Approved 4/4/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p~~m~~ on ~~March 26,~~, 1990 in room 526S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research
Emalene Correll, Legislative Research
Norman Furse, Revisor's Office
Sandra Nash, Committee Secretary

Conferees appearing before the committee:

The Chairman called the meeting to order, calling the Committees attention to H.B. 3022.

The first proponent was Pat Johnson, Kansas State Board of Nursing. Ms. Johnson said she was appearing in support of the bill and asked that Section 4(e)(2) which was deleted by the House be reinstated in the bill. This section refers to the survey of continuing education providers.(Attachment 1)

The Chairman called the next proponent, Terri Roberts, J.D., R.N., Executive Director of the Kansas State Nursing Association. Ms. Roberts said she is appearing in support of the bill, except for the Section 4(e)(2) which Ms. Johnson wanted to have reinstated. Ms. Roberts said her association feels that Kansas nursing C.E. providers are doing an exceptional job of providing quality and accessible C.E. and that surveying the continuing education providers is not related to the protection of the public.(Attachment 2)

The Chairman called the next proponent to H.B. 3022 Kay Hale, Director of Educational Services, Kansas Hospital Association. She said she was a registered nurse with the Hospital Association for eight years. In her role she serves as staff to the Kansas Organization of Nurse Executives and the Kansas Association of Hospital Education Coordinators. She also serves on the board of Kansas Association of Continuing Education Providers. She was here to testify for all these organizations. In regard to this bill, we support the bill as it has been amended. In particular, they support the deletion of Section4(e)(2), which provided for surveys of continuing education providers. We believe that such surveys are unnecessary to protect the public and we believe that they would be costly. Therefore, we support the amendment that remove this section from the bill.

The Chairman called the Committee's attention to H.B. 2586, calling the Committee's attention the a letter from The Kansas District Judge's Association, Paul E. Miller, District Judge, requesting a broadening of the definition of "qualified mental health professionals." (Attachment 3)

The Chairman called the Committee's attention to a letter from the Kansas Psychological Association, Dr. David C. Rodeheffer, expressing concerns over the exclusiveity of the contracts between SRS and the Mental Health Centers; the definition and role of the "Qualified Mental Health Professional"; add "psychologist" in Section 16, Paragraph (w), lines 18-19, as "...who is acting under the supervision of a physician or psychologist"; expressing strong reservations about the role and powers of the "Qualified Mental Health Professional" as written, removing "authorizing such admission" in Section 17(a), lines 16-24, removing "receiving recommendations from" Section 18(a), Lines 24-26, remove "recommending evaluation at a state psychiatric hospital"

in Section 19(a), lines 9-14, remove "recommending" from Section 20(b), Lines 19-26, removing "authorizing" in Section 20(c), lines 3-8, remove "recommending that" in Section 20(d), Lines 27-33, removing "recommending" in Section 21(d), Lines 20-24, removing "authorization" in Section 23(b), lines 40-43, removing "recommendation" in Section 25(f), Lines 34-39, removing "recommendation" in Section 26(a), lines 16-21. He also expressed concerns about the "zero rejection"policy to be developed by the secretary of SRS in New Section 3(g), lines 42-43. And he expressed concerns about Section 34,(a), subsection (13) which eliminates the need for a signed release of information by the patient, believing that this unnecessarily violates a person's civil rights. The last concern was with the mandating of the downsizing of the state hospitals by statute.(Attachment 4)

The Chairman called the next proponent, Representative Henry Helgerson.

Representative Helgerson said he would offer to be available later if the Committee would like to ask questions, since there are so many conferees to be heard. The bill is the culmination of the Governor's Task Force, two interim committees and lengthy discussions in the House. He said he would be glad to come back at any convenient time of the Committee

The Chairman called the next proponent, Al Nemec, Commissioner of Mental Health and Retardation Services, Department of Social and Rehabilitation Services. Mr. Nemec said Dr. Mani Lee, Director of Mental Health would appear in his place.

Dr. Lee appeared as a proponent for H.B. 2586, citing the structural and financial reform of the mental health system consistent with the recommendations of the Governor's Task Force on Mental Health Reform and the provisions of PL99-660(Attachment 5) Dr. Lee said they have prepared a financing plan which would make the bill workable in a systematic way.

Staff Furse asked how does this bill provide for coordination of services. What kind of mechanism is contained in this legislation that allows the department on the state level to coordinate.

Dr. Lee said that at the present time people come to state hospitals without any single point of entry. People are referred from various sources, the judges can refer people to state hospitals, the psychiatrists, the families and it is the assumption that if there is a single point of entry, a responsible entity, then maybe some of those people do not have to come to the hospitals. Thereby, wasting a good amount of state resources. So, this bill requires community mental health centers be the gate-keepers, screening entity, that becomes the single point of entry. The other one is, the bill requires centers to come out with a coordinated service plan in their local area. If there are 10 different providers at the centers, they would come out with one coordinated plan that would take care of the coordination. The other thing that is in the bill is the free flow of information. Because of the confidentially of the law, there are restrictions as to what can be shared between community centers and state hospitals. So, with this bill, there would be lots freer communication between providers involved.

Staff Furse said so the only way an individual mental ill person can get into a state institution, is through a community mental health center. Is that what the bill says?

Dr. Lee says the bill says that at least the centers should be aware of who is going into the hospitals, so incase the Centers feel they are able to take care of these individuals in community

and they don't have to go in.

Staff Furse asked if they go in on their own or do they have to have the approval of the local community mental health center to be committed.

Dr. Lee said in a sense it is the approval, but the intent is to somehow the centers have, indeed, access to this individual so that they know whether they can provide services to this individual so that they don't have to be admitted to the state hospital.

Staff Furse asked who makes the decision, who finally determines who goes into a state institution.

Dr. Lee said the final decision is made by the clinician, in terms of whether somebody is need of state hospital care or not. It is made by the M.D. and the psychologist.

Staff Furse asked if it was the M.D. or psychologist for the mental health center or the state hospital.

Dr. Lee said state hospital and state hospital. Nothing really changes when it comes to the final clinical decision in terms of where somebody should be served. The Center staff are given a chance to meet with individuals who are supposedly needing state hospital care.

Staff Furse asked if they make a recommendation to the state institution or how does it interface.

Dr. Lee said the center screening by professionals simply state these individuals could not be looked after in the community so they would need an evaluation or treatment in a hospital. So far the bill is limited to that.

The Chairman asked if his personal physician could admit him to Larned State Hospital without going through the Community Mental Health Center.

Dr. Lee said it is not possible but it is possible in a sense because at the present time the state is very short of manpower resources. It is our thinking if the bill passes, the mental health centers would mobilize all the resources, including private practitioners. And your doctor, Senator, so that if your doctor says the patient is in need of services, then most likely the centers would go along with the doctors opinion.

Staff Correll said your testimony refers to implementation plan entitled "The Financing Plan, Revision II", dated February 23 which has not been given to the Committee. The last version of that I have seen, does nothing but show what projected costs of the State Institutions would be through the next five or seven years. It does not indicate what the cost of this program would be in terms of any additional assistance from Community Mental Health Centers or whatever. It simply shows what costs savings might accrue to the state by closing beds at the state institutions. Now, first off, do you plan to distribute to the Committee whatever financing plan revision II is?

Dr. Lee said yes.

Staff Correll said secondly, is it more complete than the first one she has seen?

Dr. Lee said he supposed it is more completed.

Dr. Lee handed Staff Correll one copy of their plan. The Chairman instructed Dr. Lee to provide a copy for each member of the Committee.

The Chairman asked Staff Correll if she got her quetioned answered.

Staff Correll said it is the same one that she has seen.

The Chairman asked Dr. Lee, when we are looking at compliance as of today, are all of our state hospitals in compliance, at the present time.

Dr. Lee said yes.

Senator Salisbury said that the questions pursued by the Revisor. She said she sat on the interim committee when they reviewed this plan. She thought some of the answers are to be found on pages 18 and 19 of the bill. Senator Salisbury said she was confused by the responses of the Department as to what had to happen before a person was placed at a state institution for an evaluation. I believe that the bill requires a qualified mental health professional.

The Chairman said he concurs with Senator Salisbury. He did sit in on the interim study on this and the way it was brought out that before a person be admitted to a state hospital, they have be treated locally or evaluated locally before there would be any admission to the state hospital.

Dr. Lee said yes, evaluated in a sense that the mental health professional patient accessment is in need of state evaluation or treatment. Not in the sense of evaluation whether somebody is mentally ill or not.

The Chairman said the question arises, the admission to a state hospital. Who makes the admission. Does my private physician or a medical doctor contracting with the mental health center.

Dr. Lee said all admissions have to have some kind of a written statement from qualified mental health professional working in the community mental health centers. But the final admission, whether somebody is in need of treatment because somebody is mentally ill, is not made by qualified mental health professional working in the community.

Senator Salisbury said she thought that was an important distinction. And that was one that we questioned several times during the interim study. Who actually determines whether mental health treatment should be done. The bill proposes no change in current law as to who determines whether a person is in need of mental health treatment. A qualified mental health professional does not make the determination on mental illness but evaluates whether the person can be more appropriately treated at the community level or should be admitted to a state hospital. Staff Furse said that is correct.

Senator Hayden asked if this bill came out of the interim committee?

The Chairman said there was an interim study on this bill. The bill, the original bill, has been around for two years. This is a substitute for a House bill that had been introduced.

The Chairman called the next proponent, Dave Seaton, Chairman of the Kansas Mental Health Planning Council.

Mr. Seaton said that he is appearing in support of H.B. 2586.

Mr. Seaton said the key provisions of the bill are: the target population, the community centers as gatekeepers, the role of the state, a "zero rejection" policy, a provision for consumer mediation, the composition of mental health center boards, the composition of the future Governor's planning council.(Attachment 6)

The Chairman said the other day a person approached him in his office, indicating that children were left out. Just for clarification, that's why I'm asking the question. Are children left out of H.B. 2586?

Mr. Seaton said not at all. Representatives, family members and advocates seeking assistance for children and adolescents have served on the planning council and have endorsed the bill. The bill contains a pilot project, the authority under the Secretary, to undertake a pilot project for children's services. Reducing some hospital beds for children and beginning full services for children in a community. The bill has that authority and provides it to the Secretary and our council has unanimously endorsed it.

The Chairman said the reason for the questions was to make sure they were in the minutes.

Senator Hayden said on page 3. Is this the basic finding of all the council, you find this system to be "...tired, divided, poorly coordinated and essentially drifting system" at the present time.

Mr. Seaton said he works as a journalist in his spare time and that those were his words and that that is his opinion. The task force report in the state plan, which was drafted under the guidance of the planning council, used, in my view, similar language concerning the present state system.

Senator Hayden said that is quite a condemnation of a system we have now and we have all been a part of forming over the years. You are strong on that feeling?

Mr. Seaton said unfortunately, that feeling is well founded. The people in the system are wonderful people. I have great respect for them, both here and in the community. The system itself is severely in need.

The Chairman called the proponent, Bill Rein, Director of Hospitals and Medical Programs, Department of Health and Environment.

Mr. Rein appeared in support of H.B. 2586. (Attachment 7) He said problems associated with this bill are tied to the difficulty of change itself, and not the pursuit of bad policy. This legislation is good policy, but the changes it brings will require hard work for many people. The anticipated result will be a mental health system which is less fragmented.

The Chairman called the next proponent, Barbara Anders, Director of the Breakthrough Club.

Ms. Anders said the Breakthrough Club works with people who are long term mentally ill. This is a club where the staff and members of the club are colleagues. Ms. Anders appeared in support of H.B. 2586 citing what people who attend the Breakthrough Club are doing as recovered individuals from mental illness with the support the Breakthrough Club offers.

The Committee adjourned at 11:00a.m. and will reconvene March 27, 1990, at 10:00 in room 526S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3/26/90

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Mary Hillin	SRS/DMP
William C. Rein	Attorney
Richard Morrissey	KDHE
Paul Shelby	OJA
Paul M. Klotz	~~Assoc. of CMHCs Ks, Inc.~~
Terri Roberts	KSNA
Michael Lechner	KDHR CDC
Alan Cobb	KS Resp. Care Soc.
Bev Bradley	KS Assoc of Counties
Dwight M. Goering	Grad. Teacher - Maranatha H.S. Christian Science Committee on Publication for Kansas
KEITH L LANDIS	
Lou & Howard Snyder	Kansas Alliance for the Mentally Ill
Sara Sanders	KTCA
~~Kenya Upward~~	~~Ks MH Planning Council - staff~~ SRS/MH staff
Dave Seaton	Kansas Mental Health Planning Council
Terry Larson	Ks Alliance for the Mentally Ill
Pat Johnson	KSBN
MIKE WOSKINSKI	DOB

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SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3/26/90 (cont)

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Larry Hinton	topeka	SRS
Mami Lee	Topeka	MHRS/SRS
LARRY MEIKEI	TOPEKA	MENTAL HEALTH CONSORTIUM, INC.
Bob Harder	Topeka	Mental Health Consort.
Chip Wheelen	Topeka	KS Medical Society
Bill Dean	O P	
Lori Class	Topeka	Kansas Mental Health Assoc.
Brian Blake	Kansas City	
Al Manner	Topeka	SRS/MH&RS
Barb Andres	Wichita KS	Breakthrough Club
Bob Clawson	Topeka	SRS

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Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

Janette Pucci, R.N., M.S.N.
Educational Specialist

Patsy L. Johnson, R.N., M.N.
Educational Specialist

Belva J. Chang, R.N., M.N., J.D.
Practice Specialist

TO: The Honorable Senator Roy Ehrlich, Chairman & Members of the Public Health & Welfare Committee

FROM: Patsy L. Johnson, R.N., M.N.
Executive Administrator
Kansas State Board of Nursing

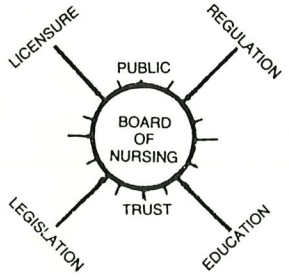
RE: HB 3022

DATE: March 26, 1990

Thank you, Mr. Chairman and Committee Members for letting me present testimony on behalf of the Board of Nursing with regard to HB 3022. Most of the changes proposed are for clean-up language and would strengthen processing procedures.

Section 1(d), page 2, discusses the temporary permit that is given to the registered nurse who is enrolled in a refresher course which includes 60 hours of theory and 180 hours of clinical. We wish to expand the language to include not only the nurse who is requesting reinstatement but also the nurse who is endorsing from another state and has not worked for five years or more. The prior language did not cover the nurse who is endorsing. At present, a 60 day temporary permit is issued in those cases. Most refresher courses are equivalent to a college semester; however, one refresher course is an independent study model and takes at least nine months to complete. Extending the time limit would assist at least a few nurses completing the refresher course without time difficulty.

Section 2(d), page 3, is in regard to the licensed practical nurse and the temporary permit for refresher course. The change in this statute would also extend the



SPH+W
Attachment #1
3/26/90

temporary permit to 180 days for the licensed practical nurse attending a refresher course. At present, only a 60 day permit is issued for both those reinstating and endorsing.

Section 3(a), page 3, increases the statute limits for fees:

Application for accreditation - schools of nursing
Biennial renewal of accreditation - schools of nursing
Application for approval of continuing education providers
Annual fee for continuing education providers
Approval of single continuing education offerings
Consultation by request, not to exceed per day on site.

The limits on these fees were established in July 1981. The last regulatory changes in K.A.R. 60-4-103 were completed in May 1982. There have been no increases in any of the fees since that date. The Board has no problem with the fees as amended by the House.

Section 4(e)(1), page 5, changes the renewal period on reviewing the continuing education providerships. Approved providers would submit an annual report along with an annual fee. Rather than paying a large fee every five years, one-fifth of that cost would be paid on an annual basis. This would assist those from organizations with restricted budgets. Also, a providership could be cancelled during the five year period with no loss of a five year fee. The annual report would primarily contain statistical data, total program evaluation, and any changes in the program.

A five year summary would be required and consist of a copy of the master plan of the program. No additional fee would be required at the five year review. The intent of this change is to minimize the amount of duplicative work that is now being done every two years.

Section 4(e) (2), page 6, was deleted by the House based on objections of continuing education coordinators. We presently have in regulation that continuing education providers must offer quality programs.

> 60-12-104(i) If quality programs are not maintained to the Board's satisfaction, or if there is a material misrepresentation of any

fact within the information required to be submitted to the Board by a provider, the Board shall withdraw approval from that provider.

Upon the recommendation of the Board of Nursing's legal counsel, Mark Stafford, we wish to strengthen our position if approval of a providership needs to be withdrawn. That is the reason this revision to the statute was introduced. A copy of the revision is attached.

I was surprised at the amount of objection there was to surveys. Based on established criteria, I reviewed 30 continuing education offerings throughout Kansas over the last year. In general, I believe I was an educational resource to the coordinators of those providerships. Of course, it is understandable that such reviews may make coordinators rather nervous. No one really likes to be surveyed.

