges stated in adjudication.</p>

		<p>LE5. Law Enforcement Referrals. Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact (this includes securing funding to increase access to services for this population).</p> <p>LE6. Good Samaritan. Enact a 911 Good Samaritan Law. This law must be crafted to avoid unintentionally allowing persons to avoid persecution for serious felony charges, especially when their actions directly involved providing illicit substance to the ill individual.</p>		<p>Law Enforcement Agency Administrative Survey: The analysis for numbers and nature of alleged offender behaviors of crossover youth taken into custody by law enforcement pursuant to KSA 38-2330(d)(1) and amendments thereto could not be conducted. If data are consistently and reliably collected in the future, topics of interest may include relationship between crime classification and age of youth, additional law enforcement outcomes beyond arrests stemming from juvenile law enforcement contact, and geographic distribution of particular offense, including anecdotal "hot spots" for juvenile law enforcement calls.</p>
		<p>LE7. Correctional Employees. Provide training in correctional facilities to allow employees to better recognize those with substance use disorders and other mental health needs and connect those with needs available to services.</p>		

Topic 9. System Transformations				
Child Welfare System Task Force	Governor's Behavioral Health Services Planning Council Subcommittees	Governor's Substance Use Disorders Task Force	Mental Health Task Force	Crossover Youth Working Group
<p>Tier Two Recommendation: Analysis of Service Delivery. The State of Kansas should establish a work group or task force to conduct an analysis to: 1) determine what it costs to adequately fund high-quality child welfare services; 2) by 2021, evaluate the benefits of privatizing child welfare services; and 3) determine the best public/private collaboration to deliver child welfare services. DCF shall determine appropriate outcomes measures and periodic evaluations shall be conducted to ensure contractors are achieving set outcomes and provide opportunities for ongoing collaboration and review. Summary reports should be provided to the Legislature annually.</p>	<p>PS Recommendations. Increase healthcare linkages and identify care transition best practices for mental health, substance abuse, and emergency departments across the state. Periods following discharge from these settings are times of particularly high risk for suicide. A model for follow-up with clients during this period should be implemented in Kansas. Modify the KDADS requirements to become approved to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to Medicaid-eligible clients.</p> <p>VS Recommendation. The State of Kansas should apply for a demonstration waiver to provide employment supports and other services for individuals with behavioral health issues on Medicaid.</p>	<p>TR6. Service Integration. Adopt coding practices that allow for the integration of services across the continuum of care domains (e.g., primary care, substance use disorder, and mental health) to provide more integrative services to clients with co-occurring conditions.</p> <p>TR7. SBIRT. Increase access to and utilization of SBIRT across health care provider disciplines by reimbursing appropriately trained and licensed professionals to provide this service across locations.</p> <p>TR8. Payment Reform. Support substance use disorder payment reform targeted to improve population health.</p> <p>TR14. Kansas Placement Criteria Program (KCPC). Replace KCPC with modern technology and data collection mentors consistent with current and future electronic health recodes to prevent major systematic failure.</p>	<p>Recommendation 1.4 Comprehensive Housing (2019). Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness, and/or substance use disorders.</p> <p>Recommendation 4.1 Licensing Structure (2019). Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care.</p>	<p>Juvenile Intake and Assessment: The review of Juvenile Intake and Assessment Services was limited in scope to only FY 2019. Data from intake and assessments completed throughout a youth's lifetime should be reviewed. Robust analysis from completed the Kansas Detention Assessment Instrument (KDAI) could be conducted when integrated into the data system.</p>

			<p>Recommendation 7.1 Learning Across Systems (2019). Create a position/entity to track information about adverse outcomes that occur and identify strategies for addressing them in a timely manner.</p> <p>Recommendation 4.2 Regional Model (2018). In lieu of a single request for proposal, the Task Force recommends a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care.</p>	
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Mental Health Modernization and Reform Committee – Working Group Charter

Purpose

The Special Committee on Mental Health Modernization and Reform (the Committee) was tasked to analyze the state's behavioral health system to ensure that both inpatient and outpatient services are accessible in communities, review the capacity of current behavioral health workforce, study the availability and capacity of crisis centers and substance abuse facilities, assess the impact of recent changes to state policies on the treatment of individuals with behavioral health needs; and make recommendations on steps needed to make Kansas a nationwide leader on behavioral health delivery, specifically focusing on how Kansas should modernize its behavioral health delivery system.

To achieve this directive, the Committee established three working groups related to Finance and Sustainability; Policy and Treatment; and System Capacity and Transformation. The three working groups will work in between each of the Committee meetings and report back on progress as requested. The Committee will determine what information from the working groups is included in a final product to the legislature. In addition to this determination on final products, the Committee will also provide leadership to the working groups through the development of a guiding vision statement for the final product, the identification of key performance indicators to be included in a final product and input on any criteria that should inform the priorities put forward by the working groups.

Scope

- Finance and Sustainability – workforce, funding and accessibility, community engagement
- Policy and Treatment – prevention and education, treatment and recovery, special populations
- System Capacity and Transformation – data systems, interaction with the legal system and law enforcement, system transformation

Note: Topics as designated in crosswalk of behavioral health and mental health recommendations. Any additional topics identified by the Committee should be assigned to a work group.

Related to each of these topics the working groups will review and update past recommendations, additionally the working groups may identify new recommendations as needed. All recommendations will seek to include the following:

- Identified policy mechanism through which the recommendation could be made actionable
- Available notes related to net costs that may affect the feasibility of implementation
- Identify collaborating partners to ensure effective implementation
- Available notes related to equity or sustainability that should inform how recommendation implementation is prioritized
- Address any known barriers related to the implementation of the recommendation

Working groups will seek to make recommendations to promote health, equity and sustainability, support cross-sector collaboration, define mutually beneficial goals, engage stakeholders and create structural change.

Product

The working groups will share a summary of their work for consideration by the Committee in their final product. It is expected that the final product from the Committee will provide long-term strategic direction for the modernization and reform of the mental health system in Kansas. This final product is also anticipated to have immediate, near term action steps to support the implementation of this plan.

Membership

Membership in working groups will be voluntary. Working group membership may be considered in the following categories.

- **Chair and Vice Chair:** The Chair and the Vice Chair of the group should be identified from among the content experts included in the working group. Working group staff may consult with the Chair and Vice Chair when timely decisions must be made about agenda and other meeting logistics. The Chair and Vice Chair should be ready to volunteer to present to the Committee on the product and process of their working group.
- **Content Experts:** Content experts on the working group should aim to participate with the goal of sharing information related to their expertise and using that expertise to ask questions of others in the group. Content experts may be asked to present information shared in the working groups with the full Committee.
- **Legislature:** Members of the special committee could volunteer to participate in the meetings of the working groups as consultants with the goal of gathering information that may inform the final prioritization provided by the committee. Legislative expertise will be especially valuable to the working groups in identifying policy levers by which the aims identified by content experts may be achieved.

Individuals with supplemental expertise (e.g., state agency staff) may be invited to attend the working group to provide information as appropriate.

Operating Process

Each working group will be guided by the following operational processes.

- Active virtual engagement
- Consensus-based decision making
- Virtual meetings up to two-times per month
- Review relevant reports and materials ahead of meetings
- Come ready to discuss and compromise
- Working groups will be live streamed to allow for public viewing and relevant materials to the meeting will be shared with members and stakeholders
- Working group may set other ground rules as needed to support their effective collaboration

Strategic Framework for Modernizing the Kansas Behavioral Health System

*Working Groups Report to the Special Committee
on Mental Health Modernization and Reform*

December 18, 2020

Acknowledgments

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Report Overview

The Special Committee on Mental Health Modernization and Reform (Special Committee) was tasked with analyzing the state’s behavioral health system and developing a strategic effort to modernize the system.

To achieve this directive, the Special Committee established three Working Groups to review and update recommendations from five previous collaborative efforts to improve components of the behavioral health system.

The Working Groups established by the Special Committee included those on Finance and Sustainability (WG1), Policy and Treatment (WG2) and System Capacity and Transformation (WG3). This report summarizes the work of those groups. This effort was made possible by the previous work of the Child Welfare

System Task Force, the Governor’s Behavioral Health Services Planning Council, the Governor’s Substance Use Disorder (SUD) Task Force, the Mental Health Task Force and the Crossover Youth Working Group. Recommendations from these past efforts provided the foundation for this report.

The behavioral health system refers to the system of care that includes the promotion of mental health, resilience and well-being; the prevention, referral, diagnosis, and treatment of mental and substance use disorders; and the support of persons with lived experience in recovery from these conditions, along with their families and communities.

Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)

Navigating this Report: High-priority recommendations are included in Figure 1 (page vi) and are designated as either:

- **Immediate Action** are those that the Working Groups believe can be completed in the next two years.
- **Strategic Importance** are those that should be initiated in the near term but will be completed in the longer term.

In addition to high-priority recommendations, the group also offered one high-priority discussion item to urge the Special Committee to consider the potential contribution of Medicaid expansion to a modernized behavioral health system. Recommendations not considered a high-priority are available in *Appendix A*, page A-1.

This report summarizes the efforts of the three Working Groups to put forward recommendations to the Special Committee. High-priority recommendations are sorted by topic, either for immediate action or for strategic importance. Topics around which the Working Groups were asked to make recommendations include workforce, funding and accessibility, community engagement, prevention and education, treatment and recovery, special populations, data systems, interactions with the legal systems and law enforcement, system transformation and telehealth.

Recommendations in this report collectively form a strategic framework that can be considered a ‘living document’ to support ongoing collaboration between the many contributing partners in the behavioral health system, government agencies and state Legislature.

Vision for Modernization

At meetings of the Special Committee between August and October 2020, Working Group, roundtable and Special Committee members discussed each of the ten identified topics to articulate a vision for modernization. The following key points summarize those discussions. More detail related to the vision discussion is included in the section of the report corresponding to each topic.

- **Workforce.** A modernized workforce is one where behavioral health staffing is adequate to meet needs across rural, frontier and urban areas of the state. Telehealth will play a role in meeting needs, but local staffing will remain important. Modernization will require both growing the workforce and retaining staff. (See [page 7](#)).
- **Funding and Accessibility.** A modernized approach to funding behavioral health will require continuous and timely pursuit of new funding mechanisms to ensure that reimbursement rates are competitive. Accurate and appropriate funding of care for Kansans is a key element of a sustainably funded, modern behavioral health system. A modern system will identify the right populations to serve, make services meaningfully accessible and rely on measurable outcomes to drive decisions. (See [page 11](#)).
- **Community Engagement.** Effective community engagement in a modernized behavioral health system will include a collaboration of individuals in recovery and behavioral health providers to support key efforts. Key efforts include those to support employment, re-entry planning for incarcerated individuals, behavioral health supports and education for foster homes. (See [page 17](#)).

- **Prevention and Education.** Modernized prevention efforts will seek to meet the behavioral health needs of populations at increased risk for poor outcomes, requiring a collaborative, trauma-informed approach and appropriate funding. (See [page 22](#)).
- **Treatment and Recovery.** A modernized behavioral health system will deliver an expanded array of early, affordable, accessible, evidence-informed behavioral health services for all, with an emphasis in serving consumers in the settings that are most likely to support effective engagement with treatment, and with meaningful coordination and collaboration across disciplines and settings. (See [page 26](#)).
- **Special Populations.** To serve special populations in a modernized behavioral health system, data, consumers and families will drive the system. Building on existing strengths, a modernized approach will be integrated, proactive and responsive whenever there is a need or a self-identified crisis, and data will be used to understand disparities. (See [page 30](#)).
- **Data Systems.** A modernized system will require a seamless, real-time data system with multi-directional data sharing among behavioral health providers, other health care providers and systems, community organizations, social service providers and payers. A collaborative data system will support reporting of measurable outcomes while maintaining privacy protections. (See [page 35](#)).
- **Interactions with the Legal System and Law Enforcement.** Through collaboration, a modernized behavioral health system will have the ability to make timely connections for individuals in crisis to services in the least restrictive setting appropriate to ensure safety. (See [page 40](#)).
- **System Transformation.** A modernized system will work in both evidence-based treatment and prevention with focus on the patients to address a continuum of needs. Transformation will result in a mission-driven, rationally funded and outcome-oriented system that uses data to identify problems and develop solutions. (See [page 44](#)).
- **Telehealth.** A modernized behavioral health system will deliver technologically current telehealth services as a strategy to provide meaningful access to care across rural, frontier and urban areas. These services will be high-quality, integrated with other modes of care delivery and ensure consumer choice and privacy, in addition to supporting the full spectrum of behavioral health care. (See [page 49](#)).

High-Priority Items for Special Committee Consideration

Figure 1. Working Group High-Priority Recommendations by Topic

WORKFORCE
Immediate Action
<u>Recommendation 1.1 Clinical Supervision Hours</u> . Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers.
<u>Recommendation 1.2 Access to Psychiatry Services</u> . Require a study be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses. [Note: The Committee requests consideration be given to educational institutions, regardless of size, that can provide this expertise and assistance.]
<u>Recommendation 1.3 Provider MAT Training</u> . Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT.
Strategic Importance
<u>Recommendation 1.4 Workforce Investment Plan</u> . The State of Kansas should 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. Specific steps include: <ul style="list-style-type: none"> • Develop a career ladder for clinicians, such as through the development of an associate's-level practitioner role; and • Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency.
<u>Recommendation 1.5 Family Engagement Practices</u> . Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families.

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

FUNDING AND ACCESSIBILITY
Immediate Action
<p><u>Recommendation 2.1 Certified Community Behavioral Health Clinic Model.</u> Support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model.</p>
<p><u>Recommendation 2.2 Addressing Inpatient Capacity.</u> Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.</p>
<p><u>Recommendation 2.3 Reimbursement Rate Increase and Review.</u> Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a Working Group to regularly review the reimbursement rates available for behavioral health services, including mental health and substance use disorder treatment.</p>
<p><u>Recommendation 2.4 Suicide Prevention.</u> Allocate resources to prioritized areas of need through data driven decision-making. Assist local suicide prevention efforts and promote local support groups in fund-raising efforts, building capacity, and increasing availability for survivors of suicide loss. Dedicate resources and funding for suicide prevention.</p>
<p><u>Recommendation 2.5 Problem Gambling and Other Addictions Fund.</u> Recommend the State continue to incrementally increase the proportion of money in the Problem Gambling and Other Addictions [Grant] Fund that is applied to treatment over the next several years until the full fund is being applied as intended.</p>
High-Priority Discussion
<p>In addition to these recommendations for immediate action and of strategic importance, the Finance and Sustainability Working Group also puts forward the issue of Medicaid expansion as a high-priority discussion item for the Special Committee. The recommendation discussed by the Working Group related to Medicaid Expansion read, “Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans.” More information on this item is available in the Funding and Accessibility section beginning on page 16.</p>

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

COMMUNITY ENGAGEMENT	
Immediate Action	
<u>Recommendation 3.1: Crisis Intervention Centers</u> . Utilize state funds to support the expansion of crisis centers around the state.	
<u>Recommendation 3.2 IPS Community Engagement</u> . Increase engagement of stakeholders, consumers, families, and employers through the Kansas Department of Health and Environment (KDHE) or Kansas Department for Aging and Disability Services (KDADS) by requiring agencies implementing the Individual Placement and Support (IPS) program to create opportunities for assertive outreach and engagement for consumers and families.	
Strategic Importance	
<u>Recommendation 3.3 Foster Homes</u> . The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth.	
<u>Recommendation 3.4 Community-Based Liaison</u> . Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and co-occurring conditions.	
PREVENTION AND EDUCATION	
Immediate Action	
<u>Recommendation 4.1 988 Suicide Prevention Line Funding</u> . Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources.	
<u>Recommendation 4.2 Early Intervention</u> . Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment, and treatment.	
<u>Recommendation 4.3 Centralized Authority</u> . Centralize coordination of behavioral health – including substance use disorder and mental health – policy and provider coordination in a cabinet-level position.	
Strategic Importance	
<u>Recommendation 4.4 Behavioral Health Prevention</u> . Increase state funds for behavioral health prevention efforts (e.g., SUD prevention, suicide prevention).	

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

TREATMENT AND RECOVERY	
Immediate Action	
<p><u>Recommendation 5.1 Psychiatric Residential Treatment Facilities.</u> Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools.</p>	
Strategic Importance	
<p><u>Recommendation 5.2 Service Array.</u> Explore options to expand the behavioral health service array, including the expansion of MAT in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured.</p>	
<p><u>Recommendation 5.3 Frontline Capacity.</u> Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.</p>	
<p><u>Recommendation 5.4 Housing.</u> Expand and advance the SSI/SSDI Outreach, Access, and Recovery (SOAR) program (including additional training regarding youth benefits) and the Supported Housing program.</p>	

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

SPECIAL POPULATIONS	
Immediate Action	
<u>Recommendation 6.1 Domestic Violence Survivors.</u>	Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies and community providers serving individuals impacted by domestic violence.
<u>Recommendation 6.2 Parent Peer Support.</u>	Increase access to parent peer support for caregivers and families of youth in the behavioral health system, including ensuring appropriate supports for fathers of dependent children.
Strategic Importance	
<u>Recommendation 6.3 Crossover Youth.</u>	Continue to develop linkages between the behavioral health system, juvenile justice system and the child welfare system to increase understanding of treatment options available to youth externalizing trauma in the crossover youth population as current treatment options are not meeting the needs of this population. Then, develop specialty services to meet the needs of this population.
<u>Recommendation 6.4 I/DD Waiver Expansion.</u>	Fully fund the I/DD waiver and expand I/DD waiver services. Increase reimbursement rates for I/DD services to support workforce expansion.
<u>Recommendation 6.5 Family Treatment Centers.</u>	Increase the number and capacity of designated family SUD treatment centers as well as outpatient treatment programs across the state.

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

DATA SYSTEMS	
Immediate Action	
<u>Recommendation 7.1 State Hospital EHR.</u>	The new state hospital electronic health record (EHR) system should be interoperable with other data systems in the state. Interoperability should include the ability to automate the current process to reinstate Medicaid benefits following discharge.
<u>Recommendation 7.2 Data and Survey Informed Opt-Out.</u>	Collect, analyze, use, and disseminate surveillance data to inform prevention. Change legislation regarding public health and behavioral health state surveys, including changing the Kansas Communities That Care (KCTC) and Youth Risk Behavior Surveillance System (YRBSS) surveys from an opt-in consent to an informed opt-out consent, to allow for meaningful data collection.
<u>Recommendation 7.3 Information Sharing.</u>	Utilize Medicaid funds to incentivize participation in health information exchanges (e.g., LACIE/KHIN). Explore health information exchanges as information source on demographic characteristics, such as primary language and geography for crossover youth and other high priority populations.
<u>Recommendation 7.4 Needs Assessment.</u>	Conduct a statewide needs assessment to identify gaps in funding, access to SUD treatment providers and identify specific policies to effectively utilize, integrate and expand SUD treatment resources.
Strategic Importance	
<u>Recommendation 7.5 Cross-Agency Data.</u>	Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

LEGAL SYSTEM AND LAW ENFORCEMENT	
Immediate Action	
<u>Recommendation 8.1 Correctional Employees.</u>	Expand training provided in correctional facilities to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services.
<u>Recommendation 8.2 Criminal Justice Reform Commission Recommendations.</u>	Implement recommendations developed by the Criminal Justice Reform Commission (CJRC) related to specialty courts (e.g., drug courts) and develop a process for regular reporting on implementation status and outcomes.
<u>Recommendation 8.3 Law Enforcement Referrals.</u>	Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact (this includes securing funding to increase access to services for this population).
Strategic Importance	
<u>Recommendation 8.4 Defining Crossover Youth Population.</u>	Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population.

