Approved: Jan 21, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on January 20, 2000 in Room 423-S of the Capitol.

All members were present except: Representative Geraldine Flaharty, excused
Representative Ray Merrick, excused
Representative Dale Swenson, excused

Committee staff present: Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Laura Howard, Chief of Staff, Kansas Department of Social and Rehabilitation Services
Ellen Piekalkieicz, Director of Policy and Planning, Association of Community Mental Health Centers of Kansas
Melvin Goering, CEO, Prairie View, Inc., Newton, KS
Kermit George, Executive Director, High Plains Mental Health Center, Hays, Kansas

Others attending: See Attached Sheet

The Chairperson briefed the committee on the next week's agenda.

Representative Gary Hayzlett requested bill introduction concerning school districts; relating to persons authorized to sign certifications of health of employees and striking "signed by a person licensed to practice medicine and surgery under the laws of any state" and adding "and signed by a person licensed to practice medicine and surgery under the laws of any state or by a person holding a certificate of qualification to practice as an advanced registered nurse practitioner under the laws of this state."

Representative Storm moved and Representative Bethell seconded to accept bill introduction. The motion carried.

Representative Bob Bethell requested three bill introductions: (1) concerning the emergency medical services relating to the certificates being on a per application basis rather than a calendar basis and also certification for a an emergency medical technician to be a two year certification rather than a one year certification. (2) relating to emergency medical technician felony background checks revoking the license of an individual who is convicted of committing a crime against persons (abuse, assault, neglect, battery, rape). (3) correcting bill that has been in effect since 1998 regarding background checks for individuals working in long term care institutions and home health institutions convicted of a crime against persons is prohibited from working in long term health care facilities but a person who is convicted of conspiracy to commit that crime or convicted on attempt to commit that crime is not prohibited and the Board would like that corrected. It is also requested the background checks should be completed by the KBI rather than Health and Environment.

Representative Geringer moved and Representative Lightner seconded to accept all three requests for bill introduction. The motion carried.

Staff briefed the committee on the deadlines and gave a review of the 1990 Mental Health Reform Act. Staff stated that Topeka State Hospital was mentioned many times in the statutes, K.S.A.39-1601 thru 39-1613 and that language should possibly by addressed.

Laura Howard, Chief of Staff, Department of Social and Rehabilitation Services, briefed the committee on mental health reform, state hospital closure and diagnostic related groups. There was reduction in the

number of available beds in state hospitals was mandated and in FY 1990 there were 1,003 psychiatric hospital beds and by the end of FY 1999, this had been reduced to 375. The average length of stay has decreased for children and adolescents from 220 days in FY 1990, to 119 days at the end of FY 1999. A similar decrease is seen for adults with 108 days in FY 1990, and 57 days in FY 1999.

SGF expenditures for community-based services increased from $12.7 million in FY 1990, to $45.4 million in FY 2000.

Kansas Medicaid began using the Diagnostic Related Group (DRG) payment system in 1989 as a means of paying reasonable costs and controlling hospital cost increased. There currently are more than 500 DRGs. There is considerable variation in the portion of days at hospitals for Medicaid beneficiaries. From 1994 to 1999, the average percentage of Medicaid days to all inpatient days has declined from 15.3 percent to 12 percent. In general, urban hospitals tend to serve a higher percentage of Medicaid. For example, general hospitals in Wichita have had between 12 percent of Medicaid patients. For example, general hospitals in Wichita have had between 12 percent and 20 percent utilization for this same time period. It is not uncommon for many rural hospitals to have less than five percent Medicaid beneficiaries (See Attachments 1&2).

Ellen Piekalkiewicz, Director of Policy and Planning, Association of Community Mental Health Centers of Kansas, Inc., stated prior to mental health reform admissions were around 4,000 annually to state hospitals. There were no restrictions about who could refer an individual to a state hospital. Many people in the state hospitals did not need to be there. Most state dollars were spsent in the state hospitals. The state was constantly struggling with HCFA decertification of the state hospitals.

A post audit report in 1988 stated the current system is not sufficiently coordinated or integrated. Legislative concerns have again been raised that the system for providing mental health programs and services in Kansas is not integrated, and that clients are being sent to State institutions who could be treated within their communities.

Mental Health Reform and the closure of Topeka State Hospital provided additional state funds to mental health centers to offset hospital bed reduction. The gatekeeping/screening and community based services to adults and children must be covered by the funding. The total amount of funding under Mental Health Reform is $18 million from the State General Fund. An appropriation of $8.0 million from the State General Fund was made to support the closure of 231 beds and the entire Topeka State Hospital Facility. There were already some state dollars being provided to CMHCs in 1990 such as $10 million in basic state aid and special purpose grants for case managers (See Attachment 3).

Melvin Goering, CEO, Prairie View, Inc., Newton, Kansas, stated Mental Health Reform established procedures to decrease the number of persons with mental illness who are treated in state hospitals and to increase community services by using the Community Mental Health Centers as gatekeepers and service providers. It worked. State hospital beds have been reduced dramatically. Community-based services have increased, though the promise of state hospital savings being redirected to community services has not been fully realized and normal inflationary increases for those services have not been provided.

Mental Health Reform requires local hospitals to remain open to serve persons in the community setting. Equitable payment systems are needed to avoid having the state spend excess money and to assure that some hospitals, such as Prairie view, will not be driven from the Medicaid market due to the unfair payment system that strengthens its competition. A level playing field is needed (See Attachment 4).

Kermit George, Executive Director of High Plains Mental Health Center, Hays, Kansas, stated be believed the 1990 Mental Health Reform Act was one of the most carefully considered public policy transformations in Kansas. Kansas is seen as a leader in mental health policy. All hospitalized persons are first screened by mental health center staff to determine whether or not the individual can be safely and appropriately served in the community (See Attachment 5).

Representative Gerringer moved and Representative Bethell seconded the minutes of January 12 be approved. The motion carried.

The committee adjourned at 3:15 p.m. The next meeting will be January 24.

HEALTH AND HUMAN SERVICES

DATE 1-20-2000

NAME	REPRESENTING
Stan Parsons	KGC
KEITH R HANDIS	CHRISTIAN SCIENCES COMMITTEE ON PUBLICATION FOR KANSAS
WM Wesley MARSHALL	Indian Trails MHLC
Jolene Goering	Observer
Melvin Neufeld	Prairie View
Marcil Haba	State of KS - Bd. of EMS
Cecil Gutierrez	Health Midwest
Karrie Ann Power	KAHP
Josie Torres	KS Council on Developmental Disabilities
Paul W. Klotz	Association of CMHCs of KS, Inc.
Kermit George	High Plains MHC
Sally Finney	Ks. Public Health Assn.
Mary Blubaugh MSN, RN	State Board of Nursing
Amy Campbell	Kansas Mental Health Coalition
Mary Ellen Conlee	Via Christi
Mike Gutles	KS. Govt. Consultant
Diane Zemke MN ARNP	Franklin Co MHC
Ellen Piekalkiewicz	Assoc. of CMHCs
Karen Suddath	SRS
Lana K Howard	SRS

State of Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

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House Health and Human Services Committee
January 20, 2000

Mental Health Reform Update
Hospital Reimbursement and Diagnostic Related Groups Payments

Office of the Secretary
Janet Schalansky, Secretary
785-296-3271

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Mental Health Reform, State Hospital Closure, and Diagnostic Related Groups

Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today to provide this information about mental health reform, state hospital closure, and diagnostic related groups.

