534 S. Kansas, Suite 330, Topeka, Kansas 66603
Telephone: 785-234-4773 / Fax: 785-234-3189
www.acmhck.org

Testimony to Joint meeting of

House Children and Families Committee
and
House Corrections and Juvenile Justice Committee

on

Psychiatric Residential Treatment Facilities

February 9, 2012

Presented by:

Michael J. Hammond, Executive Director
Association of CMHCs

Good morning Committee Chairs and members of the respective Committees, my name is Mike Hammond, I am the Executive Director of the Association Community Mental Health Centers of Kansas, Inc. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. I do have numerous CMHC Directors and staff in the room today and they are prepared to help answer any questions you might have about processes at the local level. I also have staff from Kansas Health Solutions (KHS), the Medicaid managed care organization, in the room to help answer questions.

Snapshot of the CMHC System in Kansas

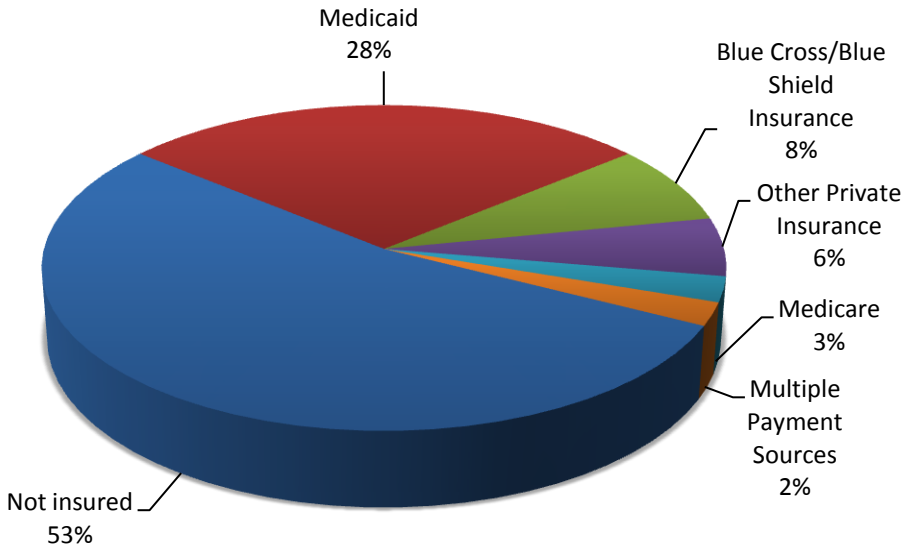
In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. In Kansas, you first must be designated by your County to serve as the CMHC to the county residents, then you must secure a license from the Kansas Department of Social and Rehabilitation Services (SRS), to become the publicly funded CMHC and recognized as such by the State of Kansas. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. Together, they employ over 4,500 professionals.

The CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs. Collectively, the CMHC system serves over 123,000 Kansans with mental illness. Some of the demographics of those we serve are listed below.

Characteristics		
SPMI	19,997	16%
SED	21,299	17%
Non-SPMI	67,937	55%
Non-SED	13,247	11%

Age		
0-17	35,593	29%
18-20	7,364	6%
21-64	74,867	61%
65+	4,909	4%

Gender		
Male	57,685	47%
Female	65,048	53%



The federally mandated target population consists of adults who have a severe and persistent mental illness (SPMI) and children/adolescents who have a serious emotional disturbance (SED). The non-target population is basically everyone else served by the CMHC. We also know that of those served by the CMHC system who are non-Medicaid, and reporting income information, 69% earn less than $20,000 a year.

The pie chart reflects a payor mix of those served by the CMHC system (the groupings do overlap). Once the particular benefits run out or we determine coverage limits, if that particular source of payment is exhausted and the need is still there, the grants would then pick up the cost of care. Sliding fee scales and the grants are what make

our services affordable to those who either have no resources or their ability to pay prohibits them paying 100 percent of the cost.