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

SYSTEM TRANSFORMATION	
Immediate Action	
<p><u>Recommendation 9.1 Regional Model.</u> Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas.</p>	
<p><u>Recommendation 9.2 Long-Term Care Access and Reform.</u> Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care. Increase access to long-term care (LTC) facilities, particularly for individuals with past involvement with the criminal justice system or those with a history of sexual violence.</p>	
<p><u>Recommendation 9.3 Integration.</u> Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. Adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions.</p>	
Strategic Importance	
<p><u>Recommendation 9.4 Evidence Based Practices.</u> Kansas should continue and expand support for use of evidence based practices (EBP) in the state, including for housing and supported employment. Coordinate EBP utilization across systems (e.g., law enforcement, SUD, mental health care) with a goal of implementing programs with fidelity, when possible.</p>	
<p><u>Recommendation 9.5 Family Psychotherapy.</u> Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility.</p>	

Figure 1 (continued). Working Group High-Priority Recommendations by Topic

TELEHEALTH	
Immediate Action	
<p><u>Recommendation 10.1 Quality Assurance.</u> Develop standards to ensure high-quality telehealth services are provided. This includes:</p> <ul style="list-style-type: none"> • Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies. • Requiring standard provider education and training. • Ensuring patient privacy. • Educating patients on privacy-related issues. • Allowing telehealth supervision hours to be consistently counted toward licensure requirements. • Allowing services to be provided flexibly when broadband access is limited. 	
<p><u>Recommendation 10.2 Reimbursement Codes.</u> Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.</p>	
<p><u>Recommendation 10.3 Telehealth for Crisis Services.</u> Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities.</p>	
Strategic Importance	
<p><u>Recommendation 10.4 Originating and Distant Sites.</u> The following items should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations:</p> <ul style="list-style-type: none"> • Adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act. • Allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met. • Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts. 	
<p><u>Recommendation 10.5 Child Welfare System and Telehealth.</u> Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Consider how the unique needs of parents of children in the child welfare system can be met via telehealth.</p>	

Introduction

The 2020 Special Committee on Mental Health Modernization and Reform (Special Committee) was directed as follows:

“Analyze the Kansas behavioral health system to ensure that both inpatient and outpatient services are accessible in communities, review the capacity of the current behavioral health workforce, study the availability and capacity of crisis centers and substance use disorder treatment facilities, assess the impact of recent changes to State policies on the treatment of individuals with behavioral health needs, and make recommendations on steps needed to make Kansas a nationwide leader on behavioral health delivery, specifically focusing on how Kansas should modernize its behavioral health delivery system.” Legislative Coordinating Council, June 18, 2020

To achieve this directive, the Special Committee utilized a roundtable format and established three Working Groups. The roundtable format engaged a wide range of experts in the discussion at each meeting of the Special Committee. From a combined pool of Special Committee members, roundtable members and state agency staff, three Working Groups were established to review and update recommendations from five previous collaborative efforts to improve components of the behavioral health system. The Working Groups established included those on Finance and Sustainability (WG1), Policy and Treatment (WG2) and System Capacity and Transformation (WG3). Additionally, volunteers from each of the three Working Groups came together in a subgroup to discuss the topic of telehealth. This report summarizes the work of those groups. This effort was made possible by the previous work of the Child Welfare System Task Force, the Governor’s Behavioral Health Services Planning Council, the Governor’s SUD Task Force, the 2017 and 2018 Mental Health Task Force and the Crossover Youth Working Group. Recommendations from these past efforts provided the foundation upon which this report has been built.

The Working Groups made recommendations based on the following topics: workforce, funding and accessibility, community engagement, prevention and education, treatment and recovery, special populations, data systems, interactions with the legal systems and law enforcement, system transformation and telehealth. Throughout this report, high priority recommendations have been designated for immediate action or of strategic importance.

- Recommendations for immediate action are those that can be completed in the next two years.
- Recommendations of strategic importance are those that should be initiated in the near-term but will be completed in the longer term.

Collectively these high priority recommendations form a strategic framework that should be considered a 'living document' to support ongoing collaboration between the many contributing partners in the behavioral health system, government agencies and state Legislature. This document is further intended to provide long-term strategic direction for the modernization and reform of the behavioral health system in Kansas.

Working Group Process

The Special Committee established the Working Groups on Finance and Sustainability, Policy and Treatment and System Capacity and Transformation. The three Working Groups reviewed, updated and prioritized recommendations related to each of the topics assigned to them and reported back to the Special Committee on progress. Membership in all Working Groups was voluntary and fall in the categories of content experts and legislative members. Additionally, individuals with supplemental expertise were invited to attend Working Group meetings to provide information on specific topics. From among content expert members of each Working Group, co-chairs were selected.

The Working Groups structured their discussions around the ten topic areas defined by the Special Committee. The Finance and Sustainability workgroup examined workforce, funding and accessibility, and community engagement. The Policy and Treatment addressed prevention and education, treatment and recovery, and special populations. The System Capacity and Transformation Working Group discussed data systems, interaction with the legal system and law enforcement, and system transformation. Lastly, members from each of the three Working Groups participated in the telehealth subgroup. Related to the assigned topics, the Working Groups reviewed and updated past recommendations, and proposed new recommendations as needed based on identified barriers. *Figure 2* (page 3) illustrates the structure of the Working Group process, including a list of meetings held by each group, as well as the topics addressed.

All Working Group decisions were reached based upon consensus. Each of the Working Groups adopted the following meeting commitments: to come ready to discuss and compromise, keep remarks succinct and on topic, not to hesitate to ask clarifying questions, and

to start and end meetings on time. As members discussed each topic and recommendations, decisions were made based on proposals offered by Working Group members and adopted by verbal agreement or absence of objections.

In order to guide discussion and ensure consistency across Working Groups, each of the three Working Groups adopted the Recommendations Rubric (*Appendix B, [page B-1](#)*) as a tool to assist in ranking and modifying existing recommendations or when writing new recommendations. Using the rubric, Working Groups were able to assign numeric values to recommendations based on a 1-10 scale for both ease of implementation and potential for high impact. Working Groups utilized these scores as they prioritized recommendations. Recommendations that were not scored during Working Group meetings were scored by a Qualtrics survey. Average scores and discussion items were reviewed at the next meeting. After review of the scored recommendations, Working Groups determined up to five high-priority recommendations for each topic.

Figure 2. Working Group Process Diagram

Special Committee on Mental Health Modernization and Reform		
Working Group on Finance and Sustainability (WG1)	Working Group on Policy and Treatment (WG2)	Working Group on System Capacity and Transformation (WG3)
<ul style="list-style-type: none"> • Meeting #1, 9/16/2020, Establish Group and Brainstorm Barriers • Meeting #2, 10/01/2020, Discuss Workforce • Meeting #3, 10/14/2020, Discuss Funding and Accessibility • Meeting #4, 10/28/2020, Discuss Community Engagement • Meeting #5, 11/02/2020, Prioritization Meeting • Meeting #6, 11/19/2020, Prioritization Meeting • Meeting #7, 12/04/2020, Finalize Report 	<ul style="list-style-type: none"> • Meeting #1, 9/15/2020, Establish Group and Brainstorm Barriers • Meeting #2, 9/29/2020, Discuss Prevention and Education • Meeting #3, 10/13/2020, Discuss Treatment and Recovery • Meeting #4, 10/23/2020, Discuss Special Populations • Meeting #5, 11/04/2020, Prioritization Meeting • Meeting #6, 11/19/2020, Prioritization Meeting • Meeting #7, 12/08/2020, Finalize Report 	<ul style="list-style-type: none"> • Meeting #1, 9/18/2020, Establish Group and Brainstorm Barriers • Meeting #2, 9/30/2020, Discuss Data Systems • Meeting #3, 10/09/2020, Discuss Interactions with the Legal System and Law Enforcement • Meeting #4, 10/22/2020, Discuss System Transformation • Meeting #5, 11/06/2020, Prioritization Meeting • Meeting #6, 11/17/2020, Prioritization Meeting • Meeting #7, 12/08/2020, Finalize Report
Telehealth Subgroup		
<ul style="list-style-type: none"> • Meeting #1, 11/10/2020, Identify Recommendations • Meeting #2, 11/13/2020, Prioritize Recommendations 		

Data Profile

Across meetings the Special Committee discussed the value of using data to closely monitor outcomes related to the behavioral health system. In addition, these data could provide the information needed to ensure that Kansas is on track to achieve a high-quality, modernized behavioral health system and that funds expended toward this end have appropriate impact.

KHI convened two meetings with state agency staff from Kansas Department for Aging and Disability Services (KDADS), Kansas Department of Health and Environment (KDHE), Kansas Department for Children and Families (DCF), Kansas Department of Corrections (KDOC), Kansas State Department of Education (KSDE) and the Kansas Attorney General's office to identify measures for two purposes: (1) to prepare a high-level data profile that would provide a systemic assessment of the state's behavioral health system (see *Figure 3*, page 5); and (2) to provide a list of process and outcomes measures that could measure the impact of many of the high priority recommendations identified by the Working Groups if implemented (see recommendation summary tables starting on [page 8](#)). Please note that the impact of COVID-19 on the behavioral health system is likely not yet reflected in the data or proposed measures included in this report, but specific measures could be added in subsequent years.

The following process measures are identified to monitor the progress on the work completed by this committee and its convened Working Groups:

- Number of recommendations implemented and
- Number of recommendations implemented with identified key collaborators.

In addition, the high-level data profile presented in *Figure 3* (page 5) would provide a systemic assessment of the state's behavioral health system, and includes only a subset of the wide range of data that are available about the Kansas behavioral health system.

Figure 3. Select Measures to Assess the Kansas Behavioral Health System

PROCESS MEASURE				
Measure:	Number		Percent	
Kansas counties recognized as a Mental Health Professional Shortage Area . <i>Lower number/percentage of counties is better.</i>	99 (2019)		94.3% (2019)	
Counties served by Mobile Response and Stabilization Services. <i>Higher number/percentage of counties is better.</i>	*		*	
Counties served by Crisis Intervention Centers. <i>Higher number/percentage of counties is better.</i>	*		*	
OUTCOME MEASURES				
Measure:	Kansas current (year)	Kansas previous (year)	U.S. current (year)	U.S. previous (year)
Uninsured rate (adults age 19-64). <i>Lower rates are better.</i>	13.1% (2019)	12.6% (2018)	12.9% (2019)	12.5% (2018)
Uninsured rate (children age 0-18). <i>Lower rates are better.</i>	5.8% (2019)	5.1% (2018)	5.7% (2019)	5.2% (2018)
Statewide age-adjusted mortality rate for suicide per 100,000 population. <i>Lower rates are better.</i>	19.9% (2017)	19.2% (2016)	15.2% (2017)	14.7% (2016)
Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities (i.e., criteria for and predictors of clinical depression). <i>Lower percentage is better.</i>	32.5% (2019)	24.8% (2017)	36.7% (2019)	31.5% (2017)
Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling. <i>Higher percentage is better.</i>	55.9% (2018-2019)	52.7% (2017-2018)	53.2% (2018-2019)	52.7% (2017-2018)
Individuals with SPMI that have been enrolled in supportive housing and have not had an ER or Psychiatric Hospital admission in the last 12 months. <i>Higher percentage is better.</i>	*	*	NA	NA

Figure 3 (continued). Select Measures to Assess the Kansas Behavioral Health System

OUTCOME MEASURES (continued)							
Measure:	Kansas current (year)	Kansas previous (year)	U.S. current (year)	U.S. previous (year)			
Individuals with SPMI that have been enrolled in supportive employment and have not had an ER or Psychiatric Hospital admission in the last 12 months. <i>Higher percentage is better.</i>	*	*	NA	NA			
Percent of individuals with an inpatient psychiatric stay in the previous year, that have returned to and remain in the community without additional hospitalizations. <i>Higher percentage is better.</i>	**	**	NA	NA			
MENTAL HEALTH in AMERICA RANKINGS of 50 states and Washington D.C. by report year							
Select Measure: <i>States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes.</i>	2021	2020	2019	2018	2017	2016	2015
Kansas rankings: overall.	#29	#42	#24	#19	#21	#15	#19
Kansas ranking: Adult (prevalence and access to care).	#38	#43	#28	#22	#23	#16	#23
Kansas ranking: Youth (prevalence and access to care).	#26	#37	#21	#19	#18	#15	#8
Kansas ranking: Adults with mental illness who report unmet needs.	#51	#46	#29	#39	#38	#28	#51
Kansas ranking: Youth with at least one major depressive episode who did not receive mental health services.	#18	#47	#40	#29	#12	#12	NA

Note: The asterisk (*) indicates that data are reportable by a state agency. The double-asterisk (**) means that the measure could be reported in the future, assuming implementation of certain recommendations related to data interoperability and higher rates of participation in health information exchanges. NA stands for not available.

The Mental Health in America overall ranking uses national data from surveys including the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). The overall ranking is comprised of 15 measures for adults and youth around mental health issues, substance use issues, access to insurance, access to adequate insurance, as well as access to and barriers to accessing mental health care. A rank of 1-13 indicates lower prevalence of mental illness and higher rates of access to care, and an overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. Data in each reporting year come from previous reporting periods. For example, in the 2021 report, most indicators reflect data from 2017-2018, while the 2020 report includes data from 2016-2017 and so forth. The baseline report year is 2015. For more information, go to <https://www.mhanational.org/issues/2021/ranking-guidelines>.

Report Links: [2015](#); [2016](#); [2017](#); [2018](#); [2019](#); [2020](#).

Source: Data as reported by the Kansas Department for Aging and Disability Services (KDADS), Kansas Department of Health and Environment (KDHE), Kansas Department of Corrections (KDOC), Kansas State Department of Education (KSDE) and KHI analysis of data from the U.S. Census Bureau 2018-2019 American Community Survey Public Use Microdata Sample files for uninsured rates and 2015-2021 Mental Health in America Rankings.

[Note: In above fields where data is absent and denoted with an asterisk (* or **), the Committee requests the reporting agency or entity submit data as it becomes available or upon program changes.]

Finance and Sustainability Working Group (WG1)

The Finance and Sustainability Working Group made recommendations related to the topics of workforce, funding and accessibility and community engagement.

Workforce

A modernized workforce is one where behavioral health staffing is adequate to meet needs across rural, frontier and urban areas of the state. Telehealth (discussed beginning on [page 49](#)) will play a role in meeting needs, but local staffing remains important. Modernization will require both growing and retaining the workforce.

The Finance and Sustainability Working Group discussed and made recommendations recognizing the ongoing importance of studying and investing in the behavioral health workforce in the state. Steps to modernize the State’s behavioral health workforce include: addressing regional provider shortages, particularly in underserved areas; expanding inpatient psychiatric emergency services by recruiting more staff; prioritizing care in the community and developing mobile crisis teams; and expanding recruiting and “grow-your-own” programs. Further, the group repeatedly discussed the importance of establishing measures to track the success of any new efforts.

Recommendations

The Working Group advanced five recommendations as highest priority, with three highlighted for immediate action, and two for strategic importance. Items highlighted for immediate action are recommendations that should be completed within the first two years of the strategic plan. Items of strategic importance are recommendations for which work should begin in the near-term, but will take longer to implement.

Workforce Recommendation 1.1: Clinical Supervision Hours [Immediate Action]

Recommendation: Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers.	
Rationale: A version of this recommendation was originally developed by the Committee on Alcohol and Other Drug Abuse of the Governor's Behavioral Health Services Planning Council. ¹ A similar change was made for social workers in 2019 and has made recruitment of social workers easier in some parts of the state. BSRB intends to support legislation that would enact this change in the 2021 Legislative Session. This change would bring Kansas licensing requirements in alignment with neighboring states.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Would require a program change and change in legislation.• Cost is not a barrier to implementation.	<ul style="list-style-type: none">• Would impact the entire state.• Could lead to a reduction in workforce inequities by geography, particularly in rural and frontier counties.
Measuring Impact: Percent or number of master's-level behavioral health clinicians practicing in Kansas.	
Action Lead: BSRB	Key Collaborators: Legislature, KDADS

Return to [Figure 1](#) or [Figure C-1](#).

Workforce Recommendation 1.2: Access to Psychiatry Services [Immediate Action]

Recommendation: Require a study be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses. [Note: The Committee requests consideration be given to educational institutions, regardless of size, that can provide this expertise and assistance.]	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force. ² Multiple areas in the state are struggling to recruit and retain psychiatrists and psychiatric nurses, with an additional 54 psychiatrists needed to eliminate the Mental Health Care Health Professional Shortage Areas (HPSAs) in Kansas. ³ An important next step once the study is completed would be exploring implementation of the strategies outlined in the report.	
Ease of Implementation (Score 1-10): 9	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Would be relatively easy to implement once funding is available.	<ul style="list-style-type: none">• Implementing strategies from the report could impact frontier and rural communities that struggle to recruit psychiatric providers.
Measuring Impact: <ul style="list-style-type: none">• Percent or number of mental health care professionals participating in the Kansas State Loan Repayment Program.• Number of Kansas counties recognized as a Mental Health Professional Shortage Area.• Number of adult and child/adolescent psychiatry residents in Kansas.	
Action Lead: KDHE	Key Collaborators: Educational institution

Return to [Figure 1](#) or [Figure C-1](#).

Workforce Recommendation 1.3: Provider MAT Training [Immediate Action]

Recommendation: Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT.	
Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force. ⁴ MAT, in conjunction with therapy, can help treat and sustain recovery for SUD. ⁵ MAT was added to KanCare billable services in October 2020, and expanded treatment options will be important for Kansas as the opioid epidemic continues. Additional steps should be taken to recruit and train providers, including capacity of primary care providers, to offer this treatment. Providers may currently be reluctant to serve MAT patients — who may be viewed as high-risk — and may not understand the benefits or evidence base associated with MAT, which could be mitigated via training.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 6
<ul style="list-style-type: none"> • Could require expansion of existing programs. • Funds may be needed for training and to cover medications. 	<ul style="list-style-type: none"> • High impact for a smaller population, including increased survival, retention in treatment and ability to gain and maintain employment. • Could result in cost savings, including reducing inpatient services.
Measuring Impact: <ul style="list-style-type: none"> • Number of providers who have completed MAT prescriber training. • Number of caseload carriers who have completed MAT prescriber training. • Number of age-adjusted non-fatal drug overdose emergency department admissions per 100,000 population. 	
Action Lead: KDADS	Key Collaborators: KDHE, KDOC

Return to [Figure 1](#) or [Figure C-1](#).