Mental Health Reform and Hospital Closure

During the 1980s, several studies completed on mental health services in Kansas indicated that 80 percent of state's mental health funding was spent on institutional care, yet individuals challenged by mental and/or emotional illnesses spent most (approximately 95 percent) of their time in communities. At the time, community resources and incentives did not exist in Kansas to fully implement comprehensive community level care statewide. In 1988, a Legislative Post Audit Report of mental health services found that state hospitals and community mental health centers did not provide integrated services or continuity in care and made recommendations for improvements. Another study, by E. Fuller Torrey, M.D., ranked Kansas 42nd in the nation in providing mental health services.

In May of 1990, the Mental Health Reform Act was passed by the Kansas Legislature. This act provided for the phased implementation of reform in mental health across the state by initiating a screening process for all state hospital admissions and providing funding (via state block grants) to the Community Mental Health Centers to increase community based mental health services. The goals of the legislation included shifting the funding emphasis from institutional to community-based care, and creating an array of community based services that enabled individuals to live and work in the community.

The reform act identified adults with severe and persistent mental illness, and seriously emotionally disturbed children and adolescents as the targeted population for mental health services. The following were major stipulations included in the reform effort, and the progress made on each:

1. A reduction in the number of available beds in state hospitals was mandated.

   Progress:
   In FY 1990, Kansas operated 1,003 psychiatric hospital beds, and by the end of FY 1999, this had been reduced to 375. The average length of stay has decreased for children and adolescents from 220 days in FY 1990, to 119 days at the end of FY 1999. A similar decrease is seen for adults with 108 days in FY 1990, and 57 days in FY 1999.

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2. Funds from the state would follow persons from state facilities into community programs.

Progress:
SGF expenditures for community-based services increased from $12.7 million in FY 1990, to $45.4 million in FY 2000.

3. Mental Health Centers were assigned responsibility as gatekeepers to state hospitals and community services.

Progress:
All CMHCs perform these functions and are required to provide a liaison to state hospitals in order to assist individuals in connecting to community services.

4. The capacity of community programs was increased through allocation of state and federal dollars.

Progress:
The number of individuals served in community programs has grown steadily over the last 10 years, and in FY 1999, there were nearly 23,000 individuals in target populations served in the community. For comparison, in 1990, there were very few individuals receiving case management services, in 1994, there were 3,089 adults in case management services, and at the end of FY 1999, there were 13,808 adults in case management services.

5. Consumers, family members, and advocacy groups were recognized as partners in the mental health system by mandating their representation on mental health center governing boards.

Progress:
In addition to participation on governing boards, consumers and families are also represented on the Governor's Mental Health Planning Council, regular advocacy meetings with SRS staff, and other policy committees such as those making recommendations on rewriting the licensing regulations.

By all measures, Mental Health Reform has been a success. In fact, with continuing decreased use of state hospital beds, a hospital closure commission was appointed and Topeka State Hospital was closed.

It is now time to evaluate the changes that need to occur in the next decade. SRS is pursuing the following initiatives at this time, in order to focus on changes needed over the next several years:

1. Appointing a committee to review alternatives to hospital treatment for children 12 and under, and alternatives to the Rainbow State Hospital acute care beds for adults.

2. Establishing a work group that would review alternative funding mechanisms for CMHC's, with the goal of maximizing federal funds and increasing accountability for current funds.

3. Finalizing work on recommendations for changes in licensing regulations for CMHC's.

4. Combining the Divisions of Mental Health and Substance Abuse Treatment and Recovery under one program, with the goal of developing improved services for individuals who suffer from both disorders.

Diagnostic Related Groups Payment System

Kansas Medicaid began using the Diagnostic Related Group (DRG) payment system in 1989 as a means of paying reasonable costs and controlling hospital cost increases. Based on the Medicare system, the Kansas DRG system groups patients with similar characteristics and resource usage. There currently are more than 500 DRGs. Each year, the payment system is updated with recent hospital claims and cost report data. As a result, adjustments are made in DRG payments based on the actual cost incurred by the hospitals.

For payment purposes, Kansas has assigned hospitals into one of three groups based on number of hospital beds; location of the hospital within a metropolitan statistical area (MSA); and proximity to another hospital. Also taken into consideration were hospitals with similar costs. As a result:

1. Group 1 hospitals generally are large urban hospitals and are paid 16 percent more than Group 2 hospitals.
2. Group 2 hospitals typically are medium sized hospitals.
3. Group 3 are small hospitals and are paid 7 percent more than Group 2 hospitals.

Hospitals that offer medical education for physicians or nurses are afforded an additional rate that is unique to the hospital's medical education program. This rate is not considered in the above-mentioned comparisons.

A major factor in the design of the current system was provisions contained in the federal Boren Amendment that required that reasonable costs must be paid. At the time, it was determined that to comply with Boren without having hospital-specific rates, hospitals had to be grouped based on average cost as adjusted for case mix. The result was the above-mentioned categories.

Although the Boren Amendment has since been repealed at the national level, it still is in Kansas law. In addition, the State Plan methodology has not been changed. However, the groupings determined in the original system design have been reviewed to determine if there is any need for change. This review was based upon the same original principles, even though it was no longer required by the Boren Amendment. The determination, however, was that it would be more equitable if higher cost hospitals were paid more than lower-cost hospitals. Therefore, no changes have been proposed.

In 1989, Kansas' relatively few free-standing psychiatric and rehabilitation hospitals were excluded from the DRG system and paid on a cost-based reimbursement system. However, a significant increase in the number of such facilities shortly thereafter resulted in uncontrollable cost increases. As a result, both free-standing rehabilitation and psychiatric hospitals were added to the DRG system in 1993.

The DRG system has been very effective in controlling Medicaid inpatient care costs – especially in light of the fact that the patient's length of stay is the hospital's major cost determinant. Under previous systems such as cost reimbursement and the per diem payment method (payment of a set amount per day regardless of the type of care provided), any increase in length of stay resulted in higher cost to the State. Under DRGs that paid only a fixed amount for each discharge, excepting unusual cases, there was an incentive to reduce the lengths of stay.

Under the DRG system, the average length of stay has declined from 5.5 days in FY 1990, to four days in FY 1999. Some services, such as psychiatric stays, showed more significant declines.

The national standard in comparing inpatient utilization is number of days for each thousand beneficiaries. This has declined in Medicaid from 1742 days in FY 1991, to 967 days in FY 1999. This reduction has occurred despite the fact that the number of disabled beneficiaries has increased from 19,483 in FY 1991, to 37,018 in FY 1999. These are the beneficiaries who are among the heaviest users of inpatient care.

