

Approved: 1-26-00
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on January 20, 2000 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:

Lisa Montgomery, Revisor of Statutes
Hank Avila, Legislative Research Department
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Mack Smith, Executive Secretary, Kansas Board of Mortuary Arts
Pam Scott, Executive Director, Kansas Funeral Directors and Embalmers Assn.
Ellen Piekalkiewicz, Association of Community Mental Health Centers of Kansas
Kermit George, Executive Director, High Plains Mental Health Center, Hays
Clyde Graeber, nominee for Secretary of the Kansas Department of Health and Environment

Others attending: See attached list

Introduction of bills

Mack Smith, Executive Secretary, Kansas Board of Mortuary Arts, requested the Committee introduce legislation that would authorize regulation and licensing of crematories in the state. (Attachment 1) Senator Steineger made a motion the Committee introduce the proposed legislation, seconded by Senator Salmans. The motion carried.

Pam Scott, Executive Director, Kansas Funeral Directors and Embalmers Association, requested the Committee introduce legislation that would define by statute who has the right to control disposition of a decedents remains. (Attachment 2) Senator Jones made a motion the committee introduce the proposed legislation, seconded by Senator Becker. The motion carried.

Briefing on Mental Health Issues

Ellen Piekalkiewicz, Director of Policy and Planning, Association of Community Mental Health Centers of Kansas, briefed the Committee on the mental health system prior to mental health reform, mental health reform objectives, and highlights of the Mental Health Reform Act as outlined in her written testimony. (Attachment 3). A report from the University of Kansas entitled, "Mental Health Reform in Kansas: Cost Containment and Quality of Life" was also distributed to the Committee. (Attachment 4)

Kermit George, Executive Director of the High Plains Mental Health Center in Hays, Kansas, spoke to the Committee about his experience and involvement with mental health issues before and after the 1990 Mental Health Reform Act. He noted that today the High Plains Mental Health Center's relationship with the state hospital is a close and collaborative push for continuity of care and treatment, and that Kansas is seen as a leader in mental health policy. (Attachment 5)

Confirmation hearing

Clyde Graeber, nominee for the position of Secretary of the Kansas Department of Health and Environment, briefed the Committee on his experience with the agency since his appointment by the governor. He noted that Kansas leads the nation in awareness and testing of underground water contamination. Some of the topics discussed by the Committee included clean air and water quality standards, separation of the Department of Health and Environment into two agencies, federal inspection guidelines of nursing homes, and cooperation with the Department on Aging in regard to nursing home regulations.

Senator Steineger made a motion the Committee recommend to the full Senate the name of Clyde Graeber for Secretary of the Kansas Department of Health and Environment, seconded by Senator Becker. The

motion carried.

Approval of Minutes

Senator Salmans made a motion to approve the Committee minutes of January 12 and 13, 2000, seconded by Senator Jones. The motion carried.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for January 26, 2000.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: 1/20/00

NAME	REPRESENTING
Judy Molar	Ks. Assn. of Counties
Paul M. Blotz	Assoc. of CMHC's of Ks. Inc.
Kenneth George	High Plains MHC
Ally Tracy	Ks. Public Health Assn.
Pam Scott	Ks Funeral Directors Assn.
Karen Suddath	SRS
Ann Kellogg	Ks. Chapter of National Ass. of Socialworkers
Rin Griffin	Health Midwest
Jim Wood	Via CHRISTI HEALTH System
Josie Torres	Ks Council on Dev. Disabilities
Chip Wheelen	Osteopathic Assoc.
Debra Zehr	Ks Homes + Services for Aging
Larrie Ann Lower	Ks Assoc of Health Plans
Jerry Slaughter	Ks Medical Society
Chris Collins	"
Tom Bell	Kansas Hosp. Assn.
Danielle Noe	Governors Office
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The Kansas
State Board of Mortuary Arts

CREATED AUG. 1, 1907

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WEB SITE: <http://www.ink.org/public/ksbma/>

Tuesday, January 18, 2000

Senator Sandy Praeger
Room 128-South
State Capitol
Topeka, Kansas 66612

Dear Senator Praeger:

The Kansas State Board of Mortuary Arts is requesting introduction of a bill that would authorize regulation and licensing of crematories in the state of Kansas. Due to the increase number of consumers choosing cremation for purposes of final disposition and the increasing number of questions by consumers directed to our office, the Board believes that such regulation is necessary at this time.