For one coordinator, the site surveys were very threatening. At a nationally known institution with a reputation for high excellence in patient care, research and education, I found several major deficiencies with the continuing education providership. It took three site visits as well as reviewing additional written materials from the providership before the Board discontinued monitoring. We believe there was due process and we gave the coordinator every opportunity to make corrections. Of course, it was difficult for the coordinator to believe that minimum standards were not being met.

Some other concerns expressed involve money. Because there was a request for such a large increase in the statutory limits for fees, some coordinators were afraid that there was going to be a charge for site visits. That was not the intention. In fact, the Board does not want to put any additional financial stress on the providerships. That was the reason for going to an annual fee. Another objection voiced was that Board funds be spent on more important work such as the disciplinary cases. All work of the Board is being carefully prioritized and funds allocated accordingly.

The Board asks that Section 4(e)(2) with regard to surveys **not** be deleted. Although only 1 out of 30 providerships failed to meet minimum standards, there was the possibility a providership might have been revoked. Although public safety is not really threatened by poor continuing education programming, the nurses in Kansas are required to attend at least thirty hours of continuing education every two years for

licensure; thus they place a trust in the Board that continuing education programs be of acceptable quality.

Section 5(a)(1) & (7), page 7, was suggested by the Board of Nursing's legal counsel, Steve Schwarm and Mark Stafford. Suggestions were made to expand on these two areas in order to strengthen these sections in determining grounds for disciplinary action.

Section 5(a)(3), page 7, was a change in language to complement the Risk Management statutes. Section 5(8), (e), (1),(2) and (3), page 8, were additions to also complement Risk Management language. In 1989, we had 240 cases reported to the Board for disciplinary action. There was some difficulty in grounds for action particularly in cases of unlicensed practice.

In summary, I would like to say that the Board of Nursing is asking for these changes in order to strengthen the statutes in regard to temporary permits, continuing education, and disciplinary action. Except for small increases in certain fees within the next few years, there should be no economic impact on the Board or public from the changes in this bill.

Thank you for considering passage of HB 3022. I will gladly answer any questions.

PLJ:bph

with an annual report for the previous fiscal year. Applications for renewal as an approved provider of continuing education offerings *and annual reports* shall be made in writing on forms supplied by the board and shall be submitted to the board together with the application fee fixed by the board.

(2) Survey of continuing education providers. As deemed necessary by the board, a survey of the continuing education provider shall be made by an authorized employee of the board or members of the board, who shall submit a written report of the survey to the board. From time to time, as determined by the board, it shall cause to be made a resurvey of continuing education providers and written reports of such resurveys submitted to the board. If the board determines that any continuing education provider is not maintaining the standards required by this act and by rules and regulations prescribed by the board, notice thereof in writing, specifying the failures of such continuing education provider, shall be given immediately to the continuing education provider. A continuing education provider which fails to correct such conditions to the satisfaction of the board within a reasonable time shall be removed from the list of approved providers of continuing education until such time as the provider shall comply with the standards.

(f) *Criteria for evaluating out-of-state schools.* For the purpose of determining whether an applicant for licensure who is a graduate of a school of professional or practical nursing located outside this state meets the requirements of item (2) of subsection (a) of K.S.A. 65-1115 and amendments thereto or the requirements of item (2) of subsection (a) of K.S.A. 65-1116 and amendments thereto, as appropriate, the board by rules and regulations shall establish criteria for determining whether a particular school of professional nursing located outside this state maintains standards which are at least equal to schools of professional nursing which are accredited by the board and whether a particular school of practical nursing located outside this state maintains standards which are at least equal to schools of practical nursing which are accredited by the board. The board may send a questionnaire developed by the board to any school of professional or practical nursing located outside this state for which the board does not have sufficient information to determine whether the school meets the standards established under this subsection (f). The questionnaire providing the necessary information shall be completed and returned to the board in order for the school to be considered for approval. The board may contract with investigative agencies, commissions or consultants to assist the board in obtaining information about schools. In entering such contracts the authority to

KSNA
the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:
TERRI ROBERTS J.D., R.N.
EXECUTIVE DIRECTOR
KANSAS STATE NURSES' ASSOCIATION
700 JACKSON, SUITE 601
TOPEKA, KANSAS 66603
(913) 233-8638
March 26, 1990

H.B. 3022 Amendments to the Nurse Practice Act.

Chairman Erhlich and members of the Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of Kansas State Nurses' Association. Thank you for the opportunity to testify on House Bill 3022.

As you know this bill amends the Kansas Nurse Practice Act in several ways. The Kansas State Nurses' Association would like to go on record supporting amendments to the Practice Act that will enable nurses from other states who hold valid licenses to be able to endorse into the state of Kansas. The first change being proposed on line 21 through 24 on page 2 deals with issuance of temporary permits. The second change in section 3, the caps for Board of Nursing fees are being raised. The Board of Nursing has not indicated their immediate intent regarding raising fees. When this bill was heard in the House Public Health and Welfare Committee KSNA and several other organizations offered amendments to these fee caps that were adopted. As Section 3 now reads with the amended fee caps is supported by the Kansas State Nurses' Association.

The fee cap increases as amended by the house still offer substantial latitude to the Board of Nursing in adjusting their current fees. Below is a breakdown of the increases with the amended language:

	CURRENT	AMENDED LANGUAGE	INCREASE
Application for Accreditation	$700.00	$1,000	$300
Biennial renewal of accreditation of schools fo nursing	$300.00	$ 500	$200
Application for approval of continuing education providers	$200.00	$ 200	same
Biennal Annual fee for C.E. providers	$100.00	$ 75	$ 25 (Annual)
Approval of single C.E. offering	$ 25.00	$ 25	same
Consultation by Request, not to exceed per day on site	$300.00	$ 400	$100

SP H & W
Attachment #2
3/26/90

On page 6 of the bill was a new section providing for surveys of C.E. providers. The Boards purpose is protection of the public and mandatory C.E. is one vehicle that has been implemented by this legislature to meet this goal. The process of "approving C.E. providers and programs" has been going on for over 10 years. There appears no data to support that the C.E. providers approved by the Kansas State Board of Nursing warrant survey visits for compliance with the Boards standards, therefore KSNA offered an amendment that was adopted by the House Public Health and Welfare Committee to delete this entire section. This amendment was offered by other organizations as well. We continue to support this version, and believe that C.E. provider site visits would be costly, and unneccessary. Additionally, there are a number of providers from out of the state, and site visits to these would seem very cost prohibitive.

Additionally, we believe that the Kansas Nursing C.E. providers are doing an exceptional job of providing quality and accessible C.E.

Considering the workload of the Board of Nursing, accrediting all the schools preparing R.N.'s, L.P.N.'s and L.M.H.T.'s as well as licensing and disciplining the more than 37,000 licensees, we questioned the wisdom in this new layer of oversight on something that is not directly related to the protection of the public.

Lastly, we'd like to bring to your attention a matter of concern relative to the Board of Nursings approval process for C.E.

Attached is a position statement that has been endorsed by several other statewide nursing organizations. It specifically requests that the implementation of C.E. requirements be consistent for programs presented both in Kansas and outside the state. At this time it is not. Programs presented outside of the state of Kansas by non-Board of Nursing providers are allowed to be used by licensees of KSBN, however, if these same programs were presented **within** the state boundaries, then they would not be acceptable **unless** they were provided by a Kansas State Board of Nursing Provider or had been submitted to the KSBN for a single program approval process. The currently recognized approvers for programs outside Kansas include "other Boards of Nursing, National League of Nursing, and American Nurses' Association." The Board of Nursing is in the process of revising the Continuing Education Regulations and if this particular issue is not resolved then we may need to pursue legislative language next year.

Thank you.

RECOGNITION OF ANA APPROVED PROGRAMS IN KANSAS

POSITION

The Kansas State Nurses' Association recommends that:

The Kansas State Board of Nursing adopt a policy recognizing ANA and other nationally accredited Nursing Continuing Education programs presented in Kansas.

These programs be acceptable Continuing Education for relicensure **without** the requirement for KSBN provider approval.

SUPPORTING DOCUMENTATION

Background:

Mandatory Continuing Education for relicensure currently exists in twelve (12) states. Only three other states require approval through the State Board of Nursing for ANA and nationally accredited programs. These are Iowa, Kentucky and California. The remaining eight mandatory states accept ANA approved programs. On July 1, 1978, Kansas was the third state to institute this type of competency demonstration for relicensure by RN's and LPN's. The Legislature passed the mandatory language in 1976 with a 1978 implementation date. Guidelines were implemented by September 1976.

Historical:

Continuing Education has been provided by KSNA since 1973. In 1974 KSNA administered a federal grant to implement a continuing education program for RN's in Kansas.

In 1976 the Kansas State Board of Nursing began to set up a system for providing and approving continuing education. From February to July, 1977 workshops were held throughout the state for potential providers. The Task Force on Continuing Education operational bylaws were adopted on April 18, 1978. The Continuing Education Task Force has been instrumental in dissemination of KSBN CE Provider information since their inception in 1978. This committee then existed to provide information to the Kansas State Board of Nursing regarding Continuing Education. In FY 1986, there were 96 longterm continuing education providers approved by the Kansas State Board of Nursing.

KSA 65-1117 (1985)

KAR 60-9-101 (1984) provides that nurses attending CE outside Kansas be approved by accrediting acencies recognized by the Kansas State Board of Nursing.

There are currently organizations recognized by KSBN to provide Continuing Education that is acceptable when nurses seek Continuing Education outside Kansas. The organizations are:

The state's Board of Nursing
The National League for Nursing
The CEARP of a state's professional nurse association
The National Federation of Licensed Practical Nurses
The National Association for Practical Nurse Education & Service
National "speciality" nurse associations
Agencies accredited/approved by the American Nurses Association

KSNA believes the current KSBN policy should be revised based on the following:

1) There exists no documentation that the quality of Continuing Education accredited by the ANA is less than that of KSBN providers.
2) ANA accredited Continuing Education obtained outside Kansas is currently acceptable for relicensure.
3) There are six (6) other Health Related Disciplines in Kansas requiring Continuing Education. All of them recognize nationally accredited Continuing Education in the particular discipline, both inside/outside Kansas for relicensure.
4) The current KSBN policy discourages programs that have been accredited by ANA and other nationally accredited organizations from entering Kansas to present programs. Instead these programs are presented across state lines for Kansas nurses to attend.

The Kansas State Board of Nursing has developed criteria to accredit Providers of Continuing Education in Kansas. At this time we believe it is essential that KSBN evaluate their commitment to access for quality Continuing Education in Kansas by licensees.

KSBN functions are to:

1. Adopt Rules and Regulations in the Nurse Practice Act defining what constitutes CE for licensees.
   The purpose is to identify for licensees what is expected of them for relicensure. These requirements are broadly defined to cover in-state and out-of-state licensees. (K.A.R. 60-9-101 & 60-9-102)
2. Adopt Rules and Regulations in the Nurse Practice Act for CE Providers that are accredited by the Kansas State Board of Nursing.
   The purpose is to ensure an adequate number of Continuing Education providers with board-recognized quality in the Continuing Education they provide. (K.A.R. 60-9-103 & 60-9-104)
3. Accredit and ongoing monitoring of Kansas State Board of Nursing Continuing Education Providers. (K.A.R. 60-9-104 (B))
4. Monitor satisfactory proof that the licensee has met the minimum continuing education requirements as established in K.A.R. 60-9-102.

The purpose of KSBN accrediting Continuing Education providers has been to assure quality of programing and access for Kansas nurses to approved programs. The Kansas State Nurses' Association recommends that the Board of Nursing revise regulations to accept ANA and other nationally accredited nursing Continuing Education programs. This progressive step is parallel to gaining access to quality programs for Kansas nurses.

Adopted by the KSNA Board of Directors
May 29, 1987
Adopted by the KSNA Convention Body
October 8, 1987
Endorsed by the Kansas Association of Nursing Continuing Education Providers.
October 19, 1987
Endorsed by the Kansas Association of Nurse Anesthetists

2-3

The Kansas District Judges' Association

March 19, 1990

Senator Roy M. Ehrlich
Chairman, Public Health and Welfare Comm.
State Capitol
Topeka, Kansas 66612

Senator Gus Bogina
Chairman, Ways and Means Committee
State Capitol
Topeka, Kansas 66612

Gentlemen:

I write on behalf of the Kansas District Judges' Association. At a meeting of our Executive Committee, held on March 15, 1990, it was unanimously resolved that the Association recommend that Substitute House Bill 2586 be amended to broaden the definition of "qualified mental health professionals" to allow those health professionals in communities without local mental health centers to make the appropriate recommendations and referrals required by the proposed bill. Our concern is that there are a number of counties throughout Kansas that do not have local mental health centers and that the definition of "qualified mental health professional" found in the bill will make it difficult, if not impossible, for emergency mental illness cases to be appropriately treated. We would appreciate your consideration of this request and if you need further input, please do not hesitate to contact me.

Very truly yours,

Paul E. Miller

PAUL E. MILLER
District Judge
Chairman, Legislative Coordinating Comm.
Member, Executive Comm.
Kansas District Judges' Association
100 Courthouse Plaza, P.O. Box 158
Manhattan, Kansas 66502

SPH&W
Attachment 3
3/26/90

KANSAS PSYCHOLOGICAL ASSOCIATION

TESTIMONY ON HB 2586

MARCH 26, 1990

Mr. Chairman, members of the sub-committee, I am Dr. David C. Rodeheffer representing the Kansas Psychological Association, its President, Dr. Joseph Weaver and its Board of Governors.

The Kansas Psychological Association is in support of the general principals on which this bill is based. As we understand them, any mental health system directing care for the severely and/or persistently mentally ill must be a coordinated system allowing for a continuum of care across treatment systems and should be primarily community based. To these ideas, we would add that it must assure the highest quality of care possible, should respect the rights and privileges of the people it is treating and should be organized in such as manner as to allow for checks and balances between the powers granted to various parts of the total system.

It is important in trying to understand the issues presented in this bill what the bill is trying to address. While its name, Mental Health Reform Act, might lead one to believe that it is an attempt to address programmatic issues related to service delivery, for the most part this is not the case. This bill is an attempt to address the organizational issues that are seen as interfering with service delivery. It is an attempt to say how the system will be organized; who will be in charge of what aspects of the system; and what checks and balances should be in place. Therefore, in attempting to analyze the bill and to reach your conclusions about it, it is importnat to consider it in this light. What are the relationships defined in the bill between the various parts of the system - SRS, The mental health centers, the state hospitals, consumer groups, various practitioners, and other governmental entities? What responsibilities and powers are given to each entity and what oversight and checks are provided for that power? In a sense this is a business deal between all aspects of the mental health system and should be critiqued in that light.

Our organization feels that HB 2586 is a step in the right direction for addressing longstanding problems that have plagued Kansas's treatment system for the severely and/or persistently mentally ill. While we are in support of the efforts of this bill, we would like to raise a number of concerns.

In the first place, we must raise concerns about the exclusivity of the contracts between SRS and the Mental Health Centers. New Section 10 states that "...the secretary shall enter into contracts with mental health centers..." We are in support of the amendments being offered

Central Office / 400 SW Croix / Topeka, Kansas 66611 / (913) 267-7435
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3/26/90

by the Kansas Association of Professional Psychologists that would allow SRS greater latitude in developing contractual services for a given area of the state.

Secondly, we have concerns about the definition and role of the "Qualified Mental Health Professional". The need for a gatekeeper or oversight person for this population of patients is a valid concept. However, we feel it is somewhat narrowly defined here, in that it eliminates the private mental health provider who is working with a patient. The therapeutic relationship between a person with a severe mental illness becomes a critical link for that person. However, this bill would interfere with that relationship when it is outside the mental health center setting, by positing another bureaucratic step between the patient and hospitalization. In addition, the mental health provider who has been working with the patient in an ongoing relationship, is the one most qualified to make judgments about that person's treatment needs. We believe that when a person is in treatment with a private practitioner, that treater should retain control, along with the patient, over vital decisions regarding treatment. We would propose then the following addition to the definition of the "Qualified Mental Health Professional":

> ...(1) a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist, respectively, under a contract with a participating mental health center, or who **is currently treating or evaluating the voluntary or proposed patient** or ... (Section 16, Paragraph (w), lines 12-16).

We would also add psychologist to physician for supervising the other disciplines named as qualified mental health providers. Licensed psychologists are sanctioned by statute to diagnose and treat mental disorders. They are also authorized by statute to supervise and direct the Master Level Psychologist. Adding psychologists as supervisors would, we believe, increase the resources at hand for the mental health centers for evaluating and expediting treatment of members of the targeted population:

> ... who is acting under the supervision of a physician **or psychologist.** (Section 16, Paragraph (w), lines 18-19)

We would like to express strong reservations about the role and powers of the "Qualified Mental Health Professional" (QMHP) as written. The powers granted the QMHP would give them virtual veto power over every check and balance in the system designed to protect the patient. They could prevent the courts from admitting and discharging a patient and prevent the hospitals from discharging once the patient had reached maximum benefit of treatment. While we feel that a gatekeeper function is necessary, the role of that gatekeeper should be to evaluate and to

make recommendations, not to have complete control over the system. In that light we would propose the following change in wording:

.. the head of the treatment facility ... determines such person is in need of treatment therein, except that no such person shall be admitted to a state psychiatric hospital, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, without a written statement ~~authorizing such admission~~ from a qualified mental health professional **regarding the need for such admission.** (Section 17, Paragraph (a) lines 16-24)

...No patient shall be discharged from a state psychiatric hospital without ~~receiving recommendations from~~ written **notification to** the participating mental health center... (Section 18, Paragraph (a), lines 24-26).