Workforce Recommendation 1.4: Workforce Investment Plan [Strategic Importance]

<p>Recommendation: The State of Kansas should 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. Specific steps include:</p> <ul style="list-style-type: none"> • Develop a career ladder for clinicians, such as through the development of an associate’s-level practitioner role and • Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency. 	
<p>Rationale: A version of this recommendation was originally developed by the Child Welfare System Task Force.⁶ Kansas is struggling to maintain an adequate behavioral health workforce across the state, particularly as surrounding states recruit Kansas clinicians. Working Group members discussed the importance of utilizing a “grow-your-own” approach, increasing reimbursement and salaries, financing provider education and training, and promoting entry to the behavioral health workforce in young students. Additionally, a modernized workforce should include a diverse group of practitioners to better serve an increasingly diverse Kansas population. An adequate workforce is key to ensuring access to services within the behavioral health system.</p>	
<p>Ease of Implementation (Score 1-10): 1</p> <ul style="list-style-type: none"> • Could include program changes and pilot programs. • Cost will be a barrier to implementation. • Could changes in a legislative session, federal approval process, agency budget development and grant cycles. 	<p>Potential for High Impact (Score 1-10): 9</p> <ul style="list-style-type: none"> • Would impact a large population. • Would impact multiple special populations, including those in foster care, those with limited English proficiency, children and those with low-income.
<p>Measuring Impact:</p> <ul style="list-style-type: none"> • Number of behavioral health providers practicing in Kansas by age, race/ethnicity, language and sexual orientation. • Number of students enrolling in post-secondary behavioral health education/training programs in Kansas schools. • Number of community colleges offering a behavioral health track associates degree. 	
<p>Action Lead: KDADS</p>	<p>Key Collaborators: KDHE, BSRB, Legislature, providers, clinics, educational institutions</p>

Return to [Figure 1](#) or [Figure C-2](#).

Workforce Recommendation 1.5: Family Engagement Practices [Strategic Importance]

Recommendation: Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families.	
Rationale: A version of this recommendation was originally developed by the Children’s Subcommittee of the Governor’s Behavioral Health Services Planning Council. ⁷ Parent and family engagement practices can create shared responsibility between providers and families, such as by involving families in decision making. It can lead to improved clinical outcomes, as well as improved educational outcomes and health behaviors when parents and families are engaged by schools.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Cost could be a barrier to implementation.• Could require changes in a legislative session and agency budget development.	<ul style="list-style-type: none">• High impact for pediatric behavioral health population.
Measuring Impact: <ul style="list-style-type: none">• Number of families served.• Percent of children and parents whose functionality scores improved (over set time period).• Rate of provider turnover.	
Action Lead: KDADS	Key Collaborators: KDHE, Legislature

Return to [Figure 1](#) or [Figure C-2](#).

Funding and Accessibility

In a modernized behavioral health system, the State will need to proactively pursue new funding mechanisms, including alternative models such as the Certified Community Behavioral Health Clinic (CCBHC) model, to ensure that reimbursement rates are competitive. The State has the expertise, research and recommendations in place to support changes to how behavioral health is funded in Kansas, and implementation should be pursued across administrations.

The Working Group asserted that accurate and appropriate funding for all Kansans is a key element of a sustainably funded, modern behavioral health system, and a modernized system will successfully identify the right populations to serve and make services meaningfully accessible. Likewise, a modernized system should rely on measurable outcomes to drive decisions. Key challenges related to funding and accessibility requirements for budget neutrality on the 1115 Medicaid Waiver, limited availability of SUD block grant dollars, and low reimbursement rates at community mental health centers and for SUD providers.

Recommendations

The Working Group advanced five high priority recommendations for funding and accessibility, all highlighted for immediate action, as well as one high-priority discussion item regarding Medicaid expansion.

Funding and Accessibility Recommendation 2.1: Certified Community Behavioral Health Clinic Model [Immediate Action]

Recommendation: Support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF). ⁸ Passed in 2014, the Excellence in Mental Health Act was a demonstration project that provided funding to establish CCBHCs, which receive cost-based reimbursement for providing: 1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization; 2) screening, assessment and diagnosis, including risk assessment; 3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; 4) outpatient mental health and substance use services; 5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; 6) targeted case management; 7) psychiatric rehabilitation services; 8) peer support and counselor services and family supports; and 9) intensive, community-based mental health care for members of the armed forces and veterans. Working Group members expressed interest in Kansas pursuing a CCBHC model, which would provide a modern payment system to support the behavioral health system in the state. Ideally, this would be done under an expansion of the Excellence in Mental Health Act, so that additional federal funds could be used to support its implementation. If the Act is not expanded, Working Group members recommended pursuing the CCBHC model through a state plan amendment or change to the Section 1115 Waiver, similar to an approach taken by Texas.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Would be a new program.• Cost could be a barrier to implementation, assuming no federal funds are available.• Would require a legislative session, federal approval process, regulatory process and agency budget development to implement.	<ul style="list-style-type: none">• Would impact a large population.
Measuring Impact: <ul style="list-style-type: none">• Number of CCBHCs	
Action Lead: KDHE	Key Collaborators: KDADS, Providers

Return to [Figure 1](#) or [Figure C-1](#).

Funding and Accessibility Recommendation 2.2: Addressing Inpatient Capacity [Immediate Action]

Recommendation: Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force. ⁹ A related recommendation was prioritized by the System Capacity and Transformation Working Group under the topic of System Transformation. That recommendation (9.1) is related to a regional model for the provision of inpatient mental health services. This may be one strategy within a comprehensive plan to address voluntary and involuntary hospital inpatient capacity. Working Group members highlighted the need to address inpatient capacity as a high priority for the behavioral health system long term. Of particular importance was ensuring that facilities have the capacity to care for individuals who are both a danger to themselves and a danger to others, with Working Group members indicating that the latter can be difficult for smaller facilities. Working Group members acknowledged and expressed support for the work that the Kansas Department for Aging and Disability Services (KDADS) has done to develop a plan to lift the moratorium at Osawatomie State Hospital (OSH), the implementation of which could begin to address the recommendation.	
Ease of Implementation (Score 1-10): 4	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Cost will be a barrier to implementation. 	<ul style="list-style-type: none"> • Would impact a large population.
Measuring Impact: <ul style="list-style-type: none"> • Number of private hospitals enrolled in KanCare as State Institution Alternatives. • Number of new private psychiatric hospital (PPH) beds licensed in Kansas. • Number of new state mental health hospital (SMHH) beds added at state hospitals. • Increases in community-based treatment service delivery or utilization like supported employment and supported housing. 	
Action Lead: KDADS	Key Collaborators: Legislature

Return to [Figure 1](#) or [Figure C-1](#).

Funding and Accessibility Recommendation 2.3: Reimbursement Rate Increase and Review [Immediate Action]

Recommendation: Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a Working Group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF). ¹⁰ The MHTF recommendation included a detailed review of reimbursement rates and recommended rates be updated accordingly. Working Group members, however, felt that a pressing need was an overall increase to reimbursement rates for behavioral health services in order to maintain the Community Mental Health Center (CMHC) system in the state. In discussion, Working Group members highlighted that few changes to reimbursement rates had occurred in the last 20 years and were overdue. Once reimbursement rates are increased, Working Group members recommend having a task force review the behavioral health reimbursement structure of both the uninsured and Medicaid populations to ensure long-term sustainability. In the 2020 Legislative Session, the final budget bill included a proviso requiring KDHE to complete a detailed review of costs and reimbursement rates for behavioral health services in the state. ¹¹ This review is due in January 2021 and may include information to be reviewed by a Working Group or task force.	
Ease of Implementation (Score 1-10): 6	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Cost will be a barrier to implementation. 	<ul style="list-style-type: none"> • Would impact a large population.
Measuring Impact: <ul style="list-style-type: none"> • Frequency of reimbursement rate updates 	
Action Lead: Legislature	Key Collaborators: KDADS, KDHE, CMHCs

Return to [Figure 1](#) or [Figure C-1](#).

Funding and Accessibility Recommendation 2.4: Suicide Prevention [Immediate Action]

Recommendation: Allocate resources to prioritized areas of need through data driven decision-making. Assist local suicide prevention efforts and promote local support groups in fund-raising efforts, building capacity, and increasing availability for survivors of suicide loss. Dedicate resources and funding for suicide prevention.	
Rationale: A version of this recommendation was originally developed by the Prevention Subcommittee of the Governor’s Behavioral Health Services Planning Council. ¹² The rate of suicides in Kansas has increased in recent years, particularly among veterans and children and adolescents. ¹³ Working Group members highlighted the importance of supporting suicide prevention activities, and acknowledged that the Kansas Department for Aging and Disability Services (KDADS) has multiple efforts happening around the state related to suicide prevention but that ongoing funding is needed to support and expand these efforts. Further, Working Group members and members of the Special Committee repeatedly highlighted the importance of data to drive ongoing decisions related to policy and prevention efforts in a modernized behavioral health system.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Would require a program change. • Would require a legislative session, contracts and agency budget development to implement. 	<ul style="list-style-type: none"> • Would impact special populations, including those in foster care, children frontier communities, rural communities—particularly those in the agricultural sector—and veterans.
Measuring Impact: <ul style="list-style-type: none"> • Percent change in the age-adjusted mortality rate for suicide per 100,000 population. <ul style="list-style-type: none"> • Subsets of data: suicide rate by gender, age group, socio-demographics (marital status, veteran, and education), occupational classification, cause of death (firearm, suffocation, etc.), and circumstances (mental health, substance use, and interpersonal problems). • Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities. 	
Action Lead: KDADS	Key Collaborators: Legislature, local efforts

Return to [Figure 1](#) or [Figure C-1](#).

Funding and Accessibility Recommendation 2.5: Problem Gambling and Other Addictions Fund [Immediate Action]

Recommendation: Recommend the State continue to incrementally increase the proportion of money in the Problem Gambling and Other Addictions Grant Fund (PGOAF) that is applied to treatment over the next several years until the full funding is being applied as intended.	
Rationale: A version of this recommendation was originally developed by the Committee on Alcohol and Other Drug Abuse of the Governor’s Behavioral Health Services Planning Council. ¹⁴ Currently, two percent of lottery gaming facility revenues are to be allocated to the PGOAF to support addiction services. Working Group members indicated that in practice, however, the funds are often used to support other service areas beyond addiction. To bring the use of funding in line with the original intent, Working Group members recommended that the full two percent be used to support the services for which it was originally intended. This could include additional clarification of which services are eligible for money from the PGOAF.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 5
<ul style="list-style-type: none"> • Would require a legislative session to implement. 	<ul style="list-style-type: none"> • Would have a high impact on a small population.
Measuring Impact: <ul style="list-style-type: none"> • Number of calls to problem gambling hotline. • Of the two percent lottery gaming facility revenues, funds appropriated (\$) to problem gambling and addiction treatment. 	
Action Lead: Legislature	Key Collaborators: Providers, KDADS

Return to [Figure 1](#) or [Figure C-1](#).

Funding and Accessibility High Priority Discussion Item: Medicaid Expansion

Rationale: Medicaid expansion has been recommended by previous task forces, including the Mental Health Task Force, the Governor’s Substance Use Disorders Task Force and the Child Welfare System Task Force. Medicaid Expansion was flagged by the Working Group as a high priority discussion when considering opportunities to modernize the behavioral health system due to the opportunity that it represents to improve access to behavioral health services at all levels of care and allow investment in workforce and system capacity. Expanding Medicaid under the terms of the Affordable Care Act would provide insurance coverage to an estimated 130,000 to 150,000 Kansans. Working Group members noted that many of these individuals may already be utilizing services within the behavioral health system, but in many cases those services are uncompensated or subsidized by state grants. Ninety percent of Medicaid expansion costs would be covered by the federal government. Other Kansans with behavioral health needs may be foregoing care completely until they reach a crisis. The Working Group considered Medicaid expansion as a high priority discussion item for the Special Committee, as the Kansas Legislature is the body to determine whether expansion will move forward.	
Action Lead: Legislature	Key Collaborators: Working Group members

Return to [Figure 1](#) or [Figure C-3](#).

Community Engagement

Effective community engagement in a modernized behavioral health system will include collaboration between individuals in recovery and behavioral health providers to support key efforts. Key efforts include those to support employment, re-entry planning for incarcerated individuals, behavioral health supports and education for foster homes. Another important activity for a modernized behavioral health system will include making strategic connections between the criminal justice system and behavioral health resources. Effective community engagement will require greater collaboration to involve and utilize the resources of cities, counties, health departments, community advisory boards, law enforcement, and the criminal justice system. Additionally, work will be needed to promote understanding among consumers, behavioral health providers and community partners. This understanding will ensure that behavioral health consumers are able to effectively navigate the system, and the professionals working in that system are able to engage consumers productively to meet their needs and continuously improve care delivery. The Working Group also discussed the need to make services available to those in crisis, as well as supports for foster parents. foster parents.

Recommendations

The Working Group advanced four high-priority recommendations for community engagement, with two highlighted for immediate action and two for strategic importance.

Community Engagement Recommendation 3.1: Crisis Intervention Centers [Immediate Action]

Recommendation: Utilize state funds to support the expansion of Crisis Intervention Centers, as defined by state statute, around the state.	
Rationale: This is a new recommendation developed by the Finance and Sustainability Working Group. Expanding the reach of Crisis Intervention Centers would allow more behavioral health needs to be met locally, by providing consumers with access to critical services closer to home. Increasing access to crisis services can reduce wait times for emergency room treatment and decrease inpatient psychiatric admissions. ¹⁵ Existing crisis stabilization services in Kansas rely on multiple, varied funding streams, including Medicaid, county and city funding, and funds generated by lottery ticket vending machines in the state. The current funds available to Kansas Department for Aging and Disability Services (KDADS) for crisis stabilization centers from the lottery ticket vending machines are fully allocated to current crisis centers, requiring additional state investment to expand or develop new Crisis Intervention Centers in the state, particularly in rural and frontier areas.	
Ease of Implementation (Score 1-10): 7	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none"> • Cost could be a barrier to implementation. • Could likely require a legislative session and agency budget development to implement. 	<ul style="list-style-type: none"> • Could impact a large population. • Could produce cost savings by reducing need for stays at state hospitals or psychiatric beds in community hospitals.
Measuring impact: <ul style="list-style-type: none"> • Percent or number of counties served by Crisis Intervention Centers. 	
Action Lead: KDADS	Key Collaborators: KDHE, Legislature

Return to [Figure 1](#) or [Figure C-1](#).

Community Engagement Recommendation 3.2: IPS Community Engagement [Immediate Action]

<p>Recommendation: Increase engagement of stakeholders, consumers, families, and employers through the Kansas Department of Health and Environment (KDHE) or Kansas Department for Aging and Disability Services (KDADS) by requiring agencies implementing the Individual Placement and Support (IPS) program, an evidence-based supported employment program, to create opportunities for assertive outreach and engagement for consumers and families.</p>	
<p>Rationale: A version of this recommendation was originally developed by the Vocational Subcommittee of the Governor's Behavioral Health Services Planning Council.¹⁶ An important predictor of positive outcomes in recovery is employment, and the IPS program is an evidence-based supported employment program that can help individuals with behavioral health conditions find employment. Working Group members indicated that a modernized behavioral health system is one that should consider the impact of the social determinants of health, including employment.</p>	
<p>Ease of Implementation (Score 1-10): 5</p>	<p>Potential for High Impact (Score 1-10): 8</p>
<ul style="list-style-type: none"> • Could require a program overhaul to improve supported employment statewide. • Could require a legislative session, federal approval process, regulatory process and agency budget development to implement. 	<ul style="list-style-type: none"> • Would impact a large population, given the size of the veteran population in Kansas. • Could produce savings by preventing a need for crisis services or hospitalizations.
<p>Measuring Impact:</p> <ul style="list-style-type: none"> • Number of individuals participating in an IPS program. • Percent of individuals with SPMI that have been enrolled in supportive employment and have not had an ER or Psychiatric Hospital admission in the last 12 months. • Number of counties served by an IPS program. 	
<p>Action Lead: KDHE & KDADS</p>	<p>Key Collaborators: Legislature</p>

Return to [Figure 1](#) or [Figure C-1](#).

Community Engagement Recommendation 3.3: Foster Homes [Strategic Importance]

Recommendation: The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth.	
Rationale: A version of this recommendation was originally developed by the Child Welfare System Task Force. ¹⁷ Providing additional training and support to foster homes caring for youth with behavioral health needs, particularly SED youth, could improve retention of foster homes as well as incentivize placement of youth who may be more difficult to place otherwise.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none"> • Would require a program change. • Could require a legislative session, regulatory process and contracts to implement. 	<ul style="list-style-type: none"> • Would have a high impact on a small population (foster care youth). • Could produce savings through reductions in hospitalizations and residential care.
Measuring Impact: <ul style="list-style-type: none"> • Placement stability rate for children entering care. • Percent or number of foster youth on the SED waiver. 	
Action Lead: DCF	Key Collaborators: KDADS

Return to [Figure 1](#) or [Figure C-2](#).

Community Engagement Recommendation 3.4: Community-Based Liaison [Strategic Importance]

Recommendation: Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and co-occurring conditions.	
Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force. ¹⁸ A community-based liaison position has been added to community mental health center (CMHC) participating agreements to support pre-release services, but additional funding was not provided to support the position. KDADS is currently using the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant technical assistance (TA) funds to support the creation of a Kansas Stepping Up Initiative TA Center, which is focused on reducing the number of individuals in jails with mental illnesses through local government policy change and training efforts.	
Ease of Implementation (Score 1-10): 6	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none"> • Would require a program change. • Funding could be a barrier to implementation, although recent SAMHSA guidance indicates that block grant funds can now be used to provide services to individuals in jail settings. • Could be impacted by a legislative session and agency development. 	<ul style="list-style-type: none"> • Would have a high impact on a relatively small population. (incarcerated individuals). • Could produce savings through a reduction in recidivism.
Measuring Impact: <ul style="list-style-type: none"> • Number of contacts with the CMHC liaison prior to release. • Number of patients that continue services upon release. • Reduced recidivism for SPMI patients/offenders. • Number of CMHCs with a community-based liaison. 	
Action Lead: KDADS	Key Collaborators: KDOC, CMHCs, Legislature

Return to [Figure 1](#) or [Figure C-2](#).

Policy and Treatment Working Group (WG2)

The Policy and Treatment Working Group made recommendations related to the topics of prevention and education, treatment and recovery, and special populations.

Prevention and Education

Modernized prevention efforts will seek to meet the needs of special populations at increased risk for poor outcomes. This will require a collaborative, trauma-informed approach to prevention with appropriate reimbursement and other funding. Modernized prevention and education will entail improving suicide prevention outreach and engagement; examining points of entry and access within the system; taking a population-based approach which can operate developmentally across a lifetime and deliver trauma informed services; and bolstering employment supports including skills identification. The Policy and Treatment Working Group identified and discussed additional barriers, including the need to fund prevention services, improve information sharing between providers, and expand early intervention.