There is considerable variation in the portion of days at hospitals for Medicaid beneficiaries. From 1994 to 1999, the average percentage of Medicaid days to all inpatient days has declined from 15.3 percent to 12 percent. In general, urban hospitals tend to serve a higher percentage of Medicaid. For example, general hospitals in Wichita have had between 12 percent and 20 percent utilization for this same time period. It is not uncommon for many rural hospitals to have less than five percent Medicaid beneficiaries.

Psychiatric and rehabilitation hospitals fall in different categories with regard to their Medicaid utilization. Most have lower than average Medicaid utilization. For example, Prairie View in Newton, a psychiatric hospital, had 30 percent Medicaid utilization from 1994 to 1996, but declined to seven percent utilization in 1998.

There are several alternatives to paying some hospitals different rates. One would be to modify the definitions of the groups to reclassify hospitals. For example, if bed size criteria were eliminated, hospitals currently within an MSA would be in Group 1 regardless of their bed size. Although there would be no net change in overall payment, the rates paid to both Group 1 and Group 2 hospitals would be reduced. Only those hospitals switching from Group 2 to Group 1 would benefit from such a change at the expense of all previous Group 1 and Group 2 hospitals. Some of the hospitals that would benefit from such a change, such as Prairie View, are already being paid their cost for providing Medicaid services. Placing them into Group 1 would result in payments that are above their cost for providing services.

Another option would be to exempt some hospitals from the DRG system. The obvious alternatives of cost reimbursement or a per diem system previously have been used and found to result in cost increases. The level of these increases could be significant depending upon the hospitals and services involved. Without additional restrictions on hospitals, such as maximum lengths of stay, or maximum costs to be paid, there is no assurance that the State could control costs. Even assuming some maximums were set, it is still likely that costs would increase.

Thank you for the opportunity to share these issues with you. I will now stand for questions.

Mental Health Reform in Kansas: Cost Containment and Quality of Life

Ronna Chamberlain,
Charles A. Rapp,
Priscilla Ridgway,
Robert Lee &
Cynthia Boezio

Ronna Chamberlain, PhD, is the director of the Office of Social Policy Analysis, School of Social Welfare, University of Kansas, Lawrence, Kansas.

Charles A. Rapp, PhD, is a professor and the associate dean of the School of Social Welfare at University of Kansas, Lawrence.

Priscilla Ridgway, MSW, is a research assistant at the School of Social Welfare, University of Kansas, Lawrence.

Robert Lee, PhD, is professor at Health Services Administration, The University of Kansas, Lawrence, Kansas.

Cynthia Boezio, MS, is a research assistant at the School of Social Welfare, University of Kansas, Lawrence, Kansas.

This paper reports on an evaluation of the impact of the Kansas Mental Health Reform Act. The act sought to reduce state hospital utilization, enhance community programming, improve client outcomes, and increase consumer influence over programs. The results are overwhelmingly positive. The unique phased-in implementation plan allows increased confidence that the results were in fact attributable to the act.

The rapidly increasing cost of inpatient psychiatric care and concern about client rights and quality of life has lead many states to attempt to operate with the smallest possible number of state hospital beds. Downsizing facilities and reducing length of stay to induce cost-savings does not necessarily serve the needs of people with severe and persistent psychiatric disabilities. Reduced access to intensive inpatient services may achieve short-term cost savings at the expense of the quality of life of persons with disabilities, their families, and their communities unless a community support system is in place to meet their needs.

This study evaluated costs and client outcomes associated with implementation of the Kansas Mental Health Reform Act, enacted in 1990. The primary research question asked was "What impact did mental health reform have on the quality of life of persons with severe and persistent psychiatric disabilities?" The impact reform had on systems-level concerns, such as cost and transfer of care to other sectors, was also explored to determine whether allied systems were being taxed because people with severe disorders lacked access to inpatient care.

Background

Kansas began implementing mental health reform in 1991, after a long period of intensive policy research (Rapp & Hanson, 1987; Zimmerman, 1989), advocacy on the part of families and con-

sumers, and leadership on the part of the key legislators. The state's mental health system had been characterized as moving backwards and received a low ranking relative to most states in a 1988 national evaluation--Care of the Severely Mentally Ill—conducted by E. Fuller Torrey and the National Alliance for the Mentally Ill (Torrey, Wolfe & Flynn, 1988). The mental health system was fragmented, with no fixed responsibility for continuity of care and little access to basic services and supports in some areas of the state.

Kansas had among the lowest rates of spending for community mental health in the nation. Nearly 93% of public funds in the mental health system were tied to 24-hour care settings. The state had very high rates of psychiatric hospitalization relative to other states—4.55 per 10,000 population, versus approximately 2.68 in progressive states (Rapp & Moore, 1995). Unlike most other states, Kansas continued to use mental health nursing homes that were fully state-funded. Kansas did not take full advantage of the federal Medicaid program to fund important community support services. The system was not consumer-oriented, with family members and mental health consumers rarely involved in policy-making or planning.

Mental health reform sought to address these deficits using several approaches:

Assignment of responsibility for care to community mental health centers. Primary emphasis was placed on designating community mental health centers as the entity responsible for serving those with serious and persistent mental illness in the least restrictive setting. CMHCs became the designated gatekeeper to the state hospitals.

Reduction of unnecessary inpatient care. A specific allocation of state hospital bed days was made to each CMHC. Targets for inpatient treatment were established 10% below the catchment area's historic usage. Funds were made available for improved services such as emergency screening and diversion activities.

Improved consumer quality of life. The performance of each center was evaluated based on a core set of client outcomes: independent living status, vocational status and community tenure. Funding was augmented to improve and expand community support services in local service areas.

Increased consumer and family involvement. Families and primary consumers were to become partners in reforming the mental health system. Involvement of consumers was sought through mandating their inclusion on CMHC boards of directors and development of advocacy groups and consumer-run programs.

Financing of reform was focused on shifting funds from state hospitals to community programs. State hospital annual allocations exceeded inflation throughout the 1980's. The reform strategy was to provide an up-front allocation to community programs (approximately $8.7 million), and then to recoup the funds by downsizing the hospitals and otherwise controlling costs. The phased-in approach to reform (one of three hospital catchment areas per year) allowed reductions in the rate of hospital budget growth to affect subsequent up-front allocations for subsequent catchment areas. A parallel effort was made to increase Kansas' federal financial participation through Title XIX.

METHODS

Settings and Procedures

Mental health reform was phased in over a period of time. An evaluation of the first phase concerned Osawatomie State Hospital and its associated CMHC catchment areas (Rapp & Moore, 1993; 1995). This paper describes an extensive study, conducted by the University of Kansas, School of Social Welfare's Office of Social Policy Analysis, that assessed the longer term, statewide impact of reform (Chamberlain, Boezio, Lee, et al., 1995). Data pertain to the state's 3 state hospitals and 27 CMHC catchment areas, and relate only to findings among the adult service population.

Since reform efforts were phased in, the evaluation period varies. This report is based on 3 years of reform in the Osawatomie State Hospital service region, 2 years in the Topeka State Hospital region, and 1 year in the Larned State Hospital region.