...except that no person shall be transported to a state psychiatric hospital for examination, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, unless a written statement ~~recommending evaluation at a state psychiatric hospital~~ has been obtained from a qualified mental health professional **regarding the need for such an evaluation.** (Section 19, Paragraph (a), Lines 9-14).

...except that no person shall be admitted to a state psychiatric hospital for emergency observation and treatment, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, unless a written statement ~~recommending~~ **regarding the need for** the emergency observation and treatment at a state psychiatric hospital has been obtained from a qualified mental health professional. (Section 20, Paragraph (b), Lines 19-26)

...except that a state psychiatric hospital shall not admit and detain any such person, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, without a written statement ~~authorizing~~ **regarding the need for** such admission from a qualified mental health professional. (Section 20, Paragraph (c), Lines 3-8).

...except that no person shall be transported to a state psychiatric hospital under this subsection, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, unless a written statement ~~recommending that~~

regarding the need for the person **to** be transported to a state psychiatric hospital has been obtained from a qualified mental health professional. (Section 20, Paragraph (d), Lines 27-33)

The court shall not provide in any order of protective custody that the person be transported and placed or detained at a state psychiatric hospital unless a written statement ~~recommending~~ **regarding the need for** such placement or detention has been obtained from a qualified mental health professional. (Section 21, Paragraph (d), Lines 20-24)

... The written ~~authorization~~ **evaluation regarding** the need to have the evaluation performed at a state psychiatric hospital must be presented to the court by the administrator of the participating mental health center or by a qualified mental health professional (Section 23, Paragraph (b), lines 40-43 & 1)

... except that the court shall not order treatment at a state psychiatric hospital, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, unless the court has received a written ~~recommendation~~ **evaluation regarding the need** for treatment at a state psychiatric hospital from a qualified mental health professional. (Section 25, Paragraph (f), Lines 34-39

... except that no order of referral for treatment in a state psychiatric hospital shall be entered, if there are one or more participating mental health centers located in the catchment area in which the state psychiatric hospital is located, unless the court has received a written ~~recommendation~~ **evaluation regarding the need** for such admission from a qualified mental health professional (Section 26, Paragraph (a), Lines 16 - 21

We would also like to express our concerns about other areas of the bill. Previous bills, esp. HB 2577, made reference to a "zero rejection" policy to be developed by the secretary of SRS for the Mental Health Centers. We believe that the current bill weakens this provision and would propose instead the following wording to assure that no person in this population is denied access to treatment:

(g) to adopt rules and regulations for targeted population members which provide that no person shall be ~~inappropriately~~ denied necessary mental health services from any mental health center or state psychiatric hospital. (New Section 3, Paragraph (g), lines 42-43 and 1)

We applaud the attempts in a number of sections that call for governing board and advisory board composition to include various family and consumer groups and strongly support these provisions.

We would like to express our concerns about Section 34, paragraph (a), subsection (13) which eliminates the need for a signed release of information by the patient. We believe that this unnecessarily violates a person's civil rights. We believe it is worth the extra effort to obtain a written release both with respect to the patient's civil rights and treatment considerations. The violation of any patient's rights must be done only with due course of law and with consideration of the treatment implications such a violation may have.

As a final note, we would like to raise some concern about mandating the downsizing of the state hospitals by statute. It is important to reiterate that this bill does not address programmatic issues. However, it is effective community programs that will allow the movement of patients from institutions back into their communities for treatment. There is nothing in this bill which assures the development of such programs. Yet, this bill would require that as many as 270 inpatient beds would be eliminated in six years. If these beds are turned over once every 60 days (probably a conservative estimate), that would mean a loss of inpatient services for roughly 1,620 persons. Stated another way, the community treatment programs would have to be able to keep 1,620 patients in the community who are now utilizing the hospital at some time during a year. It would seem to us a wiser course to allow SRS to make the decisions regarding bed closings as it becomes clear that those hospital beds are no longer needed.

Mr. Chairman, thank-you for the opportunity to respond to HB 2586. I trust that these comments have been helpful and would of course be ready to answer any questions that the committee might have.

Department of Social and Rehabilitation Services

Testimony before

The Senate Public Health & Welfare Committee

Regarding

House Bill 2586

on

March 19, 1990

Mani Lee, Ph.D.
Director of Mental Health

presented on behalf of:

Al Nemec, Commissioner
Mental Health and Retardation Services
Department of Social and Rehabilitation Services
Telephone (913) 296-3773

SPH+W
Attachment #5
3/26/90

Kansas Department of Social and Rehabilitation Services

Mr. Chairman, and Members of the Committee, I appreciate the opportunity to briefly talk with you today about HB 2586. I hope to be able to provide you with a historical perspective of this legislation, the importance of it and the reasons why the Department is in support of it.

HISTORY

For several years, the mental health system in Kansas has been the subject of numerous studies. These studies, including the report, "Toward An Agenda For Mental Health In Kansas" (December, 1987) by Charles Rapp, Ph.D. and James Hanson, the Legislative Performance Audit Report, entitled "Improving the System for Providing Mental Health Programs and Services in Kansas" (August, 1988), "The Kansas Plan for a Community Based Mental Health System" (September, 1989), and the report by the Governor's Task Force on Mental Health Reform (1989) all reached a number of conclusions. These conclusions included the following:

. . . . The system is fragmented.
. . . . The services within the system are not coordinated.
. . . . Approximately 80% - 85% of current funds are devoted to State psychiatric hospitals while individuals spend 90% - 95% of their time in the community.
. . . Individuals who receive services in the system sometimes are "lost between the cracks" because of the fragmentation and lack of coordination.
. . . . There is a lack of sufficient community-based services to meet the needs of those requiring mental health services who reside in their community.
. . . The costs of maintaining hospitals is escalating rapidly.
. . . .It will not be possible to contain the escalating costs of unless there is the development of an adequate community-based system of care.
. . . . These conclusions dramatically illustrate the need for <u>reform</u> of the mental health system.

IMPLEMENTATION OF HB 2586

Mental Health and Retardation Services is confident that it can, in partnership with community mental health centers, other providers, families and consumers, implement this landmark legislation.

Our plan for implementation is contained in the **Financing Plan**, Revision II, dated February 23, 1990. It is our strong opinion that this financing plan is sound, practical, and workable. We believe it accomplishes a number of goals that our citizens deserve. These goals are as follows:

> Structural and financial reform of the mental health system consistent with the recommendations of the Governor's Task Force on Mental Health Reform and the provisions of PL 99-660.
> Incremental (phased) development of a community-based mental health system while maintaining the fiscal integrity of the State.
> Containment of escalating costs of maintaining State psychiatric hospitals.
> Reallocates scarce resources in a way that allows individuals currently employed in the system to maintain their jobs or move into new jobs in community programs.
> Individuals are served in the least restrictive and most normal setting possible.
> Allows for the maintenance of accreditation and certification of State psychiatric hospitals, thereby insuring quality of care and retention of federal financial participation.

Thank you for taking the time to listen to me. I will be happy to respond to any questions you may have.

REVISION II

FINANCING PLAN

MENTAL HEALTH SERVICES IN KANSAS

FEBRUARY 23, 1990

PREPARED BY: AL NEMEC, COMMISSIONER
MENTAL HEALTH AND RETARDATION SERVICES
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TABLE OF CONTENTS

EXECUTIVE SUMMARY

THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES/MENTAL HEALTH AND RETARDATION SERVICES, IN PARTNERSHIP WITH COMMUNITY MENTAL HEALTH CENTERS, FAMILIES AND CONSUMERS, HAS DEVELOPED A PLAN DESIGNED TO ACHIEVE STRUCTURAL AND FINANCIAL REFORM OF THE MENTAL HEALTH SYSTEM CONSISTENT WITH RECOMMENDATIONS BY THE GOVERNOR'S TASK FORCE ON MENTAL HEALTH REFORM AND THE PROVISIONS OF FEDERAL LEGISLATION, PUBLIC LAW 99-660. THE PLAN IS A BLUEPRINT FOR THE PHASED DEVELOPMENT OF A COMMUNITY-BASED MENTAL HEALTH SYSTEM.

THIS SECTION IS A SUMMARY OF THE PLAN. THE PLAN DESCRIBES HOW THE ESCALATING COSTS OF STATE PSYCHIATRIC HOSPITALS ARE CONTAINED WHILE AT THE SAME TIME, RESOURCES ARE REALLOCATED TO COMMUNITY PROGRAMS, AND MOST IMPORTANTLY, INDIVIDUALS ARE SERVED IN THE LEAST RESTRICTIVE AND MOST NORMAL SETTING POSSIBLE. FURTHER, THE PLAN ALLOWS FOR THE MAINTENANCE OF ACCREDITATION AND CERTIFICATION OF THE STATE PSYCHIATRIC FACILITIES, THEREBY INSURING QUALITY OF CARE AND RETENTION OF FEDERAL FINANCIAL PARTICIPATION.

THE INITIAL PHASE OF THE PLAN INVOLVES TEMPORARY FUNDING FOR OSAWATOMIE TO RETAIN ACCREDITATION/CERTIFICATION. FUNDING FOR COMMUNITY PROGRAMS TO DEVELOP GATEKEEPING (SCREENING) AND COMMUNITY SUPPORT SERVICES IN THE OSAWATOMIE CATCHMENT AREA IS RECOMMENDED. AS THESE COMMUNITY PROGRAMS ARE DEVELOPED, OSAWATOMIE STATE HOSPITAL WILL BE ABLE TO CLOSE ONE UNIT, AND THE CENSUS CAPACITY WILL BE MAINTAINED AT THAT LEVEL. THE SAME PROCESS WILL CONTINUE AT OSAWATOMIE STATE HOSPITAL UNTIL 3 UNITS (2 ADULTS AND 1 ADOLESCENT) ARE PERMANENTLY CLOSED BY JUNE 30, 1993. SAVINGS REALIZED FROM THE CLOSURE OF TWO OF THE UNITS WILL BE REALLOCATED TO COMMUNITY PROGRAMS.

THE PROCESS OF COMMUNITY PROGRAM DEVELOPMENT AND HOSPITAL COST CONTAINMENT IS REPEATED IN A PRESCRIBED SCHEDULE IN THE TOPEKA STATE HOSPITAL AND LARNED STATE HOSPITAL CATCHMENT AREAS UNTIL ULTIMATELY, IN FY97, 9 UNITS, OR APPROXIMATELY 270 BEDS ARE PERMANENTLY CLOSED. OF THESE BEDS (90 IN EACH FACILITY), APPROXIMATELY 60 OF THEM ARE FOR CHILDREN AND ADOLESCENTS.

FISCAL NOTES ARE INCLUDED IN THE PLAN AS ARE STRATEGIES FOR THE DISTRIBUTION OF FUNDS. THE RATIONALE FOR A PHASED APPROACH IS EXPLAINED, AND THE LEGISLATION REQUIRED TO IMPLEMENT THE PLAN IS PRESENTED. THE ABILITY TO IMPLEMENT THE PLAN IS CONTINGENT UPON THE MAINTENANCE OF MEDIKAN AND GENERAL ASSISTANCE PROGRAMS AS THESE PROGRAMS HELP TO KEEP PEOPLE IN THE COMMUNITY SETTINGS.

INTRODUCTION

Kansas, like most other states, faces a serious difficulty in adequately financing its mental health system.

... Approximately 80% - 85% of current funds are devoted to State hospitals.

... Costs of maintaining/operating State hospitals escalate rapidly.

... Currently, there are 962 State hospital beds (excluding Security) that can serve 658 adults and 243 children and 61 substance abuse clients at any one time.

... There are an estimated 24,000 adults in Kansas with severe mental illness: approximately 8,000 of those 24,000 would need public mental health services at any one time, and there are an estimated 5,600 - 10,000 children/adolescents with severe emotional disabilities.

... Individuals with severe mental illness spend approximately 95% of their time in the community and only 5% of their time in a hospital.

... The technology is present to provide community-based services to most adults with severe mental illness and children and adolescents with severe emotional disabilities.

... Kansas, like every other state, is mandated by federal legislation to develop a <u>community-based</u> mental health system.

... Kansas must contain rising hospital costs, maintain individuals in the community, and achieve a more equitable distribution of funds between State hospitals and community programs.

The short-term financing plan for mental health services as proposed in the SRS/MH&RS "C" level budget for FY 91 continues to be a fiscally responsible method of mental health reform on an incremental basis. However, the current budget situation suggests that full funding of this proposal may not be possible this year.

With this situation in mind and because of the potential loss of certification at Osawatomie State Hospital (OSH), a contingency financing proposal is indicated. It should be emphasized that only preliminary discussions have occurred with State hospital and community mental health center (CMHC) representatives, other service providers, consumers and family members about this contingency proposal. As joint planning with all concerned parties continues, the plan will be subject to further revision, however, the basic concept of this plan has been approved unanimously by the Governor's Mental Health Services Planning Council.

SUMMARY

This discussion is a refinement and further development of the short-term contingency plan presented on January 18, 1990. At that time, it was proposed that $300,000 in new State General Funds be appropriated for Osawatomie State Hospital (OSH) for new temporary positions. This appropriation, for FY 91, would enable OSH to retain accreditation and certification. At the same time, the proposal indicated that $600,000 would be needed for a six month period to develop the necessary programs that would allow OSH to close one 20 to 30 bed unit. Further, $417,000 was proposed for a six month period to develop necessary gatekeeping services in the community.

BACKGROUND

During surveys by JCAHO and HCFA in 1989, OSH was advised that, while accreditation and certification would be retained, these statuses could be lost if identified deficiencies were not corrected by the time of the next surveys scheduled in late spring and mid-summer, 1990, respectively.

The major deficiency cited was that of inadequate staffing. OSH indicates that an appropriation of approximately $600,000 to fund 28 new positions would provide sufficient resources to satisfy the contingencies.

The foregoing situation is an example of the manner in which the mental health system continues to invest its resources primarily in institutional settings. Namely, institutions require ever-increasing resources at ever-increasing costs to provide high standards of care. Failure to provide a high level of care in accordance with standards set by JCAHO and HCFA results in loss of accreditation and certification. The State is then unable to capture third party reimbursement and federal financial participation.

MH&RS ALTERNATIVE PROPOSAL

As the summary above suggested, MHRS proposes an alternative to an appropriation of $600,000 for the funding of 28 new positions at OSH. MHRS recommends partial funding over a 6 month period. This alternative would permit the hiring of temporary staff during that period of time.

At the same time, MH&RS recommends a six month appropriation for community programs that will enable the community programs to develop the services necessary to reduce bed utilization at OSH that would be the equivalent to a 20 to 30 bed unit.

The ability to be the "gatekeeper" to the State hospital is essential for CMHCs if admissions, census, and growth of hospital programs are to be contained. Thus, the ability to screen all potential admissions by CMHCs is necessary if these agencies are to be effective gatekeepers. In order to develop this screening capability, MH&RS recommends a six month appropriation.

DESIRED OUTCOMES

... Maintenance of certification/accreditation

... Maintenance of high level of care

... Maintenance of federal financial participation

... Maintenance of ability to capture third party reimbursement

... Maintenance of integrity of hospital program

... No expansion of hospital programs

... Shifting of funds to community programs

... Improved ability to serve clients in the least restrictive environment

FISCAL NOTE

Temporary OSH positions - **$300,000:** when accreditation and certification secured, temporary staff would no longer be needed when a 20 to 30 bed unit is closed.

Community support services development - **$600,000:** this figure for six months is, as indicated earlier, the amount OSH reports being needed for new positions.

Gatekeeping (Screening) - **$417,000:** this figure for six months was calculated on the basis of **$2,500,000** estimated by CMHCs and MHRS to implement screening for all populations, statewide for one year; taking one half (six months) of that amount and then dividing by one third since the OSH catchment area comprises approximately one third of the State.

PROGRAM DESCRIPTION

This short-term program is one that will require a partnership between the CMHCs, other community providers, consumers, and family members and MH&RS (including OSH), one like that recommended by the Governor's Task Force on Mental Health Reform. That is, there must be cooperation and collaboration if this program is to succeed. The State, through MHRS, will provide the funds and monitoring mechanisms while the CMHCs will provide the needed services. To better understand the parameters of the program, it may be helpful to describe the OSH catchment area, the CMHCs in that area, and the services currently available.

The OSH catchment area consists of 22 counties on the eastern edge of the state from Atchison County south to the State of Oklahoma. These counties are divided into 12 community mental health center catchment areas, which provide an array of local mental health services to the communities in their districts. The total population served by the community mental health centers and OSH is estimated to be 933,600. The community mental health centers are located in heavily populated urban areas encompassing the Kansas side of metropolitan Kansas City, as well as the more rural areas of southeast Kansas.