We are a system that is not self contained, but rather one that crosses boundaries. For example, the correctional system is one that if you haven't broken the law, you don't get in their system. For community mental health, there aren't any boundaries. Literally every other human service system recognizes the need for mental health services. The CMHCs integrate and collaborate with systems such as education (regular education and special education), juvenile justice, developmental disabilities, corrections, aging, child welfare, general medicine, law enforcement, and many more.

As the local Mental Health Authorities for community-based mental health services in Kansas, CMHCs provide the primary linkages between and among service agencies as well as transitioning consumers from child to adult services. The CMHCs serve as the gatekeepers to state mental health hospital treatment by screening all referrals to state hospitals. Also, to ensure necessary linkages with community supports, mental health reform legislation mandates "that no patient shall be discharged from a state hospitals if there is a participating CMHC serving the area where the patient intends to reside, without receiving recommendations from such participating mental health center." Each CMHC has one or more liaisons who go to the state hospitals to assist with discharge and aftercare plans, as well as coordinating with private psychiatric facilities and nursing facilities for mental health (NFMHs).

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals through mental health programs in the least restrictive environment. The CMHCs strongly endorse treatment at the community level in order to allow individuals to keep functioning in their own homes and communities at a considerably reduced cost to them, third-party payers, and the taxpayer.

Highlights of funding reductions sustained by the CMHC system:

1. **$20 million reduction in Mental Health Reform grants since FY 2008 – a 65 percent reduction.**
2. **$33.4 million all funds in Medicaid reductions (10% rate reduction in FY 2010; Medicaid spending reduction through a directive from SRS for FY 2011 and FY 2012).**
3. **$3.1 million in MediKan funding in FY 2010 – a 45 percent reduction.**
4. **$560,000 SGF in Community Support Medication Program funding during FY 2010 – a 53 percent reduction.**
5. **$1.8 million SGF reduction (total elimination) for non-Medicaid psychiatric inpatient screening in FY 2012.**

Collectively, the CMHC system has seen a reduction of $38.2 million in SGF since FY 2007 ($59.1 million AF).