Data Sources

Data were gathered using multiple methods. State-run management information systems provided data on several factors including hospitalization rates, diversion screenings, and service utilization. The Client Status Report (CSR) System, implemented in 1988, was used to track residential status; participation in work, school, and social activities; and hospitalization on a quarterly basis for each participant in a community support program (Rapp, Gowdy, Sullivan, & Wintersteen, 1988). Data reported here are from the final quarter of FY '94, unless otherwise noted.

Qualitative methods, including structured and semi-structured interviews and focus groups, were used to gather the perspectives of families, mental health consumers, and key informants. Fifty mental health consumers were involved in focus groups in six catchment areas. Members of the Kansas Alliance for the Mentally Ill also participated in these groups. CMHC directors, the leaders of consumer advocacy groups, and other informants were questioned using telephone survey methods.

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Information was also garnered from state corrections and Medicaid authorities concerning court commitment (involuntary hospitalization) proceedings, and the numbers of Medicaid-funded admissions to local psychiatric inpatient units and nursing facilities for mental health. A statewide survey of 31 homeless shelters was conducted by mail; the response rate was 61%. A chart review was conducted to abstract data from records of long-stay patients discharged from the state hospitals. Mental health centers were surveyed by mail to determine the placement disposition of these patients. Hospital budget documents were examined to identify trends in costs of inpatient care.

RESULTS

Hospital Bed Use

In the period FY '90–'94, a cap was placed on inpatient bed use, which represented a 10% reduction from historical levels. Total patient days were actually reduced by 21%. At Osawatomie, where reform was first initiated, total patient days fell nearly 36%.

Some of the reduction in bed days was associated with the release of nearly half of the relatively small number of inpatients whose length of stay had exceeded 5 years. Improved discharge planning and increased availability of intensive levels of community support services allowed a reduction in length of stay of those admitted with a high degree of disability. Average length of stay across the state fell nearly 30%.

Gatekeeping and Admission Rates

Data indicated that all admissions to state hospitals had been screened by a CMHC. Statewide, actual admissions rates did not reflect a strong downward trend. Statewide data masked a very high degree of variability in admission rates across catchment areas. In fact, some CMHCs cut admissions by as much as half, while others continued admitting at pre-reform rates, and some areas actually had higher admissions than in the past.

Key informant interviews with CMHC executives whose admission rates did not fall indicated that the complexity of systems change made rapid reductions in admissions difficult. These administrators encountered initial difficulties coordinating multiple providers and law enforcement agencies in multi-county systems. Several cited the need to increase community education. All expressed confidence that diversion would prove successful over time.

Consumer Feedback

Mental health consumers participating in focus groups identified the diversion services they felt helped them avoid hospitalization. Crisis case management, out-of-home respite, emergency medication, attendant care, and assistance in the evening and at night were found to be the most important elements to those who had used diversion services in the past year.

Some family members participating in focus groups were not as enthusiastic about diversion efforts. They felt that CMHC staff members sometimes tried too hard to keep people in the community and felt relief when hospitalization finally occurred. Families appreciated the increased assistance with involuntary hospitalization and outpatient commitment they were experiencing as a result of the screening mandate.

Both primary consumers and family members complained about telephone crisis lines in high volume areas of the state. Uncaring attitudes and abrupt and even rude treatment had been experienced. Alternative, consumer-run crisis assistance such as support groups and drop-in centers were recommended by consumers.

Quality of Life

Quality of life indicators from the Client Status Reports showed generally positive outcomes with the positive effects being more pronounced in the OSH catchment area where 3 years of reform had occurred, in contrast to the rest of the state, which had only experienced one year of reform for the adult system. Statewide, most of the 3,089 people served by community support programs (70.4%) were housed in an independent living situation, such as a mainstream home or apartment (OSH = 77%, remainder of the state = 67%). Another one in five (19.4%) were living in semi-independent settings, such as group homes or board and care-type settings; 2.7% were living with others who were responsible for the person's care; and 7.4% were housed in mental health nursing homes (NFMH).

Most community support clients (86%) had not been hospitalized during the previous quarter. Of those hospitalized, more than half had stays of less than 2 weeks. Most inpatient stays were in community inpatient units; only 4.3% of CSP clients had spent time in a state facility in that period.

Almost all CSP clients had participated in organized social activities or other community activities. Just over 2% engaged in social activity less than weekly. More than 70% spent time with other people in social activities at least weekly (OSH = 77%; other catchments = 69%). Over half (56%) had some kind of vocational activity (SH = 63%; other catchments = 51%). One quarter (25.8%) were involved in competitive employment (OSH = 28%; other catchments = 22%).

The relationship between these factors was examined. Those in independent living had significantly less hospitalization ($p < .01$), significantly more vocational activity ($p < .01$), and significantly more social activity ($p < .001$) than

those in semi-independent and institutional settings.

Consumer Involvement and Empowerment

Consumer involvement and empowerment were goals of mental health reform. Most empowerment groups were developed under a grant program initiated in 1991. These were focused on providing consumer-run services, advocacy, and building leadership among consumers.

Twelve consumer groups were surveyed using telephone survey methods. Four pre-existed reform; eight had incorporated under the reform initiative. The groups had an estimated total membership exceeding 850. Services provided included drop-in centers, socialization and recreational activities, peer counseling, transportation, educational and vocational support, assistance with personal needs, and financial management. Members also conducted public education aimed at reducing stigma.

Reform legislation required CMHCs to include consumers and family members on their boards of directors. This was intended to give consumers a voice in decisions and policies that shaped services and affected their lives. All did so, but some centers included former recipients of outpatient counseling, rather than those with prolonged disabilities, thereby circumventing the intent of this mandate.

Impact on Related Systems

The impact reform had on other systems was evaluated. These systems included nursing homes specializing in mental health consumers, the court system, homeless shelters, and local inpatient units.

State hospital discharges to mental health nursing homes (NFMHs) increased only slightly from pre-reform levels. In FY '89, 3.4% of all discharges were to such settings, in FY '95 this figure had increased to 4.6% (+1.2%). The census of NFMHs had not increased. Discharge disposition data for long stay patients indicates a tendency for some CMHCs to rely heavily on NFMH placements for such consumers.

Reform efforts did not include disincentives for utilizing nursing facilities, nor were special incentives provided for serving people with heavy service needs in mainstream housing. Nevertheless, some CMHCs did not transfer long-stay inpatients to 24-hour-care settings. Instead, they focused on provision of intensive case management, living skills training, attendant care, and supported housing alternatives for those with a high level of need. Directors of these centers were queried about their greater ability to serve persons with severe disabilities in mainstream housing. They attributed their success to strong leadership (particularly from program managers), willingness to assume risks, and the tendency to embrace challenges as opportunities.

Reform was found to have no adverse impact on court commitments and local psychiatric inpatient unit admissions. In fact, slight positive effects (reductions) were found in the number of both voluntary and involuntary psychiatric admissions. Commitment proceedings in the court system showed a slight declining trend. There was no significant difference in Medicaid-funded psychiatric hospitalization, indicating local psychiatric units did not replace state hospital beds. Data from homeless shelters found no significant increase in homelessness among adults with psychiatric disabilities subsequent to reform.