Specifically, the following community mental health centers comprise the state funded community mental health service system in the OSH catchment area:

COMMUNITY MENTAL HEALTH CENTER	LOCAL OFFICES	COUNTIES SERVED	POPULATION
Cowley County MHC	Arkansas City Winfield	Cowley	37,000
Crawford County MHC	Pittsburg	Crawford	37,600
Family Life Center	Columbus Baxter Springs Galena	Cherokee	22,200
Four County	Independence Coffeyville Fredonia Neodesha	Chautauqua Elk Montgomery Wilson	61,200

Franklin County MH Clinic	Ottawa	Franklin	21,900
Johnson County MHC	Mission Olathe Merriam	Johnson	318,300
Labette Center for Mental Health Services	Parsons Oswego	Labette	25,400
Miami County MHC	Paola Louisburg Osawatomie	Miami	22,600
Northeast Kansas MHC	Leavenworth Atchison Oskaloosa Tonganoxie	Atchison Jefferson Leavenworth	94,500
South Central Mental Health Counseling Center	El Dorado Andover Augusta	Butler	48,000
Southeast Kansas MHC	Humboldt Chanute Fort Scott Garnett Mound City	Allen Anderson Bourbon Linn Neosho Woodson	70,800
Wyandot MHC	Kansas City Bonner Springs	Wyandotte	174,100
			933,600

All of the above centers provide the five basic services required for licensure. These include outpatient therapy, twenty-four hour emergency service, screening for state hospital admissions, services provided after discharge from state hospitals, and consultation/education. Some of the larger mental health centers are able to provide a broader array of more specialized services to their population.

Census capacity: As indicated previously, this short-term plan calls for the permanent closing of a 20 to 30 bed unit OSH. When those beds are closed by June 30, 1991, the permanent staff assigned to the closed ward would be distributed to other areas of the hospital. This distribution would allow staffing at a level sufficient to maintain accreditation/certification. In order to sustain this level of care however, it is absolutely imperative that the hospital census not exceed the number of beds reached when the unit is closed. This maximum census capacity is reasonably easy to maintain with respect to voluntary admissions, since by policy, voluntary admissions can be restricted. For involuntary admissions however, statutory modifications relative to the commitment law would be necessary.

GATEKEEPING

INTRODUCTION

The Governor's Task Force on Mental Health Reform recommended that community mental health centers (CMHC's) be designated as the "gatekeepers" to the public mental health system. Gatekeeping activities include screening, evaluation, crisis/emergency services and liaison/coordination functions. The purpose of these activities is to insure that individuals with mental illness receive the most appropriate services in the least restrictive environment. When possible, individuals are diverted from the most restrictive service levels, such as state hospitalization, or are discharged from these service levels expeditiously. However, diversion and early discharge are only possible if appropriate community support services are available.

SCREENING AS HB 2586 MANDATES

HB 2586 would mandate the screening portion of gatekeeping activities through language that states "that no person shall be admitted to a state psychiatric hospital without a written statement authorizing such admission from a qualified mental health professional (who is employed by a participating mental health center). In this context, screening is the process of assessing the mental health service needs to determine whether an individual can be fully evaluated and/or treated in the community or whether they should be presented to the state psychiatric hospital for further evaluation and/or treatment. Since this type of screening is most often done on an emergency/crisis basis, funding is needed for both screening and evaluation capacity and for crisis/emergency services. The existing screening and 24-hour emergency service capacity of the CMHC's is inadequate to provide these services for all state psychiatric hospital admissions. Currently about one third of all state hospital admissions are listed by hospitals as having been screened by a CMHC.

FISCAL NOTE

Mental Health and Retardation Services has recommended the appropriation of $2.5 million to implement screening/evaluation and 24-hour crisis/emergency services on a statewide basis. This amount would approximately double the amount of funds CMHC's are presently spending on screening and emergency services. Although hospital data shows only one third of admissions currently being screened by CMHC's, this figure underestimates the actual number of screenings since it only shows cases where the CMHC was the last point of contact prior to admission. In court committed admissions, the court would be shown as the referral source to the hospital; however, the CMHC may have, in fact, been involved in the admission decision and would have done a "screening". Therefore, in the absence of reliable data, it is reasonable to assume that at least half of the current admissions are being screened by CMHC's.

The $2.5 million recommended by MH&RS would allow CMHC's statewide to add additional staff to provide the availability of face-to-face emergency contact on a 24-hour basis. Some CMHC's may provide the service by contracting with other CMHC's or with other emergency personnel in their catchment area to form an "extended team" of screeners who could assure service availability throughout the catchment area. The program expectation for this service would be that 100% of all state psychiatric hospital admissions would be screened by a CMHC.

PHASED PROGRAM

As recommended in the contingency plan, the full screening/ emergency service could be phased in by funding one third of the statewide service for one state hospital catchment area at a time. Therefore, if the Osawatomie State Hospital area were chosen to begin this service, $417,000 would be allocated to the 12 CMHC's in the OSH catchment area for the first six months of the service. The $417,000 is half of the one third portion of $2.5 million. This would fund six months for one state hospital catchment area. The funds would be distributed to the CMHC's based on a formula to be determined by MH&RS and the CMHC's involved. The following sample distribution formula ~~that~~ would include their catchment area population and the number of state hospital admissions from their area currently.

SAMPLE SCREENING FUNDS DISTRIBUTION METHOD

The 12 CMHC's in the OSH area, their catchment area population and FY 89 admissions are as follows:

CMHC	Population	FY 89 Admissions
Northeast Kansas	94,500	82
Wyandot	174,100	182
Johnson County	318,300	150
Franklin County	21,900	16
Miami County	22,600	43
Southeast Kansas	70,800	61
South Central	48,000	28
Crawford County	37,600	28
Family Life Center	22,200	13
Labette Center	25,400	22
Four County	61,200	36
Cowley County	37,000	10
TOTAL	933,600	671

The chart below illustrates the amount of screening/emergency service funds that would be allocated to each CMHC for FY 91 and FY 92 using a distribution formula that gives a weight of 30 to catchment area population and a weight of 70 to FY 89 hospital admissions to OSH (excluding alcohol and drug admissions).

CMHC	FY 91 Allocation	FY 92 Allocation
Northeast Kansas	$ 47,538	$ 95,076
Wyandot	$102,582	$205,164
Johnson County	$106,752	$213,504
Franklin County	$ 11,259	$ 22,518
Miami County	$ 20,016	$ 40,032
Southeast Kansas	$ 36,279	$ 72,558
South Central	$ 17,931	$ 35,862
Crawford County	$ 16,680	$ 33,360
Family Life Center	$ 8,340	$ 16,680
Labette Center	$ 12,510	$ 25,020
Four County	$ 26,271	$ 52,542
Cowley County	$ 10,842	$ 21,684
TOTAL	$417,000	$834,000

SUMMARY

GATEKEEPING AND SCREENING

- Includes: screening, evaluation and 24-hour emergency/crisis services

- Purpose: to insure that individuals with mental illness receive the most appropriate services in the least restrictive environment

- HB 2586: mandate screening - "no person shall be admitted to a state psychiatric hospital without a written statement authorizing such admission from a qualified mental health professional (employed by a participating mental health center)

- Phased implementation: statewide cost estimated at $2.5 million. First phase - January, 1991 half of one third of the total would be allocated to the 12 CMHC's in the OSH catchment area for the first six months of the program. July, 1991 - one third of the statewide total ($834,000) would be allocated to CMHC's in OSH area for first full year of the program and each fiscal year thereafter. Phase two would start a full year's funding in the TSH area in July, 1992 and phase three would start funding in the LSH area.

- Total cost:

FY 91 -	$ 417,000
FY 92 -	$ 834,000
FY 93 -	$1,668,000
FY 94 -	$2,502,000
FY 95 -	$2,502,000

COMMUNITY SUPPORT SERVICES-ADULTS (INCLUDING HOUSING)

INTRODUCTION

The closing of one adult 20 to 30 bed unit at OSH would necessitate a substantial enhancement of present community support programs and services. To conceptualize the range of services necessary to accomplish this goal it is more useful, however, to address the reduction of state hospital bed days rather than individual beds. Addressing the reduction of state hospital bed days better illustrates the range of flexible services needed to decrease the demand for state hospital treatment. The elimination of one 30 bed unit would translate into a diversion of 10,950 bed days (30 beds x 365 days) of state hospital treatment to the community mental health system. The fundamental principle of community programming is to design services based on individual needs.

SAMPLE HOSPITAL CENSUS REDUCTION STRATEGIES

The actual programming will be done by CMHC's in consultation with MH&RS and will be based on the CMHC's individual needs assessment. The following is presented to illustrate some examples of the strategies that could be used to reduce state hospital beds. Other innovative program options will also be considered. MH&RS will offer technical assistance to any CMHC for help with needs assessment and program design. The elimination of the demand for state hospital bed days can be accomplished in at least three ways: 1) direct diversion, 2) early discharge, and 3) ongoing support.

1) **Direct Diversion:**

Direct diversion of imminent state psychiatric hospital admission requires an array of options which can be called upon in an attempt to intervene in a crisis and avoid hospitalization. If participating community mental health centers were designated as the single point of entry into the state hospitals, they would be the most logical agency to identify clients who could be diverted (through the gatekeeping/screening process) and coordinate the provision of crisis stabilization services. One of the most innovative and effective mechanisms for crisis stabilization involves mobile crisis stabilization teams to provide extended services on an outreach basis. Information from the field suggests that mobile crisis stabilization outreach services can be particularly effective in responding to crisis and in minimizing the need for hospitalization. Mobile crisis stabilization teams would go to the client and provide services in the setting in which the crisis is occurring - private homes, boarding homes, ICFs/MH, work settings, hospital emergency rooms, police stations, jails, human service agencies, and virtually anywhere else in the community where it is deemed safe and appropriate to meet the client. While this involves moving outside the usual space and time limitations of traditional mental health practice, effective

stabilization programming means that community mental health professionals must be capable, 24 hours a day, of going to the scene of an emergency.

The mobile crisis stabilization outreach team may stay with the client and significant others for as long as is necessary to intervene successfully in the crisis, initiating necessary treatment, resolving problems, providing high levels of support and making arrangements for ongoing services. A 30 to 60 day period for the crisis stabilization staff to work with an individual client should be sufficient to allow continuity from crisis intervention to resolution.

Although the mobile crisis stabilization team's primary objective would be to resolve the crisis in the natural environment, in some cases temporary separation is necessary for a client in crisis. Accordingly, innovative and flexible services which provide this option must be developed and enhanced. These options may include moving the client to a foster home, a crisis apartment, a crisis bed in a group setting (or ICF/MH) or a local hospital unit. The protective, supportive and supervised residential setting is used to assist the client to re-stabilize, to resolve problems and to access ongoing services.

2) **Early Discharge:**
The second strategy for eliminating the demand for state hospital bed days is to decrease the length of stay for patients by early discharge from the hospital. The most common barrier to early discharge cited by mental health professionals in Kansas is the lack of appropriate housing and support in the community. Local community support systems will need to increase access to a wide range of rehabilitative and supportive housing options for clients not in crisis. The choices should be broad enough to allow each client an opportunity to live in an atmosphere offering the degree of support necessary while also providing incentives and encouragement for clients to assume increasing responsibility for their lives. It is now apparent that community mental health agencies must assume a major role in helping clients meet their housing needs. The highest priority should be placed on helping clients secure mainstream or typical housing and helping them select, secure and be successful in a whole range of living situations.

Maximum flexibility should be allowed participating mental health centers in using available funds for housing and residential services. Flexibility is necessary to maximize available housing/residential and support options in a local catchment area and to facilitate the development of options to fill locally identified gaps.

3) **Ongoing Support:**
Finally, demand for state hospital beds can be reduced by "preventing" state hospital admissions through ongoing community support services. This could also be conceptualized as pre-crisis intervention. Ongoing support is accomplished through a comprehensive and coordinated community based mental health system which targets the most vulnerable individuals with severe and persistent mental illness. In a recent survey of Kansas' state psychiatric hospitals, almost 75% of the current patients were identified as "heavy users". Heavy users being identified as individuals who have either been hospitalized six months or more, or have had two or more admissions to the state hospital within the last three years. An organized network of caring and responsible people committed to assisting these vulnerable individuals meet their needs and develop their individual coping skills while they are in the community will help prevent future readmission by proactively resolving problems before they become full blown crises. This network is called a community support system. Besides the functions already discussed (24 hour crisis assistance and rehabilitative/supportive housing) a comprehensive community support system should also provide assistance in meeting basic human needs, psychosocial and vocational services, consultation and education, mental health care, protection of client rights and ongoing case management.

Selected elements and functions of a comprehensive community support system are present in all community mental health center catchment areas in Kansas. However, no area has the full array of services and/or capacity in their existing services necessary to meet the increased demands resulting from the closing of one adult 20 to 30 bed unit. Since local communities are in various stages of community support development each has their own unique barriers and gaps in the system. Therefore, funding to enhance local community support systems must be flexible and based on identified need.

FISCAL NOTE
The first phase of MH&RS' Long Range Financing Plan calls for the closing of one adult 20 to 30 bed unit at Osawatomie State Hospital. As indicated earlier this would necessitate the transfer of a maximum of 10,950 bed days of state hospital treatment to the community. It is proposed to accomplish this transfer through direct diversion, early discharge and prevention. The resulting fiscal note for the State of Kansas is analyzed below. Again, this fiscal note is based on the sample programs described ~~data available at this time~~ and is an estimate only.

I. Direct Diversion

A. Mobile Crisis Stabilization Teams - Fifteen F.T.E. positions will need to be funded by state general funds to staff approximately 5 - 7 crisis stabilization teams. These teams will be staffed by social workers,

psychiatric nurses, psychologists, and/or other professionals/paraprofessionals depending on local human resources and identified need. The average annual salary for these positions is estimated to be $30,000 for a total cost of $450,000/year ($30,000 x 15 F.T.E.s) and $225,000 for the initial six-month period.

B. $82,500 for the initial six-month period ($165,000/year) of flexible funding will need to be available to the crisis stabilization teams to purchase, develop or otherwise secure crisis residential beds in the community when temporary separation from the clients' natural environment is necessary. Options should include foster homes, crisis apartments, crisis beds in group settings and access to local hospital psychiatric units.

Direct diversion activities for the initial six-month period would cost $307,500 ($615,000/year) and would provide the capacity to divert approximately 35 (70/year) imminent admissions to Osawatomie State Hospital. On average, these individuals diverted from hospitalization would decrease demand on state psychiatric hospitalization by 4,258 (8,516/year) bed days.

II. Early Discharge

A. For the initial six-month period approximately $50,000 ($100,000/year) will be needed to provide the capacity to successfully discharge 7-8 (15/year) currently hospitalized patients into the community earlier than projected discharge. Funding at this level would provide the capacity to access the appropriate and desired mainstream housing for patients from the existing community housing stock and to provide the services and supports required to enable them to remain in the living situation they have chosen. Approximately, $17,500 ($35,000/year) should be available for rent subsidies, deposits and start-up costs for securing the housing and $32,500 ($65,000/year) should be available for providing the necessary support. Support would be primarily provided by case managers. Since these case managers will be working with the most demanding and immediate support needs, case manager to client ratios will have to be low. The recommended ratio for this proposed early discharge initiative is one F.T.E. case manager to every five clients for a total of 3 F.T.E. case managers during the adjustment period when they would need the most intensive service.

B. Rehabilitative Housing - Even with the capacity for appropriate community support to assist clients in living in mainstream housing, it is still anticipated that a successful early discharge strategy should provide the capacity for a more structured residential option.

Therefore, approximately $45,000 ($90,000/year) should be available to the community support program to accessmore structured rehabilitative housing options. These options include, but are not limited to, group homes, 5/40 bed resident care facilities and ICFs/MH. At an average cost of $50 per day this option would provide the capacity for the early discharge of five patients annually from the state hospital.

Through the enhanced supported and rehabilitative housing initiatives, the early discharge initiative has the capacity to serve an average of 10 (20/year) patients. The early discharge initiative should target the "heavy users" of state psychiatric hospital treatment to obtain the greatest impact on the demand for state hospital beds. The anticipated reduction in demand is 600 (1,200/year) bed days at Osawatomie State Hospital.

III. Ongoing Support - The impact of preventive admissions or "pre-crisis" intervention on state psychiatric hospitalization is probably the most difficult strategy to quantify. However, its importance in accomplishing the goal of eliminating a 20 to 30-bed unit at Osawatomie State Hospital cannot be overemphasized. Indeed, direct diversion and early discharge activities are necessarily time limited. Ongoing services for clients who have resolved the immediate crisis or made a successful transition to the community is necessary to maintain the individual in the community and allow him/her the opportunity to learn, grow and change with dignity.

A. Case management - an additional 10 case managers will be required to provide this core service for the Osawatomie catchment area. With an average annual salary of $21,000 per case manager, the fiscal note for this function is $105,000 for the initial six-month period and $210,000 annually.