Recommendations

The Working Group advanced four high-priority recommendations for prevention and education, with three highlighted for immediate action and one for strategic importance.

Prevention and Education Recommendation 4.1: 988 Suicide Prevention Lifeline Funding [Immediate Action]

<p>Recommendation: Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources.</p>	
<p>Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. The NSPL is a national network of local crisis centers that provides support to people in suicidal crisis or emotional distress. The NSPL will transition from a 10-digit phone number to 988 by July of 2022, making it easier for individuals to know what number to call when in crisis; some phone providers have already begun making this transition.¹⁹ The change is expected to contribute to an increase in the number of individuals using the NSPL, which currently attempts to match callers to in-state crisis centers when possible. Between October 1, 2019, and December 31, 2019, 60 percent of NSPL calls initiated in Kansas were answered by Kansas providers.²⁰ Increasing the in-state answer rate will ensure that Kansans in crisis are connected to providers who can direct them to local resources.</p>	
<p>Ease of Implementation (Score 1-10): 5</p>	<p>Potential for High Impact (Score 1-10): 8</p>
<ul style="list-style-type: none"> • Would likely involve a program overhaul, involving additional staff and training. • Sustainability is considered in the recommendation via fee collection. The recommendation does not include funding for a crisis text line. • Could require a legislative session, contracts, grant cycles and systems to implement. 	<ul style="list-style-type: none"> • Will benefit a large population. • Could produce savings in other areas.
<p>Measuring Impact:</p> <ul style="list-style-type: none"> • National Suicide Prevention Lifeline Answer Rate • Percent change in the statewide age-adjusted mortality rate for suicide per 100,000 population. 	
<p>Action Lead: KDADS</p>	<p>Key Collaborators: Crisis centers, CMHCs, Legislature</p>

Return to [Figure 1](#) or [Figure C-1](#).

Prevention and Education Recommendation 4.2: Early Intervention [Immediate Action]

Recommendation: Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment and treatment.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force, and action steps that could support this recommendation can be found in Recommendation 3.4 of the Mental Health Task Force Report to the Kansas Legislature, January 14, 2019. ²¹ <p>Early identification of behavioral health symptoms can allow for earlier intervention, leading to better outcomes for youth. Additional funds would be needed to continue and expand this work statewide, which was partially piloted via the Substance Abuse and Mental Health Administration (SAMHSA) Systems of Care grant.</p>	
Ease of Implementation (Score 1-10): 3	Potential for High Impact (Score 1-10): 10
<ul style="list-style-type: none"> • Would require a program change and potentially new services if additional diagnosis codes are approved. • Cost could be a barrier to implementation. • Could require a federal approval process, agency budget development and systems to implement. 	<ul style="list-style-type: none"> • Would benefit a large population. • Would impact individuals in foster care, low-income individuals, children and those with limited English proficiency. • Could produce cost savings via reductions in ER visits, pediatrics visits, and use of the criminal justice system and state hospitals.
Measuring Impact: <ul style="list-style-type: none"> • Percent of Medicaid-eligible children age 0-5 receiving initial trauma and mental health screen within 90 days of entering coverage. • Utilization of early childhood mental health screening, assessment, and treatment Medicaid codes. 	
Action Lead: KDHE & KDADS	Key Collaborators: DCF, MCOs

Return to [Figure 1](#) or [Figure C-1](#).

Prevention and Education Recommendation 4.3: Centralized Authority [Immediate Action]

Recommendation: Centralize coordination of behavioral health – including substance use disorder and mental health – policy and provider coordination in a cabinet-level position.	
Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force. ²² Creating a centralized authority for behavioral health would help ensure that behavioral health efforts in the state are consistently prioritized, coordinated and reported on to the Governor. Responsibilities of this position would be to ensure collaboration across the state agencies (e.g., KDHE, KDADS, DCF, KDOC) and other partners involved in the behavioral health system (e.g., community mental health centers, federally qualified health centers, managed care organizations, private insurers and behavioral health consumers). This could allow for coordinated efforts to modernize the behavioral health system, as well as additional coordination of the various behavioral health funding streams spread across entities.	
Ease of Implementation (Score 1-10): 2	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none">• Could require a new program.• Could require a regulatory process, agency budget development and systems to implement.	<ul style="list-style-type: none">• Would benefit a large population.
Measuring Impact: <ul style="list-style-type: none">• More work is needed to identify measures appropriate to capture the impact of this recommendation.	
Action Lead: Office of the Governor	Key Collaborators: KDADS, KDHE, KSDE

Return to [Figure 1](#) or [Figure C-1](#).

Prevention and Education Recommendation 4.4: Behavioral Health Prevention [Strategic Importance]

Recommendation: Increase state funds for behavioral health prevention efforts (e.g., substance use disorder [SUD] prevention, suicide prevention).	
Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Working Group members highlighted the importance of a balance between prevention and treatment in a modernized behavioral health system in Kansas. Prioritizing prevention efforts is needed in the behavioral health system broadly, and it was highlighted that currently only the minimum amount of funds within the SUD block grant are allocated toward prevention activities, and the state has not allocated any money from the state general fund for SUD prevention efforts. Other steps toward prioritizing prevention could include expanding the number of Certified Prevention Specialists in the state and allocating funding for a state suicide prevention coordinator, a position for which the Kansas Department for Aging and Disability Services (KDADS) has already created a job description.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none">• Could require a program overhaul.• Cost could be a barrier to implementation.• Sustainability is contingent on ongoing funding.• Could require a legislative session and agency budget development to implement.	<ul style="list-style-type: none">• Would benefit a large population.• Would benefit multiple special populations, including foster care, rural communities, frontier communities, urban communities, and children.• Could produce cost savings in the child welfare and corrections systems.
Measuring Impact: <ul style="list-style-type: none">• Number of age-adjusted non-fatal drug overdose emergency department admissions per 100,000 population.• Select indicators from the Kansas Behavioral Health Indicators Dashboard (KBHID.org)	
Action Lead: KDADS	Key Collaborators: KDHE, Legislature, providers

Return to [Figure 1](#) or [Figure C-2](#).

Treatment and Recovery

A modernized behavioral health system will deliver an expanded array of early, affordable, accessible, evidence-informed behavioral health services for all, with an emphasis in serving consumers in the settings that are most likely to support effective engagement with treatment. Modernized treatment and recovery will include a data-driven, person-centered approach that improves health outcomes for persons served through access to evidence-based treatment and other promising practices, regardless of income or ability to pay. This system will include timely information exchange to support meaningful coordination across settings (e.g., schools, primary care providers, law enforcement and the judicial system). Additionally, entry into and navigation of the behavioral health system should be clear and consistent. The Working Group also

discussed the need to offer additional crisis services, including: intensive outpatient programs (IOP), partial hospitalization, day programs, substance use disorder (SUD) family residential treatment, respite and crisis beds. The system should have the flexibility to be adaptive to changing trends and needs in behavioral health indicators and service needs such as suicide rates, substance use trends or pandemic impacts.

Recommendations

The Working Group advanced four high-priority recommendations for treatment and recovery, with one highlighted for immediate action and three for strategic importance.

Treatment and Recovery Recommendation 5.1: Psychiatric Residential Treatment Facilities [Immediate Action]

Recommendation: Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools.	
Rationale: This is a new recommendation developed by the Treatment and Recovery Working Group that updates language originally included in Recommendation 3.3 from the Mental Health Task Force Report to the Legislature, January 14, 2019. ²³ Working Group members highlighted the progress made by the KDADS in recent years to bring down the waitlist to enter PRTFs. Ongoing effort is still needed, however, to ensure that youth who require PRTF-level care can access it when needed. Focusing on reintegration and discharge planning, in partnership with community partners, like schools, could help reduce the need for additional PRTF stays in the future. Additionally, the implementation of other recommendations — such as <i>Recommendation 5.2 Service Array</i> , below — could help youth receive needed services earlier and prevent potentially unnecessary PRTF stays.	
Ease of Implementation (Score 1-10): 7	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Would require a program overhaul. • Cost may be a barrier to implementation. • Would require agency budget development and systems to implement. 	<ul style="list-style-type: none"> • Would have a large impact on a small population (youth requiring PRTF-level care).
Measuring Impact: <ul style="list-style-type: none"> • Average length of stay in a PRTF. • Number of individuals served by a PRTF. • Average number of individuals on the three MCO PRTF waitlist per month. 	
Action Lead: KDADS	Key Collaborators: KSDE, KDHE, CMHCs, managed care organizations

Return to [Figure 1](#) or [Figure C-1](#).

Treatment and Recovery Recommendation 5.2: Service Array [Strategic Importance]

Recommendation: Explore options to expand the behavioral health service array, including the expansion of medication-assisted treatment (MAT) in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured.	
Rationale: This is a new recommendation developed by the Treatment and Recovery Working Group that builds on language originally included in Recommendation 3.2 from the from the Mental Health Task Force Report to the Legislature, January 14, 2019. ²⁴ Increasing the service array within the behavioral health system could help ensure that Kansans can access the appropriate level of care when needed. For example, the expansion of crisis stabilization services, intensive outpatient services and other community-based options may reduce the need for stays in institutional settings. Expanding the service array could include an expansion of MAT, which has been shown to lead to better outcomes. Additional MAT could include a focus on specific populations and settings, such as pregnant women or jails. Additionally, when expanding the service array, the group discussed the value of providing services in natural settings (e.g., homes, schools, primary care offices) in the community.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 9
<ul style="list-style-type: none"> • Could require program overhauls or new programs. • Cost could be a barrier to implementation, as could workforce shortages. • Could require regulatory processes or agency budget development to implement. 	<ul style="list-style-type: none"> • Would benefit a large population. • Could produce costs savings by reducing need for inpatient or PRTF stays.
Measuring Impact: <ul style="list-style-type: none"> • Average number of expanded services provided to an individual. • Number of counties offering services by type. 	
Action Lead: KDADS	Key Collaborators: KDHE, DCF, providers, private insurers.

Return to [Figure 1](#) or [Figure C-1](#).

Treatment and Recovery Recommendation 5.3: Frontline Capacity [Strategic Importance]

Recommendation: Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.	
Rationale: This is a new recommendation developed by the Treatment and Recovery Working Group. Kansas Department of Health and Environment (KDHE) currently has two federal grants focused on this issue, one focused on providers who work with pregnant and postpartum individuals, and another focused on pediatric primary care providers. These grant programs are modeled after two psychiatric access programs developed in Massachusetts, where they proved to be effective. ^{25,26} While federal grants have covered initial implementation activities (e.g., provider-to-provider consultation), these funds will expire in 2023. North Carolina has added provider-to-provider consultations as a reimbursable service under Medicaid, which could be one path forward for sustainability. Private insurers may also be interested in this service and could be collaborated with to move this recommendation forward. Additionally, see <i>Appendix A</i> (page A-1) for a recommendation related to Screening, Brief Intervention and Referral to Treatment (SBIRT).	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Could require an expansion of an existing program. • Existing programs are currently grant funded, making long-term sustainability contingent upon additional funding streams, such as Medicaid reimbursement. • Could require federal approval processes and agency budget development to implement. 	<ul style="list-style-type: none"> • Would benefit a large population. • Could produce cost savings through early intervention and a reduction in need for crisis services.
Measuring Impact: <ul style="list-style-type: none"> • Number of pediatric primary care providers who enroll in a pediatric mental health care access program. • Number of perinatal providers who enroll in a perinatal psychiatric access program. • Utilization of Maternal Depression Screening Medicaid codes. 	
Action Lead: KDHE	Key Collaborators: Private insurers, providers, KDADS

Return to [Figure 1](#) or [Figure C-2](#).

Treatment and Recovery Recommendation 5.4: Housing [Strategic Importance]

Recommendation: Expand and advance the Supported Housing program and the SSI/SSDI Outreach, Access, and Recovery (SOAR) program, including additional training regarding youth benefits.	
Rationale: A version of this recommendation was originally developed by the Housing and Homelessness Subcommittee of the Governor's Behavioral Health Services Planning Council. ²⁷ The Supported Housing program provides affordable housing linked to services for low-income, homeless, or potentially homeless individuals with a severe mental illness. SOAR is a federal program designed to help states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and have a mental illness or other co-occurring disorders. Preventing or mitigating homelessness can support recovery and result in improved outcomes. The expansion of support housing could include allowing non-waiver individuals to participate in programs. While making funding available to support expansion of these program is an important step, funding alone does not mitigate other barriers to housing in some parts of the state, including a lack of available housing in western Kansas.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Would require a program change or overhaul. • Could require federal approval processes, regulatory processes, and agency budget development to implement. 	<ul style="list-style-type: none"> • Would have a high impact on those involved in the programs, including low-income individuals, transition-age youth children, veterans and justice-involved individuals. • Could produce cost savings via a reduction in uninsured services.
Measuring Impact: <ul style="list-style-type: none"> • Number of individuals served by the SSI/SSDI Outreach, Access, and Recovery (SOAR) program. • Percent of individuals with SPMI that have been enrolled in supportive housing, and have not had an ER or Psychiatric Hospital admission in the last 12 months. 	
Action Lead: KDADS	Key Collaborators: Homelessness Subcommittee of Governor's Behavioral Health Services Planning Council, ACMHC, Association of Addiction Professionals, KDHE

Return to [Figure 1](#) or [Figure C-2](#).

Special Populations

To serve special populations in a modernized behavioral health system, data, consumers and families will drive the system. Building on existing strengths, a modernized approach will be integrated, proactive and responsive whenever there is a need or a self-identified crisis. Additionally, data will be utilized to understand where there are disparities that should be

addressed. Changes may be needed to education, training, and agency requirements to enable service providers to serve people in a more comprehensive manner. Ultimately, a modernized system will provide wraparound services which meet all the behavioral health needs of an individual such as treating co-occurring disorders and providing housing. The Policy and Treatment Working Group discussed that some special populations to consider include, but are not be limited to, victims of domestic violence, children of incarcerated parents, individuals with limited English proficiency, pregnant women experiencing perinatal mood and anxiety disorders, and others listed on the Recommendation Rubric (*Appendix B, [page B-1](#)*).

Recommendations

The Working Group advanced 5 high priority recommendations for special populations, with 2 highlighted for immediate action and 3 for strategic importance.

Special Populations Recommendation 6.1: Domestic Violence Survivors [Immediate Action]

Recommendation: Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies and community providers serving individuals impacted by domestic violence.	
Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. According to the CDC, one in four women and one in 10 men have experienced some form of intimate partner violence, also known as domestic violence. ²⁸ Domestic violence has multigenerational impacts as well, impacting children and youth live in homes where domestic violence occurs. Given its prevalence and multigenerational impact, Working Group members expressed a desire to better support the behavioral health needs of domestic violence survivors. Working Group members highlighted that multiple community resources are currently available to support domestic violence survivors, but these resources could be better coordinated across agencies and entities to ensure individuals receive the care they need.	
Ease of Implementation (Score 1-10): 6	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Would require a pilot program or program overhaul to connect existing systems. • Would require contracts, agency budget development and systems to implement. 	<ul style="list-style-type: none"> • Would benefit a large population, including multiple special populations.
Measuring Impact: <ul style="list-style-type: none"> • More work is needed to identify measures appropriate to capture the impact of this recommendation. 	
Action Lead: DCF	Key Collaborators: KDADS, KDHE, community- based organizations, providers

Return to [Figure 1](#) or [Figure C-1](#).

Special Populations Recommendation 6.2: Parent Peer Support [Immediate Action]

Recommendation: Increase access to parent peer support for caregivers and families of youth in the behavioral health system, including ensuring appropriate supports for fathers of dependent children.	
Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Peer support would connect parents with lived experience to parents or other caregivers currently navigating the behavioral health system on behalf of their child. Supporting parents is an integral component of behavioral health treatment, and parent peer support for parents with substance use disorders have proven to be effective in other states. Exploring opportunities to expand peer support could provide a cost-effective strategy to improving care outcomes, in addition to providing an outlet through which parents can receive additional support when navigating the behavioral health system. Further, increasing access to peer support services also creates additional job opportunities for those with lived experiences.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none">• Would require a program change.• Cost could be a barrier to implementation, as well as workforce capacity.	<ul style="list-style-type: none">• Would impact a large population.
Measuring Impact: <ul style="list-style-type: none">• Number of children entering care of the Secretary of DCF.	
Action Lead: KDADS	Key Collaborators: DCF, KDHE

Return to [Figure 1](#) or [Figure C-1](#).

Special Populations Recommendation 6.3: Crossover Youth [Strategic Importance]

Recommendation: Continue to develop linkages between the behavioral health system, juvenile justice system and the child welfare system to increase understanding of treatment options available to youth externalizing trauma in the crossover youth population as current treatment options are not meeting the needs of this population. Then, develop specialty services to meet the needs of this population.	
Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Although not a large population, the Working Group highlighted the large amount of resources invested by multiple state agencies currently to support this population. While recent efforts have begun to improve communication and information sharing between agencies regarding this population, gaps in services still exist. Providing additional services to meet the unique needs of this population, including preventive services, could assist crossover youth in working through unresolved trauma and potentially reduce juvenile justice system involvement.	
Ease of Implementation (Score 1-10): 4	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Would require a new program. • Cost would be a barrier to implementation. • Could require a federal approval process, regulatory process, contracts and grant cycles to implement. 	<ul style="list-style-type: none"> • High impact to a small, resource-intensive population. • Could create cost savings within the juvenile justice system. • Could produce cost savings in other areas, including within the justice system.
Measuring Impact: <ul style="list-style-type: none"> • Number of crossover youth • Number of EBP programs available for crossover youth • Percent of crossover youth with a mental/behavioral condition who receive a referral to services 	
Action Lead: DCF	Key Collaborators: KDADS, KDOC, KDHE

Return to [Figure 1](#) or [Figure C-2](#).

Special Populations Recommendation 6.4: I/DD Waiver Expansion [Strategic Importance]

Recommendation: Fully fund the Intellectual and Developmental Disabilities (I/DD) waiver and expand I/DD waiver services. Increase reimbursement rates for I/DD services to support workforce expansion.	
Rationale: This is a new recommendation developed by the Policy and Treatment Working Group. Working Group members highlighted that individuals with I/DD who have co-occurring disorders are not adequately served within the behavioral health system currently. This is partially due to challenges with finding providers who can address both behavioral health issues and I/DD, but also underfunding of the I/DD waiver. Working Group members highlighted a current lack of services to support individuals with I/DD within the behavioral health system, which can cause parents and families to seek out services provided under other waivers as a last resort. Further, this lack of services has led to some children entering the foster care system, because they are unable to receive the level of supports needed to remain at home, and this lack of services is often not resolved by entering foster care. These issues are exacerbated by workforce issues within the I/DD system, which could partially be addressed through increase reimbursement rates.	
Ease of Implementation (Score 1-10): 4	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none"> • Would require a program change and potentially the addition of new programs. • Would require a federal approval process, regulatory process and agency budget development to implement. 	<ul style="list-style-type: none"> • High impact for the targeted population, which includes families of those with I/DD.
Measuring Impact: <ul style="list-style-type: none"> • Number of individuals on the waiting list for the I/DD waiver and average length of wait time. 	
Action Lead: KDADS	Key Collaborators: DCF, KDHE

Return to [Figure 1](#) or [Figure C-2](#).