Hospital Costs

State hospital budgets, which had grown at a rate that exceeded inflation for several years, were curbed. As reform was implemented, the rate of increase was markedly reduced. The Osawatomie State Hospital budget grew only 3.5% total from fiscal years 1990–1994, which included 3 years of reform. The Topeka State Hospital budget increased 6.5% over this period, under 2 years of reform. The Larned State Hospital budget, where 1 year of reform had occurred, increased 13.2% in the same 4 years. The longer a state hospital was a part of reform, the greater the cost containment. At the same time efforts to better capture federal funds actually led to an overall reduction in state general funds going to state hospitals, from $57.3 million in FY '90 to $34.6 million in FY '94.

Community Care and Its Cost

Continuity of care improved significantly, as expressed by much higher proportions of discharge referrals to CMHCs for follow-up, and a concomitant decrease in those released with no mental health referral or no information available. The budgets and responsibilities of community mental health centers increased substantially over the study period. Staff provision of emergency and diversion services, which included hospital liaison and crisis case management, increased 123% . Staff provision of other community support services increased 117%. Within CMHCs, Community Support Programs (CSPs) provide a cluster of services to assist persons with severe and persistent psychiatric disabilities to control the symptoms of their disorders, remediate their functional limitations, set goals, and obtain the supports necessary to lead successful lives in the community.

All centers focused on enhancing case management, which is the primary mode of CSS delivery in Kansas. In rural areas, case managers are generalists providing most direct services. In urban areas, where more program elements exist, case management is often augmented with supported employment, psychosocial clubhouses, supported housing, crisis assistance, attendant care, outreach crisis assistance, and

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other community support services. Case managers are trained in the strengths approach, a model that focuses on consumer talents, abilities, and goals across a variety of life domains, and focuses on linkages to natural community resources in addition to formal services (Rapp, 1998; Saleebey, 1992).

The average annual cost of providing CMHC services to persons with severe and persistent disabilities was calculated at $4,342. This figure was based on an analysis of program costs for all services delivered to community support program clients active in FY '93. This figure includes both direct service costs and applicable administrative overhead. This average was calculated across all clients, programs, and CMHCs.

A special study was conducted of heavy service users. A purposive sample of 10 clients who used a disproportionate amount of formal services was identified by each center. The average cost of formal services for this group was $22,593 annually, or more than 6 times the average for all CSP clients. This variability is relatively modest compared to other health systems (Chamberlain, Boezio, Lee, et al, 1995).

Community service costs compared favorably to costs of state hospital care, which were $102,000 per patient per year at the least costly facility in Kansas during the same period (FY '93).

Service costs alone do not reflect the public expenditures necessary for community-based care. Basic living expenses, other entitlements such as food stamps, and ancillary services must be added. These costs were estimated to double the amount of entitlement income from supplemental security income (SSI). When this amount was added to formal treatment and community support services, costs for community living and support services were found to range from $15,000 to $34,000 per year, on average. These figures represent significant costs savings over continuous institutionalization.

Service Gaps

The evaluation identified several unmet needs. Some locales continued to have serious gaps in their community support system–lacking elements such as intensive case management, supported housing, in-home crisis assistance, and weekend programming. Gaps in availability of services create inequities in life opportunities among persons with psychiatric disabilities. Options were limited to service area offerings, rather than being responsive to their individual needs. While the numbers of CSP consumers increased 88% from 3,089 to 5,792 during the first 3 years of implementation of reform, many more than a thousand clients received only medication follow-up. Many of these clients were waiting for important CSP services. Consumer groups also expressed the need for additional funding, technical assistance, and leadership training.

Reform rewarded decreased use of inpatient services. While some CMHCs were very innovative and highly committed to carrying out this goal, others were not achieving the same results. A successful shift in the focus of care from institutions to local communities is complex. Formal mental health services are only part of the equation; basic needs must also be met. A widespread unmet need for decent affordable housing was identified throughout the state. Despite this, many CMHCs demonstrated creativity in meeting this need by using flex funds to supplement rent and to cover moving costs, damage deposits, and furnishings; by more assertively working with local housing authorities; by developing relationships with landlords; and by creating a roommate selection service.

Attribution of Effects

Research of the kind reported here seeks to attribute the results to the intervention, in this case a change in mental health policy. Rarely does policy research allow the isolation of policy from all the other environmental variables. In this project, increased confidence that the results are attributable to mental health reform is warranted because of the unique phase-in approach.

Rapp and Moore (1995) reported on the first phase of reform involving only the Osawatomie State Hospital catchment area. Their findings showed positive results in terms of state hospital bed day utilization, diversion from state hospitals; and increases in independent living, employment, and consumer involvement only for the catchment area experiencing the effects of the policy shift. They also found a significant shift in funding from hospital to community. The other two hospital catchment areas showed few changes in any of these variables.

The current report found that once reform was implemented in the other hospital catchment areas, the results paralleled those found for Osawatomie during the first phase. Furthermore, OSH, with the most time under reform, continued to outperform the other catchment areas.

Conclusions

Mental health reform fundamentally restructured the Kansas mental health system. Implementation of this major systems change proceeded with remarkable speed and success. The reform's goals were met–the public system was refinanced, the bias toward institutional care was reduced, and resource inequities were redressed between institution and community-based systems.

Reform did not seem to have adverse effects on related systems. The system's ability to serve people with severe psychiatric disabilities in their home communities improved, even when they experienced acute disorders and were at risk of inpatient care.

Bed day utilization in state hospitals sharply declined and length of stay was shortened dramatically, exceeding the targets set. These reductions did not result simply from rationing bed days. Continuity of care improved and community systems were upgraded to better meet consumer wants and needs.

There seem to be several key features of the reform effort that may be important for other states. First, the client outcomes of Kansas Mental Health Reform were explicit; reduce hospitalization and improve independent living and vocational status and community participation. Information systems collected and reported this data to all units on a regular basis. Second, authority was decentralized to 27 mental health centers. Detailed prescriptions on how to achieve the outcomes were avoided. Each CMHC had great latitude to formulate its own unique strategies and mix of services. Third, the capitated Funding (whereby each center received an amount of money and was responsible for all people with severe and persistent mental illness in its catchment area) and a set amount of state hospital bed days provided a powerful incentive to develop effective screening and diversion services and stronger community partnerships.

Many of the goals of managed care (contain costs, reduce hospitalization, improve quality of life) were shared by the Kansas Mental Health Reform. Yet the approach taken was notably different in some respects. First, there was not one statewide contractor but 27. Second, there were few new regulations, utilization review procedures and policy, and multiple other control mechanisms to typically built into managed care operations.