B. Psychosocial Rehabilitation Services - An estimated $92,500 ($185,000/year) should be available for the development or enhancement of community psychosocial rehabilitation services. Psychosocial rehabilitation services is defined broadly and includes but is not limited to vocational/supportive employment services, drop-in centers, supported housing, consumer-run services, recreation services, compeer, self-help services, etc. Distribution of these funds should be flexible and based on locally identified needs and gaps in service.

Ongoing community support is estimated to have at least the impact of early discharge activities in reducing the demand for state hospital bed days. Therefore, it is conservatively estimated that 618 (1,235/year) state hospital bed days will be saved with the enhancement of the existing community support system.

IV. Total Fiscal Note

The total fiscal note for closing one 20 to 30 bed adult unit from State General Fund dollars is $600,000 for the initial six-month period and $1,200,000 annually thereafter.

SUMMARY - CSS

- Includes: Mobile crisis stabilization teams, rehabilitative and supported housing, case management, and psychosocial rehabilitation services.

- Purpose: To reduce the demand for state psychiatric hospital treatment by providing a comprehensive, coordinated, and flexible community support system which addresses the needs and desires of individuals with severe and persistent mental illness.

- H.B. 2586: "The secretary shall assist and coordinate the development by each mental health center of a community assessment of needs and a plan for the community system to provide community based mental health services for persons who reside in the service delivery area of the mental health center, including all targeted population members." "Targeted population means the population group designated by rules and regulations of the secretary as most in need of mental health services which are funded, in whole or in part, by state or other public funding sources, which group shall include, but not be limited to, adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care."

- **FISCAL NOTE:** $600,000 for the initial six month period. Funds would be allocated to local community mental health center catchment areas based on ~~(using~~ a distribution formula that would be developed by MH&RS and CMHC's. ~~gives a~~ The sample distribution formula below gives a weight of 30 to population and 70 to FY 89 state hospital bed days used) as follows:

CMHC	FY 91 Allocation
Northeast Kansas	$ 54,720
Wyandot	$162,420
Johnson County	$135,720
Franklin County	$ 14,400
Miami County	$ 36,660
Southeast Kansas	$ 46,020
South Central	$ 21,780
Crawford County	$ 29,040
Family Life Center	$ 11,040
Labette Center	$ 19,980
Four County	$ 45,060
Cowley County	$ 23,160
TOTAL	$600,000

LONG-TERM PHASED IMPLEMENTATION

The short-term alternative described so far (closing a 20 to 30 bed unit at OSH) is merely the beginning and part of system reform described in our long-term financing plan. As a beginning, it directs us toward a long-term solution of the difficulties in our current system.

Mental health reform must include both structural reform and financing reform.

Structural Reform: a single point of entry into the system. Currently, there are multiple points of entry. We propose that CMHCs become that single point of entry through the screening mechanism mentioned earlier.

Implementation of the screening mechanism means that all admissions to State Hospitals are screened by the CMHC. In effect, the CMHC becomes the "gatekeeper". Through screening, individuals are diverted to less restrictive settings when possible. Individuals receive services when and where they are needed.

Structural reform insures that an individual is not "lost" in the system. There is accountability. At the same time, community programs are strengthened, and a mechanism for controlling State hospital growth is developed.

Financing reform: the ability to achieve a more equitable distribution of funds between State hospitals and community programs. Reversing the current dilemma of spending more and more funds (in State Hospitals) while serving fewer and fewer individuals. Implementing the concept of dollars following the clients. Redistribution of scarce resources.

Financing reform includes: incentive financing and risk protection.

Incentive financing: a means of enhancing the development of community-based programs by shifting (reallocating) State hospital funds to communities according to contracts with each CMHC. Based on previous utilization of hospital bed days, each CMHC would determine how much they could reduce utilization of the hospital with the availability of strengthened/expanded community programs.

Risk protection: the ability to protect service providers against unforeseen circumstances particularly in a health care profession where in the delivery of mental health services, all eventualities cannot be predicted consistently. In this plan, CMHCs would be allocated a pre-determined number of bed days based on historical utilization. The CMHCs would be protected against unforeseen variables that might result in exceeding their "reserved" bed allocation by borrowing or purchasing reserved bed days from other centers without incurring undue financial risk.

PHASED PROGRAM - COST CONTAINMENT
OSAWATOMIE STATE HOSPITAL (OSH)

If the escalating costs of maintaining satisfactory State hospital programs are to be contained in a reasonable manner, the size of these facilities must be reduced, the resources realized through savings by downsizing reallocated, and as a result, community programs enhanced. No longer can State hospitals be used because there is "nothing else". The hospitals must be used because the clinical condition of any given client so warrants. ~~Long-term projected costs for total cost of mental health reform~~.

See attachment #1 for long-term projected costs for total cost of mental health reform.

MH&RS recommends a phased approach to mental health reform and cost containment. Specifically, this phased approach is as follows:

OSH closes one adult unit of 20 to 30 beds by June 30, 1991 - financing previously discussed.

OSH closes one adolescent unit of 20 to 30 beds by June 30, 1992. Financing: $834,000 appropriation to maintain screening services for one year (the previous appropriation of $417,000 was for six months)

$1,200,000 appropriation to maintain 90 adults in the community for one year-average length of stay in hospital is approximately 120 days; thus, each bed (30) "turns over" 3 times: 30 x 3 =90. $1,200,000 is double the $600,000 appropriation for 6 months in the preceding year. Another way of approaching hospital census reduction would be planning community programs according to bed utilization.

$1,200,000 to develop community services needed to sustain the adolescents in the community.

* Note - there are no anticipated savings in the first year because when the first adult unit is closed, existing permanent staff will be redistributed to other parts of the hospital to maintain certification.

OSH closes second adult unit of 20 to 30 beds by June 30, 1993. Financing: $834,000 to maintain screening

$1,200,000 to maintain the 90 individuals from closing of first 20 to 30 beds.

$1,200,000 to maintain the approximately 20 to 30 adolescents in the community from closure of 20 to 30 adolescent beds (average length of stay for adolescents is approximately one year, therefore beds do not "turn over").

LESS - $681,955 projected savings (approximately) from closing of adolescent unit.

Financing needs for FY 94 - OSH catchment area
$834,000 to maintain screening.

$1,200,000 to maintain original 90 adults in the community.

$1,200,000 to maintain 20 to 30 adolescents in the community.

$1,200,000 to maintain second group of 90 adults in the community.

LESS - $681,955 projected savings from closure of second unit.

LESS - $631,755 projected savings from closure of third unit.

PHASED PROGRAM - COST CONTAINMENT
TOPEKA STATE HOSPITAL (TSH)

TSH closes one, 20 to 30 bed unit (children/adolescents) by June 30, 1993. Financing: (FY 93) - $834,000 for screening for one year (1/3 of original $2.5 million for statewide screening -TSH catchment area comprises approximately 1/3 of State).

$1,200,000 to develop community services for adolescents in anticipation of closing adolescent unit (20 to 30 beds).

TSH closes one adult 20 to 30 bed unit by June 30, 1994.
Financing: $834,000 to maintain screening for one year.

$1,200,000 to maintain 20 to 30 adolescents in the community.

$1,200,000 for community support funds in anticipation of closing one, 20 to 30 bed unit for adults.

LESS - $900,000 projected savings from closure of 20 to 30 bed adolescent unit (approximate).

TSH closes one, 20 to 30 bed adult unit by June 30, 1995.
Financing: $834,000 to maintain screening for 1 year.

$1,200,000 to maintain original 20 to 30 adolescents in community.

$1,200,000 to maintain the first 90 adults in the community.

$1,200,000 for community support funds in anticipation of closing one adult unit.

LESS - $961,885 projected savings for closure of adolescent unit-actual savings may be less because of federal financial participation for children.

LESS - $878,753 projected savings for closure of first adult unit.

Financing Needs - FY 96
$834,000 to maintain screening for one year.

$1,200,000 to maintain original 20 to 30 adolescents in community.

$1,200,000 to maintain original 90 adults in community.

$1,200,000 to maintain second group of 90 adults in the community.

LESS - $961,885 projected savings for closure of adolescent unit.

LESS - $878,753 projected savings for closure of first adult unit.

LESS - $896,290 projected savings for closure of second adult unit.

PHASED PROGRAM - COST CONTAINMENT
LARNED STATE HOSPITAL (LSH)

LSH closes one, 20 to 30 bed unit for adults by June 30, 1994. Financing: $834,000 for screening for one year. (1/3 of original $2,500,000 for statewide screening).

$1,200,000 for community support funds in anticipation of closing first 20 to 30 bed adult unit.

LSH closes second 20 to 30 bed unit for adults by June 30, 1995. Financing: $834,000 to maintain screening for one year.

$1,200,000 to maintain original 90 adults in community.

$1,200,000 for community support funds in anticipation of closure of second unit for adults.

LESS - $999,963 projected savings (approximately) for closure of first 20 to 30 bed unit for adults.

LSH closes third 20 to 30 bed unit for adults by June 30, 1996. Financing: $834,000 to maintain screening for one year.

$1,200,000 to maintain first group of 90 adults in the community.

$1,200,000 to maintain second group of 90 adults in the community.

$1,200,000 for community support funds in anticipation of closure of third 20 to 30 bed unit for adults.

LESS - $999,963 projected savings for closure of first unit.

LESS - $999,963 projected savings for closure of second unit.

Financing needs FY 97 - $834,000 to maintain screening for one year.

$1,200,000 to maintain first group of 90 adults in the community.

$1,200,000 to maintain second group of 90 adults in the community.

$1,200,000 to maintain third group of adults in the community.

LESS - $999,963 projected savings from closure of first unit.

LESS - $694,463 projected savings of closure of second unit.

LESS - $804,112 projected savings from closure of third unit.

TOTAL ESTIMATED COST FOR PHASED PROGRAM

FY 91 OSH - $1,317,000	Total - $1,317,000
FY 92 OSH - $3,234,000	Total - $3,234,000
Fy 93 OSH - $2,552,045 TSH - $2,034,000	Total - $4,586,045
FY 94 OSH - $3,120,290 TSH - $2,593,362 LSH - $2,234,037	Total - $7,426,045
FY 95 OSH - $3,120,290 TSH - $2,593,362 LSH - $2,234,037	Total - $7,1947,689
FY 96 OSH - $3,120,290 TSH - $1,697,072 LSH - $2,739,574	Total - $7,556,936
FY 97 OSH - $3,120,072 TSH - $1,697,072 LSH - $1,935,462	Total - $6,752,824

COST COMPARISON

~~**Please see Attachment #2, Compare Future Costs of MH Hospitals With Census Reduction Plan.**~~

~~Attachments #2, #2A, and #2B dramatically illustrate the escalating costs of maintaining the current State psychiatric hospital system. It shows eventual cost savings created by the financing plan presented in this document. The plan achieves not only fiscal efficiency, but it also accomplishes an effective community-based mental health system.~~

~~The figures in Attachment #2 are based on historical inflation rates beginning in FY 1970. Specifically, it is estimated that the cost of maintaining the status quo for the three large State psychiatric hospitals will be **$111,551,358** in FY 1997. The cost of maintaining the same hospitals with a budget cap that includes a modest inflationary increase and State funded community programs to sustain the census reduction is estimated to be **$103,534,938** in FY 1997. A budget cap means no expansion of State psychiatric hospital programs and only a modest inflationary budget increase.~~

In revision I of the financing plan by MHRS, data was presented on Attachments #2, #2A, and #2B that illustrated the escalating costs on maintaining the current State psychiatric hospital system as compared to projected savings resulting from this financing plan. However, a recalculation of these projections suggests that a 5% inflation rate "cap" will not be realized for **all** three large hospitals until there is a census reduction in **all** three facilities and subsequent transfer of resources to community programs.

In other words, a cap can only be realized partially; in those hospitals where a census reduction occurs. The budget will continue to grow at the historical rate until the specified census reduction is achieved.

These revised cost projections are reflected in **NEW** Attachment #2, #2A and #2B. For example, on new Attachment #2, the grand total for all hospitals in FY 97, **if no new community programs are added**, will be (estimated) $111,094,142. With a reduction in census of approximately 270 beds and a corresponding expansion of community programs, the total cost (hospital plus community) is estimated to be $112,147,451.

Despite the revised projections, there are considerable benefits to be derived from this plan.

1. **Increased numbers of individuals residing in community settings.** We estimate that approximately 690 individuals, previously served in an institutional setting, would be served in community settings. This figure includes approximately 630 adults and 60 children. The specific number was calculated by taking the total number of beds reduced for adults (210) and multiplying by 3 (each adult bed "turns over" approximately 3 times per year) which

yields a total of 630 adults. The 630 adults are then combined with the 60 children/adolescent bed reduction (these beds "turn over" approximately once per year).

2. **Better quality of life.** The 690 individuals would live in more normal situations, and hence, their quality of life would be improved, assuming adequate community-based services. Furthermore, they would be contributing to their community by purchasing goods and services, maintaining jobs when appropriate, and achieving greater degrees of independence.

3. **Cost containment.** The incremental development of community-based services becomes possible at a modest cost with the reduction of hospital beds and implementation of an inflationary cap on hospital costs. This benefit is achieved while serving some of the heaviest users of the public mental health system.

4. **P. L. 99-660.** This plan is consistent with the provisions of P. L. 99-660 in terms of the development of a community-based system.

Rationale for a phased approach to
mental health reform in Kansas

... Consistent with recommendations by the Governor's Task Force on Mental Health Reform.

... Encourages consumer and family involvement in planning process.

... Allows for the gradual, incremental development of a community-based system.

... Allows for planning in an orderly fashion.

... Allows for fiscal integrity of State funding particularly in times of economic difficulties.

... Allows for careful monitoring, review, and evaluation of phased programs.

... Allows for compliance with P. L. 99-660 in terms of developing a community-based system.

LEGISLATIVE REVISIONS NEEDED

In order to implement this plan, several revisions in the current proposed legislation, HB 2586, will be necessary.

1. Page 1, line 30, remove ", but not be limited to,".

2. Page 2, line 17, New Sec. 2. Insert (g)
Mental health reform phase program means the implementation of mental health reform in Kansas will be a three phase program with the first phase beginning July 1, 1990 and will cover the counties in the Osawatomie State Hospital catchment area and the full implementation of this phase will be completed by June 30, 1994. The second phase will cover the Topeka State Hospital catchment area beginning July 1, 1992, and will end by June 30, 1996. The third phase will cover the Larned State Hospital catchment area beginning July 1, 1993, and will end by June 30, 1997.

3. New language - Section 9, (c), Subject to and in accordance with the provisions of this act and appropriations acts, the secretary shall assist in the establishment of a phased program of mental health reform. Beginning with the Osawatomie State Hospital catchment area, the secretary will enter into contracts with participating mental health centers to reduce the size of Osawatomie State Hospital by one 20 to 30 bed unit for adults by June 30, 1991. By June 30, 1992, an additional 20 to 30 beds will be closed for adolescents. By June 30, 1993, an additional 20 to 30 adult beds will be closed.

The secretary also will enter into contracts with participating mental health centers to reduce the size of Topeka State Hospital by 20 to 30 adolescent beds by June 30, 1993; an additional 20 to 30 adult beds by June 30, 1994; and an additional 20 to 30 adult beds by June 30, 1995.

Further, the secretary will enter into contracts with participating mental health centers to reduce the size of Larned State Hospital by 20 to 30 adult beds in each of the Fiscal years ending June 30, 1994, June 30, 1995, and June 30, 1996.

4. Page 27, Line 30, New Sec. 27. Insert the following;
No patient shall be admitted to a state psychiatric hospital pursuant to any of the provisions of the treatment act for mentally ill persons, including court ordered admissions, if the secretary has notified the supreme court of the state of Kansas and all district courts which have jurisdiction over all or part of the area served by the state psychiatric hospital, that the required program of the state psychiatric hospital has reached capacity. Following notification that a state psychiatric hospital program has reached its capacity, any district court, which has jurisdiction over all or part of the area served by such state psychiatric hospital and by any participating mental health center serving all or part of the same area, may request that patients be placed on a waiting list maintained by the state psychiatric hospital. As each vacancy at the state psychiatric hospital occurs, the district court and participating mental health center shall be notified, in the order of their previous requests for placing a patient on the waiting list, that a patient may be admitted to the state psychiatric hospital. As soon as the state psychiatric hospital is able to being admitting patients on a regular basis to a program for which notice has been given under this section, the state psychiatric hospital shall inform the supreme court and affected district courts that the moratorium on admissions is no longer necessary. The provisions of this section shall apply to those state psychiatric hospitals included in the Mental Health Reform Phased Program.

5. Additional new language in the proposed legislation will be needed to give CMHCs more authority concerning discharges from State hospitals and limit the liability of hospital staff for those discharges.

6. Appropriation - The ability to initiate the implementation of these revisions in the proposed legislation is dependent upon an initial appropriation during FY 91 in the amount of $1,317,000. The rationale for this amount is explained earlier.

DRAFT

REVISION II

FINANCING
OF KANSAS MENTAL HEALTH SERVICES
FOR CHILDREN AND ADOLESCENTS

JANUARY 30, 1990

NOTE - This plan, namely the pilot project section, is designed for use when Topeka State Hospital is scheduled to close a 20 to 30 bed adolescent unit by June 30, 1993. It can be used as a model for the closing of the adolescent unit at Osawatomie State Hospital by June 30, 1992. Revisions and modifications will be needed.