Special Populations Recommendation 6.5: Family Treatment Centers [Strategic Importance]

Recommendation: Increase the number and capacity of designated family SUD treatment centers, as well as outpatient treatment programs across the state.	
Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force. ²⁹ Expanding access to family SUD treatment centers would allow more individuals to receive treatment, by not requiring parents to choose between caring for their family and receiving treatment. Treating individuals in a family setting can also benefit the entire family, by allowing family members to participate in the treatment process and therapy sessions.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 5
<ul style="list-style-type: none">• Would require an expansion of an existing program.• Would require systems changes to implement, including information sharing between agencies.	<ul style="list-style-type: none">• Would impact special populations, including foster care, low-income individuals and children.
Measuring Impact: <ul style="list-style-type: none">• Number of family SUD treatment centers in Kansas.• Number of family outpatient treatment programs in Kansas.	
Action Lead: KDADS	Key Collaborators: DCF, KDHE

Return to [Figure 1](#) or [Figure C-2](#).

System Capacity and Transformation (WG3)

The System Capacity and Transformation Working Group made recommendations related to the topics of data systems, interactions with the legal system and law enforcement and system transformation.

Data Systems

A modernized system requires a seamless, real-time data system with multi-directional data sharing among behavioral health providers, other health care providers and systems, community organizations, social service providers, law enforcement and payers. The highest priorities for modernizing data systems within the Kansas behavioral health system are to promote information sharing across the system, particularly between state agencies by incentivizing providers to use electronic health records (EHR) and to participate in health information exchanges. Additionally, modernized data systems will require that prevention data surveys be collected with an informed opt-out consent process rather than opt-in consent. A modernized data system will support the ability to assess and aggregate data between service

providers to ensure the individual is getting appropriate and coordinated care and to ensure that health care providers are notified when patients are hospitalized. Modernized data systems should make all appropriate considerations for privacy protection and support measurement of key outcomes. The System Capacity and Transformation Working Group additionally discussed the need for data systems at the state hospitals to support automation of key functions and interoperability with other systems, when appropriate.

Recommendations

The Working Group advanced five high-priority recommendations for data systems, with four highlighted for immediate action and one for strategic importance.

Data Systems Recommendation 7.1: State Hospital EHR [Immediate Action]

Recommendation: The new state hospital electronic health record (EHR) system should be interoperable with other data systems in the state. Interoperability should include the ability to automate the current process to reinstate Medicaid benefits following discharge.	
Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group. Kansas Department for Aging and Disability Services (KDADS) has already issued a request for proposals (RFP) to implement a new state hospital EHR, with the RFP indicating that the selected EHR should be interoperable with other data systems in the state. Initial funding has been authorized to support the adoption of a new EHR, but ongoing funding may be needed to sustain it, and challenges may occur during implementation.	
Ease of Implementation (Score 1-10): 9	Potential for High Impact (Score 1-10): 9
<ul style="list-style-type: none"> Initial funding has been authorized to implement, but ongoing funding will be necessary for long-term sustainability. Could require agency budget development to implement. 	<ul style="list-style-type: none"> Would impact the state hospital populations and support continuity of care in other settings.
Measuring Impact: <ul style="list-style-type: none"> Percent or number of hospitals that have adopted the new state hospital EHR. 	
Action Lead: KDADS	Key Collaborators: EHR vendor, KDHE

Return to [Figure 1](#) or [Figure C-1](#).

Data Systems Recommendation 7.2: Data and Survey Informed Opt-Out [Immediate Action]

Recommendation: Collect, analyze, use, and disseminate surveillance data to inform prevention. Change legislation regarding public health and behavioral health state surveys, including changing the Kansas Communities That Care (KCTC) and Youth Risk Behavior Surveillance System (YRBS) surveys from an opt-in consent to an informed opt-out consent, to allow for meaningful data collection.

Rationale: Previous versions of this recommendation were originally developed by the Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council and the Governor's Substance Use Disorders Task Force.^{30,31} Due to the current protocol of opt-in consent, the amount of data collected via surveys like the KCTC is too limited to reliably inform policymaking. Collecting better surveillance data can inform which types of prevention activities are necessary to mitigate behavioral health issues, including work on suicide prevention and ongoing improvement of mental health programs in schools. The lack of reliable data also makes it difficult for state agencies to complete required activities for federal block grants. Relative to other recommendations, this would not require a high financial investment by the state to implement.

Ease of Implementation (Score 1-10): 8

- Cost would not be a barrier to implementation.
- Would require a legislative session to implement.

Potential for High Impact (Score 1-10): 9

- Would impact a large portion of school-aged youth.

Measuring Impact:

- Percent or number of school districts participating in survey administration.
- Survey response rate.

Action Lead: Legislature

Key Collaborators: KDADS, KSDE

Return to [Figure 1](#) or [Figure C-1](#).

Data Systems Recommendation 7.3: Information Sharing [Immediate Action]

Recommendation: Utilize Medicaid funds to incentivize participation in health information exchanges (e.g., Kansas Health Information Network [KHIN] or Lewis and Clark Information Exchange [LACIE]). Explore health information exchanges as an information source on demographic characteristics, such as primary language and geography for crossover youth and other high priority populations.	
Rationale: Previous versions of this recommendation were originally developed by the Child Welfare System Task Force and the Crossover Youth Working Group. ^{32,33} Health information exchanges (HIE) can lead to better coordinated care, by allowing providers to access the most recent health records of their patients. Participating in an HIE requires investment in an electronic health record (EHR) system and interfaces to connect the EHR and HIE, which can be cost prohibitive for some providers. Working Group members did not want to mandate participation in either KHIN or LACIE, suggesting that incentives were a more effective way to encourage participation in an HIE. The working group noted that funding streams to incentivize EHR adoption were not available to all behavioral health providers, and federal funding to support incentives may be limited as earlier incentive programs have concluded. This recommendation encourages the state to pursue the most feasible option (e.g., waiver amendments, federal innovation models) to incentivize participation in an HIE.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 9
<ul style="list-style-type: none"> • Would require a program change. • Cost could be a barrier to implementation. • Incentives should be ongoing and could be offset by reductions in the Medicaid program. • Could require agency budget development to implement. 	<ul style="list-style-type: none"> • Could impact a large population, including special populations such as those in foster care, rural, frontier and urban communities, children, veterans, individuals with low-income and individuals with limited English proficiency. • Could potentially produce cost savings.
Measuring Impact: <ul style="list-style-type: none"> • More work is needed to identify measures appropriate to capture the impact of this recommendation. 	
Action Lead: KDHE	Key Collaborators: KHIN, Providers

Return to [Figure 1](#) or [Figure C-1](#).

Data Systems Recommendation 7.4: Needs Assessment [Immediate Action]

Recommendation: Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers and specific policies to effectively utilize, integrate and expand SUD treatment resources.

Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force.³⁴ Working Group members highlighted a need to expand resources for SUD treatment, which could also lead to an increase in the number of providers offering SUD treatment in the state. Conducting a statewide needs assessment could help identify where to specifically target SUD treatment expansions. A needs assessment should be conducted soon, and on a rolling basis thereafter.

Ease of Implementation (Score 1-10): 7	Potential for High Impact (Score 1-10): 7
<ul style="list-style-type: none">• Cost could be a barrier to implementation.• Could require a state plan amendment of agency budget development to implement recommendations from a needs assessment.	<ul style="list-style-type: none">• High impact to a small population.
Measuring Impact: <ul style="list-style-type: none">• More work is needed to identify measures appropriate to capture the impact of this recommendation.	
Action Lead: KDADS	Key Collaborators: KDHE

Return to [Figure 1](#) or [Figure C-1](#).

Data Systems Recommendation 7.5: Cross-Agency Data [Strategic Importance]

Recommendation: Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.	
Rationale: A version of this recommendation was originally developed by the Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council. Improved processes and policies on sharing data across agencies could lead to improved prevention efforts across the state, help establish common goals across agencies and increase efficiency. Additionally, it could highlight gaps in care for some vulnerable populations that are served by multiple agencies.	
Ease of Implementation (Score 1-10): 6	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Could require systems and agency memoranda of understanding to implement.	<ul style="list-style-type: none">• Could impact a large population.• Could lead to increased efficiencies and improve decision making by highlighting needs across systems.
Measuring Impact: <ul style="list-style-type: none">• More work is needed to identify measures appropriate to capture the impact of this recommendation.	
Action Lead: KDADS	Key Collaborators: KDHE, DCF, KDOC, KSDE

Return to [Figure 1](#) or [Figure C-2](#).

Interactions with Legal System and Law Enforcement

Through collaboration among the legal system, law enforcement and others in an interdisciplinary behavioral health team, a modernized behavioral health system has the ability to make timely connections for individuals in crisis to services in the least restrictive setting appropriate to ensure safety. A modernized approach will increase treatment options for justice-involved adults and youth. Training will be made available to law enforcement officers, the courts and others in the legal system to increase awareness of mental health issues and to support timely connection to treatment opportunities. Treatment opportunities will include those for a full spectrum of behavioral health issues include mental health and substance use disorder (SUD). More collaboration between the criminal justice system and behavioral health professionals will be needed to ensure this. Sufficient community support services, such as housing, will also be necessary to maintain clients in least restrictive setting possible while maintaining safety. Key strategies may include expanding crisis intervention teams (CIT) and crisis centers so that first responders have robust and efficient options for responding to mental

health crises, expanding specialty courts, utilizing robust data system to help communities identify high utilizers of crisis services so that those individuals can be connected to services.

Recommendations

The Working Group advanced four high priority recommendations for interactions with the legal system and law enforcement, with three highlighted for immediate action and one for strategic importance.

Interactions with Legal System and Law Enforcement Recommendation 8.1: Correctional Employees [Immediate Action]

Recommendation: Expand training provided in correctional facilities to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services.	
Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force. ³⁵ The Kansas Department for Aging and Disability Services (KDADS) has existing training for employees of correctional facilities, and implementation of this recommendation would expand the current reach and breadth of those trainings for employees throughout the justice system. While the current training largely focuses on mental health, the Working Group spoke to the importance of educating employees on substance use disorders and incorporating a trauma-informed approach to identification of mental health needs. Expanding these trainings will require additional financial resources, and they should be offered on a consistent and ongoing basis.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 9
<ul style="list-style-type: none"> • Would require an expansion of existing training efforts. • Would be a low-cost recommendation. • Could require changes to grant cycles, state agency contracts and agency budget development. 	<ul style="list-style-type: none"> • Would benefit a large population. • Would benefit urban, rural and frontier communities. • Could generate cost savings by reducing recidivism, if individuals are connected to treatment.
Measuring Impact: <ul style="list-style-type: none"> • Number and percent of unit team counselors working in a correctional facility that received training on substance abuse programs and services • Number and percent of staff working in a correctional facility that received trauma informed training 	
Action Lead: KDADS	Key Collaborators: KDOC, local law enforcement agencies.

Return to [Figure 1](#) or [Figure C-1](#).

Interactions with Legal System and Law Enforcement Recommendation 8.2: Criminal Justice Reform Commission Recommendations [Immediate Action]

Recommendation: Implement recommendations developed by the Criminal Justice Reform Commission (CJRC) related to specialty courts (e.g., drug courts) and develop a process for regular reporting on implementation status and outcomes.	
Rationale: This recommendation was newly developed by the System Capacity and Transformation Working Group. This recommendation was developed to recognize the value of aligning efforts to modernize the behavioral health system with parallel efforts related to criminal justice reform in the CJRC. The Working Group was particularly supportive of the CJRC recommendation to expand pre- and post-charge diversion sobriety and treatment options for first time, non-violent, simple drug possession charges.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Cost could be a barrier to implementation. • Would require training of courts and judicial staff. 	<ul style="list-style-type: none"> • Recommendation could produce cost savings through reducing KDOC population and connecting individuals to treatment services in a more timely manner.
Measuring Impact: <ul style="list-style-type: none"> • Number and percent of judicial districts with one or more specialty courts (by type) • Consider tracking goals and outcomes using KDOC's soon to be ATHENA system 	
Action Lead: Legislature	Key Collaborators: KDADS, KDOC

Return to [Figure 1](#) or [Figure C-1](#).

Interactions with Legal System and Law Enforcement Recommendation 8.3: Law Enforcement Referrals [Immediate Action]

Recommendation: Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to services for this population.	
Rationale: A version of this recommendation was originally developed by the Governor's Substance Use Disorders Task Force. ³⁶ Additionally, this recommendation is in alignment with recommendations from the Kansas Pre-Trial Justice Task Force that focus on behavioral health issues. ³⁷ The Working Group discussed the value of this recommendation in highlighting the particular need for substance use disorder (SUD) treatment among those individuals with law enforcement contact. This recommendation could be co-implemented with Recommendation 2.3 toward the goal of installing the Certified Community Behavioral Health clinics (CCBHC) model in Kansas as a requirement of the CCBHC model is the development of partnerships between behavioral health providers and law enforcement.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 6
<ul style="list-style-type: none"> • Would require a program change and implementation of new programs. • Cost would be a barrier to implementation but would be needed to support new programs. 	<ul style="list-style-type: none"> • Would have a high impact for those individuals who would benefit. • Would address disparities, as this recommendation would provide the opportunity for individuals to be connected to services who are missing that opportunity in the current system.
Measuring Impact: <ul style="list-style-type: none"> • More work is needed to identify measures appropriate to capture the impact of this recommendation. 	
Action Lead: KDOC	Key Collaborators: KDADS, providers

Return to [Figure 1](#) or [Figure C-1](#).

Interactions with Legal System and Law Enforcement Recommendation 8.4: Defining Crossover Youth Population. [Strategic Importance]

Recommendation: Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population.	
Rationale: A version of this recommendation was originally developed by the Crossover Youth Working Group. ³⁸ Building upon the work of that group, this recommendation highlights the importance of having a clear definition for which individuals fit within the crossover youth population and incorporating behavioral health within the definition. Understanding the behavioral health needs of individuals dually involved with the juvenile justice and child welfare systems will be critical to serving that population.	
Ease of Implementation (Score 1-10): 7	Potential for High Impact (Score 1-10): 6
<ul style="list-style-type: none">• Cost would not be a barrier to implementation.	<ul style="list-style-type: none">• Understanding the needs of the crossover youth population will be important to have a high impact on those individuals.
Measuring Impact: <ul style="list-style-type: none">• Number of crossover youth	
Action Lead: KDOC, KDADS	Key Collaborators: DCF

Return to [Figure 1](#) or [Figure C-2](#).

System Transformation

A modernized system will work both in evidence-based treatment and prevention with focus on the patients to address a continuum of needs. Transformation will result in a mission driven, rationally funded and outcome-oriented system of providers that uses data as an asset to identify problems and develop solutions. An important strategy for system transformation will be addressing the continuum of care to ensure an integrated and coordinated approach to care delivery. The System Capacity and Transformation Working Group also discussed barriers related to cross system collaboration, infrastructure changes, and Medicaid payment for services to families.

Recommendations

The Working Group advanced five high priority recommendations for system transformation, with three highlighted for immediate action and two for strategic importance.

System Transformation Recommendation 9.1: Regional Model [Immediate Action]

<p>Recommendation: Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas.</p>	
<p>Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).³⁹ It was a standalone recommendation in the 2018 MHTF report and then consolidated into Recommendation 1.1 and 1.2 in the 2019 MHTF report. The Working Group discussed that while cost is a primary barrier to implementation, there are opportunities for cost savings by reducing the high cost of transporting individuals to Osawatomie State Hospital (OSH) or Larned State Hospital. Both institutions are a significant distance from key population centers, particularly in the south-central region of the state. This recommendation could be implemented by a combined approach of state institution alternatives (SIAs) and smaller, regional state facilities.</p> <p>Cost savings accrued via the recommendation could be redirected to the provision of evidence-based services. In addition to cost savings, a reduction in travel would increase safety of the individuals in need of care as well as those in the behavioral health workforce currently providing transportation services, as well as allow individuals to remain closer to local support systems. This recommendation is also seen as a key component to lifting the ongoing moratorium at OSH and is included in the current plan to do so.</p>	
<p>Ease of Implementation (Score 1-10): 8</p>	<p>Potential for High Impact (Score 1-10): 9</p>
<ul style="list-style-type: none"> Cost would be a barrier to implementation based on the need for appropriation. 	<ul style="list-style-type: none"> Would benefit a large population. Could produce cost savings via reduction in transportation costs.
<p>Measuring Impact:</p> <ul style="list-style-type: none"> More work is needed to identify measures appropriate to capture the impact of this recommendation. 	
<p>Action Lead: KDADS</p>	<p>Key Collaborators: Providers, Local Units of Government, Law Enforcement</p>

Return to [Figure 1](#) or [Figure C-1](#).

System Transformation Recommendation 9.2: Long-Term Care Access and Reform
[Immediate Action]

<p>Recommendation: Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within the continuum of care. Increase access to long-term care (LTC) facilities, particularly for individuals with past involvement with the criminal justice system or those with a history of sexual violence.</p>	
<p>Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group that updates language originally included in Recommendation 4.1 from the Mental Health Task Force Report to the Legislature, January 14, 2019.⁴⁰ The Working Group adapted this recommendation on NFMH reform to include new information on the need to increase access to LTC facilities, particularly for individuals with a history of involvement with the criminal justice system. The Working Group described the status quo as one where individuals are often required to stay in acute hospitals because there is not a nursing facility with the capacity to care for them. At times, these individuals may be discharged from acute hospitals into homelessness, so the Working Group discussed the importance of supportive housing. For more information on supportive housing see <i>Recommendation 5.4 Housing</i>. Increasing access to LTC facilities could include discharging individuals currently in LTC back to their communities, if appropriate discharge planning occurs to connect individuals with supports available within the community. Further, reformation of NFMHs could improve quality of care and discharge planning. This recommendation is a high priority to the Working Group due to the importance of protecting the rights of citizens by providing individuals with disabilities the opportunity to live and receive care in the least restrictive environment possible.</p>	
<p>Ease of Implementation (Score 1-10): 8</p> <ul style="list-style-type: none"> Reforming the NFMH licensing structure may require a federal approval process. 	<p>Potential for High Impact (Score 1-10): 8</p> <ul style="list-style-type: none"> Would have a high impact for those who receive care at NFMHs or require access to LTC.
<p>Measuring Impact:</p> <ul style="list-style-type: none"> Percent of individuals who transition back to the community. Percent of individuals with stability/tenure in the community. Average length of stay in NFMH. Rate of discharge back to community/supported housing placements. 	
<p>Action Lead: KDADS</p>	<p>Key Collaborators: KDHE</p>

Return to [Figure 1](#) or [Figure C-1](#).