The results of reform were positive and this was true for each of the three hospital catchment areas. Time and experience under reform seems to explain the different performance by catchment area. While all 27 centers demonstrated improved performance compared to the pre-reform period, differences in performance between mental health centers were still found, even within the same catchment area. Part of the explanation seems to be due to a combination of values, ideology, knowledge, and willingness to assume risks. The highest performing centers tended to have stronger commitments to the target population and the goals of reform, be more consumer-centered, and be more aware of best practices in the field. They also tended to be more willing to take the necessary steps to implement the best practices, to take on the most severe of the population, and to experiment with innovative case plans and community resources.

The Kansas Reform initiatives sought cost containment and improved consumer quality of life, rather than sacrificing one of these outcomes to achieve the other. Assessment of mental health and allied systems demonstrates that cost containment can be achieved without pushing the most vulnerable and challenging to serve out of the system and onto the streets.

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Testimony
January 20, 2000
Ellen Piekalkiewicz, Director of Policy and Planning

THE SYSTEM PRIOR TO MENTAL HEALTH REFORM

- Admissions to the state hospitals were around 4,000 annually.

- There were no restrictions about who could refer an individual to a state hospital.

A post audit report in 1988 stated:

> The current system is not sufficiently coordinated or integrated. Although the system anticipates that people will be served in the communities when possible, the community centers have not been required to participate in that system; they are not responsible for providing all types of mental health services or for treating all types of mentally ill patients. The ultimate responsibility --and most of the State resources – for treating the mentally ill people still rests with the State. This is especially true for indigent people who cannot afford the types of services and program offered by other licensed or regulated facilities.

- Many people in the State Hospital did not need to be there.
- Most state dollars were in the State Hospital.
- The State was constantly struggling with HCFA decertification of the State Hospitals.

The post audit report of 1988 stated:

> Legislative concerns have again been raised that the system for providing mental health programs and services in Kansas is not integrated, and that clients are being sent to State institutions who could be treated within their communities. The renewed interest stems in part from problems that State mental health institutions have experienced recently with overcrowding and understaffing. Finally, there are concerns that Kansas' mental health system does not operate as effectively or efficiently as it could.

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MENTAL HEALTH REFORM OBJECTIVES

I. Focus state mental health agenda on specific targeted populations. Community Mental Health Centers now in 2000 serve 12,000 adults who have a serious and persistent mentally illness and 11,000 children with severe emotional disturbance.

II. Transfer state mental health resources from institutional system to community service system.

A. Reduce state hospital bed utilization by 270 beds 6-year period. (Average daily census went from 4,000 to 360).
B. Enhance and improve community-based services for targeted populations.
C. Average daily went from 4,000 to 250.

III. Establish state hospitals, community mental health centers, and other public mental health providers as a continuous treatment system.

IV. Assure that services are responsive to needs of community, consumers, and family members, closer to home.

KANSAS MENTAL HEALTH REFORM ACT

I. Mental Health Reform

A. Establishes targeted populations

B. Defines role of SRS Secretary in mental health services.

C. Requires local and statewide needs assessments.

D. Transfers NF/MH and group home oversight to state division of mental health services.

E. Provides for reduction of 270 state hospital beds statewide.

1. Includes adult and children's beds.

2. Reductions were phased-in over 6 years beginning with Osawatomie State Hospital, then proceeding to Topeka State Hospital, and ending with Larned State Hospital.

F. Topeka State Hospital was closed in 1997 with 231 additional beds. (Closure of TSH was not part of the original MH Reform.)

II. Makeup of mental health center governing boards.

Requires mental health center governing board to include consumers and family members of mentally ill persons.

III. Privileged communication.

Creates exception to privileged communications statutes to allow for exchange of confidential information between state hospitals and mental health centers.

IV. State Hospital Gatekeeping.

(Amendments to Treatment Act for Mentally Ill Persons)

A. Requires participating CMHC's to provide screening of all proposed admissions to state hospitals before person is transported. No exceptions!

B. Screening is to determine if individual can be further evaluated and treated in the community.

C. Screening must be performed by a qualified mental health professional.

D. Requires MHCs to participate in planning for all persons discharged from a state hospital.

E. Prohibits MHCs from refusing outpatient commitment orders.

F. Provides for moratorium on admissions to state hospitals.

G. Gatekeeping is phased-in according to same schedule as planned state hospital bed reduction.

FUNDING TO SUPPORT MENTAL HEALTH REFORM

Mental health Reform and the closure of Topeka State Hospital provided additional state funds to mental health centers to off set hospital bed reduction. The gatekeeping/screening and community based services to adults and children must be covered by the funding. The total amount of funding under Mental Health Reform is $18 million from the State General Fund. An appropriation of $8.0 million from the State General Fund was made to support the closure of 231 beds and the entire Topeka State Hospitals Facility. There were already some state dollars being provided to CMHCs in 1990 such as $10 million in basic state aid and special purpose grants for case managers.

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TESTIMONY BEFORE THE
HEALTH AND HUMAN SERVICES COMMITTEE
Representative Garry Boston, Chair
January 13, 2000

PrairieView Inc.
A regional behavioral and mental health system founded in 1954.

1901 E. First St.
P.O. Box 467
Newton, KS 67114-0467
(316) 284-6400
Fax (316) 284-6490

Mr. Chairman and Members of the Committee:

Thank you for allowing me to speak on issues related to Mental Health Reform. I am Melvin Goering, CEO at Prairie View, a comprehensive, regional mental health provider with a full continuum of services, including inpatient services. Prairie View contracts with Marion, McPherson and Harvey Counties as each county's Community Mental Health Center. We have 45 years of experience in treating those with severe and persistent mental illness, both children and adults.

Mental Health Reform established procedures to decrease the number of persons with mental illness who are treated in state hospitals and to increase community services by using the Community Mental Health Centers as gatekeepers and service providers. It worked. State hospital beds have been reduced dramatically. Community-based services have increased, though the promise of state hospital savings being redirected to community services has not been fully realized and normal inflationary increases for those services have not been provided.

Mental Health Reform heightened the need for community hospitals capable of treating people with acute symptoms of mental illness in a secure environment. Prairie View is a unique specialty hospital due to its dual role as a CMHC provider and a full continuum private psychiatric system. We have been a leader in providing short term inpatient treatment for children, a service few provide in Kansas, and one that will become critical if SRS fulfills its stated desire to eliminate all children's beds from state hospitals.

It is my concern for the future of Prairie View and other community hospitals that prompts me to draw your attention to the inequitable Medicaid hospital payment system currently used by SRS. The payment formula places Prairie View at a competitive disadvantage by paying nearby providers significantly more for the same treatment need, even though we are in the same specialty field and metropolitan area. It also causes the Kansas taxpayer to pay more for the same service need because the state does not guide clients to the lower cost provider.

The attachment to my testimony illustrates the problem using the most common diagnosis for children. Hospitals receive a set amount of payment based on the Diagnostically Related Group (DRG). Item 2 shows how the current system pays two Wichita competitors 16.1% ($597) and 29.9% ($1,334) more for the same DRG with no higher expectation for clinical results, even though we are 25 miles apart, located in the same metropolitan market, reside in a Metropolitan Statistical Area and draw from the same employee pool of specialty personnel.