INTRODUCTION

Kansas, like most other states, is struggling to develop a comprehensive community-based system of mental health services for children and adolescents. The lack of a comprehensive array of community-based services makes it necessary to continue the use of State hospitalization, often because there is "nothing else". Not only is state hospitalization costly, or for that matter, any out-of-home placement, from a financial perspective, it is costly from a social economic perspective also. For example, it costs approximately $65,000 per year for state hospitalization of a child or adolescent. Further, estimates indicate that 50% to 75% of all children who are placed out of their own homes in state psychiatric hospitals become patients in psychiatric institutions as adults or become involved as offenders in the adult correctional system.

Children and adolescents who have mental health needs often are involved in several systems other than mental health. That is, they are involved in the educational system, can be involved in the correctional system and may be involved in the child welfare system. Thus, planning for mental health services must take into account these other systems, and interagency coordination is essential. When this coordination does not occur, the potential for fragmentation and duplication is great.

SHORT-TERM FINANCING PLAN

MHRS, in line with recommendations by the Governor's Task Force on Mental Health Reform, has indicated that the development of a system of mental health services should occur in an incremental and an orderly fashion. The "C" level budget request by MHRS for FY 91 reflects this incremental notion in that it permits the gradual expansion of core services on a statewide basis.

. . . Case management - to serve 150 children/adolescents and their families

. . . Home-based family services - expand from the present present coverage of four catchment areas to statewide coverage

. . . Respite care - expand from one metropolitan to three three metropolitan areas serving a total of 100 children

. . . Therapeutic foster care - expand to serve an additional 50 children

. . . School-based mental health liaison - development of five additional cooperative CMHC/local education agency programs

. . . Therapeutic pre-school - continuation funding of current program in Garden City

. . . $1,501,500

LONG-TERM FINANCING PLAN

In testimony provided to the Interim Committee on Ways and Means/Appropriations on October 30, 1989, MHRS indicated that approximately $28,000,000 is estimated to be needed to develop a comprehensive community-based system of care for children and adolescents in Kansas. This estimate was based on an estimate of 5,600 children and adolescents in Kansas with severe emotional disabilities at a cost of $5,000 per year. The 5600 was derived from national prevalence studies. It should be noted that other, earlier estimates indicated that there were approximately 10,000 children and adolescents with serious emotional disabilities. The $5,000 per year per child figure was based on estimates in the State of Maine. In Ventura County, California annual figures per child were approximately $2,351. This figure is somewhat misleading since only a small number of the identified population were served. Families of children and adolescents with severe emotional disabilities have stated emphatically that the $5,000 figure is under-estimated significantly. It is felt that a figure of $12,000 to $15,000 annually per child is more appropriate.

Regardless of the figure used per child per year, $28,000,000 would be a major step in developing and implementing a comprehensive, community-based system. The development of accurate projections for children and adolescents is a national problem and is complicated by a number of factors including the fact that children with severe emotional disabilities often are involved in several systems at the same time. A system for collecting accurate data simply has not been developed. MHRS has developed a proposed structure for such a system through interagency collaboration in a pilot site which could be expanded on a statewide basis. A copy of that proposal is attached.

In its overall long-term financing plan for mental health services for all populations, MHRS has included a plan for the gradual reduction of State psychiatric hospital beds. The money saved by closing of the beds would be re-allocated to community programs. The closing of 60 children/adolescent beds is included in that plan. A copy of the initial draft of the plan is enclosed.

SHORT-TERM FINANCING OPTION

HB 2577, currently HB 2586, contains a section (New Sec.11) calling for a contract for a pilot project for Medicaid eligible residents under the age of 21. In essence, this section would require the State to apply for a Medicaid Waiver from the Health Care Financing Administration (HCFA).

Recently, in an effort to explore the feasibility of implementing this section of the proposed legislation, MHRS participated in a meeting with staff from the HCFA regional office in Kansas City. HCFA staff indicated that the data required to submit a waiver application is difficult and time consuming to obtain. Further, that data must prove that the community-based services provided under the waiver are cost-effective. Namely, those services must cost less and be more effective than institutional beds.

The type of data needed to prove cost effectiveness includes th closing of institutional beds and making a determination about the cost of the community services required to maintain the individuals in the community who previously occupied those beds. A simple description of the needed services is not sufficient; it is necessary to be able to identify the degree of service. Failure to accurately project this data could result in underestimating the cost, thereby resulting in an inability to prove cost effectiveness and jeopardizing continuation of the waiver. Unfortunately, at this time, Kansas does not have the structure in place that would enable this data to be generated. The proposal for interagency collaboration previously mentioned would provide that structure and allow that data to be obtained.

Given the situation described above, it does not seem appropriate to have a provision in the law that ties service development to a **successful** Medicaid Waiver application. Rather, MHRS recommends that a Medicaid Waiver application remain a viable option assuming that the data obtained in the interagency collaboration project would support a potentially successful application.

MHRS strongly recommends that Kansas move forward in initiating community-based services for this population while, at the same time it begins to collect necessary information in a comprehensive way. MHRS proposes to achieve these goals through the interagency proposal previously mentioned as well as a pilot project.

The pilot project would be a relatively small venture, designed to demonstrate, as families consistently state and as current technology indicates, that children and adolescents with severe emotional difficulties can reside in their own homes, their own communities, and their own schools with adequate services and with adequate support to their families. MHRS believes that we can no longer continue to place children out of their own home on a large scale basis. As indicated, the cost socially and financially is too great. The pilot is discussed and proposed below.

We suggest that 20 to 30 children/adolescents currently hospitalized at Topeka State Hospital (TSH) be selected for the project. The number, 30, coincides with the number needed to close one unit, which would be an option the State could exercise if appropriate when the project reached the appropriate phase.

These 20 to 30 children, hopefully all from Shawnee County, would be evaluated in terms of what services they, and their families, would need for them to reside in the community. This evaluation would be conducted by an interagency team that would include at least one child/family advocate knowledgeable about services to this population. Other members would be determined by MHRS and might include representatives of CMHC's, TSH staff, SRS Area Office, local school district, etc. Clearly, interagency collaboration/ cooperation would be essential, and evaluation team membership would be dependent upon agency willingness to volunteer.

As individuals are evaluated and community-based services are developed, these children/adolescents would be returned to their own homes when and where possible, their communities and their schools, and needed services would be implemented. We recognize that a return to one's natural home may not be possible; we are however, maintaining that a child should be returned to a family setting. We are not recommending that hospital settings or highly structured group homes be created because of their high cost socially and economically. We would anticipate that the 20 to 30 discharges would all occur during FY 93. As of January 23, 1990, there are 24 children/adolescents from Shawnee County in TSH. Since the number is less than 30, the other six children would be selected based upon their appropriateness for placement in Shawnee County.

FISCAL NOTE:
This fiscal note is based on data available to us at this time and is an estimate only. It is expected that projections will change over time as more accurate information is collected.

Out patient care (therapy) - felt to be an essential service estimated to be needed by all 20 to 30 children given their "heavy" use of the system. This service currently is available and is reimbursable by Medicaid.

Case management - a core service, estimated to be needed by all 20 to 30 children. Given their current level of care, caseload size should not exceed 10. To serve 20 to 30 children and their families with a caseload size of 10, 3 case managers needed at $20 to 30,000 each which is consistent with recommendations made by the Governor's Task Force on Mental Health Reform = **$90,000.** Case management is reimbursable by Medicaid, currently available only on limited basis, needs expansion by above.

Home-based family services (therapy) - a core service estimated to be needed by all 20 to 30 children given current level of care and the likelihood of significant adjustments, over time, that will have to be made within the families. To serve 20 to 30 children/families with a maximum caseload size of 7 (consistent with current draft standards) = 4.2 therapists at an approximate cost of $35,000 - high, mid-range (including fringe benefits plus 1/2 of one salary to account for vacancies, sick and annual leave,etc.) = **$164,500.** This service is Medicaid reimbursable. Service available for up to ten hours per week.

Crisis intervention - mobile services, available 24 hours per day, 365 days per year with back up medical/physician services, including **short-term** hospitalization. One social worker at $20 to 30,000 mid-range (including fringe benefits); one psychiatric nurse at $20 to 30,000 mid-range (including fringe benefits); one part-time psychiatrist at $66,600 (including fringe benefits calculated at 1/2 rate); $20,000 discretionary funds to purchase temporary emergency (crisis) services (ex. hire

temporary home aide during normal sleeping hours t maintain stabilization after crisis team has intervened); 1/2 of one salary to account for illness, vacation, etc. at $15,000. Note: it is assumed that the 20 to 30 children will be Medicaid eligible because of their current hospitalization status; therefore hospitalization (short-term) is available. However, those children who return to their own home may not retain eligibility if parental income exceeds eligibility requirements. Total = **$161,000.**

Therapeutic foster care - service currently is available and is Medicaid reimbursable. This service would need to be expanded.

Vocational services - assessment and training; one counselor at **$25,000** including fringe benefits.

Respite care - a crucial family support service estimated to be needed by the families (natural and foster) of all 30 children. Estimated cost at $10 per hour, 8 hours per week for 52 weeks for 30 families = **$124,800.** Training of respite care providers at **$10,500** including refresher courses and materials.

After school programs - a part-time service estimated to require 4 part-time staff at $10,000 each = **$40,000.**

Summer programs - day camp, recreation, therapeutic activities: estimated at $1,000 per child = **$30,000.**

Day Treatment - At varying times, at varying levels; some children may not need service at all, others for a short-term; others may need the service intensively for extended period. **$130,000.**

General support services - There are a number of support services needed by this population that are informal and may be needed by only a few of the 20 to 30 children or their families at any given time. These type of services may include transportation, special recreation needs, educational materials, big brother, big sister activities, etc. While some of these services may have no or minimal cost, there is a need to coordinate those types of activities that currently is being done only on a part-time basis = **$24,000.**

TOTAL COST OF PILOT PROJECT = $799,800

It is noted that the average cost for all of the above services, per child is $26,660 per year. This amount is nearly double the rate of $15,000 mentioned earlier. However, these are estimates subject to change with the collection of better data. It should be emphasized that $26,660 is less than **one half** of the approximate cost of hospitalization. Thus, a pilot project of this type avoids a cost of **$38,340** (65,000 less 26,660) per child.

LONG-TERM PROJECTED COSTS

FISCAL YEAR	OSAWATOMIE STATE HOSPITAL DISTRICT		TOPEKA STATE HOSPITAL DISTRICT		LARNED STATE HOSPITAL DISTRICT		FY MENTAL HEALTH COSTS	
FY 91	OSH/CMHC'S SCREENING	417,000	TSH/CMHC'S SCREENING	0	LSH/CMHC'S SCREENING	0	FY 91	
	MAINTENANCE	600,000	MAINTENANCE	0	MAINTENANCE	0	CMHC TOTAL	1,017,000
	CMHC TOTAL	1,017,000	CMHC TOTAL	0	CMHC TOTAL	0	SH TOTAL	300,000
	OSH/SH TEMP STAFF COST	300,000					GRAND TOTAL	1,317,000
	GRAND TOTAL	1,317,000						
FY 92	OSH/CMHC'S SCREENING	834,000	TSH/CMHC'S SCREENING	0	LSH/CMHC'S SCREENING	0	FY92	
	MAINTENANCE	2,400,000	MAINTENANCE	0	MAINTENANCE	0	CMHC TOTAL	3,234,000
	CMHC TOTAL	3,234,000	CMHC TOTAL	0	CMHC TOTAL	0	SH SAVINGS	0
	OSH/SH 1ST YR SAVINGS *	0					GRAND TOTAL	3,234,000
	GRAND TOTAL	3,234,000						

* NO SAVINGS REALIZED THE FIRST YEAR DUE TO MAINTAINING STAFF TO MEET ACCREDITATION AND CERTIFICATION STANDARDS

FY 93	OSH/CMHC'S		TSH/CMHC'S		LSH/CMHC'S		FY93
	SCREENING	834,000	SCREENING	834,000	SCREENING	0	
	MAINTENANCE	2,400,000	MAINTENANCE	1,200,000	MAINTENANCE	0	
	CMHC TOTAL	3,234,000	CMHC TOTAL	2,034,000	CMHC TOTAL	0	CMHC TOTAL 5,268,000
	OSH/SH						
	2ND YR SAVINGS	681,955					SH SAVINGS 681,955
	GRAND TOTAL	2,552,045					GRAND TOTAL 4,586,045
FY 94	OSH/CMHC'S		TSH/CMHC'S		LSH/CMHC'S		FY 94
	SCREENING	834,000	SCREENING	834,000	SCREENING	834,000	
	MAINTENANCE	3,600,000	MAINTENANCE	2,400,000	MAINTENANCE	1,200,000	
	CMHC TOTAL	4,434,000	CMHC TOTAL	3,234,000	CMHC TOTAL	2,034,000	CMHC TOTAL 9,702,000
	OSH/SH		TSH/SH				
	3RD YR SAVINGS	1,313,710	1ST YR SAVINGS	961,885			SH SAVINGS 2,275,595
	GRAND TOTAL	3,120,290	GRAND TOTAL	2,272,115			GRAND TOTAL 7,426,405

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FY 95		
	OSH/CMHC'S SCREENING	834,000
	MAINTENANCE	3,600,000
	CMHC TOTAL	4,434,000
	OSH/SH 4TH YR SAVINGS	1,313,710
	GRAND TOTAL	3,120,290

	TSH/CMHC'S SCREENING	834,000
	MAINTENANCE	3,600,000
	CMHC TOTAL	4,434,000
	TSH/SH 2ND YR SAVINGS	1,840,638
	GRAND TOTAL	2,593,362

	LSH/CMHC'S SCREENING	834,000
	MAINTENANCE	2,400,000
	CMHC TOTAL	3,234,000
	LSH/SH 1ST YR SAVINGS	999,963
	GRAND TOTAL	2,234,037

FY 95	
CMHC TOTAL	12,102,000
SH SAVINGS	4,154,311
GRAND TOTAL	7,947,689

FY 96		
	OSH/CMHC'S SCREENING	834,000
	MAINTENANCE	3,600,000
	CMHC TOTAL	4,434,000
	OSH/SH 5TH YR SAVINGS	1,313,710
	GRAND TOTAL	3,120,290

	TSH/CMHC'S SCREENING	834,000
	MAINTENANCE	3,600,000
	CMHC TOTAL	4,434,000
	TSH/SH 3RD YR SAVINGS	2,736,928
	GRAND TOTAL	1,697,072

	LSH/CMHC'S SCREENING	834,000
	MAINTENANCE	3,600,000
	CMHC TOTAL	4,434,000
	LSH/SH 2ND YR SAVINGS	1,694,426
	GRAND TOTAL	2,739,574

FY 96	
CMHC TOTAL	13,302,000
SH SAVINGS	5,745,064
GRAND TOTAL	7,556,936

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FY 97		
OSH/CMHC'S		
SCREENING		834,000
MAINTENANCE		3,600,000
CMHC TOTAL		4,434,000
OSH/SH		
6TH YR SAVINGS		1,313,710
GRAND TOTAL		3,120,290

TSH/CMHC'S	
SCREENING	834,000
MAINTENANCE	3,600,000
CMHC TOTAL	4,434,000
TSH/SH	
4TH YR SAVINGS	2,736,928
GRAND TOTAL	1,697,072

LSH/CMHC'S	
SCREENING	834,000
MAINTENANCE	3,600,000
CMHC TOTAL	4,434,000
LSH/SH	
3RD YR SAVINGS	2,498,538
GRAND TOTAL	1,935,462

FY 97	
CMHC TOTAL	13,302,000
SH SAVINGS	6,549,176
GRAND TOTAL	6,752,824

S-4/2

*** COMPARE FUTURE COSTS OF MH HOSPITALS WITH CENSUS REDUCTION PLAN

Fiscal<---- OSAWATOMIE STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	OSH @ 5% CAP	CMHC's	TOTAL
'90	$20,078,978		$20,078,978		
'91	$21,324,779	$0	$20,078,978	$1,017,000	$21,095,978
'92	$22,647,876	$0	$21,082,927	$3,395,700	$24,478,627
'93	$24,053,065	$751,855	$21,385,218	$3,565,485	$24,950,703
'94	$25,545,439	$1,520,784	$21,723,143	$5,132,909	$26,856,053
'95	$27,130,407	$1,596,823	$22,809,301	$5,389,555	$28,198,855
'96	$28,813,715	$1,676,664	$23,949,766	$5,659,032	$29,608,798
'97	$30,601,464	$1,760,497	$25,147,254	$5,941,984	$31,089,238

Fiscal<------ TOPEKA STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	TSH @ 5% CAP	CMHC's	TOTAL
'90	$21,353,230		$21,353,230		
'91	$22,536,147	$0	$21,353,230	$0	$21,353,230
'92	$23,784,595	$0	$22,420,892	$0	$22,420,892
'93	$25,102,203	$0	$23,541,936	$2,242,485	$25,784,421
'94	$26,492,804	$1,113,502	$23,605,531	$3,743,759	$27,349,290
'95	$27,960,441	$2,237,307	$23,718,678	$5,389,555	$29,107,232
'96	$29,509,382	$3,493,091	$23,759,[illegible]	$5,659,032	$29,418,675
'97	$31,144,130	$3,667,745	$24,947,[illegible]	$5,941,984	$30,889,609