System Transformation Recommendation 9.3: Integration [Immediate Action]

<p>Recommendation: Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. Adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions.</p>	
<p>Rationale: Multiple previous collaborative efforts developed recommendations highlighting the importance of integration (e.g., Governor’s Substance Use Disorders Task force, Governor’s Behavioral Health Services Planning Council), and the System Capacity and Transformation Working Group built this recommendation from that work. SAMHSA describes integration as, “The care that results from a practice team of primary care and behavioral health clinicians and other staff working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”⁴¹ Integrated care can lead to better outcomes for patients, as well as more streamlined care delivery. Adopting coding practices in support of integration is seen as critical to the goal of providing best practice, whole-person care.</p>	
<p>Ease of Implementation (Score 1-10): 6</p> <ul style="list-style-type: none"> • Would require legislation. • Would require a Federal approval process. • Also would require work related to agency budget development, grant cycles and system changes (e.g., IT). 	<p>Potential for High Impact (Score 1-10): 9</p> <ul style="list-style-type: none"> • Would benefit a large population. • Special populations who would benefit include: foster care, urban, rural and frontier communities, those with limited English proficiency, low-income individuals, children. • Could potentially produce cost savings by reducing duplicative care.
<p>Measuring Impact:</p> <ul style="list-style-type: none"> • Percent or number of certified CCBHCs in the state of Kansas. • Percent or number of Counties served by Mobile Response and Stabilization Services. 	
<p>Action Lead: KDADS/KDHE</p>	<p>Key Collaborators: Legislature, CMHCS, FQHCs, other safety net providers</p>

Return to [Figure 1](#) or [Figure C-1](#).

System Transformation Recommendation 9.4: Evidence Based Practices [Strategic Importance]

Recommendation: Kansas should continue and expand support for use of evidence based practices (EBP) in the state, including for housing and supported employment. Coordinate EBP utilization across systems (e.g., law enforcement, SUD, mental health care) with a goal of implementing programs with fidelity, when possible.	
Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group. The Working Group discussed the delivery of evidence based models of service as a key part of a modernized behavioral health system. With that in mind, the group also discussed that fidelity to these programs, as originally designed, can be challenging due to the variety of standards that exist between different EBPs. Regardless, the Working Group noted the importance of delivering evidence-based services throughout the behavioral health system and, in particular, for those in long-term care settings.	
Ease of Implementation (Score 1-10): 6	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Would require changes to existing programs. • Cost would be a barrier to implementation. 	<ul style="list-style-type: none"> • Would benefit a large population.
Measuring Impact: <ul style="list-style-type: none"> • Percent of EBPs adopted by providers. • Number of EBP programs funded and appropriations. • Percent of individuals with SPMI that have been enrolled in supportive employment, and have not had an ER or Psychiatric Hospital admission in the last 12 months. • Percent of individuals with SPMI that have been enrolled in supportive housing, and have not had an ER or Psychiatric Hospital admission in the last 12 months. • EBP utilization across systems. 	
Action Lead: KDADS	Key Collaborators: DCF

Return to [Figure 1](#) or [Figure C-2](#).

System Transformation Recommendation 9.5: Family Psychotherapy [Strategic Importance]

Recommendation: Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility.	
Rationale: This is a new recommendation developed by the System Capacity and Transformation Working Group, related to recommendations from the 2018 and 2019 Mental Health Task Force Reports to the Kansas Legislature. ⁴² This recommendation would allow for the provision of family therapy services without the child present. This was highlighted as important given that discussing the behavioral health needs of a child with a parent or guardian is an important part of care provision and, at times, inappropriate in the presence of the child. The group also noted how the code could support the implementation of an evidence-based program called Generation Parent Management Training – Oregon (PMTO). PMTO is an evidence-based structured intervention program designed to help strengthen families that has demonstrated positive outcomes throughout a nine-year follow-up period, including reductions in delinquency, depression and police arrests, among others. ⁴³ This is a program of high interest to those in the state working to implement the Federal Families First Act and requires a significant amount of the services to be delivered to parent(s) or guardian(s), without the child present. The Working Group also noted that the Centers for Medicare and Medicaid Services (CMS) has flagged this code as one with a high potential for fraud or abuse in some states. Working Group members were not overly concerned about the potential for fraud in Kansas, however, because the code was previously allowed under the Children’s Health Insurance Program (CHIP). When allowed in Kansas under CHIP, the code was not highly utilized, but utilization may be higher if allowed again due to implementation of the PMTO program.	
Ease of Implementation (Score 1-10): 10	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Would require changes in the regulatory process.• Cost would not be a barrier to implementation.	<ul style="list-style-type: none">• Could potentially generate cost savings.
Measuring Impact: <ul style="list-style-type: none">• Percent of families served by the Generation Parent Management Training – Oregon (PMTO) program.	
Action Lead: KDHE, Division of Healthcare Finance	Key Collaborators: DCF

Return to [Figure 1](#) or [Figure C-2](#).

Telehealth

The Special Committee on Mental Health Modernization and Reform recognized that telehealth was a topic of high importance that cut across the three Working Groups that had been created. As this was considered to be a topic of interest to each Working Group, members of each group volunteered to contribute to a telehealth subgroup. The topic was of high interest across

Working Groups due, in part, to the ongoing COVID-19 pandemic. The COVID-19 pandemic has created a unique situation due to the increased number of services provided via telehealth to ensure patient safety and to the temporary changes to reimbursement practices and other policies related to telehealth to support the change in service delivery. Subgroup members developed recommendations for modernizing the telehealth system based on experiences delivering telehealth during and prior to the COVID-19 pandemic.

The following recommendations are part of the strategic work that will be required to modernize the approach to delivering behavioral health services via telehealth in Kansas. In a modernized system, the delivery of sophisticated telehealth services will be a strategy to provide meaningful access to care across rural, frontier and urban areas of the state. While a key strategy to improving access, the delivery of behavioral health services via telehealth does not preclude the need for behavioral health clinicians to provide services in person across the state. A modernized behavioral health system will offer a balance between service delivery via telehealth and in person. Telehealth services provided will be high-quality, integrated with other modes of care delivery and allow for consumer choice, in addition to supporting the full spectrum of behavioral health care. The telehealth subgroup discussed the need to address telephonic access to services when needed, broadband access, long-term changes to reimbursement strategies, crisis services and issues related to care delivery across state lines.

Recommendations

The Working Group advanced five high-priority recommendations for telehealth, with three highlighted for immediate action and two for strategic importance.

The Working Group did not have previous task force recommendations to consider regarding telehealth, so all recommendations in this section were created by the task force with support from supplemental experts. Because these are new recommendations, additional rationale has been provided when available and the recommendation rubric was not used for these recommendations. As a result, information on ease of implementation and potential for high impact are limited and may need to be assessed in later discussion of these recommendations.

Telehealth Recommendation 10.1: Quality Assurance [Immediate Action]

<p>Recommendation: Develop standards to ensure high-quality telehealth services are provided, including:</p> <ul style="list-style-type: none">• Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies.• Implementing standard provider education and training.• Ensuring patient privacy.• Educating patients on privacy-related issues.• Allowing telehealth supervision hours to be consistently counted toward licensure requirements.• Allowing services to be provided flexibly when broadband access is limited.	
<p>Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts.</p> <p>Due to the rapid expansion of telehealth services during the COVID-19 pandemic, Working Group members highlighted a variety of needs to address to ensure that high-quality telehealth services are provided in Kansas beyond the pandemic.</p> <p>Relevant regulatory agencies and providers should develop guidelines for the provision of telehealth services that align with established best practices. Guidelines should recognize the value of consumer choice and provision of in-person services when needed or desired. Measures should be identified to assess the impact of telehealth on access, quality and equity within behavioral health care.</p> <p>Providers should be trained on issues related to telehealth by existing professional organizations, telehealth resource centers and other providers of continuing education curriculum. This could include: completing a basic telehealth training with a focus on the clinical delivery of services; education about the basic parameters of telehealth billing, record keeping, and criteria for reimbursement; and training and support to mitigate the increased cognitive, physical, and emotional demands associated with a significant increase in productivity and use of technology to provide care.</p> <p>The privacy of patients should be protected when telehealth is provided. This includes payers requiring utilization of platforms and other secure technologies that are compliant with all relevant State and Federal statute and regulations (e.g., HIPAA, 42 CFR Part 2), in addition to providers educating patients on privacy-related issues. Privacy issues extend beyond technology, however, and include ensuring that services are provided and received in locations that meet safety and privacy requirements.</p> <p>Some behavioral health providers can use supervision hours conducted via telehealth to qualify for licensure, but this is not consistent across provider types licensed by the Kansas Behavioral Sciences Regulatory Board (BSRB). Consistently allowing telehealth supervision to meet licensure requirements could increase the number of high-quality providers in the state.</p> <p>Working Group members indicated that video services are the preferred, and highest-quality, option for providing telehealth services. Given current broadband deficiencies in the state, however, telephonic behavioral health services should be allowed by payers when needed to address access issues, and guidelines for audio-only telehealth visits should be established.</p> <p>Finally, it was noted that electronic health record (EHR) utilization is critical to support effective, high-quality delivery of telehealth, particularly to ensure care coordination across providers. Implementation of Recommendation 7.3 Information Sharing could support this recommendation.</p>	
<p>Measuring Impact: More work is needed to identify measures appropriate to capture the impact of this recommendation.</p>	
<p>Action Lead: Various</p>	<p>Key Collaborators: KDHE, KDADS, Providers, BSRB, Private insurers, regulatory agencies</p>

Return to [Figure 1](#) or [Figure C-1](#).

Telehealth Recommendation 10.2: Reimbursement Codes [Immediate Action]

Recommendation: Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.

Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. While many behavioral health services could be provided via telehealth prior to the COVID-19 pandemic, additional codes (e.g., for the SED waiver, crisis intervention, tobacco cessation) have become eligible for reimbursement during the public health emergency (PHE).^{44,45,46} Working Group members indicated that some of these services should be maintained after the PHE ends, though the changes were initially intended to be temporary. Additionally, the PHE has led to an expansion of the types of sites where patients can receive care, including at home. Services provided to patients in their homes are not eligible for a facility fee payment for the originating site. In situations where support (e.g., IT support, patient education and preparation) is provided to patients receiving telehealth services in their home, commensurate compensation should be made available to service providers.

Services provided to patients in their homes do not receive a facility fee payment for the originating site, which can contribute to lost revenue for providers, many of whom are having to do additional work (e.g., IT support, patient education and preparation) to provide high-quality services to patients in their home. Consideration should be given to the feasibility of providing additional reimbursement for providers who furnish technical support for patients who receive telehealth services in their homes.

However, further study and consideration should be given to the unintended consequences of mandating payments to providers in excess of in-person mental health visits. The committee would not want to encourage telemedicine in a manner that would incentivize providers to leave their community practices, especially in rural and underserved areas or otherwise reduce their availability for the delivery of in-person care. In addition, if this proposal for additional telemedicine provider payments is applicable beyond the Medicaid program, it likely qualifies as a “provider or benefit” mandate requiring the production of a cost benefit analysis and the “test tracking” of the proposed new charges on the state employees health plan as required by K.S.A. 40-2248 through 40-2249a. Considerations for commercial insurance plans may include different applicable provisions.

Measuring Impact:

- Number of telehealth codes open for Medicaid reimbursement pre- and post-pandemic
- Utilization of these telehealth codes

Action Lead: KDHE Division of Healthcare Finance

Key Collaborators: KDADS, managed care organizations, community mental health centers

Return to [Figure 1](#) or [Figure C-1](#).

Telehealth Recommendation 10.3: Telehealth for Crisis Services [Immediate Action]

Recommendation: Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities.	
Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. Telehealth can create immediate access to services in an area where providers are not physically located. Working Group members highlighted a specific need for crisis services to be provided via telehealth, particularly in rural or frontier areas where these services are less likely to be available currently. Covering telehealth for crisis services could also support police departments or law enforcement agencies who frequently respond to behavioral health crises, such as through co-responder models that pair local law enforcement with remote clinicians. Some neighboring states have already implemented co-responder models, which have the potential to generate savings by reducing arrests, jail admissions and hospital stays. ⁴⁷ Related to the measures indicated in the “Measuring Impact” field below, the group noted that many individuals in crisis will not be Medicaid beneficiaries, so additional measures should be developed to better capture the impact of this recommendation.	
Measuring Impact: <ul style="list-style-type: none">• Number of telehealth crisis codes open for Medicaid reimbursement• Utilization of these telehealth crisis codes	
Action Lead: KDHE	Key Collaborators: KDADS, KDOC, DCF, local law enforcement, providers

Return to [Figure 1](#) or [Figure C-1](#).

Telehealth Recommendation 10.4: Originating and Distant Sites [Strategic Importance]

<p>Recommendation: The following items should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations:</p> <ul style="list-style-type: none">• Adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act.• Allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met and• Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts.	
<p>Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. Issues related to where providers can offer care and where patients can receive care will need to be addressed in order for high-quality telehealth care to be provided flexibly to patients.</p> <p>The definition of originating sites included in the Kansas Telemedicine Act is: “a site at which a patient is located at the time healthcare services are provided by means of telemedicine.”⁴⁸ Prior to the COVID-19 pandemic, allowed originating sites were limited by some insurers, preventing patients from receiving care in places like their homes. Adopting a broad definition of “originating site” would ensure that patients can receive care in a wider variety of settings, if those settings meet patient privacy and safety standards.</p> <p>Distant sites — the location from which a provider offers care — could also be expanded to allow providers to offer services from their home or other non-clinical sites, if patient privacy and safety standards can be met. Allowing providers to offer services in flexible locations could help address workforce issues by increasing access to providers in areas of the state with shortages.</p> <p>The location of patients when telehealth is provided can be complicated by state lines. This could include scenarios in which a patient needs care while traveling or residing outside of their home state (e.g., if a Kansan goes to college in another state). The state in which the patient is located typically determines the criteria for licensure, and Kansas providers who want to continue offering services to their patients outside of the state must contact the licensing body in the state where their patient is located. Often, licensing bodies will want to ensure that providers can connect patients to local service or crisis resources, if needed, and other states may have options for temporary licensure. Exploring Kansas participation in interstate licensure compacts could address some of these issues.</p> <p>Additionally, since the onset of COVID-19, multiple out-of-state providers have expressed interest in providing virtual-only services to Kansas residents. While these providers could potentially address access issues, they could result in reduced care coordination with in-state providers. Issues related to practicing and receiving services across state lines will need to be addressed as telehealth continues to evolve and grow.</p>	
<p>Measuring Impact:</p> <p>More work is needed to identify measures appropriate to capture the impact of this recommendation.</p>	
<p>Action Lead: Legislature</p>	<p>Key Collaborators: KDHE, KDADS, Providers</p>

Return to [Figure 1](#) or [Figure C-2](#).

Telehealth Recommendation 10.5: Child Welfare System and Telehealth [Strategic Importance]

Recommendation: Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Consider how the unique needs of parents of children in the child welfare system can be met via telehealth.

Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. It is exploratory in nature and will require further development to assess how telehealth can be used as a tool to provide consistent, high quality behavioral health services for individuals who interact with the child welfare system. In situations where placements are unstable, foster youth may move frequently, resulting in a disruption of services as youth move from one behavioral health catchment area to another. Allowing telehealth to be an option for foster youth to continue receiving services from providers they have established relationships with could lead to better outcomes, as changing care providers can delay access to behavioral health care, impedes the benefit of the therapeutic relationship, and delays positive outcomes for child well-being. Additionally, parents of children in the child welfare system may have behavioral health treatment needs – substance use, mental health, or both - that need to be resolved in order to support reunification of the child back into the home. Consistent access and availability of telebehavioral health services for parents could significantly increase case plan compliance and support timely reunification for children.

Measuring Impact:

- Utilization of telehealth across foster children eligibility groups.
- When child comes into care or goes to a new placement the CMHC will provide therapy within 72 hours of receiving the request.
- Percentage of CINC children/adolescents, age 17 or younger, that received crisis intervention services 30 calendar days prior to a screen resulting in inpatient psychiatric admission, excluding PRTF (i.e., CINC crisis intervention rate).
- The percentage of CINC children/adolescents that received therapeutic intervention services (includes more than initial assessment and diagnosis such as Peer Support, Psychosocial individual/group, Community Psychiatric Support and Treatment, Therapy and/or Intake) within 30 calendar days prior to a screen resulting in an inpatient psychiatric admission, excluding PRTF (i.e., CINC Therapeutic Intervention Rate).

Action Lead: KDHE

Key Collaborators: KDADS, DCF

Return to [Figure 1](#) or [Figure C-2](#).

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Appendix A: Other Recommendations

Included below are other recommendations related to each of the ten topics. These recommendations were maintained by the Working Groups for future work but were not considered a high priority at this time.

Figure A-1. **Other Recommendations**

Source	Recommendation
WORKFORCE	
New Recommendation	Tuition Reimbursement. Establish tuition reimbursement for master's level behavioral health providers, including addiction counselors, that agree to practice for a set period of time in a rural and frontier area. This could be tested as a pilot program in order to assess impact on workforce shortages.
New Recommendation	Workforce Promotion. Establish programs for those 12-18 years of age to promote familiarity with and interest in careers in behavioral health.
Governor's Substance Use Disorder Task Force	Workforce Development. Implement workforce development programs to increase capacity of addiction professions.
FUNDING AND ACCESSIBILITY	
Governor's Substance Use Disorder Task Force	K-TRACS Funding. K-TRACS should be sustainably funded by the State General Fund after any available grant funding is exhausted.
Governor's Substance Use Disorder Task Force	Senate Bill 123. Assure adequate funding for SB 123 (2003) (provides certified SUD treatment for offenders convicted of drug possession who are nonviolent with no prior convictions) to allow appropriate provision of medically necessary treatment services and allow for an expanded list of qualifying offenses.
Child Welfare System Task Force	Maximizing Federal Funding. The State of Kansas should conduct an audit of potential funding streams by program area to ensure the State is maximizing federal benefits.
Governor's Substance Use Disorder Task Force	Opioid Addiction Project ECHO. Identify funding for Opioid Addiction Project ECHO telementoring.

Figure A-1 (continued). **Other Recommendations**

Source	Recommendation
FUNDING AND ACCESSIBILITY (CONTINUED)	
Child Welfare System Task Force	Access to Care. The State of Kansas should require access to high-quality and consistent medical and behavioral healthcare for Medicaid-eligible high-risk youth through the state Medicaid state plan or other appropriate sources of funding.
Child Welfare System Task Force	Service Setting. The State of Kansas should prioritize delivering services for children and youth in natural settings, such as, but not limited to, homes, schools, and primary care offices, in the child's community when possible. The needs of the child and family should be the most important factor when determining the settings where services are delivered.
Governor's Substance Use Disorder Task Force	Sober Housing. Study the efficacy of sober housing and strategies for success from other states including funding mechanisms.
Mental Health Task Force, 2019	Regional Community Crisis Center Locations. Develop regional community crisis centers across the state including co-located or integrated SUD services.
Governor's Behavioral Health Services Planning Council	Vocational Subcommittee (VOS) Recommendations. Actively seek out and provide grants to CMHCs from the State General Fund to offset costs initiating and implementing Individual Placement and Support (IPS) Supported Employment model.
Governor's Substance Use Disorder Task Force	Mental Health Parity. Review procedures for mental health parity laws to ensure compliance.
New Recommendation	Maintenance of Effort. Increase the state's Maintenance of Effort in the SUD Block grant for providers in the Beacon Network. Medicaid expansion may be one mechanism for additional funding.
Governor's Substance Use Disorder Task Force	IMD Waiver. Explore waiver of Medicaid Institutions for Mental Diseases (IMD) exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment.
Governor's Substance Use Disorder Task Force	Addiction Treatment. Create additional services for the treatment of addiction as well as any co-occurring mental health diagnoses.
Governor's Behavioral Health Services Planning Council	CAODA Recommendation. Facilitate a pursuit of grant funding. Recommend creating a new state-level grant-support position to work directly with agencies to help secure and maintain these opioid related funds as well as other addiction prevention and treatment opportunities. A state-level coordinator could provide the grant-specific expertise.