Other Locations:

701 E. Comanche, Ste. D
Dodge City, KS 67801-4500
(316) 227-7823

1125 N. Main
Hutchinson, KS 67501-4405
(316) 694-4590

504 S. Roosevelt St.
Marion, KS 66861-1358
(316) 382-3701

1102 Hospital Drive
McPherson, KS 67460-2318
(316) 245-5000

645 E. Iron, Ste. G
Salina, KS 67401-2697
(785) 827-5200

7570 W. 21st St. N., Ste. 1026-D
Wichita, KS 67205-1734
(316) 729-6555

2939 N. Rock Road, Ste. 100
Wichita, KS 67226-1100
(316) 634-4700

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Item 3 shows the number of admissions for one fiscal year and the total expenditures for those admissions, if all admissions had been for DRG 431. Item 4 shows the state might have saved $164,283 if all services were driven to the provider receiving the lowest DRG rate and an increased cost to the state of $211,905 if all individuals received services at the providers receiving the highest DRG rate.

Item 5 shows the negative impact on the ability of Prairie View to continue competitive, quality services. For the same DRG, with no difference in outcome expectations, Prairie View receives $122,728 less for its 92 admissions than it would receive if it were paid at the higher DRG rate.

How does this happen? SRS has divided hospitals into three groups: Urban, rural and small rural. The urban hospitals are defined by the number of beds (200 beds) or distance (within 10 miles of a 200 bed hospital, apparently to have a smaller hospital within an urban area receive the same rates as the other urban hospitals). Charter and Via Christi are classified as urban, even though neither of their psychiatric facilities meets the 200 bed requirement. Prairie View is classified as rural.

Perhaps these criteria and groupings are adequate for medical/surgical hospitals, where urban and rural hospitals may provide different levels of service. The method is unfair for specialty psychiatric hospitals where the services are similar, the pool of qualified personnel is small and shared by all three facilities in the Wichita market, and the competition is direct. The state interferes in the competitive market by providing more revenue to some facilities than others within the same economic sphere. This lack of equity would not be so harmful if SRS were willing to guide clients to the least costly qualified provider. Since they don't, the state finds itself spending more than it would need to while providing unfair advantage to some providers based on criteria that have little to do with cost or quality—number of beds.

Why is this important to the future of Mental Health Reform? Mental Health Reform requires local hospitals to remain open to serve persons in the community setting. Equitable payment systems are needed to avoid having the state spend excess money and to assure that some hospitals, such as Prairie View, will not be driven from the Medicaid market due to the unfair payment system that strengthens its competition. We need a level playing field.

Thank you for allowing me to bring this issue to your attention. I would be happy to answer your questions as I am able.

Melvin Goering, CEO
Prairie View

/jsb

INPATIENT DRG: CHILDREN'S MENTAL HEALTH

PrairieView Inc.
A regional behavioral and mental health system founded in 1954.

1901 E. First St.
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1. DRG 431 (Childhood Mental Disorders) is the most frequently used DRG for children and adolescents: will be used as the basis for numbers below

2. Current SRS methodology results in significant disparities in rates within the same competitive market and urban economic spheres.

Prairie View	$3,701
Charter-Wichita	$4,298 (16.1% higher than Prairie View with a $597 difference per DRG)
Via Christi	$5,035 (29.9% higher than Prairie View with a $1,334 difference per DRG)

3. Admission Statistics for child and adolescents from July 1, 1998 to June 30, 1999:

Charter-Wichita	121 admissions x $4,298=$	520,058
Via Christi	69 admissions x $5,035=$	347,415
Prairie View	92 admissions x $3,701=$	340,492
Total	282	$1,207,965

4. Impact to state budget at different rates (using October 1, 1999 rates)

   a. 282 x $3,701 = $ 1,043,682 (164,283)
   b. 282 x $4,298 = $ 1,212,036 4,071
   c. 282 x $5,035 = $ 1,419,870 211,905

5. Impact to Prairie View Budget

   92 x $3,701 = $340,492
   92 x $4,298 = $395,416 ($ 54,924)
   92 x $5,035 = $463,220 ($122,728)

6. Prairie View competes with these organizations for personnel, supplies and clients: Rate difference in same region has state creating an unfair competitive environment.

Ceo\legis\drgstats.j00

Other Locations:

701 E. Comanche, Ste. D
Dodge City, KS 67801-4500
(316) 227-7823

1125 N. Main
Hutchinson, KS 67501-4405
(316) 694-4590

504 S. Roosevelt St.
Marion, KS 66861-1358
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1102 Hospital Drive
McPherson, KS 67460-2318
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Wichita, KS 67205-1734
(316) 729-6555

2939 N. Rock Road, Ste. 100
Wichita, KS 67226-1100
(316) 634-4700

HIGH PLAINS

A Licensed Community Mental Health Center

Dennis Deschner
Governing Board President
Kermit George, ACSW
Executive Director
Lourdes R. Tan M.D.
Medical Director

Virginia Periola-Patriarca, M.D.
Inpatient Psychiatric Director
Walter Hill, MS, LMLP
Director of Clinical Programs

Wayne L. Lofton, Ed.S., LMLP
Director of Consultation/Education & EAP Service
Jamie Boggs, RN, MN, MHA
Director of Quality & Risk Management
Mary Beth Dreiling, CPA
Director of Administrative Services

208 East 7th Street Hays, Kansas 67601

Testimony to Senate Public Health and Welfare Committee
Mental Health Reform---10 Years Later
Kermit George, Executive Director, High Plains Mental Health Center, Hays, Kansas
January 20, 2000

My name is Kermit George; I am the Executive Director of High Plains Mental Health Center, Hays, Kansas. I was asked to speak about my experience with what, personally, I believe to be one of the most carefully considered public policy transformations in Kansas...the 1990 Mental Health Reform Act. My perspective is from one mental health center, ten years after fact. I will keep my remarks to these two pages.

You should first know that High Plains is responsible for community based services in 20 counties of northwest Kansas, about 19,000 square miles. Our budget is about $6.5 million; we have 137 employees. Staff deliver services from 14 office locations with additional mobile outreach in every county. Six full time treatment offices have TeleVideo conferencing capability. All 60 positions of the Board of Directors are appointed by their respective County Commissions; 20 are voting positions.

I have been with High Plains almost 27 years, 17 of those as Executive Director. My involvement with Mental Health Reform began as an appointed member of the original Governor's Reform Task Force, representing community mental health centers. At that time, I was President of the Association of Community Mental Health Centers of Kansas.

If I were asked to provide a succinct summary of the past decade, relative to the origin and implementation of Reform, my response would be this: "It was an exceptional moment of painstaking planning with broad stakeholder input. It was clear from legislative policy that Kansas would build an integrated system of public, community-based mental health care. It recognized and targeted the most needy mentally ill adults and children. It contractually downloaded service-delivery-system responsibility and corresponding funding from institutions to community mental health centers. It was a promise kept."