Fiscal<------ LARNED STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	LSH @ 5% CAP	CMHC's	TOTAL
'90	$29,074,333		$29,074,333		
'91	$31,398,251	$0	$29,074,[illegible]	$0	$29,074,333
'92	$33,907,920	$0	$30,528,050	$0	$30,528,050
'93	$36,618,187	$0	$32,054,452	$0	$32,054,452
'94	$39,545,087	$0	$33,657,175	$2,354,609	$36,011,784
'95	$42,705,934	$1,21[illegible]	$34,124,572	$3,930,947	$38,055,519
'96	$46,119,429	$2,1[illegible],565	$34,[illegible],470	$5,659,032	$40,603,503
'97	$49,805,765	$3,34[illegible],280	$35,614,107	$5,941,984	$41,556,091

Fiscal<------ GRAND TOTAL ALL HOSPITALS----->

Year	Status-Quo	SAVINGS	5% CAP	CMHC's	TOTAL
'90	$70,506,541	$0	$70,506,541	$0	$70,506,541
'91	$75,259,177	$0	$70,506,541	$1,017,000	$71,523,541
'92	$80,340,391	$0	$74,031,868	$3,395,700	$77,427,568
'93	$85,773,456	$751,855	$76,98[illegible],606	$5,807,970	$82,789,576
'94	$91,583,330	$2,634,286	$78,985,[illegible]	$11,231,278	$90,217,127
'95	$97,796,783	$5,049,591	$80,651,550	$14,710,057	$95,361,607
'96	$104,442,526	$7,332,319	$82,653,879	$16,977,097	$99,630,976
'97	$111,551,358	$8,776,522	$85,708,986	$17,[illegible]5,952	$103,534,938

OSH Status Quo Inflation Rate: 6.2%
TSH Status Quo Inflation Rate: 5.5%
LSH Status Quo Inflation Rate: 8.0%
All other inflation rates: 5.0%

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(ARE FUTURE COSTS OF MH HOSPITALS WITH ADC REDUCTION PLAN (ALL FUNDS

Fiscal<---- OSAWATOMIE STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$19,778,978		$20,078,978		
'91	$20,991,113	$0	$20,991,113	$1,067,850	$22,058,963
'92	$22,277,533	$0	$22,040,669	$3,565,485	$25,606,154
'93	$23,642,789	$797,932	$22,344,770	$5,132,909	$27,477,679
'94	$25,091,714	$1,613,983	$22,685,854	$5,389,555	$28,075,409
'95	$26,629,435	$1,694,682	$23,820,147	$5,659,032	$29,479,179
'96	$28,261,393	$1,779,417	$25,011,154	$5,941,984	$30,953,138
'97	$29,993,365	$1,868,387	$26,261,712	$6,239,083	$32,500,795

Fiscal<------ TOPEKA STATE HOSPITAL -------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$21,353,230		$21,353,230		
'91	$22,536,147	$0	$22,536,147	$0	$22,536,147
'92	$23,784,595	$0	$23,784,595	$0	$23,784,595
'93	$25,102,203	$0	$24,973,824	$2,354,609	$27,328,434
'94	$26,492,804	$1,181,229	$25,041,287	$3,930,947	$28,972,234
'95	$27,960,441	$2,373,386	$25,160,255	$5,659,032	$30,819,287
'96	$29,509,382	$3,705,551	$25,204,773	$5,941,984	$31,146,757
'97	$31,144,130	$3,890,828	$26,465,012	$6,239,083	$32,704,095

Fiscal<------ LARNED STATE HOSPITAL ------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$29,074,333		$29,074,333		
'91	$31,398,251	$0	$31,398,251	$0	$31,398,251
'92	$33,907,920	$0	$33,907,920	$0	$33,907,920
'93	$36,618,187	$0	$36,618,187	$0	$36,618,187
'94	$39,545,087	$0	$38,449,097	$2,472,340	$40,921,436
'95	$42,705,934	$1,388,512	$38,983,039	$4,127,495	$43,110,534
'96	$46,119,429	$2,470,459	$39,919,670	$5,941,984	$45,861,654
'97	$49,805,765	$3,824,989	$40,684,646	$6,239,083	$46,923,729

Fiscal<------ GRAND TOTAL ALL HOSPITALS----->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$70,206,541	$0	$70,506,541	$0	$70,506,541
'91	$74,925,511	$0	$74,925,511	$1,067,850	$75,993,361
'92	$79,970,047	$0	$79,733,183	$3,565,485	$83,298,668
'93	$85,363,180	$797,932	$83,936,782	$7,487,519	$91,424,300
'94	$91,129,605	$2,795,212	$86,176,238	$11,792,842	$97,969,079
'95	$97,295,810	$5,456,581	$87,963,441	$15,445,559	$103,409,001
'96	$103,890,204	$7,955,426	$90,135,597	$17,825,952	$107,961,549
'97	$110,943,259	$9,584,205	$93,411,369	$18,717,250	$112,128,619

OSH Status Quo Inflation Rate: 6.1%
TSH Status Quo Inflation Rate: 5.5%
LSH Status Quo Inflation Rate: 8.0%

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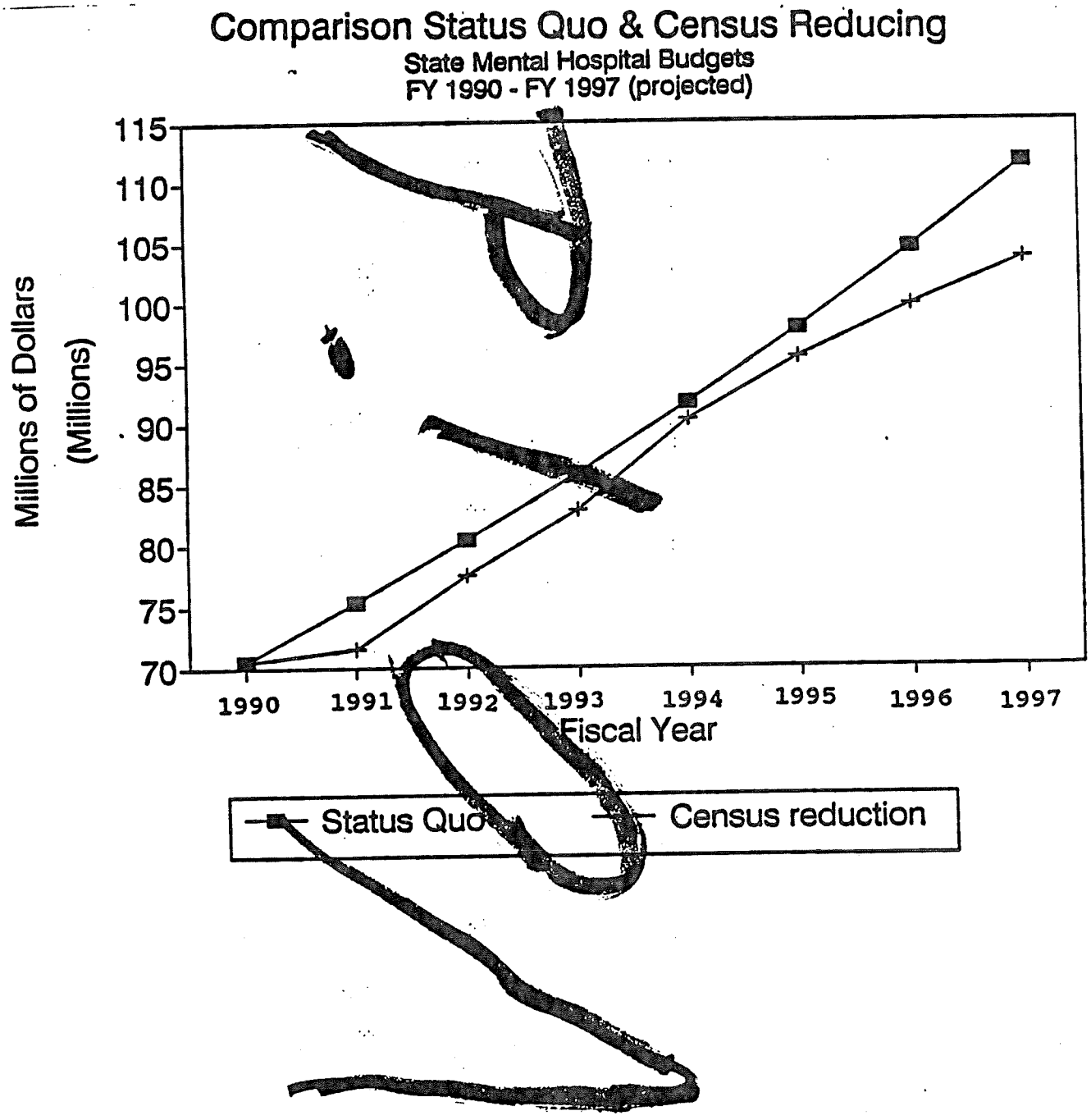
ATTACHMENT II-A

COMPARISON BETWEEN PROJECTED "STATUS QUO" STATE HOSPITAL BUDGETS AND "CENSUS REDUCTION PLAN WITH ADDED COMMUNITY PROGRAMMING"



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PARE FUTURE COSTS OF MH HOSPITALS WITH ADC REDUCTION PLAN (SGF)

Fiscal<---- OSAWATOMIE STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$13,845,285		$14,145,285		
'91	$14,704,316	$0	$14,704,316	$1,067,850	$15,772,166
'92	$15,616,647	$0	$15,439,532	$3,565,485	$19,005,017
'93	$16,585,582	$558,953	$15,652,556	$5,132,909	$20,785,465
'94	$17,614,636	$1,130,598	$15,891,486	$5,389,555	$21,281,041
'95	$18,707,537	$1,187,128	$16,686,060	$5,659,032	$22,345,093
'96	$19,868,247	$1,246,485	$17,520,363	$5,941,984	$23,462,347
'97	$21,100,974	$1,308,809	$18,396,381	$6,239,083	$24,635,465

Fiscal<------ TOPEKA STATE HOSPITAL -------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$14,947,261		$14,947,261		
'91	$15,775,303	$0	$15,775,303	$0	$15,775,303
'92	$16,649,216	$0	$16,649,216	$0	$16,649,216
'93	$17,571,542	$0	$17,481,677	$2,354,609	$19,836,286
'94	$18,544,963	$826,860	$17,528,901	$3,930,947	$21,459,848
'95	$19,572,309	$1,661,371	$17,612,179	$5,659,032	$23,271,211
'96	$20,656,567	$2,593,885	$17,643,341	$5,941,984	$23,585,325
'97	$21,800,891	$2,723,580	$18,525,508	$6,239,083	$24,764,591

Fiscal<------ LARNED STATE HOSPITAL ------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$20,352,033		$20,352,033		
'91	$21,978,775	$0	$21,978,775	$0	$21,978,775
'92	$23,735,544	$0	$23,735,544	$0	$23,735,544
'93	$25,632,731	$0	$25,632,731	$0	$25,632,731
'94	$27,681,561	$0	$26,914,367	$2,472,340	$29,386,707
'95	$29,894,154	$971,958	$27,288,127	$4,127,495	$31,415,622
'96	$32,283,600	$1,729,321	$27,943,769	$5,941,984	$33,885,753
'97	$34,864,035	$2,677,493	$28,479,252	$6,239,083	$34,718,335

Fiscal<------ GRAND TOTAL ALL HOSPITALS----->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$49,144,579	$0	$49,444,579	$0	$49,444,579
'91	$52,458,395	$0	$52,458,395	$1,067,850	$53,526,245
'92	$56,001,407	$0	$55,824,292	$3,565,485	$59,389,777
'93	$59,789,856	$558,953	$58,766,964	$7,487,519	$66,254,482
'94	$63,841,160	$1,957,458	$60,334,754	$11,792,842	$72,127,596
'95	$68,174,000	$3,820,457	$61,586,366	$15,445,559	$77,031,926
'96	$72,808,414	$5,569,691	$63,107,473	$17,825,952	$80,933,426
'97	$77,765,900	$6,709,881	$65,401,142	$18,717,250	$84,118,391

OSH Status Quo Inflation Rate: 6.2%
TSH Status Quo Inflation Rate: 5.5%
LSH Status Quo Inflation Rate: 8.0%

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STATE HOSPITAL CENSUS AND EXPENDITURE: PATTERNS AND PROJECTIONS

	LSH		OSH		TSH		Total	
	census	expenditures	census	expenditures	census	expenditures	census	expenditures
'70	630	$5,783,626	507	$5,672,047	729	$6,882,175	1866	$18,337,848
'71	671	$6,446,955	393	$5,709,757	637	$7,198,780	1701	$19,355,492
'72	698	$6,708,606	432	$5,687,352	494	$7,090,097	1624	$19,486,055
'73	688	$7,070,845	454	$5,787,503	408	$7,058,278	1550	$19,916,626
'74	665	$7,567,296	405	$6,697,365	376	$7,403,078	1446	$21,667,739
'75	539	$8,086,352	369	$7,804,675	375	$7,840,692	1283	$23,731,719
'76	460	$9,497,426	355	$8,968,610	353	$8,668,195	1168	$27,134,231
'77	393	$9,966,125	349	$8,018,430	334	$9,403,480	1076	$27,388,035
'78	427	$10,945,805	363	$8,679,832	343	$10,507,258	1133	$30,132,895
'79	414	$12,490,173	359	$9,521,584	318	$11,199,319	1091	$33,211,076
'80	400	$13,405,998	350	$10,339,044	302	$12,058,547	1052	$35,803,589
'81	427	$14,942,263	369	$11,680,997	316	$13,638,681	1112	$40,261,941
'82	436	$16,143,290	382	$12,499,500	329	$14,651,620	1147	$43,294,410
'83	404	$16,037,693	354	$[illegible]829,250	346	$14,037,176	1104	$42,904,119
'84	420	$17,531,074	356	$13,[illegible]424	[illegible]53	$15,124,264	1129	$46,070,762
'85	452	$20,237,087	338	$14,93[illegible]28	[illegible]60	$16,493,526	1150	$51,666,541
'86	488	$21,046,748	336	$15,139,[illegible]	[illegible]48	$16,615,701	1172	$52,801,995
'87	483	$21,938,321	368	$15,890,[illegible]5	[illegible]335	$17,059,127	1186	$54,888,063
'88	459	$23,199,360	340	$16,483,[illegible]	324	$17,831,452	1123	$57,514,590
'89	451	$26,432,207	339	$18,[illegible]83[illegible]	304	$20,626,561	1094	$65,839,599
'90		$29,074,333		$20,07[illegible]		$21,353,230		$70,506,541
'91		$31,398,251		$21,324,77[illegible]		$22,536,147		$75,259,177
'92		$33,907,920		$22,647,876		$23,784,595		$80,340,391
'93		$36,618,187		$[illegible]05[illegible]65		$25,102,203		$85,773,456
'94		$39,545,087		$2[illegible]45,[illegible]		$26,492,804		$91,583,330
'95		$42,705,934		$27,[illegible]0,407		$27,960,441		$97,796,783
'96		$46,119,429		$28,81[illegible]15		$29,509,382		$104,442,526
'97		$49,805,765		$30,601,[illegible]		$31,144,130		$111,551,358

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STA 'ITAL CENSUS AND EXPENDITURE: PATTERNS AND PROJECTIONS

Fiscal	LSH		OSH		TSH		Total	
Year	census	expenditures	census	expenditures	census	expenditures	census	expenditures
'70	630	$5,783,626	507	$5,672,047	729	$6,882,175	1866	$18,337,848
'71	671	$6,446,955	393	$5,709,757	637	$7,198,780	1701	$19,355,492
'72	698	$6,708,606	432	$5,687,352	494	$7,090,097	1624	$19,486,055
'73	688	$7,070,845	454	$5,787,503	408	$7,058,278	1550	$19,916,626
'74	665	$7,567,296	405	$6,697,365	376	$7,403,078	1446	$21,667,739
'75	539	$8,086,352	369	$7,804,675	375	$7,840,692	1283	$23,731,719
'76	460	$9,497,426	355	$8,968,610	353	$8,668,195	1168	$27,134,231
'77	393	$9,966,125	349	$8,018,430	334	$9,403,480	1076	$27,388,035
'78	427	$10,945,805	363	$8,679,832	343	$10,507,258	1133	$30,132,895
'79	414	$12,490,173	359	$9,521,584	318	$11,199,319	1091	$33,211,076
'80	400	$13,405,998	350	$10,339,044	302	$12,058,547	1052	$35,803,589
'81	427	$14,942,263	369	$11,680,997	316	$13,638,681	1112	$40,261,941
'82	436	$16,143,290	382	$12,499,500	329	$14,651,620	1147	$43,294,410
'83	404	$16,037,693	354	$12,829,250	346	$14,037,176	1104	$42,904,119
'84	420	$17,531,074	356	$13,415,424	353	$15,124,264	1129	$46,070,762
'85	452	$20,237,087	338	$14,935,928	360	$16,493,526	1150	$51,666,541
'86	488	$21,046,748	336	$15,139,546	348	$16,615,701	1172	$52,801,995
'87	483	$21,938,321	368	$15,890,615	335	$17,059,127	1186	$54,888,063
'88	459	$23,199,360	340	$16,483,778	324	$17,831,452	1123	$57,514,590
'89	451	$26,432,207	339	$18,780,831	304	$20,626,561	1094	$65,839,599
'90		$29,074,333		$19,778,978		$21,353,230		$70,206,541
'91		$31,398,251		$20,991,113		$22,536,147		$74,925,511
'92		$33,907,920		$22,277,533		$23,784,595		$79,970,047
'93		$36,618,187		$23,642,789		$25,102,203		$85,363,180
'94		$39,545,087		$25,091,714		$26,492,804		$91,129,605
'95		$42,705,934		$26,629,435		$27,960,441		$97,295,810
'96		$46,119,429		$28,261,393		$29,509,382		$103,890,204
'97		$49,805,765		$29,993,365		$31,144,130		$110,943,259