Figure A-1 (continued). **Other Recommendations**

Source	Recommendation
FUNDING AND ACCESSIBILITY (CONTINUED)	
Child Welfare System Task Force	Resources and Accountability. The State of Kansas and DCF should provide services that are in the best interest of children in their care by supporting a system that is accountable and resourced well enough to provide the needed services. Considerations should include, but not be limited to, the awarding of funds based upon qualifications and not financial factors, improving workforce morale and tenure, and providing technology to improve efficiencies.
Governor's Behavioral Health Services Planning Council	CAODA Recommendation. Allow addiction counseling agencies to become approved providers for co-occurring issues providing they have the appropriate resources to do so. This expansion of services should only apply to addiction counseling clients with co-occurring issues, not to general mental health clientele.
Governor's Behavioral Health Services Planning Council	CAODA Recommendation. Adopt coding practices that allow for the integration of CMHC, primary care, and behavioral health services to reduce the waste and gaps in service.
Governor's Substance Use Disorder Task Force	Prior Authorizations. Remove prior authorization requirements for MAT (medication-assisted treatment).
Community Engagement	
Governor's Behavioral Health Services Planning Council	Justice Involved Youth and Adult Subcommittee (JIYAS) Recommendations. Engage community partners using three pilot communities that the workgroup identified, which would involve a coordinated effort between the Kansas Department of Corrections (KDOC), CMHCs, and SUD providers.
PREVENTION AND EDUCATION	
Governor's Behavioral Health Services Planning Council	Children Subcommittee. Support, encourage, and provide resources to early childhood programs in implementing and sustaining the Kansas Family Engagement and Partnership Standards for Early Childhood.

Figure A-1 (continued). **Other Recommendations**

Source	Recommendation
PREVENTION AND EDUCATION (CONTINUED)	
Governor's Substance Use Disorder Task Force	Coroner Letters. Explore the feasibility of and consider a pilot program for coroners or medical examiners sending educational letters to prescribing providers upon their own patient's death from prescription drug or other illicit substance overdose.
Governor's Behavioral Health Services Planning Council	Suicide Prevention Workgroup. Write, distribute, and promote op-eds, and disseminate information about safe messaging covering suicide, and urge the development of effective materials including through local media outlets. Increase number of trainings and workshops to promote and support application of best practices and evidence-based approaches in the field of suicidology among Behavioral Sciences Regulatory Board (BSRB) licensed behavioral health practitioners and community gatekeepers when working to prevent suicides.
TREATMENT AND RECOVERY	
Mental Health Task Force, 2019	Care Management Program. Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt into a health home to have access to activities that help coordinate care.
Governor's Substance Use Disorder Task Force	Expand MAT. Expand Access and utilization of medication assisted Treatment (MAT), including increasing access to MAT in jail settings and an expansion of MAT in block grant services
Governor's Behavioral Health Services Planning Council	Housing and Homelessness Subcommittee. Continue and expand Housing First in collaboration with KDADS, including an expansion of technical assistance and education to promote utilization.
Governor's Behavioral Health Services Planning Council	Supported Housing. Expand the Supported Housing Program, a program that provides affordable housing linked to services for low-income, homeless, or potential homeless people with severe mental illness.
Governor's Behavioral Health Services Planning Council	Children Subcommittee. Increase the availability of flexible treatment options (residential and outpatient) that allow children to stay with and participate in treatment with their parents, which also embrace a holistic and trauma-informed approach to treatment.
New Recommendation	Co-Occurring Disorders: Invest in community-based intellectual and developmental disability (I/DD) services and training around behavioral health.

Figure A-1 (continued). **Other Recommendations**

Source	Recommendation
TREATMENT AND RECOVERY (CONTINUED)	
New Recommendation	Supported Employment. Expand the Supported Employment Program, a program that provides employment services to individuals suffering from a severe mental illness, including those with a mental illness and co-occurring substance disorder.
Governor's Behavioral Health Services Planning Council	Housing and Homelessness Subcommittee. Create a housing specialist certification and ongoing education training curriculum.
SPECIAL POPULATIONS	
Governor's Substance Use Disorder Task Force	Neonatal Abstinence Syndrome (NAS). Provide education, screening, intervention, and support to substance using women to reduce the number of infants born substance-exposed, while expanding coverage for family planning services, preconception services, and a variety of contraceptives, including long acting reversible contraceptives. Provide education on best practices to reduce stigma and promote standardized care regarding NAS cases, develop a standardized reporting process for NAS cases across the state.
Governor's Behavioral Health Services Planning Council	Rural and Frontier Subcommittee (RFS) Recommendation. Increase funding for crisis services and beds (youth respite, mobile crisis) statewide, being sure to address existing gaps in rural and frontier areas.
Mental Health Task Force, 2019	Access to Effective Practices and Support. Deliver crisis, clinical, and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.
Crossover Youth Working Group	Child Welfare Placements. The Working Group suggests exploring what supports/services are lacking and prevent permanency from being achieved regarding placement stability of crossover youth placed in foster care.
New Recommendation	Children of Incarcerated Parents. Build awareness of and responsiveness to the behavioral health needs and risks of children of incarcerated parents into the behavioral health system through data analysis, information sharing, workforce training, and targeted interventions and coordination between KDOC, DCF, KDADS, KDHE, KSDE and community partners serving children of incarcerated parents.

Figure A-1 (continued). **Other Recommendations**

Source	Recommendation
SPECIAL POPULATIONS (CONTINUED)	
New Recommendation	Perinatal Mood and Anxiety Disorders (PMAD). Increase identification of perinatal mood and anxiety disorders (PMAD) and options for care provision, including workforce development and training on PMAD.
Data Systems	
Crossover Youth Working Group	Child Welfare Placements. The Working Group proposes future efforts to study data on outcomes for youth placed in group residential homes and to understand whether youth who might have been detained prior to SB 367 are now being placed in the child welfare system.
INTERACTIONS WITH THE LEGAL SYSTEM AND LAW ENFORCEMENT	
Mental Health Task Force, 2019	Suspension of Medicaid. Implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care.
Governor's Substance Use Disorder Task Force	Naloxone. Promote Naloxone education and use for first responders and pursue all available funding. (Note: Working Group members indicated that this recommendation had largely been implemented.)
Governor's Substance Use Disorder Task Force	Good Samaritan. Enact a 911 Good Samaritan Law. This law must be crafted to avoid unintentionally allowing persons to avoid persecution for serious felony charges, especially when their actions directly involved providing illicit substance to the ill individual.
SYSTEM TRANSFORMATION	
Governor's Substance Use Disorder Task Force	Kansas Placement Criteria Program. Implement modern technology and data collection to replace the discontinued Kansas Placement Criteria Program (KCPC).
Governor's Substance Use Disorder Task Force	Payment Reform. Support substance use disorder payment reform targeted to improve population health.
Governor's Substance Use Disorder Task Force	Screening, Brief Intervention and Referral to Treatment (SBIRT). Increase access to and utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT) by expanding who can be reimbursed for providing SBIRT (e.g., include in block grant funding) and where SBIRT can be provided (e.g., in the education system).

Figure A-1 (continued). **Other Recommendations**

Source	Recommendation
SYSTEM TRANSFORMATION (CONTINUED)	
Child Welfare System Task Force	Analysis of Service Delivery. The State of Kansas should establish a work group or task force to conduct an analysis to: 1) determine what it costs to adequately fund high-quality child welfare services; 2) by 2021, evaluate the benefits of privatizing child welfare services; and 3) determine the best public/private collaboration to deliver child welfare services. DCF shall determine appropriate outcomes measures and periodic evaluations shall be conducted to ensure contractors are achieving set outcomes and provide opportunities for ongoing collaboration and review. Summary reports should be provided to the Legislature annually.
Mental Health Task Force, 2019	Learning Across Systems. Create a position/entity to track information about adverse outcomes that occur and identify strategies for addressing them in a timely manner.
Crossover Youth Working Group	Juvenile Intake and Assessment. Their view of Juvenile Intake and Assessment Services was limited in scope to only FY2019. Data from intake and assessments completed throughout a youth's lifetime should be reviewed. Robust analysis from completed the Kansas Detention Assessment Instrument (KDAI) could be conducted when integrated into the data system.
TELEHEALTH	
New Recommendation	Verbal Consent. Recommend the opportunity to obtain verbal consent for care with written consent established as follow-up.
New Recommendation	Telehealth Care Coordination. Explore options to cover reimbursement for care coordination around the provision of telehealth services.
New Recommendation	Broadband. Expand access to broadband.
New Recommendation	Jail Telehealth Services. Explore challenges to address challenges (e.g., privacy, technology, funding) related to providing telehealth services in a jail setting.

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Appendix B. Recommendation Rubric

Figure B-1. Mental Health Modernization and Reform, Working Group Recommendation Rubric, 2020

Recommendation:	
Rationale:	
Ease of Implementation (Score 1-10):	Potential for High Impact (Score 1-10):
<p>Consider:</p> <p><input type="checkbox"/> Program Change (Easiest)</p> <p><input type="checkbox"/> Pilot Program</p> <p><input type="checkbox"/> Program Overhaul</p> <p><input type="checkbox"/> New Program (Most difficult)</p> <p>Will cost be a barrier to implementation?</p> <p>Does the recommendation include strategies for continuity? (<i>How does it consider sustainability?</i>)</p> <p>Which of the following mechanisms may affect the achievability of the recommendation?</p> <p><input type="checkbox"/> Legislative session</p> <p><input type="checkbox"/> Federal approval process</p> <p><input type="checkbox"/> Regulatory process</p> <p><input type="checkbox"/> Contracts</p> <p><input type="checkbox"/> Agency budget development</p> <p><input type="checkbox"/> Grant cycles</p> <p><input type="checkbox"/> Systems (e.g., IT)</p>	<p>Consider:</p> <p>Will it benefit a large population? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will it significantly impact special populations?</p> <p><input type="checkbox"/> Foster care</p> <p><input type="checkbox"/> Frontier communities</p> <p><input type="checkbox"/> Rural communities</p> <p><input type="checkbox"/> Urban communities</p> <p><input type="checkbox"/> Limited English Proficient (LEP) persons</p> <p><input type="checkbox"/> Low-income individuals</p> <p><input type="checkbox"/> Children</p> <p><input type="checkbox"/> Veterans</p> <p><input type="checkbox"/> Others? (<i>List here</i>)</p> <p>Does it serve those who have been disproportionately impacted by the issue? (<i>Does it address inequities?</i>)</p> <p>Could the recommendation produce savings in other areas?</p>

Figure B-1 (continued). Mental Health Modernization and Reform, Working Group Recommendation Rubric, 2020

How does this recommendation contribute to modernization?	
Action Lead: <i>(Who takes point on this recommendation?)</i>	Key Collaborators: <i>(Who should be included as decisions are made about how to implement this recommendation?)</i>
Intensity of Consensus: <i>(Is there group consensus that this recommendation is important for the modernization and reform of the behavioral health system in the state? Does a wide cross-section of stakeholders feel that this recommendation would be mutually beneficial? To be addressed during final review)</i>	

Appendix C. High-Priority Topic Lists

The Working Groups have made recommendations related to the following topics for immediate action (Figure C-1). **Recommendations for immediate action are those that should be completed in the next two years.** The full text for each recommendation and Working Group rationale is available in the body of the report (beginning [page 7](#)).

Figure C-1. Recommendation Topics for Immediate Action

Workforce	Funding and Accessibility	Community Engagement
<input type="checkbox"/> Recommendation 1.1 Clinical Supervision Hours <input type="checkbox"/> Recommendation 1.2 Access to Psychiatry Services <input type="checkbox"/> Recommendation 1.3 Provider MAT Training	<input type="checkbox"/> Recommendation 2.1 Certified Community Behavioral Health Clinic Model <input type="checkbox"/> Recommendation 2.2 Addressing Inpatient Capacity <input type="checkbox"/> Recommendation 2.3 Reimbursement Rate Increase and Review <input type="checkbox"/> Recommendation 2.4 Suicide Prevention <input type="checkbox"/> Recommendation 2.5 Problem Gambling and Other Addictions Fund	<input type="checkbox"/> Recommendation 3.1 Crisis Intervention Centers <input type="checkbox"/> Recommendation 3.2 IPS Community Engagement
Prevention and Education	Treatment and Recovery	Special Populations
<input type="checkbox"/> Recommendation 4.1 988 Suicide Prevention Line Funding <input type="checkbox"/> Recommendation 4.2 Early Intervention <input type="checkbox"/> Recommendation 4.3 Centralized Authority	<input type="checkbox"/> Recommendation 5.1 Psychiatric Residential Treatment Facilities	<input type="checkbox"/> Recommendation 6.1 Domestic Violence Survivors <input type="checkbox"/> Recommendation 6.2 Parent Peer Support
Data Systems	Legal System and Law Enforcement	System Transformation
<input type="checkbox"/> Recommendation 7.1 State Hospital EHR <input type="checkbox"/> Recommendation 7.2 Data and Informed Survey Opt-Out <input type="checkbox"/> Recommendation 7.3 Information Sharing <input type="checkbox"/> Recommendation 7.4 Needs Assessment	<input type="checkbox"/> Recommendation 8.1 Correctional Employees <input type="checkbox"/> Recommendation 8.2 Criminal Justice Reform Commission Recommendations <input type="checkbox"/> Recommendation 8.3 Law Enforcement Referrals	<input type="checkbox"/> Recommendation 9.1 Regional Model <input type="checkbox"/> Recommendation 9.2 Long-Term Care Access and Reform <input type="checkbox"/> Recommendation 9.3 Integration
Telehealth		
<input type="checkbox"/> Recommendation 10.1 Quality Assurance <input type="checkbox"/> Recommendation 10.2 Reimbursement Codes <input type="checkbox"/> Recommendation 10.3 Telehealth for Crisis Services		

The Working Groups have made recommendations related to the following topics (*Figure C-2*) and indicated that they should be considered of strategic importance. **Recommendations of strategic importance are those for which work should start immediately but will be completed in the long-term.** The full text for each recommendation and Working Group rationale is available in the body of the report (beginning [page 7](#)).

Figure C-2. Recommendation Topics of Strategic Importance

Workforce	Funding and Accessibility	Community Engagement
<input type="checkbox"/> Recommendation 1.4 Workforce Investment Plan <input type="checkbox"/> Recommendation 1.5 Family Engagement Plan	n/a	<input type="checkbox"/> Recommendation 3.3 Foster Homes <input type="checkbox"/> Recommendation 3.4 Community-Based Liaison
Prevention and Education	Treatment and Recovery	Special Populations
<input type="checkbox"/> Recommendation 4.4 Behavioral Health Prevention	<input type="checkbox"/> Recommendation 5.2 Service Array <input type="checkbox"/> Recommendation 5.3 Frontline Capacity <input type="checkbox"/> Recommendation 5.4 Housing	<input type="checkbox"/> Recommendation 6.3 Crossover Youth <input type="checkbox"/> Recommendation 6.4 I/DD Waiver Expansion <input type="checkbox"/> Recommendation 6.5 Family Treatment Centers
Data Systems	Legal System and Law Enforcement	System Transformation
<input type="checkbox"/> Recommendation 7.5 Cross-Agency Data	<input type="checkbox"/> Recommendation 8.4 Defining Crossover Youth Population	<input type="checkbox"/> Recommendation 9.4 Evidence Based Practices <input type="checkbox"/> Recommendation 9.5 Family Psychotherapy
Telehealth		
<input type="checkbox"/> Recommendation 10.4 Originating and Distant Site <input type="checkbox"/> Recommendation 10.5 Child Welfare System and Telehealth		

Figure C-3. High Priority Discussion Item

Medicaid Expansion. In addition to these recommendations for immediate action and of strategic importance, the Finance and Sustainability Working Group also puts forward the issue of Medicaid expansion as a high-priority discussion item for the Special Committee. The recommendation discussed by the Working Group related to Medicaid Expansion reads, “Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans.”

More information on this recommendation is available in the Funding and Accessibility section beginning on [page 16](#).