I'm including some proposed language that is based on the model law of the Cremation Association of North America (CANA) that has been modified to work with the state of Kansas.

Thank you in advance for your consideration. I will be glad to answer any questions that you or the committee may have at this time.

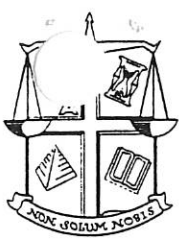
Sincerely,

Mack Smith, Executive Secretary
Kansas State Board of Mortuary Arts

MS
enclosures

a:\Bill Request .wpd-Cremation diskette

Senate Public Health & Welfare
Date:
Attachment No. /



KANSAS FUNERAL DIRECTORS AND EMBALMERS ASSOCIATION, INC.

1200 S. KANSAS AVENUE ♦ PO BOX 1904 ♦ TOPEKA, KS 66601-1904

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EXECUTIVE DIRECTOR

PAM SCOTT
Topeka

Date: January 20, 2000
To: Senate Public Health & Welfare Committee
From: Pam Scott, Executive Director
Re: Right to Control Disposition Legislation

Madam Chair and Members of the Committee, I am before you today requesting introduction of a bill that would define by statute who has the right to control disposition of a decedents remains. A copy of the proposed legislation is attached.

Currently Kansas has no statutes concerning the right to control disposition. The issue is governed by Kansas case law. This legislation will provide guidance to Kansas citizens and funeral directors as to who has the right to make decisions concerning disposition. It will also provide a means for a guardian at time of death to make decisions or authorize cremation in instances where there is no family available. This will assist in cases that fall under the SRS Funeral Assistance Program which provides those on public assistance \$550 toward funeral expenses.

We respectfully ask for the introduction of this legislation.

Senate Public Health & Welfare
Date: 1-20-00
Attachment No. 2

Right to Control Disposition

RIGHT TO CONTROL DISPOSTION (a) The following persons, in order of priority stated, when persons in prior classes are unavailable at time of death, may order any lawful manner of final disposition of a decedent's remains, including burial, cremation, entombment, or anatomical donation:

- (1) the agent for health care decisions establishment by a durable power of attorney for health care decisions pursuant to K.S.A. 58-625, et seq., and amendments thereto, if such power of attorney conveys to the agent the authority to make decisions concerning disposition of the deceased's body,
- (2) the spouse of the decedent,
- (3) the decedent's surviving adult children. If there is more than one adult child, any adult child, who confirms in writing the notification of all other adult children, may serve as the authorizing agent, unless the crematory authority receives written objection to the cremation from another adult child.
- (4) the decedent's surviving parents,
- (5) the persons in the next degree of kinship under the laws of descent and distribution to inherit the estate of the deceased. If there is more than one person of the same degree, any person of that degree may direct the manner of disposition,
- (6) a guardian of the person of the decedent at the time of such person's death,
- (7) the personal representative of the deceased,
- (8) in the case of indigents or any other individuals whose final disposition is the responsibility of the state or county, the public official charged with arranging the final disposition pursuant to K.S.A. 22a-215.

(b) A funeral director, funeral establishment or crematory shall not be subject to criminal prosecution or civil liability for carrying out the otherwise lawful instructions of the decedent or the person or persons under Section 1 whom the funeral director reasonably believes is entitled to control final disposition.



Association of Community Mental Health Centers of Kansas, Inc.

700 SW Harrison, Suite 1420, Topeka, KS 66603-3755

Telephone (785) 234-4773 Fax (785) 234-3189

Web Site: www.acmhck.org

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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Leavenworth

James E. Cain
Member at La
Pomona

Senate Public Health & Welfare

Date: 1-20-00

Attachment No. 3

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~~ ³⁶⁰.
- 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.

MENTAL HEALTH REFORM IN KANSAS: COST CONTAINMENT AND QUALITY OF LIFE

RONNA CHAMBERLAIN,
CHARLES A. RAPP,
PRISCILLA RIDGWAY,
ROBERT LEE &
CYNTHIA BOEZIO

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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 led 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 Osawatomi

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 Osawatomi 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.