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ATTACHMENT 3

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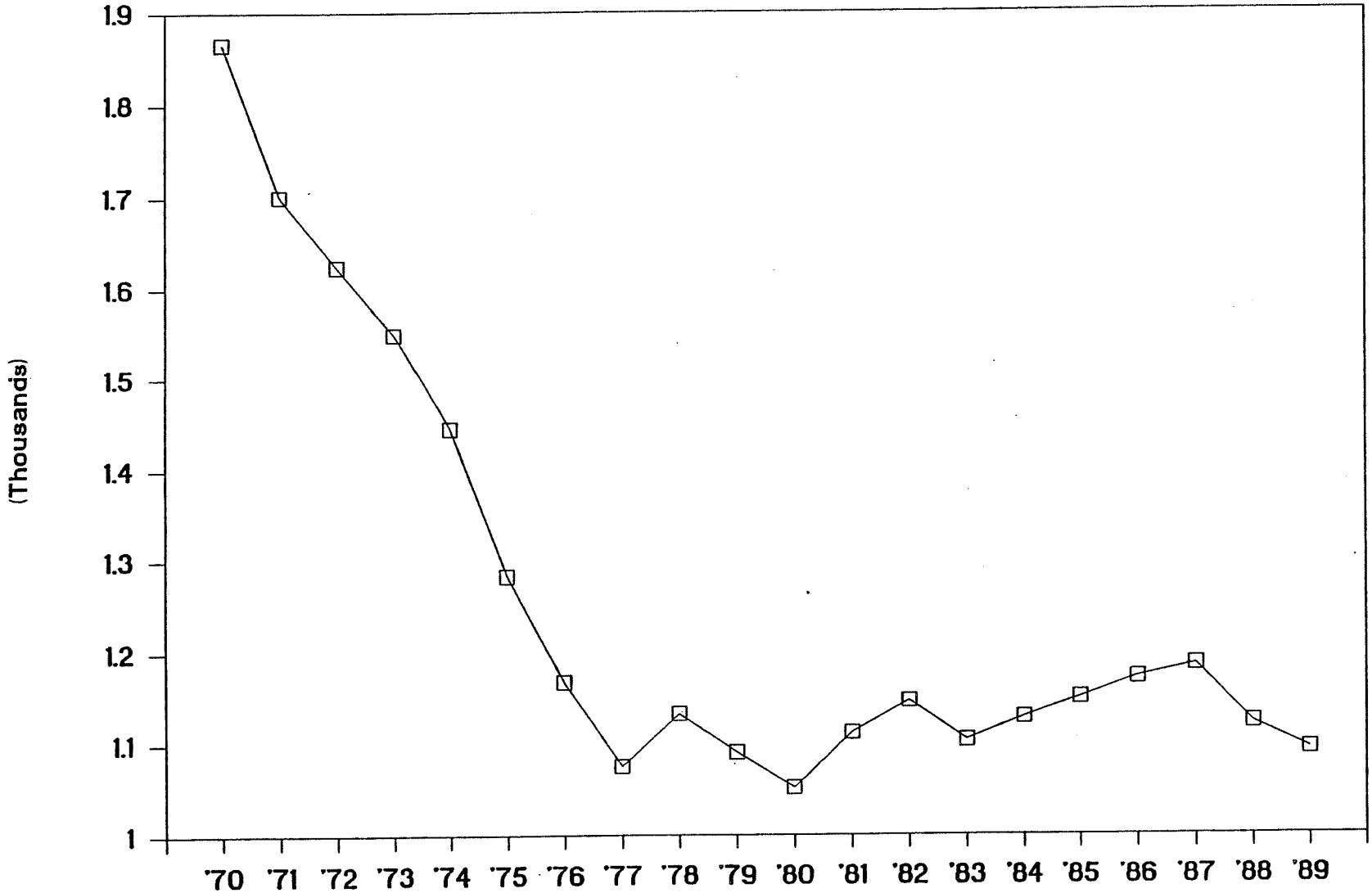
ALL MH HOSPITAL AVERAGE DAILY CENSUS
FY 1970 - FY 1989



MH Hospital Average Daily Census
From FY 1970 to FY 1989

	LSH	OSH	TSH	Total
'70	630	507	729	1866
'71	671	393	637	1701
'72	698	432	494	1624
'73	688	454	408	1550
'74	665	405	376	1446
'75	539	369	375	1283
'76	460	355	353	1168
'77	393	349	334	1076
'78	427	363	343	1133
'79	414	359	318	1091
'80	400	350	302	1052
'81	427	369	316	1112
'82	436	382	329	1147
'83	404	354	346	1104
'84	420	356	353	1129
'85	452	338	360	1150
'86	488	336	348	1172
'87	483	368	335	1186
'88	459	340	324	1123

MARCH 26, 1990

STATEMENT TO SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

DAVE SEATON, CHAIR

KANSAS MENTAL HEALTH PLANNING COUNCIL

THANK YOU, MR. CHAIRMAN.

GOVERNOR'S TASK FORCE ON MENTAL HEALTH REFORM WAS A 21-MEMBER GROUP THAT MET FOURTEEN TIMES, USUALLY FOR TWO DAYS, AT SITES ACROSS THE STATE. THE TASK FORCE INCLUDED A SHERIFF, A JUDGE, A CONSUMER OF MENTAL HEALTH SERVICES, FAMILY MEMBERS OF THE MENTALLY ILL, ADVOCATES, CITIZENS AND REPRESENTATIVES OF MENTAL HEALTH CENTERS AND THE CENTRAL OFFICE FOR MENTAL HEALTH AT THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES.

OUR REPORT WENT TO THE GOVERNOR IN JUNE.

LATE LAST YEAR, THE GOVERNOR FOLLOWED THIS INITIATIVE BY APPOINTING THE KANSAS MENTAL HEALTH PLANNING COUNCIL. UNDER FEDERAL LAW, IT HAS A RESPONSIBILITY FOR MONITORING THE IMPLEMENTATION OF REFORMS TO STRENGTHEN COMMUNITY-BASED SERVICES FOR THE MENTALLY ILL. ITS MEMBERS INCLUDE SOME PEOPLE WHO SERVED ON THE TASK FORCE. A CONSUMER, AN ATTORNEY, THE NEW PRESIDENT OF THE KANSAS ALLIANCE FOR THE MENTALLY ILL, AN ADVOCATE FOR CHILDREN'S AND ADOLESCENT'S SERVICES, A MEMBER OF THE STATE BOARD OF EDUCATION AND SEVERAL COMMISSIONERS AT SRS ARE MEMBERS.

SP H & W
Attachment #6
3/26/90

THE TASK FORCE ENDORSED THE MENTAL HEALTH REFORM LEGISLATION BEFORE YOU IN CONCEPT. THE PLANNING COUNCIL HAS ENDORSED HB 2586 SPECIFICALLY.

IN ADDITION, A COALITION OF REPRESENTATIVES OF GROUPS INTERESTED IN MENTAL HEALTH REFORM MET IN DECEMBER AND JANUARY, AND REACHED CONSENSUS IN SUPPORT OF THE KEY PROVISIONS OF THE BILL. THESE INCLUDE:

THE TARGET POPULATION

THE COMMUNITY CENTERS AS GATEKEEPERS

THE ROLE OF THE STATE

A "ZERO REJECTION" POLICY

A PROVISION FOR CONSUMER MEDIATION

THE COMPOSITION OF MENTAL HEALTH CENTER BOARDS

THE COMPOSITION OF THE FUTURE GOVERNOR'S PLANNING COUNCIL

I FEEL COMFORTABLE SAYING TO YOU, ON BEHALF OF ALL THESE GROUPS, THAT THE CONSENSUS IN SUPPORT OF THIS MENTAL HEALTH REFORM LEGISLATION IS BROAD AND DEEP. THIS REFORM MOVEMENT IS RIPE. THE TIME FOR ACTION IS NOW.

PLEASE LET ME SUGGEST TO YOU TWO IDEAS I HAVE FOUND HELPFUL IN UNDERSTANDING OUR PUBLIC MENTAL HEALTH SYSTEM AND THE NEED FOR REFORM.

ABOVE ALL, INDIVIDUALS WHO SUFFER LONG-TERM MENTAL ILLNESS ARE

PEOPLE, LIKE YOU AND ME. THEY NEED THE SAME KINDS OF THINGS WE NEED --- LOVE, SUPPORT, A PLACE TO LIVE, ENOUGH TO EAT AND HOPE FOR SOMETHING BETTER TOMORROW. I HAVE FOUND THAT BASIC UNDERSTANDING A GOOD GUIDE THROUGHOUT MY JOURNEY IN SEARCH OF IMPROVEMENTS OF THIS TIRED, DIVIDED, POORLY COORDINATED AND ESSENTIALLY DRIFTING SYSTEM.

THE LEGISLATION BEFORE YOU WOULD BEGIN, IN EARNEST, TO RESTORE BALANCE AND COORDINATION TO THAT SYSTEM. IT WOULD BEGIN TO SHIFT NEW RESOURCES FROM INSTITUTIONAL TO COMMUNITY CARE, WHERE 90 PERCENT OF THE INDIVIDUALS WHO SUFFER SEVERE AND PERSISTENT MENTAL ILLNESSES ARE.

THE OTHER IDEA I WANT TO RAISE IS THE IDEA OF REHABILITATION. IT DOES, IN FACT, WORK FOR THE SERIOUSLY MENTALLY ILL, IN MANY CASES. WE DO NOT HAVE TO SHUT THEM AWAY IN INSTITUTIONS. WHEN WE DO, EVEN WITH THE BEST OF CARE, THEY OFTEN MAKE LITTLE PROGRESS.

DR. E. FULLER TORREY, WHO HEADED THE NATIONAL STUDY THAT RANKED KANSAS 42ND IN ITS PUBLIC MENTAL HEALTH SYSTEM TWO YEARS AGO, HAS FOUND MORE THAN HALF THE INDIVIDUALS WHO SUFFER SCHIZOPHRENIA CAN REHABILITATE THEMSELVES WITH ADEQUATE COMMUNITY SUPPORT.

THIS LEGISLATION WILL WORK. IT WILL NOT CLOSE ANY HOSPITALS, BUT ONLY CHANGE THEIR ROLE SOMEWHAT AND HELP THEM TO DO AN EVEN

BETTER JOB WITH THE CLIENTS WHO NEED ACUTE CARE THE MOST.

KANSAS HAS GOT TO DO SOMETHING TO RESTORE BALANCE TO ITS PUBLIC MENTAL HEALTH SYSTEM. THE RATIONAL USE OF OUR LIMITED RESOURCES DEMANDS IT. THE FEDERAL GOVERNMENT URGES IT. MOST IMPORTANTLY, THE HUMANE APPROACH WITH THE BEST PROSPECTS FOR SUCCESS FOR THE MENTALLY ILL THEMSELVES -- THE APPROACH CONTAINED IN HB 2586 -- CALLS FOR IT.

THIS LEGISLATION IS A GOOD, TIMELY OPPORTUNITY FOR KANSAS, LADIES AND GENTLEMEN. I WARMLY URGE YOU TO ACT FAVORABLY ON IT.

Testimony Presented to

Senate Public Health and Welfare Committee

by

William C. Rein

Substitute for House Bill No. 2586

This testimony will be brief but not so brief that essential issues will be ignored!

Major Components of HB 2586:

HB 2586 is designed to secure community screening by designated professionals employed by a participating community mental health center under contract with the Kansas Department of Social and Rehabilitation Services (SRS). These professionals, defined as "Qualified Mental Health Professionals" would review all involuntary commitment cases prior to hospitalization at one of the state's four psychiatric hospitals. As such, four basic questions should be addressed in this testimony:

1. WHAT is being provided in HB 2586?
2. WHO will provide this service?
3. WHEN will this service be provided?
4. WHY is HB 2586 being proposed?

1. WHAT is being provided? HB 2586 will require participating community mental health centers under contract with SRS to provide uniform and consistent screening of all proposed admissions to state psychiatric hospitals. In affect, the participating mental health center, through a qualified mental health professional as defined by the bill, will ask one basic question before any individual is admitted to a state hospital for evaluation or treatment - Can the proposed patient be assisted by a community agency or should further evaluation and treatment be sought at a state psychiatric hospital?

2. WHO will provide the screening service? The community screening service will be provided by a "Qualified Mental Health Professional" as defined in Section 16, (w) of the bill. Primarily this will be a physician or certified psychologist; or a registered Master's level psychologist, a licensed specialist clinical social worker, or a licensed Master social worker acting under the supervision of a physician.

SPH+W
Attachment #1
3/26/90

3. WHEN will the screening be required? The community screening service by a participating community mental health center will occur prior to any involuntary admission to a state psychiatric hospital. Basically, involuntary admission proceedings are initiated by either a law enforcement officer or district court. This means that before any proposed patient is admitted to a state psychiatric hospital for emergency observation, court ordered protective custody, or court ordered evaluation and treatment, an appropriate professional at the participating community mental health center would first see the proposed patient. If the professional believed that the patient could be assisted in the community, the professional would so notify the law enforcement official and/or district court.

4. WHY is community screening necessary? Community screening of proposed admissions to state psychiatric hospitals is designed with a two-fold purpose in mind, (1) to prevent unnecessary hospitalizations and (2) to get community professionals involved with a proposed patient even before hospitalization occurs. There will be some who feel that mere screening, at the time of a crises, is too little too late! However, mandatory community screening will be worth the investment regardless of the number of actual diversions from state hospitals because it will unify the public mental health system (state hospitals and community mental health centers), prevent some hospitalizations, and enhance the possibility of working an earlier discharge from the hospital.

Major Issues

There are four basic positions which various conferees are likely to take concerning HB 2586. I would like to state these issues and make a short response with respect to each.

1. It may be argued that HB 2586 gives community mental health centers too much authority. However, I believe this legislation will give the system organization, uniformity, and a focus for accountability at the community level.

2. It may be argued that HB 2586 removes authority from local physicians. However, I believe that this legislation gives local physicians a responsible ally in their own community with more effective resources than ever before.

3. It may be argued that HB 2586 gives too much legal immunity to health care providers. However, I believe it gives community mental health centers great <u>responsibilities</u>, but does not expect them to take all of the risks alone. A bold shift in public policy to aggressive community treatment is the focus of this legislation. To refuse at least limited protection from legal liability, in asking individual professionals to pursue that public policy on behalf of all Kansans, assures little real change in the system and a public burden shouldered by a small number of citizens.

4. It may be argued that HB 2586 is an improper infringement upon the jurisdiction of the court. However, I believe that the authority of the judge is not the issue. The burden of setting public policy for the state's mental health system rests on legislative shoulders. The need to enhance community treatment is the primary goal in that policy. The Legislature is clearly authorized to decide whether court ordered evaluations will begin with screening at community facilities or at state hospitals. If the Legislature enacts HB 2586, it will not be the first time that courts have been required to use community facilities before ordering evaluations at state psychiatric hospitals. In 1984, an amendment to KSA 22-3302 required courts to obtain trial competency evaluations in criminal cases at community facilities. Only if a community facility certified to the court that the defendant needed an inpatient evaluation could the evaluation be ordered at a state hospital. In effect, HB 2586 would adopt this type of model for civil patients as well.

Conclusion

HB 2586 is extremely important legislation. There will be problems! However, those problems can best be resolved through renewable contracts between SRS and participating mental health centers as established by HB 2586. In addition to these renewable contracts, working understandings among state hospitals, community mental health centers, courts, and law enforcement agencies in each area of the state will be established.

Problems associated with HB 2586 are tied to the difficulty of change itself, and not the pursuit of bad policy. This legislation is good policy, but the changes it brings will require hard work for many people. The anticipated result will be a mental health system which is less fragmented. It has been said that the system in Kansas has been "falling behind" in recent years. One of the most important factors in "catching up," is the ability to properly fund, and adequately manage, cooperative agreements between SRS (state hospitals) and community mental health centers. The requirement for mandatory screening at the community level is an important step in that effort.

William C. Rein
March 27, 1990

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