Appendix D. Special Committee and Working Group Membership

2020 Special Committee on Mental Health Modernization and Reform

- Senator Larry Alley
- Representative Tory Marie Arnberger
- Representative Barbara Ballard
- Representative Will Carpenter
- Senator Dan Kerschen
- Representative Brenda Landwehr, Chairperson
- David Long, Committee Assistant
- Representative Megan Lynn
- Senator Carolyn McGinn, Vice-chairperson
- Senator Pat Pettey
- Representative Adam Smith
- Senator Mary Jo Taylor
- Representative Rui Xu

2020 Special Committee on Mental Health Modernization and Reform Roundtable Members

- Sandra Berg, Executive Director, United Behavioral Health – KanCare
- Kathy Busch, Chair, State Board of Education
- Wes Cole, Chair, Governor’s Behavioral Health Services Planning Council
- Denise Cyzman, Chief Executive Officer, Community Care Network of Kansas
- Sheriff Jeff Easter, Sheriff of Sedgwick County, Kansas
- Sarah Fertig, State Medicaid Director, Kansas Department of Health and Environment
- Coni Fries, Blue Cross and Blue Shield of Kansas City, Vice President Governmental Relations
- B. Russell Harper, State Government Affairs, Representative of CVS Health on Behalf of Aetna
- Greg Hennen, Executive Director, Four County Mental Health Center, Inc.
- Secretary Laura Howard, Secretary, Kansas Department for Aging and Disability Services and Kansas Department for Children and Families

- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Kyle Kessler, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
- Sheriff Scott King, Sheriff of Pawnee County, Kansas
- Spence Koehn, Court Services Specialist, Office of Judicial Administration
- Rachel Marsh, Executive Director, Children's Alliance of Kansas
- Sunee Mickle, Vice President Government and Community Relations, Blue Cross and Blue Shield of Kansas
- Josh Mosier, Manager of Client Services, Kansas Health Information Network (KHIN)
- Secretary Lee Norman, Secretary of Kansas Department of Health and Environment
- Kandice Sanaie, Senior Director State Government Affairs, Cigna
- Chief Don Scheibler, Chief of Police, Hays, Kansas
- Sherri Schuck, Pottawatomie County Attorney
- Rennie Shuler-McKinney, Director of Behavioral Health, AdventHealth Shawnee Mission
- Lisa Southern, Executive Director and Licensed Clinical Psychotherapist, Compass Behavioral Health
- Deborah Stidham, Director of Addiction and Residential Services, Johnson County Mental Health center
- William Warnes, Medical Director for Behavioral Health, Sunflower Health Plan

Finance and Sustainability Working Group (WG1)

- Senator Larry Alley
- Charles Bartlett, Director of Adult Services, Kansas Department for Aging and Disabilities Services
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Representative Will Carpenter
- Sarah Fertig, Medicaid Director, Kansas Department of Health and Environment
- Coni Fries, Vice President of Government Relations, Blue Cross and Blue Shield of Kansas City
- Greg Hennen, Co-Chair, Executive Director, Four County Mental Health Center

- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Representative Brenda Landwehr
- Representative Megan Lynn
- William Warnes, Co-Chair, Medical Director for Behavioral Health, Sunflower Health Plan

Policy and Treatment Working Group (WG2)

- Representative Barbara Ballard
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Wes Cole, Chairperson, Governor's Behavioral Health Services Planning Council
- Erin George, Person with Lived Experience
- Kellie Hans Reid, Director of Medicaid and Children's Mental Health, Kansas Department for Children and Families
- Gary Henault, Co-Chair, Director of Youth Services, Kansas Department for Aging and Disabilities Services
- Senator Dan Kerschen
- Representative Brenda Landwehr
- Rachel Marsh, Co-Chair, Chief Executive Officer, Children's Alliance of Kansas
- Senator Carolyn McGinn
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- Rennie Shuler-McKinney, Director of Behavioral Health, AdventHealth Shawnee Mission
- Deborah Stidham, Director of Addiction and Residential Services, Johnson County Mental Health Center
- Lisa Southern, Executive Director and Clinician, Compass Behavioral Health
- Kelsee Torrez, Behavioral Health Consultant, Kansas Department of Health and Environment

System Capacity and Transformation Working Group (WG3)

- Representative Tory Marie Arnberger
- Sandra Berg, Executive Director, United Behavioral Healthcare
- Representative Elizabeth Bishop
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Andrea Clark, Co-Chair, CIT/Veterans Program Coordinator, Kansas Department for Aging and Disabilities Services
- Denise Cyzman, Chief Executive Officer, Community Care Network of Kansas, formerly known as Kansas Association for the Medically Underserved
- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Kyle Kessler, Co-Chair, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
- Spence Koehn, Court Services Specialist, Office of Judicial Administration
- Representative Brenda Landwehr
- Representative Rui Xu

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Strategic Framework for Modernizing the Kansas Behavioral Health System

*Working Groups Report to the Special Committee
on Mental Health Modernization and Reform*

[Note: **Updated** to reflect recommendations approved by the Special Committee at its meetings on December 10-11, 2020.]

December 9, 2020

Figure 3. Select Measures to Assess the Kansas Behavioral Health System

PROCESS MEASURE				
Measure:	Number	Percent		
Kansas counties recognized as a Mental Health Professional Shortage Area . <i>Lower number/percentage of counties is better.</i>	99 (2019)	94.3% (2019)		
Counties served by Mobile Response and Stabilization Services. <i>Higher number/percentage of counties is better.</i>	*	*		
Counties served by Crisis Intervention Centers. <i>Higher number/percentage of counties is better.</i>	*	*		
OUTCOME MEASURES				
Measure:	Kansas current (year)	Kansas previous (year)	U.S. current (year)	U.S. previous (year)
Uninsured rate (adults age 19-64). <i>Lower rates are better.</i>	13.1% (2019)	12.6% (2018)	12.9% (2019)	12.5% (2018)
Uninsured rate (children age 0-18). <i>Lower rates are better.</i>	5.8% (2019)	5.1% (2018)	5.7% (2019)	5.2% (2018)
Statewide age-adjusted mortality rate for suicide per 100,000 population. <i>Lower rates are better.</i>	19.9% (2017)	19.2% (2016)	15.2% (2017)	14.7% (2016)
Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities (i.e., criteria for and predictors of clinical depression). <i>Lower percentage is better.</i>	32.5% (2019)	24.8% (2017)	36.7% (2019)	31.5% (2017)
Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling. <i>Higher percentage is better.</i>	55.9% (2018-2019)	52.7% (2017-2018)	53.2% (2018-2019)	52.7% (2017-2018)
Individuals with SPMI that have been enrolled in supportive housing and have not had an ER or Psychiatric Hospital admission in the last 12 months. <i>Higher percentage is better.</i>	*	*	NA	NA

Figure 3 (continued). Select Measures to Assess the Kansas Behavioral Health System

OUTCOME MEASURES (continued)							
Measure:	Kansas current (year)	Kansas previous (year)	U.S. current (year)	U.S. previous (year)			
Individuals with SPMI that have been enrolled in supportive employment and have not had an ER or Psychiatric Hospital admission in the last 12 months. <i>Higher percentage is better.</i>	*	*	NA	NA			
Percent of individuals with an inpatient psychiatric stay in the previous year, that have returned to and remain in the community without additional hospitalizations. <i>Higher percentage is better.</i>	**	**	NA	NA			
MENTAL HEALTH in AMERICA RANKINGS of 50 states and Washington D.C. by report year							
Select Measure: <i>States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes.</i>	2021	2020	2019	2018	2017	2016	2015
Kansas rankings: overall.	#29	#42	#24	#19	#21	#15	#19
Kansas ranking: Adult (prevalence and access to care).	#38	#43	#28	#22	#23	#16	#23
Kansas ranking: Youth (prevalence and access to care).	#26	#37	#21	#19	#18	#15	#8
Kansas ranking: Adults with mental illness who report unmet needs.	#51	#46	#29	#39	#38	#28	#51
Kansas ranking: Youth with at least one major depressive episode who did not receive mental health services.	#18	#47	#40	#29	#12	#12	NA

Note: The asterisk (*) indicates that data are reportable by a state agency. The double-asterisk (**) means that the measure could be reported in the future, assuming implementation of certain recommendations related to data interoperability and higher rates of participation in health information exchanges. NA stands for not available.

The Mental Health in America overall ranking uses national data from surveys including the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). The overall ranking is comprised of 15 measures for adults and youth around mental health issues, substance use issues, access to insurance, access to adequate insurance, as well as access to and barriers to accessing mental health care. A rank of 1-13 indicates lower prevalence of mental illness and higher rates of access to care, and an overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. Data in each reporting year come from previous reporting periods. For example, in the 2021 report, most indicators reflect data from 2017-2018, while the 2020 report includes data from 2016-2017 and so forth. The baseline report year is 2015. For more information, go to <https://www.mhanational.org/issues/2021/ranking-guidelines>.

Source: Data as reported by the Kansas Department for Aging and Disability Services (KDADS), Kansas Department of Health and Environment (KDHE), Kansas Department of Corrections (KDOC), Kansas State Department of Education (KSDE) and KHI analysis of data from the U.S. Census Bureau 2018-2019 American Community Survey Public Use Microdata Sample files for uninsured rates and 2015-2021 Mental Health in America Rankings.

[**Note:** In above fields where data is absent and denoted with an asterisk (* or **), the Committee requests the reporting agency or entity submit data as it becomes available or upon program changes.]

Workforce Recommendation 1.1: Clinical Supervision Hours [Immediate Action]

Recommendation: Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers.	
Rationale: A version of this recommendation was originally developed by the Committee on Alcohol and Other Drug Abuse of the Governor's Behavioral Health Services Planning Council. ¹ A similar change was made for social workers in 2019 and has made recruitment of social workers easier in some parts of the state. BSRB intends to support legislation that would enact this change in the 2021 Legislative Session. This change would bring Kansas licensing requirements in alignment with neighboring states.	
Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Would require a program change and change in legislation.• Cost is not a barrier to implementation.	<ul style="list-style-type: none">• Would impact the entire state.• Could lead to a reduction in workforce inequities by geography, particularly in rural and frontier counties.
Measuring Impact: Percent or number of master's-level behavioral health clinicians practicing in Kansas.	
Action Lead: BSRB	Key Collaborators: Legislature, KDADS

Return to [Figure 1](#) or [Figure C-1](#).

Workforce Recommendation 1.2: Access to Psychiatry Services [Immediate Action]

Recommendation: Require a study be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses. [Note: The Committee requests consideration be given to educational institutions, regardless of size, that can provide this expertise and assistance.]	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force. ² Multiple areas in the state are struggling to recruit and retain psychiatrists and psychiatric nurses, with an additional 54 psychiatrists needed to eliminate the Mental Health Care Health Professional Shortage Areas (HPSAs) in Kansas. ³ An important next step once the study is completed would be exploring implementation of the strategies outlined in the report.	
Ease of Implementation (Score 1-10): 9	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Would be relatively easy to implement once funding is available.	<ul style="list-style-type: none">• Implementing strategies from the report could impact frontier and rural communities that struggle to recruit psychiatric providers.
Measuring Impact: <ul style="list-style-type: none">• Percent or number of mental health care professionals participating in the Kansas State Loan Repayment Program.• Number of Kansas counties recognized as a Mental Health Professional Shortage Area.• Number of adult and child/adolescent psychiatry residents in Kansas.	
Action Lead: KDHE	Key Collaborators: Educational institution

Workforce Recommendation 1.5: Family Engagement Practices [Strategic Importance]

Recommendation: Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families.	
Rationale: A version of this recommendation was originally developed by the Children’s Subcommittee of the Governor’s Behavioral Health Services Planning Council. ⁷ Parent and family engagement practices can create shared responsibility between providers and families, such as by involving families in decision making. It can lead to improved clinical outcomes, as well as improved educational outcomes and health behaviors when parents and families are engaged by schools.	
Ease of Implementation (Score 1-10): 5	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none">• Cost could be a barrier to implementation.• Could require changes in a legislative session and agency budget development.	<ul style="list-style-type: none">• High impact for pediatric behavioral health population.
Measuring Impact: <ul style="list-style-type: none">• Number of families served.• Percent of children and parents whose functionality scores improved (over set time period).• Rate of provider turnover.	
Action Lead: KDADS	Key Collaborators: KDHE, Legislature

Return to [Figure 1](#) or [Figure C-2](#).

Funding and Accessibility

In a modernized behavioral health system, the State will need to proactively pursue new funding mechanisms, including alternative models such as the Certified Community Behavioral Health Clinic (CCBHC) model, to ensure that reimbursement rates are competitive. The State has the expertise, research and recommendations in place to support changes to how behavioral health is funded in Kansas, and implementation should be pursued across administrations.

The Working Group asserted that accurate and appropriate funding **of for all Kansans who currently lack coverage** is a key element of a sustainably funded, modern behavioral health system, and a modernized system will successfully identify the right populations to serve and make services meaningfully accessible. Likewise, a modernized system should rely on measurable outcomes to drive decisions. Key challenges related to funding and accessibility requirements for budget neutrality on the 1115 Medicaid Waiver, limited availability of SUD block grant dollars, and low reimbursement rates at community mental health centers and for SUD providers.

Funding and Accessibility Recommendation 2.3: Reimbursement Rate Increase and Review [Immediate Action]

Recommendation: Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a Working Group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF). ¹⁰ The MHTF recommendation included a detailed review of reimbursement rates and recommended rates be updated accordingly. Working Group members, however, felt that a pressing need was an overall increase to reimbursement rates for behavioral health services in order to maintain the Community Mental Health Center (CMHC) system in the state. In discussion, Working Group members highlighted that few changes to reimbursement rates had occurred in the last 20 years and were overdue. Once reimbursement rates are increased, Working Group members recommend having a task force review the behavioral health reimbursement structure of both the uninsured and Medicaid populations to ensure long-term sustainability. In the 2020 Legislative Session, the final budget bill included a proviso requiring KDHE to complete a detailed review of costs and reimbursement rates for behavioral health services in the state. ¹¹ This review is due in January 2021 and may include information to be reviewed by a Working Group or task force.	
Ease of Implementation (Score 1-10): 6	Potential for High Impact (Score 1-10): 8
<ul style="list-style-type: none"> • Cost will be a barrier to implementation. 	<ul style="list-style-type: none"> • Would impact a large population.
Measuring Impact: <ul style="list-style-type: none"> • Frequency of reimbursement rate updates 	
Action Lead: Legislature	Key Collaborators: KDADS, KDHE, CMHCs

Return to [Figure 1](#) or [Figure C-1](#).

[Note: Does the Committee wish to include information presented by the State Medicaid Director regarding the top 6 behavioral codes by utilization and claims.]

Prevention and Education Recommendation 4.2: Early Intervention [Immediate Action]

Recommendation: Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment and treatment.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force, and action steps that could support this recommendation can be found in Recommendation 3.4 of the Mental Health Task Force Report to the Kansas Legislature, January 14, 2019. ²¹ Early identification of behavioral health symptoms can allow for earlier intervention, leading to better outcomes for youth. Additional funds would be needed to continue and expand this work statewide, which was partially piloted via the Substance Abuse and Mental Health Administration (SAMHSA) Systems of Care grant.	
Ease of Implementation (Score 1-10): 3	Potential for High Impact (Score 1-10): 10
<ul style="list-style-type: none">• Would require a program change and potentially new services if additional diagnosis codes are approved.• Cost could be a barrier to implementation.• Could require a federal approval process, agency budget development and systems to implement.	<ul style="list-style-type: none">• Would benefit a large population.• Would impact individuals in foster care, low-income individuals, children and those with limited English proficiency.• Could produce cost savings via reductions in ER visits, pediatrics visits, and use of the criminal justice system and state hospitals.
Measuring Impact: <ul style="list-style-type: none">• Percent of Medicaid-eligible children age 0-5 receiving initial trauma and mental health screen within 90 days of entering coverage.• Utilization of early childhood mental health screening, assessment, and treatment Medicaid codes.	
Action Lead: KDHE & KDADS	Key Collaborators: DCF, MCOs

Return to [Figure 1](#) or [Figure C-1](#).

System Transformation Recommendation 9.1: Regional Model [Immediate Action]

Recommendation: Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas.

Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).³⁹ It was a standalone recommendation in the 2018 MHTF report and then consolidated into Recommendation 1.1 and 1.2 in the 2019 MHTF report. The Working Group discussed that while cost is a primary barrier to implementation, there are opportunities for cost savings by reducing the high cost of transporting individuals to Osawatomie State Hospital (OSH) or Larned State Hospital. Both institutions are a significant distance from key population centers, particularly in the south-central region of the state. This recommendation could be implemented by a combined approach of state institution alternatives (SIAs) and smaller, regional state facilities.

Cost savings accrued via the recommendation could be redirected to the provision of evidence-based services. In addition to cost savings, a reduction in travel would increase safety of the individuals in need of care as well as those in the behavioral health workforce currently providing transportation services, as well as allow individuals to remain closer to local support systems. This recommendation is also seen as a key component to lifting the ongoing moratorium at OSH and is included in the current plan to do so.

Ease of Implementation (Score 1-10): 8	Potential for High Impact (Score 1-10): 9
<ul style="list-style-type: none">• Cost would be a barrier to implementation based on the need for appropriation.	<ul style="list-style-type: none">• Would benefit a large population.• Could produce cost savings via reduction in transportation costs.
Measuring Impact: <ul style="list-style-type: none">• More work is needed to identify measures appropriate to capture the impact of this recommendation.	
Action Lead: KDADS	Key Collaborators: Providers, Local Units of Government, Law Enforcement

Return to [Figure 1](#) or [Figure C-1](#).

Telehealth Recommendation 10.2: Reimbursement Codes [Immediate Action]

Recommendation: Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.

Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. While many behavioral health services could be provided via telehealth prior to the COVID-19 pandemic, additional codes (e.g., for the SED waiver, crisis intervention, tobacco cessation) have become eligible for reimbursement during the public health emergency (PHE).^{44,45,46} Working Group members indicated that some of these services should be maintained after the PHE ends, though the changes were initially intended to be temporary. Additionally, the PHE has led to an expansion of the types of sites where patients can receive care, including at home. Services provided to patients in their homes are not eligible for a facility fee payment for the originating site. In situations where support (e.g., IT support, patient education and preparation) is provided to patients receiving telehealth services in their home, commensurate compensation should be made available to service providers.

Services provided to patients in their homes do not receive a facility fee payment for the originating site, which can contribute to lost revenue for providers, many of whom are having to do additional work (e.g., IT support, patient education and preparation) to provide high-quality services to patients in their home. Consideration should be given to the feasibility of providing additional reimbursement for providers who furnish technical support for patients who receive telehealth services in their homes.

However, further study and consideration should be given to the unintended consequences of mandating payments to providers in excess of in-person mental health visits. The committee would not want to encourage telemedicine in a manner that would incentivize providers to leave their community practices, especially in rural and underserved areas or otherwise reduce their availability for the delivery of in-person care. In addition, if this proposal for additional telemedicine provider payments is applicable beyond the Medicaid program, it likely qualifies as a “provider or benefit” mandate requiring the production of a cost benefit analysis and the “test tracking” of the proposed new charges on the state employees health plan as required by K.S.A. 40-2248 through 40-2249a. [Note: Language submitted during WG report presentation before the Committee.]

Measuring Impact:

- Number of telehealth codes open for Medicaid reimbursement pre- and post-pandemic
- Utilization of these telehealth codes

Action Lead: KDHE Division of Healthcare Finance

Key Collaborators: KDADS, managed care organizations, community mental health centers

Return to [Figure 1](#) or [Figure C-1](#).

Top 6 Behavioral Health Codes by Amount Paid

2019

Rank	Procedure Code	Procedure Code Description	Amount Paid
1	H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT FACE TO FACE PER 15 MINUTES	\$52,081,598
2	99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT TYPICALLY 15 MINUTES	\$48,197,829
3	90837	PSYCHOTHERAPY 60 MINUTES	\$27,489,425
4	H2017	PSYCHOSOCIAL REHABILITATION SERVICES PER 15 MINUTES	\$24,778,469
5	99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT TYPICALLY 25 MINUTES	\$24,164,013
6	90834	PSYCHOTHERAPY 45 MINUTES	\$8,176,032
TOTAL			\$184,887,366

*Paid Claims Only

*No Voided Claims

*First Date of Service between 1/1/2019 and 12/31/2019

*Latest Claims Only

*Dollar amounts are all funds (state + federal)

Top 6 Behavioral Health Codes by Claim Count

2019

Rank	Procedure Code	Procedure Code Description	Claim Count
1	99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT TYPICALLY 15 MINUTES	697860
2	99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT TYPICALLY 25 MINUTES	400466
3	H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT FACE TO FACE PER 15 MINUTES	333807
4	H2017	PSYCHOSOCIAL REHABILITATION SERVICES PER 15 MINUTES	274834
5	90837	PSYCHOTHERAPY 60 MINUTES	257649
6	90834	PSYCHOTHERAPY 45 MINUTES	123141

*Paid Claims Only

*No Voided Claims

*First Date of Service between 1/1/2019 and 12/31/2019

*Latest Claims Only

*Dollar amounts are all funds (state + federal)