Pre-Reform, High Plains had about half the budget and half the number of employees; we had no idea who, from northwest Kansas, was admitted or discharged from a State Hospital; we had minimal contact with some 40-60 adults and youth during their hospitalization at Larned State Hospital; and, we were essentially office bound. The most vulnerable mentally ill adults and youth were neither program nor budget priorities and they received relatively few services distinct from traditional office psychotherapy. Services

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HAYS OFFICE
208 East 7th
Hays, KS 67601
(785) 628-2871
1-800-432-0333
FAX (785) 628-1438

BRANCH OFFICES:
Colby
750 South Range
Colby, KS 67701
(785) 462-6774
FAX (785) 462-3690

Goodland
723 Main
Goodland, KS 67735
(785) 899-5991
FAX (785) 899-2533

Norton
211 S. Norton
Norton, KS 67654
(785) 877-5141
FAX (785) 877-5142

Osborne
121 West Main
Osborne, KS 67473
(785) 346-2184
FAX (785) 346-2487

Phillipsburg
425 F Street
Phillipsburg, KS 67661
(785) 543-5284
FAX (785) 543-5285

Atch # 5

were geographically centralized. We expected clients to come to us. Basic necessities such as housing and transportation were someone else's responsibility. We thought we were doing the best that could be done for these populations. We were wrong.

Reform legislation placed community mental health centers, legally and responsibly, at the front and back door of State Hospitals; it provided annual, increasing amounts of funding and increasing expectations to reduce dependence on State Hospital beds; and, it required a client-driven approach to developing new and expanded specialized community-based services for target populations. The principles of Reform demanded that we think beyond our desks concerning service-delivery design and build our individual treatment plans around a central query, "what array of services are needed to keep this person living safely and independently in the community, how do we make it happen and who can help?"

Today, in addition to about 3,000 non-target population adults and youth served by High Plains, we provide services to 479 severe and persistently mentally ill (SPMI) adults and 259 severely emotionally disturbed (SED) youth and their families. I should note that all of these 738 persons would be at risk for hospitalization without intensive community services. For State Hospital backup, we have 14 adult and 9 youth beds allocated to us at Larned. Prior to Reform we occupied a minimum of 40 beds.

Today, clients have access to case management services no matter where they live in northwest Kansas; all have access to 24/7 screening and emergency service; all have access to nursing and psychiatry; all case management clients have access to transportation; post-Reform, clients have access to an additional 48 safe and affordable USDA apartments (managed by High Plains) in Hays and Colby; and, clients have access to vocational services and supported employment. In addition to outreach children's case management throughout northwest Kansas, high risk youth in and around Ellis county have access to an alternative school, designed to keep children and families together, at home and in school.

Today, our relationship with the State Hospital is a close and collaborative push for continuity of care and treatment. All hospitalized persons are first screened by mental health center staff to determine whether or not the individual can be safely and appropriately served in the community. We participate in all discharge planning to make sure community follow-up is properly planned and scheduled. For the 75% or so that are diverted from hospitalization, we are obligated and responsible to provide appropriate community services wherever needed. For a service area the size of northwest Kansas, a substantial barrier is distance. In that regard we now have 37 vehicles and in 1999, staff logged some 568,000 miles taking care of business.

In retrospect, Mental Health Reform was remarkably planned and executed over a six-year period of east to west phase-in. It was a policy commitment of system change that was made to the mentally ill, their families and community providers across Kansas. It was a promise kept by successive administrations. Stakeholders, including the Legislature, owned it and stakeholders made it work.

As a result, Kansas is seen as a leader in mental health policy. Many have asked for information from stakeholders in this state for guidance and consultation with regard to creating and sustaining a locally managed, integrated system of public mental health care. The Reform principles were bold statements which have shown other states that change in the Kansas mental health system (contrary to some national predictions) has been considerably more interesting than "watching the wheat grow."

Thank you for this opportunity to present my point of view.

HIGH PLAINS MENTAL HEALTH CENTER

SERVICE DELIVERY SYSTEM (20 Northwest Kansas Counties - 19,000 Square Miles)

COLBY Branch Office

OP Adult &Youth
Individual, Group, Family
Emergency/Screening
Case Management
Psychiatry & Nursing
Drug & Alcohol
Consultation/Education
Psychosocial Group
Psychoeducational Classes

Colby House Apartments

Case Management
Psychosocial Services

Atwood & Hoxie Offices

OP Adult, Youth, Family
Consultation/Education

Decatur, Gove, Logan, Sheridan, & Thomas Counties

Community Case Management

FCSC Project
Cheyenne, Rawlins, Decatur, Sherman, Thomas, Sheridan, Graham, Wallace, Logan, Gove, and Trego

Family Centered System of Care

GOODLAND Branch Office

OP Adult & Youth
Individual, Group, Family
Emergency/Screening
Case Management
Psychiatry & Nursing
Evaluation
Drug & Alcohol
Consultation/Education
Psychosocial Group

Cheyenne, Rawlins, Sherman & Wallace Counties

Community Case Management

HAYS

Central Office

Adult, Child, Family
Drug & Alcohol
Sex Offender Group
Domestic Violence
Psychiatry & Nursing
Emergency/Screening
Evaluation
Clinical Consult.

Case Management
Psychosocial Group
Medication Clinic
Consultation/Educa.
Psychoeduc. Classes
Outpatient
Gatekeeping
Administration

CSS Woodhaven Apartments

Psychosocial Services
Nursing
Family Support
Case Management
State Hospital Liaison
Vocational
Psychiatry
Housing
Employment
Compeer

CBS Westside School

Youth Partial Hospital
Home Based Services
Family Therapy
Alternative Education
In-Home Crisis Services
Psychiatry
Case Management
Family Support
Respite Care

USD 489 Rural Project "Safe Schools"

Ellis, Ness, Rush, Russell & Trego Counties

Community Case Management

Quinter Office

OP Adult, Youth, Family
Consultation/Education

NORTON Branch Office

OP Adult & Youth
Individual, Group, Family
Emergency/Screening
Case Management
Psychiatry & Nursing
Evaluation
Drug & Alcohol
Consultation/Education
Psychosocial Group

Oberlin Office

OP Adult, Youth, Family
Consultation/Education

Decatur & Norton Counties

Community Case Management

PHILLIPSBURG Branch Office

OP Adult & Youth
Individual, Group, Family
Emergency/Screening
Case Management
Psychiatry & Nursing
Evaluation
Drug & Alcohol
Consultation/Education
Psychosocial Group

Phillips & Graham Counties

Community Case Management

OSBORNE Branch Office

OP Adult & Youth
Individual, Group, Family
Emergency/Screening
Case Management
Psychiatry & Nursing
Evaluation
Drug & Alcohol
Consultation/Education
Psychosocial Group

Smith Center Office

OP Adult, Youth, Family
Consultation/Education

Osborne & Smith Counties

Community Case Management

Calendar Year 1999 Clinical Services

Services	Hours
Community Support	22,658
Westside School	29,322
Emergency/Screening	3,808
Outpatient	34,159
Drug & Alcohol	1,348
Inpatient	289
Consultation/Education	2,094
Housing (Residential Days)	15,636
1999 Staff (FTE)	137
1999 Budget	$6,573,565

1-19-00