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 fig-

ure 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

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 Osawatomic 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 Osawatomic 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 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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Senate Public Health and Welfare
Date: 1-20-00
Attachment No. 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.

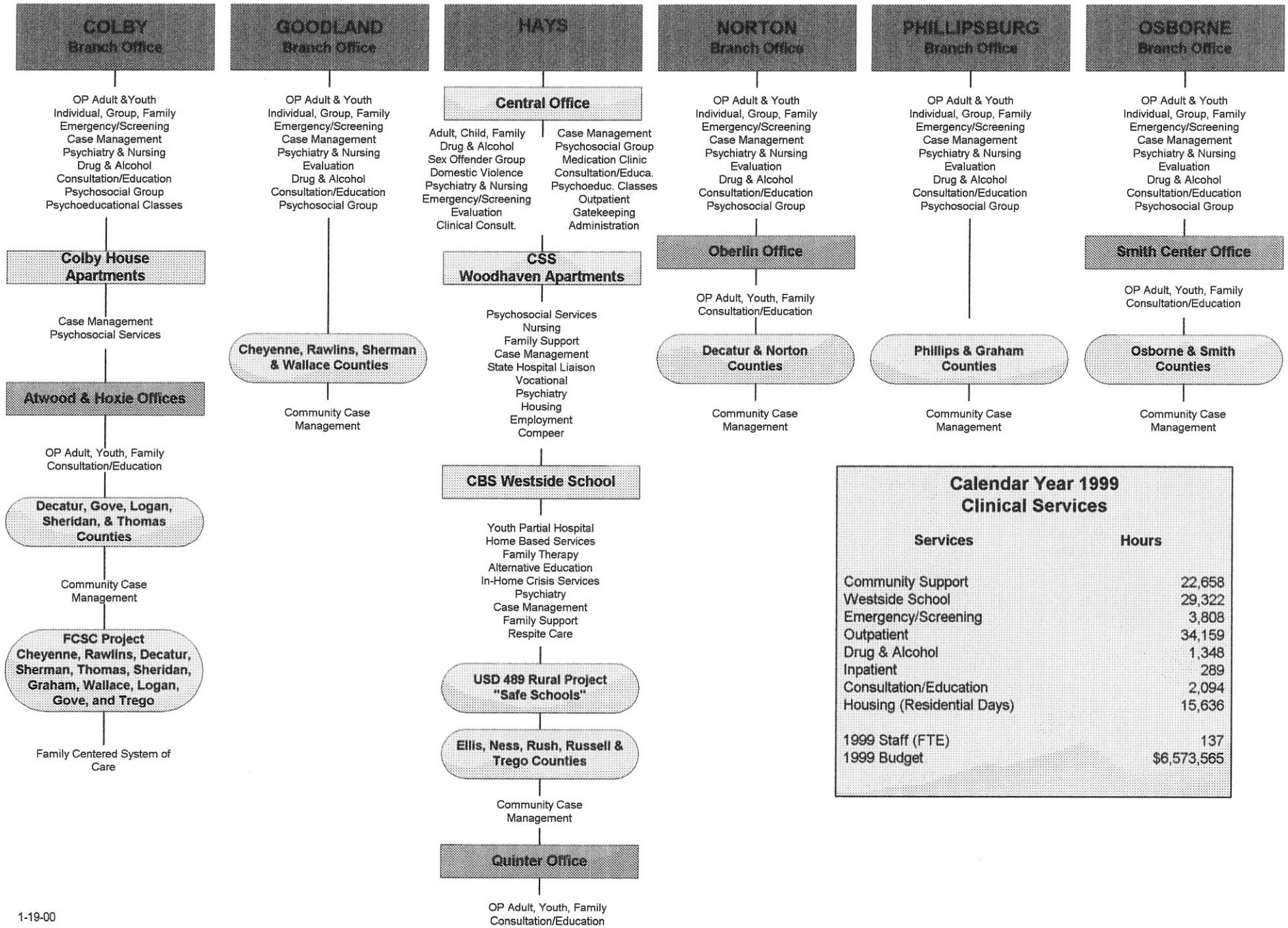
In retrospect, Mental Health Reform was remarkably planned and executed over a six-year period of east to west phase-in. It was a policy commitment of system change that was made to the mentally ill, their families and community providers across Kansas. It was a promise kept by successive administrations.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



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