Approved 4/4/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE COMMITTEE.

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

10:00 a.m./p.m. on March 27, 19 90 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, requesting approval of the minutes of March 19, 20, 21, 22, 23, 1990. Senator Hayden made the motion to approve the minutes. Senator Kanan seconded the motion. The motion carried.

The Chairman called the Committee's attention to the letter from Nancy Kirk in support of H.B. 2586.(Attachment 1)

The Chairman called the Committee's attention to the letter from Dwight Young, The Center for Counseling and Consultation in support of H.B. 2586. (Attachment 2)

The Chairman called the Committee's attention to the Fiscal Note provided by the Department of Social and Rehabilitation Services. The Fiscal Note from the Budget Division, Mr. O'Keefe is attached on the back.**(Attachment 3)**

The Chairman called the first opponent to H.B. 2586, Mr. Bill Simmons, Mental Health Services Consumer and Coordinator of Project Acceptance, Lawrence.

Mr. Simmons said most of the people you will hear from are from many groups and organizations, either public or private, with strong vested interests in the final outcome of this legislation because it will affect their financial clout or their ability to make neat statistical reports to satisfy legislators and to meet reporting criteria to receive federal dollars. As consumers we don't have to answer political realities of pressures and constraints, we just merely have to tell you there is a tremendous gap between what is needed and what this bill proposes.(Attachment 4)

The Chairman called proponent to H.B. 2586, Norma Stephens, Superintendent at Osawatomie State Hospital.

Mrs. Stephens said she is appearing in support of the bill. Mrs. Stephens gave a history of the state hospital system at Osawatomie and how they are interacting with the Rainbow Mental Health Center to be sure the patients admitted are really in need of hospitalization or if they can be helped in the community(Attachment 5)

Senator Kanan said he noticed that there are a lot of young children in Osawatomie State Hospital. What procedure do you use to get those children out of there and get them back home.

Ms. Stephens said first of all it takes a lot of treatment with those young adolescents and then it takes a lot of work with the communities because many of those adolescents have parental rights severed. And so it means that our social workers, working case managers down in the

communities, to try find other liveable appropriate places for them.

Mr. Kanan said Mr. Simmons says that he would like to put into this bill a choice of second opinion. Are you agreeable to that?

Ms. Stephens said yes, and I think we have to somehow built a trusting relationship. She thought that mental health centers are already well-developed out there in the communities. And if would be very difficult just to start with no system at all. That's basically what we have been doing, accepting referrals from everybody. And we felt our front door was open and our back door was closed. It is very, very difficult. I would think that a professional in private practice would want to work with other mental health providers in the community. And I think they would want to do that. I don't see that as a major deterent and if it were, and if we found that it were a problem, this thing shouldn't be set in stone. Next year we may see changes are needed. It should be a dynamic process and if changes are needed, we should come right back and make those changes.

The Chairman called the proponent, Paul Klotz, Association of Mental Health Centers.

Mr. Klotz said he was appearing in support of H.B. 2586. Mr. Klotz gave a quick history of the legislation, citing it goes back ten or 12 years and in the last two years we have had a number of interim committees studying this. Mr. Klotz pointed out the letter from Charles E. Worden, District Judge, Seventeenth Judicial District. Mr. Klotz said there has been in the House Appropriations report on the Senate Ways and Means, a little over a $1,000,000 with the recommendation of consideration of an additional $500,000 that we think is necessary to implement this program.(Attachment 6)

Senator Walker said that he understands that the way it is written SRS contracts with the mental health centers. They are mandated by law to issue a contract. How much negotiation really will go on?

Mr. Klotz said he thinks the relationship they have with SRS and the Division of Mental Health and Retardation continues to be good. He said he thought negotiations will be very real and meaningful because it does offer the Secretary the option that if the center does not officially mental health center, he then go out and seek an adjoining center to do that work or a local hospital or whatever he feels necessary to accomplish that task.

Senator Walker said the bill language says "he shall contract." There is an option so that he doesn't want to, he can go somewhere else?

Mr. Koltz said he believed that the bill does offer that opportunity, yes.

Senator Hayden said the use of the interactive television, is there a liability in Kansas for a mis-diagnosis from the use of this rather than actually being in the room.

Mr. Klotz said he didn't believe that to be a problem. You might want to bring back at some point Bill Rein who is one of the foremost experts on interactive television.

Senator Kanan said he saw from the testimony, that he wanted to give the Secretary of SRS more power. Would you consider an amendment for a second opinion.

Mr. Klotz said he didn't think they ever wanted to give the Secretary

of SRS more power.

Senator Kanan said it is in your own words.

Mr. Klotz says the language better defines the powers he already has. He would agree with Superintendent Stephens in saying we don't think that would probably be necessary. Certainly, again or however, wanting to work very carefully with the private sector. We would be very remissed and it just wouldn't work unless we get those second opinions. He didn't know if the bill needed to be amended that way, but we certainly intend to take those into consideration.

Staff Furse said you had four or five possible amendments.

Mr. Koltz said Dr. Harder will present those.

The Chairman called Dr. Robert Harder as the next proponent.

Dr. Harder is a representatative of the Assocation and said he would discuss the financing side of H.B. 2586. It has the potential to meet all of the mandated requirements of Public Law 99-660. Dr. Harder said SRS has a request for FY 1991 for $417,00($824,00 annually) and $600,000(1.2 million annually for therapeutic services). Also suggested is a pool of money of $500,000 to $1,000,000 for a period not to exceed two years. The money would be available to the Centers only on the basis of a demonstrated need. Dr. Harder reviewed the Osawatomie State Hospital, Larned State Hospital and Topeka State Hospital budgets and projected costs of the bill. Dr. Harder said if the bill passed out of this Committee they would present testimony to the Ways and Means Committee to obtain the $500,000 for the sheltered program. (Attachment 7)

Staff Correll said that all of this appears to predicated on the assumption that there will be sufficient resources at the community level to, in fact, implement the reduction in beds in the state institutions. And when you look at the schedule of beds set out in the state institutions, given that those beds are utilized by more than one person in a year, it's a little misleading to suggest that were only dealing with, whatever 300 or whatever bed reduction, when we are dealing with a couple times that at least in patients. So you're figures seem to be predicated on the assumption that there's going to be sufficient ability to absorb all of those patients at the community level. And I don't really see where that's a guarantee.

Dr. Harder said if you go back to the early '50's, we had approximately 5,000 people in the state hospital system. In the early '70's we had approximately 1,700 people without any kind or design or plan as suggested on these charts. We moved the 1,700 patients down to 1,150, which is the approximate number today and what we're now proposing is that the numbers may become more difficult and what we would suggest is, in terms of the community financing, for the first time in terms of lower the census or diverting people from the hospital, is the state is actually going to be putting some money into those community services.

Staff Correll said first off, you wouldn't be suggesting that we're not dealing in the kinds of patients in state hospitals than we were in the early '70's necessarily.

Dr. Harder said the clinicians would have to answer that.

Staff Correll said secondly, do you have a concern at all about putting a schedule for reduction into the law itself.

Dr. Harder said he thinks that a legislative decision. He said some parts of the law are very critical, and that is the gate-keeping function. And he thought this matter of being a phased program over the three catchment areas, is important legislation. He said he was less concerned about specific numbers of bed reduction.

Staff Furse said you had five amendments?

Mr. Klotz said they are on the back side of Dr. Harder's testimony. Mr. Klotz said the first amendment deals the issue that is of concern in this committee, there's concern in the mental health centers that we might pass a law here and not pass the money. The first amendment would address that, adding a new subsection on page 5. (Attachment 8) Also on line 42, we think the language that is there now will allow the Secretary to combine two centers without really consulting with the local counties. On Page 15, we simply want to make sure that everyone understands that we are not going to be providing physicians, day to day, hour by hour, supervising all these. They will be under direction as they currently are under state law. The fourth amendment is add register nurse which is simply an oversight in the qualified mental health professional. And the final one is on page 18, line 17. We had originally had in the law 17 hours as the time we had to serve a person, primarily, overnight. We would like to have that restored back.

The Committee called Barbara Huff, Keys for Networking, Inc. as the next proponent on H.B. 2586.

Ms. Huff said she is appearing in support of the mental health reform bill. She said that Keys for Networking is an organization working with families in Kansas who have children and adolescents with serious emotional, behavioral, or mental disorders. She said the bill contains a section calling for a contract for a pilot project for Medicaid eligible residents under the age of 21. This section indicates that the State should apply for a Medicaid waiver to pay for the services that would be covered by such a contract. It has become apparent that the data required to apply for this waiver is simply unavailable at this time. It is their recommendation that on July 1, 1990, 30 children and adolescents from the Shawnee County area currently hospitalized at Topeka State Hospital be selected for a pilot project, to begin to demonstrate that children with severe emotional disturbances can be cared for with their families, or in a family setting.(Attachment 9) She said there is very little happening for children in the state.

Senator Kanan said she had mentioned a figure of 65,000. Have you taken into consideration how many hundreds of thousands of dollars these parents have spent to get those kids back?

Ms. Huff said she would love to respond to that. Yes, she does know that. She said she sees parents in a crisis like I have never seen families in her life. She explained what happens to a family. When they get them, they are normally in crisis. And the family spends all their money on their insurances and it maxs out. The insurance is gone. We spend $3,000 a month to keep our daughter out of the institution, out of our own pocket. So when the insurance is gone, and that takes maybe a few months, then the only alternative a family has is to come to the state and give up custody of their children in order to get treatment. That is the only alternative. They go into SRS custody, and then they are the state's child. You see very, very little reunification. The only thing that is doing any justice to this right now is some family preservation money and us. This is serious problem, because the next thing that happens to these families is that the Child Support Enforcement bills them for these services.

This is happening and it's happening every day to families that I work with. So there isn't a way in this state for families and children to ask for service, without giving up custody. So when we talk about Bob Barnum's foster care budget, we talking about all these kids that have gone into custody for very needless reasons. She said she goes through the court system with these families. You know a family has to get up and say they can no longer take care of this child, we're going to abuse them or we're going to kill them, in order for a judge to take that child and give the child to SRS and they become SRS's kid and the family loses all rights but gets the bills.

Senator Salisbury said this is the first she has heard that we couldn't get a Medicaid Waiver. Is it because of the lack of data?

Ms. Huff said yes.

Dr. Mani Lee said the data is one thing, but there are a lot of conditions which we have to meet to get the waiver, and we can't.

Senator Salisbury asked what part of this $800,000 pilot, would first of all, be funded by Medicaid. Is it theraputic foster care what is eligible for Medicaid.

Ms. Huff said she thought there would be a way to keep some of these kids when they go back into their families on the Medical Card for a while. Theraputic Foster Care is totally covered. Outpatient therapy is reimburseable, some behavioral management and partial hospitalization and the day treatment programs are reimburseable.

Senator Salisbury asked what portion would be state general funds?

Ms. Huff said she would hate to say.

Dr. Lee said they estimate about 45% of the money will come from federal eligible programs.

The meeting adjourned at 11:00a.m. The committee will reconvene in Room 522S at the adjournment of the Senate.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3/27/90
10:00 A.M.

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Ben Bradley	KS Assoc of Counties
Cathe Pavlakis RN MSN	Ks State Nurses Assoc
Carla Byrne RN MSN	KSNA / Mennigers
Mike Wosick	DOB
Connie Russell	St. Bd. of Education
Mary L Dillon	SRS/DMP
Winston Barton	SRS
Mari Lee	SRS
Mike Zechner	Employment of Handicapped
Al Demer	SRS/MH&RS
Tim Paul	Kansas Mental Illness Awareness Council
Bill Dean	Peterson & Associates
Linda J. McCauley	KS Psychological Assn
Lou & Howard Snyder	Kansas Alliance for the Mentally Ill
Terry Larson	Ks Alliance for the Mentally Ill
LaDonna Jones	SRS/MH&RS
Carolyn Meier	SRS/MH/MR
Larry Hinton	SRS
Tom Gress	KS Hosp. Assn.

Please continue on next page.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 27, 1990

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Robert L. Moore 213 Clark, Bonner Springs, Ks	Self
Mary J. Burns 2007 Vilas, Lv. Ks 66048	Concerned Taxpayer
Elisa Marie Cassone 5805 Slater Place Merriam KS 66202	Self
Brian W Blake 5708 Outlook Rd, Mission KS 66202	Self
DAVE SEATON c/o WINFIELD COURIER, 201 E 9TH, WINFIELD, KAN. 67156	KANSAS MENTAL HEALTH PLANNING COUNCIL
ELIZABETH SHEILS 800 Mississippi, Lawrence, Ks. 66044	Project Acceptance, Lawrence KS.
NANCY WILSON LAWRENCE, KS. 66044	"
Elizabeth Holladay Eudora KS. 66025	"
Bill Simons - Lawrence	Project Acceptance
Ethel Hill 2627 W 9th Apt 405 67203 Wichita, Ks.	CLASS INC
Chet Unruh 716 West 7th Larned K	Self
[illegible], D.O.	Larned State Hosp.
[illegible]	SRS/MH
Barbara Huff	Keys for Networking
JoAnna Unruh 716 W 7th Larned Ks	Member of Gov Kans. Mental Health Planning Council
Robert Harder	Mental Health Consortium
Paul M. Klotz	Assoc. of CMHC's of Ks, Inc
LARRY MEIKEL	MENTAL HEALTH CONSORTIUM, INC.
Denis Kelly P.O. Box 891 Olathe, KS 66061 c/o LINC	LINC

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3/27/90 (Cont)

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Amanda Harkenrider 801 S. Harrison #635 Olathe, Ks 66061	Self-Help Resources of Kans. Inc.
Board of Stephens Box 500 Baldwin	Baldwin City St Hosp
Chip Wheelen Topeka	Ks Medical Society
KEITH K LANDIS "	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
RG Frey "	KTLA

MIDWEST HEALTH SERVICES
COUNTRYSIDE HEALTH CENTER
3401 Seward Avenue
Topeka, Kansas 66616-1697
913-234-6147

HOUSE BILL 2586

Senators:

I am an administrator of an ICF-MH and I represent ICFs-MH that are members of Kansas Health Care Association. As providers of mental health services to the long term mentally ill, we are very interested in legislation aimed at improving the delivery of services. We are in general supportive of this legislation. We do have concerns about the transfer of the ICF-MH program to Mental Health and Retardation Services.

1. What will be the fiscal impact to the State of Kansas? Currently services for those over the age of 64 are matched with federal funds. Will the transfer result in a loss of federal matching funds? This has not yet been answered.

2. The transfer of the pogram does not include a provision for establishing a program specialist position. At this time there is no one within Mental Health and Retardation Services who has any familiarity with the ICF-MH program.

   a. One of the biggest problems facing the ICF-MH program from its inception has been the lack of program development assistance from the State.
   b. Because the ICFs-MH will continue to be licensed and certified by the Department of Health and Environment, it is essential that a position be established that will facilitate coordination between the two departments.

3. Our final concern rests with adequate funding for mental health reform. The residents of my facility have already experienced the value of case manager services and we have already experienced having these services withdrawn for the lack of adequate funding. In order for mental health reform to occur, the State must fund for success.

Yours truly,

Nancy A. Kirk, LMSW
Vice Pres. Gov. Affairs
Kansas Health Care Asso.

SPHSW
Attachment #1
3/27/90

The Center
FOR COUNSELING & CONSULTATION

A Community Mental Health Center

PHONE (316) 792-2544 5815 BROADWAY

GREAT BEND, KANSAS 67530

March 22, 1990

The Honorable Roy Ehrlich
Senate
State House
Topeka, Ks. 66612

Dear Roy,

This letter is written regarding **House Bill 2586.** The Center supports mental health reform and generally supports this bill. However, there are areas of concern we would like for your committee to consider.

We believe the amendments offered by the Association of Community Mental Health Centers of Kansas are good and we support them. My understanding of these amendments follows;

Page 5 Line 13 - Add a new paragraph (u) which would authorize SRS to adopt only those rules and regulations to implement the bill for which funding has been appropriated by the legislature.

Page 5 Line 42 - Delete "the combination of the operations of two or more mental health centers or through", which would offer some protection to the mental health centers from SRS mandating service areas.

Page 15 Line 17 - Add Psychiatric Nurse to the list of "qualified mental health professional".

Page 15 Line 19 - Substitute the word direction for the word supervision. According to the Behavioral Sciences Regulatory Board supervision requires much more direct time then direction. Our intent was to demonstrate that a physician was taking the ultimate responsibility for the actions of the "qualified mental health professional".

Page 18 Line 17 - Change 12 back to 17, we need more time to make the arrangements necessary in this section.

SPH+W
Attachment 2
3/27/90

We concur with these changes and believe it is in the interest of all mental health centers for these amendments to be adopted.

As you and I have discussed over the phone there are some additional areas of concern. One of those is the question of who can refer to the state hospital. I understand that many in the private sector are concern about this. However, the bottom line is that the state can not hold the mental health centers responsible for the census of the state hospitals as long as the state allows judges and physicians to by-pass the mental health centers in sending patients to those hospitals.

The area of greatest concern to me is that of SRS control. I strongly urge you to consider the following change:

Page 4 Line 36 substitute "participating mental health center" for "mental health center". "Participating mental health center" is a reference to the definition on page 15 line 4 which is a center which has entered into a contract with SRS to provide specific services. Thus, if a center chooses to enter into a contract that puts so much control in the hands of the Secretary, they may, but at least the expectations would be contractual and less unilateral.

One final thought on this bill. It is based on the theory that new money can be directed toward the community services while the state hospitals are held harmless in funding. That is, the hospitals will not have new money allocated to them, but they will have money to work with that becomes available as the hospital is down sized. I do not know if this will work. It may be that this approach may just allow the hospitals to stay at their current size but have room for all the patients that need their services. However, it is my personal opinion that this can only be accomplished if there is a centralized administrative coordination of these community services and that function can not be served by SRS. I believe that SRS must contract with an organization that will take the money and the responsibility to fulfill the expectations of this bill. This entity should be the Mental Health Consortium. The Consortium would be the coordinating agent, and SRS would over see the project. As it stands now, the entity spending the money is also the watch dog on how the money is spent. Please have your

2-2

committee consider not only the bill but the implementation of the bill as well.

Thank you for your time in this matter. It, of course, is very important to this center, but it is also important for the citizens of Kansas who need our help.

Sincerely,

Dwight L. Young, M.S.
Executive Director

cc Paul Klotz
Association of Community Mental Health Centers of Kansas

Larry Meikel
Mental Health Consortium, Inc.

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, 915 S.W. Harrison, Topeka, Kansas 66612

(913) 296-3271

Mental Health &
Retardation Services
Fifth Floor
(913) 296-3471

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABRIEL FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

March 26, 1990

The Honorable Roy Ehrlich
Kansas Senate
Statehouse, Room 138-N
Topeka, Kansas

Dear Senator Ehrlich:

Following your request, I am submitting 17 copies of "Financing Plan: Mental Health Services in Kansas" Revision II dated February 23, 1990 along with a fiscal note associated with HB 2586. Please see the attached fiscal note prepared by Mr. O'Keefe, Governor's Budget Director, dated February 2, 1990, in connection with the bill.

In light of the State's budgetary constraints and in response to the Legislature's request, Mental Health and Retardation Services developed an alternative financing plan in which a phased development of a community-based mental health system is described.

Fiscal notes included in the plan are as follows:

FY 1991: Total $1,017,000 (please see Page 6 of the Plan)
$ 600,000 For Community Support Services Development
$ 417,000 For Gatekeeping (Screening)

Please see Page 13 of the Plan in regard to the program description of Gatekeeping and Screening and its fiscal note.

Please see Pages 16 to 19 of the Plan in regard to the program description of Community Support Services Development and its fiscal note.

SPH+W
Attachment 3
3/27/90

Please see Pages 22 to 25 in regard to the total cost of the phased program in the following years associated with HB 2586. The summary of the total estimated cost for the program is described on Page 25. Also please see Attachment I, pages 1 through 4 beginning on Page 36 of the Financing Plan for long-term projected costs.

Thank you very much for your interest and please feel free to let me know if you have any further questions.

Sincerely,

Al Nemec
Commissioner

ALN:ML:ees

cc: Secretary Barton
Mr. Michael O'Keefe
Ms. Emalene Correll

STATE OF KANSAS

DIVISION OF THE BUDGET

MIKE HAYDEN,
Governor
MICHAEL F. O'KEEFE
Director of the Budget

Room 152-E
State Capitol Building
Topeka, Kansas 66612-1575
(913) 296-2436

February 2, 1990

SRS

FEB 27 1990

MH/RS

The Honorable Bill Bunten, Chairperson
Committee on Appropriations
House of Representatives
Third Floor, Statehouse

Dear Representative Bunten:

SUBJECT: Fiscal Note for HB 2586 by Special Committee on Corrections and Mental Health

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2586 is respectfully submitted to your committee.

HB 2586 would amend current law concerning the delivery of mental health services. Sections 1 through 11 would be known as the Mental Health Reform Act.

Section 3 specifies additional powers and duties of the Secretary of Social and Rehabilitation Services. Responsibilities cited include: to develop a comprehensive mental health services plan, to evaluate and coordinate community mental health center services, to adopt rules and regulations which assure no person is inappropriately denied mental health services, to implement procedures so that funds follow persons discharged from state mental health hospitals to the community programs, and to withhold state funds from any mental health center which does not comply with the service plan.

The bill establishes a timetable for the implementation of these duties. By March 1, 1991, within the Department of Social and Rehabilitation Services, those functions of the Adult Services Division related to the delivery of mental health services would be transferred to the Division of Mental Health and Retardation Services. Before the end of FY 1991, SRS is required to contract a pilot project to provide Medicaid-covered psychiatric and substance abuse services for residents less

than 21 years old. The bill mandates that by October 1, 1991, each mental health center submit to SRS an assessment of the area's needs and a service delivery plan; and that SRS develop an assessment of the state's needs, adopt a service delivery plan and provide financial assistance. Prior to March 1, 1992, SRS is to establish contracts with a mental health center in each area of the state to provide court ordered evaluations and treatment services.

HB 2586 would also amend current law to require screening by a qualified mental health professional at a participating mental health center prior to admission to a state psychiatric hospital, including court ordered evaluations.

The bill would also create a Governor's Commission on Mental Health Services to serve as an advocate for the mentally ill population, to evaluate statewide mental health services, and to advise the Governor and the Secretary of Social and Rehabilitation Services.

The bill defines certain terms, including "targeted population", "community based mental health services", "participating mental health center", and "qualified mental health professional".

The Department of Social and Rehabilitation Services estimates the FY 1991 impact of the bill to be $10,085,715 from the State General Fund. Specific areas of expenditure and the requested FTE positions are listed in the table below.

Service	FTE	State General Fund
Case Management	80	$ 1,792,000
Gatekeeping		2,500,000
Residential Services		2,400,000
Children's Services		1,501,000
SRS Staff	8	258,306
Other Support		1,633,909
FY 1991 Total	88	$10,085,715

In FY 1992, and in subsequent years, unadjusted for inflation, the Department estimates the fiscal impact of the bill to be $43,109,930 from the State General Fund and $10,460,170 from other non-state sources for a total fiscal impact of $53,570,100. A breakdown of future position authorizations was not specified.

Service	State General Fund	All Funds
Case Management	$ 2,500,000	$ 2,500,000
Adult Services	19,609,930	23,070,100
Children's Services	21,000,000	28,000,000
FY 1992 Total	$43,109,930	$53,570,100

Michael F. O'Keefe
Director of the Budget

COMMENTS AND AN OVERVIEW OF KANSAS MENTAL HEALTH SERVICES AND HOUSE BILL NO. 2586

Presented By
Bill Simons

Mental Health Services Consumer and
Coordinator of PROJECT ACCEPTANCE
A Self-Help Mental Health Consumer Organization
P.O. Box 187
Lawrence, KS 66044
913-841-9257

SPHW
Attachment 8
3/27/90

The brevity of time allowed to respond to this piece of legislation makes it impossible to respond adequately to the number of concerns that mental health consumers have regarding not only this bill, but also the gross inadequacies of the mental health treament system that is presently in place and that will, in many ways, remain in place only in a different form, if this legislation passes.

I represent one of the few mental health consumer organizations that you will hear from that is truly consumer-initiated and consumer run and that is not attached to or an adjunct to some public or privately run professional treatment program. I, myself, am on psychiatric Social Security disability and have been for the past five years. I have been unable to hold a full-time job for over ten years and my record of hospitalizations date back to 1965. Project Acceptance, which I represent today, has served over 90 participants since we opened our Drop-In Center last September. Approximately half of this number are served by our local CMHC while the other half is not.

During the course of these hearings you will hear from many groups and organizations--most of them represent either public or private providers and governmental agencies such as SRS. They all have strong vested interests in the final outcome of this legislation because it will affect their financial clout or their ability to make neat statistical reports to satisfy legislators and to meet reporting criteria to receive federal dollars. These people are politicians, providers, and state government managers and I understand their desire to do the best they can with what is offered, to fight for what little there is, to offer compromises that rob Peter (state hospital) to pay Paul (CMHC's). I believe that most of them are sincere and trying to do the best for us

(consumers) that they can with what little they are given. Thank God, we the consumers are not under such pressures and constraints. We don't have to answer to "political realities", we merely have to tell you that there is a tremendous gap between what is needed and what is proposed.

A pig painted green is still a pig, and a rearranged grossly under funded mental health system is still a grossly inadequate mental health treatment system.

My friends, the facts are that last year Kansas was ranked 42nd in the nation in the level of mental health care and if that were not sad enough, we were also reported as "still moving backwards". This is more than embarrassing, it is a moral outrage. No legislator need fear being voted out of office by a powerful mental health consumer voting block but sometimes, as John F. Kennedy pointed out in his book, Profiles in Courage, there comes a time when politicians must rise above the political arena and address that which is morally unconscionable and make it right! Money does not fix everything and, if not properly applied, may not fix anything. But that is no answer because inadequate funding is a game of pretense almost more insulting to the consumer than no funding at all.

Some of the specific concerns regarding this legislation are as follows:

1. We will always need a quality State hospital system because there will always be those who need hospitalization. Yet, in spite of past and present decertification concerns, we hear that a community-based mental health system will be funded as we reduce hospital beds and budgets. Whether present size or smaller, our State hospital system is a consumer detention system based on heavy sedative drug use rather than a quality care and treatment system. Where will the funds come from to upgrade this deplorable system?

2. The mental health "reform" legislation is really mental health management reform, not treatment reform. There should be some way to provide local CMHC's and the State SRS with mental health patient data without violating the consumer's right of choice, and the consumer's concern with confidentiality.

3. The definition of "mental health professional" must be expanded to include private certified and licensed mental health practitioners who are not attached to a CMHC. The "gatekeeper" concept is a "management" tool, not a treatment enhancer. If a medical doctor can refer his/her cancer patient to a State facility such as the K.U. Medical Center without a bureaucratic middleman (gatekeeper), why should not a qualified private mental health practitioner and his/her patient not have the same option which guarantees the consumer choice and confidentiality. If a consumer was wealthy they could simply go through their private practitioner to a private provider such as the Menninger Foundation. Thus, this bill falls on the consumer who is poor--it is income discriminatory.

If this legislation were to pass, it should contain strong guarantees of adequate appeal procedures for consumers, the right to second opinions from a licensed or certified mental health professional of the consumer's choice and hopefully an independent body or person to serve as an omsbudsman. The gatekeeping concept locked into this legislation by the definition of "qualified mental health professional" permeates the whole bill and thus the whole system from screening, to hearings, to transfers, to discharges, etc.

In spite of this list of deep concerns, Project Acceptance applauds the efforts of SRS personnel, legislators, family members and others who have worked so hard to try to bring some meaningful change to the present deplorably inadequate system. We concur that change is necessary. If the concerns listed are adequately addressed and if resources, that's money, are provided for a truly adequate community based support system that includes such needs as adequate housing (supervised for those who need it), transportation needs, employment opportunities, and skyrocketing medical costs, especially medication, then we would enthusiastically support such a bill. Thank you for your kind consideration of our concerns.

Testimony before

Senate Public Health and Welfare
Committee

March 27, 1990

Norma J. Stephens
Superintendent
Osawatomie State Hospital

Presented on behalf of:

Substitute for HOUSE BILL 2586
"The Mental Health Reform Act"

SPHW
Attachment #5
3/27/90

I am Mrs. Norma J. Stephens, superintendent of Osawatomie State Hospital (OSH). Thank you for sharing your valuable time to hear my comments related to Substitute for House Bill 2586, "The Mental Health Reform Act."

First, I'd like to share a little about myself. I started my career at OSH December 23, 1946, as secretary to the superintendent. In 1950, I was promoted to supervisor of medical records; in 1955, to registrar; in 1982, to deputy executive officer, and in 1986 I was appointed superintendent.

Each promotion simply enlarged my job and added to existing responsibilities. For example, as secretary to the superintendent, I handled admissions and continued to do so until 1986 when I was appointed superintendent. I supervised the medical record department from 1950 to 1986.

In 1970, I completed a two year correspondence course in medical records, wrote the national exam and received certification. In 1978, I received a B.A. degree in Health Care and Administration from Ottawa University, and in 1981, a master's degree in Public Administration from K.U.

When I arrived at OSH in 1946, patient census was 1700. Professional staff consisted of two physicians and one dentist. There were no social workers, RNs, or psychologists. Custodial care of patients was the goal, as there was literally no staff to provide treatment. Patients spent their time working for "no pay," or sitting on the wards or in the canteen.

CHANGE

Today, how far we've progressed. That progression, however,

has involved change as will "The Mental Health Reform Act." To demonstrate my belief that OSH staff can successfully implement Mental Health Reform, please allow me to recall a few major changes that have occurred during the past 40 years.

In 1951, Dr. Milton H. Anderson, a young, enthusiastic, energetic psychiatrist, was appointed superintendent of OSH. Much effort was required to move the hospital out of the strictures of custodialism; and Dr. Anderson, who was a bundle of energy, focused attention on those problems that seemed to be the most urgent. He attended all patient staffings and espoused meaningful treatment and activities for patients. Additional physicians/psychiatrists were employed as well as two psychologists, a few social workers, seven RNs, a dietitian, a registered occupational therapist, a recreational director, a chaplain, and a director of public information. Being a member of OSH staff became rewarding and professionally attractive.

Dr. Anderson's successor, Dr. Wilbur Jenkins, made a concerted effort to make wards more livable and enjoyable. Walls were painted and some redecorating was done. Some wards were "opened" (unlocked) and one building was entirely opened. Admissions and discharges increased but the census continued to remain relatively constant, with 1,600 to 1,700 patients in residence.

The introduction and increased use of tranquilizing drugs facilitated the metamorphosis.

In 1956, Dr. George Zubowicz was appointed superintendent of Osawatomie State Hospital; and soon thereafter, a basic transformation was made in the hospital's organizational structure

from that of a conventionally organized hospital to the section system.

The conventional organization consisted of a 200-bed admission and intensive treatment unit to which all patients were admitted, and a 1300-bed continued-treatment service subdivided into geriatric, tidy, untidy, combative, open, and closed wards. Patients were continually shifted from one ward to another; and often the patients' problems were really never dealt with, but simply transferred to another ward.

Under the section system, the hospital was basically divided into four smaller hospitals with each section having its own treatment team consisting of psychiatrists, nurses, aides, psychologists, activity therapists and social workers. New patients were admitted to the sections on a rotation basis and remained the responsibility of that section throughout their period of hospitalization. The plan resulted in individualized attention and intensive treatment on a continuous basis.

The reorganization was a major change for staff, but basic rewards came through seeing their patients improve and become more nearly ready to return to the community.

In 1961, the section system was modified into the Kansas Plan. Under that plan, each section served a specific geographic area. Of the 1200 patients in residence, 800 had to be physically moved to another building. Dr. Zubowicz described some of the benefits derived from the Kansas Plan as follows:

> "The effect of the community on the section and the section on the community comes into focus as soon as

admissions commence to be handled by section doctors, social workers, and secretaries, putting all of them in direct communication with the community."

Each section team initiated a program of visiting their counties and meeting probate judges, county attorneys, welfare officials, sheriffs, and others in order to become personally acquainted with them, to inform them about the section's responsibilities and programs, and to invite their comments and suggestions for better service to the community.

The hospital was so successful in implementing the reorganization that in 1968, a team of Osawatomie State Hospital staff was invited to Philadelphia State Hospital (population 4,000 patients) to share reorganization experiences with them. We stayed a week, holding workshops and town hall meetings, in an effort to help them plan a similar reorganization.

In 1970, Osawatomie State Hospital staff learned of a new approach to record keeping -- "Problem-Oriented Medical Records" (POMR). Through education and staff participation, all medical records were converted in a relatively short period of time. As a result, we were invited to present workshops throughout the United States, as ours was one of the first psychiatric hospitals to adopt the POMR system. We even made a presentation to the Psychiatric Council of the Joint Commission on Accreditation of Hospitals.

Patients, during this era, were receiving active treatment; and patient population, over a span of several years, was dramatically reduced from 1600 to 800.

Although Kansas mental hospitals gained a widespread reputation, community mental health services lagged. The mental health delivery system in Kansas was fraught with fragmentation and lacked coordination.

In 1973, patient census had decreased to 454, and because of individualized needs of patients, administrative staff agreed to again reorganize the hospital into "Programs." Under the direction of Superintendent J. Russell Mills, the reorganization was implemented with programs for: Adolescents, Young Adults, Senior Adults, Medical Services, and Substance Abuse.

All of these changes described were major organizational changes. I have reflected on them to illustrate that OSH has a long history of positively accepting change if that change is perceived as being of benefit to our patients; and the Mental Health Reform Act is so perceived.

SCREENING/EVALUATION

GATEKEEPING

Since my appointment as superintendent in 1986, OSH has experienced the problem of overcrowding of patients, especially in the adult psychiatric and substance abuse programs. At OSH problems are translated into challenges and opportunity for staff growth. We have surely had much "growing" to do, for in 1987 our census had reached 381 -- one of the major factors which jeopardized our certification by the Health Care Financing Administration (HCFA). When surveyors returned three months later, our census had been reduced to 348, which was one of the major factors that helped OSH to retain HCFA certification.

Overcrowding strains staff and burdens them with guilt because they cannot spend time with patients and provide quality treatment. Aggressive outbursts of patient behavior intensify and seclusion hours increase. One solution is to request additional beds and staff. Another is to reduce census. We chose the latter, and **reducing census became an important goal in altering the treatment milieu at OSH.** To achieve that goal, strengthening relationships with community agencies was essential.

OSH professional staff feel that community screening of patients prior to admission could help divert admissions. Intervention at time of crises is effective and therapeutic. So community screening prior to admission became an objective.

A Joint Coordinating Committee was re-established in the Kansas City area (re-established because it had been originally created when Rainbow Mental Health Facility was being constructed and was administratively operated by OSH). Agencies represented included: Johnson County Mental Health Center, Wyandotte County Mental Health Center, Rainbow Mental Health Facility, KUMC Emergency Services, some private psychiatric hospitals, and OSH.

A process for accessing psychiatric services was developed, and money from the closing of 20 beds at OSH was diverted to fund an afterhours screening team.

Simultaneously, OSH staff (psychiatrists and social workers) focused on screening and evaluating those individuals who appeared at the hospital without prior screening.

The reduction in adult psychiatric admissions from Wyandotte and Johnson Counties from FY 1986 thru FY 1989 was dramatic.

Wyandotte County	288 to 159	(45% decrease)
Johnson County	136 to 127	(7% decrease)

Because our focus remained on the needs of clients, the Committee worked harmoniously to resolve issues and differences of opinion. Together, we demonstrated that screening/evaluation is an effective deterrent to psychiatric hospitalization.

DISCHARGE

I strongly believe that -- "Individuals become emotionally in the community, inpatient treatment should be expedient, and thereafter the individual should return to their place in the community."

When psychiatric patients stay too long in a mental hospital, they become institutionalized. Then when attempts are made to discharge them, they feel uprooted from a way of life to which they have adapted. The task is painful and produces discomfort both for patients and staff. Often, the task seems impossible because of a lack of needed community-based mental health services (case managers; community support programs; medication clinics; living accommodations; etc.).

So what action steps have helped us to increase placements and discharge?

-Innovative and creative thinking by social workers.

a) placing friends together

b) Green Acres Project

-Appointment of liaisons by mental health centers, their regular visits to OSH, and acceptance by

staff.

-Establishment of the case manager system.

-Reorganization of the adult psychiatric program to the Kansas Plan (patients from a mental health center catchment area reside on a given ward).

FUNDING

OSH is demonstrating that census can be reduced and, we believe, further reduced as funding is made available to communities to provide desperately needed community based mental health services. I believe that some state hospital beds will be needed for many years, but some downsizing is feasible. Dollars do need to follow the patient. The process, however, must be well planned, organized, and systematically implemented.

I have held a series of town hall meetings with OSH staff to explain the concept of mental health reform, which was enthusiastically received. I invited local newspaper reporters to attend the meetings. I have also met with a group of patients and explained the concept. You should have seen their smiles as I discussed increasing community based services. One little gentleman said, "Oh, Mrs. Stephens, we have to have something to do when we leave or we'll have to return."

Yes, jobs may shift from state hospital to community. But please, let us not decide to reject mental health reform on that basis. Instead, let us decide on the basis of what is best for those individuals suffering from mental illness.

Quality of life is valued by our society. Regardless of how

progressive a psychiatric hospital is, it cannot provide the quality of life experienced by living independently in a community.

CONCLUSION

I have a vision and a dream. My vision is that a continuum of mental health services will become a reality in Kansas -- available to all individuals requiring them. My dream is that staff at OSH can participate in "blazing the way" for mental health reform in Kansas. Kansas was once first in the nation in providing services to the mentally ill. We can again achieve that prestigious position.

The tone and momentum of an organization is established by its leader. I accept that responsibility at OSH. But for leaders to be successful in improving the delivery of mental health services, the state's legislative body must be interested -- and must care.

Thank you.

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

MEMORANDUM

TO: Members of the Senate

FROM: Paul Klotz--Association of Mental Health Centers PK
234-4773

RE: Mental Health Reform (Sub. HB 2586)

DATE: March 16, 1990

Sub. HB 2586 provides for the following:

1. The Secretary of SRS has the power to develop standards for community based mental health services. The emphasis will be on services in the least restrictive environment possible.

2. The Secretary has the power to designate the targeted population of mentally ill. The emphasis will be on lessening the number of persons needing institutional care.

3. The Secretary can enter into contracts with the mental health centers for the provision of screening and other community-based services. The purpose of screening is to determine the most appropriate setting for the potential patient. Persons will not be admitted to state hospitals without prior approval of a qualified mental health professional related to a community mental health facility.

4. The implementation of mental health reform is on a phased basis. The first phase is Osawatomie, second is Topeka, and third is Larned.

5. Over a period of 3-4 years there will be a reduction of 90 beds at each hospital.

6. A mechanism for establishing a 27-member Governor's mental health services planning council.

7. A recognition of the need to have greater representation of the mentally ill consumers or representatives of consumers on the various governing boards.

8. A mechanism for establishing a pilot project for children and youth who are mentally ill.

SPHW
Attachment 6
3/27/90

District Court of Kansas

Seventeenth Judicial District

CHAMBERS OF
CHARLES E. WORDEN, JUDGE
P.O. BOX 70
NORTON, KANSAS 67654
913-877-3373
(FAX) 913-877-5267

DECATUR GRAHAM
PHILLIPS NORTON
OSBORNE SMITH
COUNTIES

ROBERT E. BROWN, C.S.R.
OFFICIAL REPORTER
•
JANELLE K. MOREL
ADMINISTRATIVE ASSISTANT

March 23, 1990

Kermit George, Director
High Plains Mental Health
208 E. 7th
Hays, KS 67601

RE: Substitute House Bill 2586

Dear Kermit:

After discussing the above referenced House Bill with you, I believe that it has some substantial benefits for the public of western Kansas provided that the special needs of the area are met.

Sufficient money will need to be provided to implement the gatekeeper concept as set forth in the House Bill. It must also establish a method in which the public will have timely access to qualified personnel for evaluations. By timely access I mean that the public should be able to have the evaluations completed within a few hours from the time the event that has caused the need for evaluation occurs.

It is my opinion that an effective method of establishing this would be by the use of two-way interactive TV's or compressed video systems. This is similar to the program Fort Hays State University is beginning to use in teaching outreach or satellite classes.

It is feasible to have a qualified 24 hour staff in Hays, Kansas. Satellites or rooms can be set up with two-way interactive TV's to which law enforcement could bring an individual. The room would be connected by TV signal or telephone signal to the staff in Hays or elsewhere. This would allow the qualified staff to perform evaluations on the individual. By using a FAX machine, tests and the completed tests could be sent back and forth between the staff and individual. The tests could be reviewed and a report issued to law enforcement immediately.

-over-

One of our largest concerns in a rural area is time and distance. If these two factors are not managed properly tragedy may result. Tragedy costing a human life could occur. I believe effective use of two-way interactive TV's would bring the gatekeeping concept and intent of House Bill 2586 into play and would effectively serve the people of western Kansas very well.

Again, the key is to have sufficient funds and to be able to guarantee timely access to qualified personnel for evaluations and in turn to prevent tragedy.

If I can be of any assistance or if you need any further information, please let me know.

Sincerely,

Charles E. Worden
District Judge

CEW/jkm

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

MEMORANDUM

TO: Members of the Senate
Dr. Robert Hrenchir

FROM: ~~Paul Klotz~~ -- Association of Mental Health Centers PK
234-4773

DATE: March 20, 1990

RE: Mental Health Reform (HB 2586)
and
Funding for Mental Health Reform

The Centers support mental health reform (HB 2586). We have been active players in this process for a number of years.

We support SRS's plan of implementation. It is phased in over a period of time to take into account the State's current fiscal condition.

HB 2586 with amendments and appropriate funding will implement the recommendation coming from the Governor's Task Force on Mental Health Reform. It has the potential to meet all of the mandated requirements of Public Law 99-660.

The Centers support the request from SRS for FY 1991 for $417,000 ($834,000 annually) and $600,000 ($1.2 million annually for therapeutic services). We also support the statement of Commissioner Nemec recognizing the need for separate start-up funds for housing and housing related support services. It has been suggested to have a pool of money of $500,000. to $1. million for a period not to exceed two years. The money would be available to the Centers only on the basis of a demonstrated need.

SPHW
Attachment 6 7
3/27/90

The Centers also think that some form of General Assistance and Medikan needs to be maintained for persons coming out of hospitals or being diverted from hospitals.

As a minimum, the mental health services in the community will include:

1. 24 hour Emergency and Screening services
2. Outreach/case finding
3. Medication management
4. Case management
5. Daily living and supportive therapy services
6. Vocational programs
7. Residential services
8. Short term community psychiatric in-patient services
9. Intermediate care facility service for the mentally ill

There are many advantages to this plan:

1. It is attentive to patient needs.
2. It is comprehensive and unifies the two mental health systems into one system.
3. It has a wide base of public support.
4. It is responsive to the Governor's Task Force and Federal Requirements.
5. It is cost effective.
6. It is a way to strengthen local programs.
7. It is a way to reduce hospital beds and budgets.
8. It is a way to provide increased therapeutic services for the mentally ill in local communities.
9. It is workable beginning July 1, 1990.

If you have any questions, please let me hear from you.

EXECUTIVE SUMMARY

Cost containment through mental health reform unites budget controls with the necessity for significant re-structuring of the mental health system in Kansas.

Because of the many unknown factors related to accreditation and certification and the demands of the federal government; there will be significant increase in the Health Reform (HB 2586) over the next seven years.

The enclosed plan places a cap on the state hospital budgets. It outlines a mental health reform plan which responds to the issues raised by the Governor's Task Force on Mental Health Reform. It implements legislative proposal number 17. It has the potential to meet all of the federal requirements as imposed through Public Law 99-660.

This plan provides for systematic, phased planning and implementation over a seven year period. It provides for mental health services to be primarily delivered at the local level with the state maintaining an overall monitoring and supervising role.

This plan calls for outcomes tied to patient services and dollars spent in the program. This plan gives immediate attention to the need for providing comprehensive mental health services to patients in the least restrictive environments.

The financing of this plan can begin on a very modest basis; approximately $1.5 million during fiscal year 1991. The increased local funding can be handled over a period of time and as such, can be funded out of state hospital budgets as the state hospital begins to close wards, units, and programs.

This plan capitalizes on the current interest in mental health reform while at the same time places a fixed limit on state hospital budgets.

Prepared by McGill & Associates
February 27, 1990

MH/RS PLAN WITH MODIFICATIONS

MENTAL HEALTH REFORM ACT- IMPLEMENTATION

Osawatomie State Hospital

		FY '91 7/1/90	FY '92 7/1/91	FY '93 7/1/92	FY '94 7/1/93	FY '95 7/1/94	FY '96 7/1/95	FY '97 7/1/96	TOTAL MILLIONS
Hospital Budget +7.0%:		$20.6	$22.0	$23.6	$23.5	$23.5	$24.2	$24.8	
(Close Ward)				($0.7)	($0.6)				
				$22.9	$22.9				
Overhead:	-4.0%			($0.9)	($0.9)	($0.9)	($1.0)	($1.0)	
Inflation:	7.0%	$20.6	$22.0	$22.0	$22.0	$22.6	$23.2	$23.8	$156.2
Shelter Pool:		$0.5	$0.5						
Screening:	5.0%	$0.4	$0.8	$0.8	$0.9	$0.9	$1.0	$1.0	
Adult Pts. In Comm.:	5.0%	$0.6	$1.2	$1.3	$2.6	$2.8	$2.9	$3.1	
Child. Pts. In Comm.:	5.0%		$1.2	$1.3	$1.3	$1.4	$1.5	$1.5	
		$1.5	$3.7	$3.4	$4.9	$5.1	$5.3	$5.6	$29.5
Total:		$22.1	$25.7	$25.3	$26.8	$27.7	$28.6	$29.5	$185.7
Hospital Budget w/7.0%: (Without Reform)		$20.6	$22.0	$23.6	$25.2	$27.0	$28.9	$30.9	$178.3
Difference:		$1.5	$3.7	$1.7	$1.6	$0.7	($0.3)	($1.5)	$7.4

PREPARED BY MCGILL & ASSOCIATES February 27, 1990

MH/RS PLAN WITH MODIFICATIONS

MENTAL HEALTH REFORM ACT- IMPLEMENTATION

Topeka State Hospital

		FY '91 7/1/90	FY '92 7/1/91	FY '93 7/1/92	FY '94 7/1/93	FY '95 7/1/94	FY '96 7/1/95	FY '97 7/1/96	TOTAL MILLIONS
Hospital Budget +7.0%		$22.1	$23.6	$25.3	$26.1	$25.8	$25.5	$26.2	
(Close Ward)		PLANNING		($0.9)	($1.0)	($0.9)			
				$24.4	$25.1	$24.9			
Overhead:	-4.0%				($1.0)	($1.0)	($1.0)	($1.0)	
Inflation:	7.0%	$22.1	$23.6	$24.4	$24.1	$23.9	$24.5	$25.2	**$167.8**
Shelter Pool:			$0.5	$0.5					
Screening:	5.0%		$0.8	$0.8	$0.9	$0.9	$1.0	$1.0	
Adult Pts. In Comm.:	5.0%		$1.2	$1.3	$1.3	$2.8	$2.9	$3.1	
Child. Pts. In Comm.:	5.0%		$1.2	$1.3	$1.3	$1.4	$1.5	$1.5	
			$3.7	$3.9	$3.5	$5.1	$5.3	$5.6	$27.1
Total:		$22.1	$27.3	$28.3	$27.6	$29.0	$29.9	$30.8	**$195.0**
Hospital Budget w/7.0%: (Without Reform)		$22.1	$23.6	$25.3	$27.1	$29.0	$31.0	$33.2	**$191.3**
Difference:		$0.0	$3.7	$3.0	$0.6	$0.0	($1.1)	($2.4)	**$3.7**

PREPARED BY MCGILL & ASSOCIATES February 27, 1990

MH/RS PLAN WITH MODIFICATIONS

MENTAL HEALTH REFORM ACT- IMPLEMENTATION

Larned State Hospital

		FY '91 7/1/90	FY '92 7/1/91	FY '93 7/1/92	FY '94 7/1/93	FY '95 7/1/94	FY '96 7/1/95	FY '97 7/1/96	TOTAL MILLIONS
Hospital Budget +7.0%:		$30.4	$32.5	$34.8	$37.2	$37.2	$37.2	$37.1	
(Close Ward)					($1.0)	($1.0)	($1.0)		
		PLANNING							
				$34.8	$36.2	$36.2	$36.2		
Overhead:	-4.0%				($1.4)	($1.5)	($1.5)	($1.5)	
Inflation:	7.0%	$30.4	$32.5	$34.8	$34.8	$34.7	$34.7	$35.6	**$237.6**
Shelter Pool:				$0.5	$0.5				
Screening:	5.0%			$0.8	$0.8	$0.9	$0.9	$1.0	
Adult Pts. In Comm.:	5.0%			$1.3	$1.4	$1.4	$3.0	$3.2	
Child. Pts. In Comm.:	5.0%			$1.3	$1.4	$1.4	$1.5	$1.6	
				$3.9	$4.1	$3.7	$5.4	$5.7	$22.9
Total:		$30.4	$32.5	$38.7	$38.9	$38.5	$40.1	$41.3	$260.4
Hospital Budget w/7.0%: (Without Reform)		$30.4	$32.5	$34.8	$37.2	$39.8	$42.6	$45.6	$263.1
Difference:		$0.0	$0.0	$3.9	$1.6	($1.4)	($2.5)	($4.3)	**($2.6)**

PREPARED BY MCGILL & ASSOCIATES February 27, 1990

PROPOSED AMENDMENTS TO SUBSTITUTE FOR HB 2586

On page 5, line 13, (u) to adopt only those rules and regulations and policies which are within the acts of appropriations as made available by the legislature.

On page 5, line 42, delete all after the word *through* to the word *contracts* on line 4 3.

On page 15, line 19, change supervision to direction.

On page 15, line 19, add or a registered nurse who has a speciality in psychiatric nursing.

On page 18, line 17, change 12 to 17 hours.

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SP H & W
Attachment 8
3/27/90

Keys For Networking, Inc.

700 S.W. Jackson
Jackson Tower Suite 100-A
Topeka, KS 66603
(913) 233-8723

Mr. Chairman and Members of the Committee:

Thank you for allowing me the opportunity to appear before you today. I am speaking on behalf of the Board of Directors of Keys for Networking, Inc., and the families in Kansas who have children and adolescents with serious emotional, behavioral, or mental disorders.

Substitute House Bill 2586 contains a section calling for a contract for a pilot project for Medicaid eligible residents under the age of 21. This section indicates that the State should apply for a Medicaid waiver to pay for the services that would be covered by such a contract. It has become apparent that the data required to apply for this waiver is simply unavailable at this time.

It is our recommendation therefore, that on July 1, 1990 (the start of FY'91), 30 children and adolescents from the Shawnee County area, currently hospitalized at Topeka State Hospital, be selected for a pilot project, to begin to demonstrate that children with severe emotional disturbances can be cared for with their families, or in a family setting. With the children and their families thus identified, multi-disciplinary teams led by individuals with clear family-centered values would be hired to assess what it would take to have these children live with their families, developing an individualized plan for each child and family. After aggregating the service and support needs, the necessary resources will be developed in the community using the savings accrued from the closing of a 30 bed ward.

It has been recommended by the Division of Mental Health and Retardation that such a project in Topeka begin, at the earliest, in FY'93. While we realize that this is, to some extent, motivated by the Division's very real need to address some critical problems at Osawatamie State Hospital, we do not feel that the children in the rest of the state should suffer as a result of this "crisis management". A pilot project in the Topeka area, and in the immediate future (ie, FY'91), seems to be a more sensible arrangement: all of the necessary personnel resources to establish viable community services are already in existence here: we could thus reasonably expect to get a pilot project running successfully in a much lesser time: and, we would avoid many of the very real "start-up" costs that would be evident in another location.

We wish to go on record as supporting the Division's financing plan for mental health services for children and adolescents, an attachment hereto, in particular that section dealing with the pilot project, with the exceptions noted above. The array of services noted in the Plan is

SPNW
Attachment #9
3/27/90

specifically aimed at avoiding out-of-home placements, which is what families across the state have long told us that they wanted and needed.

We would further like to voice our support for the provisions of Section 12(b) relating to the inclusion of family members on the CMHC Governing Board. Keys has always felt strongly that families should have an active voice in the decision making process involving the treatment of their children; this provision would be a start in that process.

According to the figures supplied by the Division, it currently takes $65,000 per year to maintain a child in one of our State Hospitals, while the array of community-based services addressed in the pilot project is estimated at $26,660 per child per year. We feel that these figures indicate that, not only is this the <u>right</u> thing to do, it is also the most cost effective thing to do!

Once again, I thank you for the opportunity to speak with you today. I would be happy to answer any questions that you might have at this time.

Barbara Huff

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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.

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temporary home aide during normal sleeping hours to 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.

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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

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The type of data needed to prove cost effectiveness includes the 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.

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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.

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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