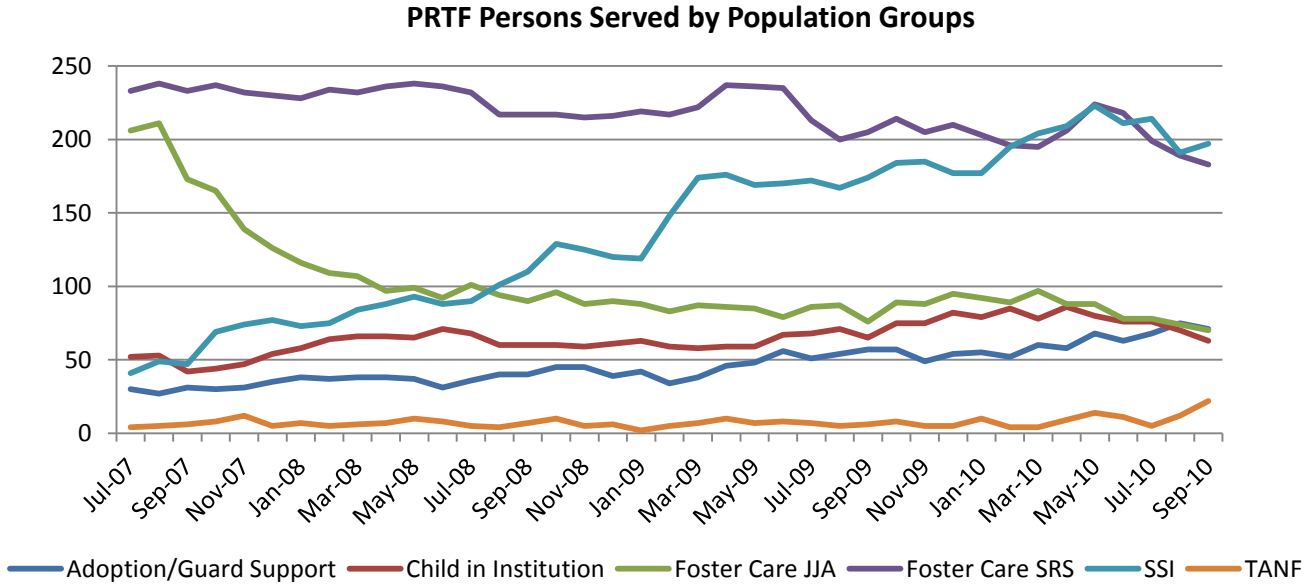
Brief Background on PRTFs

The PRTFs provide residential mental health treatment for children with SED who CMHCs and or private mental health practitioners cannot safely and effectively treat in the community. Treatment is provided to children up to 22 years of age. The PRTFs provide intensive, focused treatment to promote a successful return to the community. There are 15 privately operated Medicaid certified PRTFs in Kansas and along the Kansas-Missouri border.

The SRS budget includes the cost of all children served in PRTFs, except those in the custody of the Juvenile Justice Authority (JJA). The PRTFs are reimbursed based on reported costs subject to upper limits similar to rate setting methods used for nursing facilities and State hospitals.

Concern Around High Utilization

Discussions began in 2010 between SRS/DBHS and CMHCs around high utilization of PRTFs and the expenditures associated with such. The agency noted the average number of children in PRTFs was continually on the rise since FY 2008 (Average number of children in PRTFs paid by SRS, FY 2008 = 332; 408 in FY 2009; and 485 [10 months] in FY2010. **Some of the discussions with the agency centered around the fact that proximity may have an impact…meaning the more available the service, the more it will be used; and that it appeared parents chose to not engage their child in treatment until behaviors reached a crisis level. Once they learned about the PRTF as a treatment resource, parents insisted on accessing it rather than trying community based services first. According to SRS data, this occurred 33% of the time when admission to a PRTF had occurred. Families were not engaging in community based services and approached the CMHC only after the child was in crisis and community-based services were of no interest to the family. Among the conclusions reached was that there was no single risk factor contributing to the use of PRTFs.**



The purple line (foster care) has historically had a high use of residential treatment for high need, hard to place kids. It appears the trend began to have a downward turn in the fall of 2010. This would coincide with the Performance Improvement Plans (PIPS) that were implemented by SRS to lower PRTF use.

The light blue line (SSI) which shows the most dramatic increase makes perfect sense because it includes the waivers. The rise started in July 2007 because that is when the rules changed allowing kids in parental custody to access this treatment resource. Prior to that, a child had to be in SRS custody to access residential treatment.

Several CMHCs were placed on PIPs by SRS/DBHS in 2010 to address concerns about overutilization of PRTFs. At that time, SRS/DBHS believed much more could be done in CMHC areas that were high users of PRTFs to prevent admissions, citing that not only are PRTFs an expensive treatment option, but that residential treatment is not necessarily generalized to the child's home. In early 2011, with the transition to a new administration, SRS/DBHS was concerned about the focus of the Division of the Budget on growth in Medicaid mental health expenditures. As a result, SRS/DBHS came to the Association and to Kansas Health Solutions (KHS), asking that we work together to slow the growth in Medicaid expenditures. It was followed up with a letter from the Mental Health Director at SRS dated January 12, 2011, "directing KHS to fully and aggressively implement several new priorities that will lead to even more improvement in Kansas' public mental health system."

The primary goal was to reduce overutilization of services within PRTFs, community-based services and inpatient services. The amount estimated to be saved was $6.8 million AF in FY 2011 and $17 million AF in FY 2012. It should be noted that the $6.8 million AF became a part of the Governor's Allotments issued for FY 2011, announced on March 11, 2011.

Following receipt of the letter from SRS in January, the Mental Health Director at SRS shared trending data with the Association and KHS that was specific to utilization of PRTFs, SED Waiver, Inpatient and community-based services. The Mental Health Director at SRS sent weekly emails to the Association and KHS following at the beginning of implementation of the directive, whereby targets for hitting the new projected spending targets were identified along a series of milestones, and comparing actual expenditures with the weekly target.

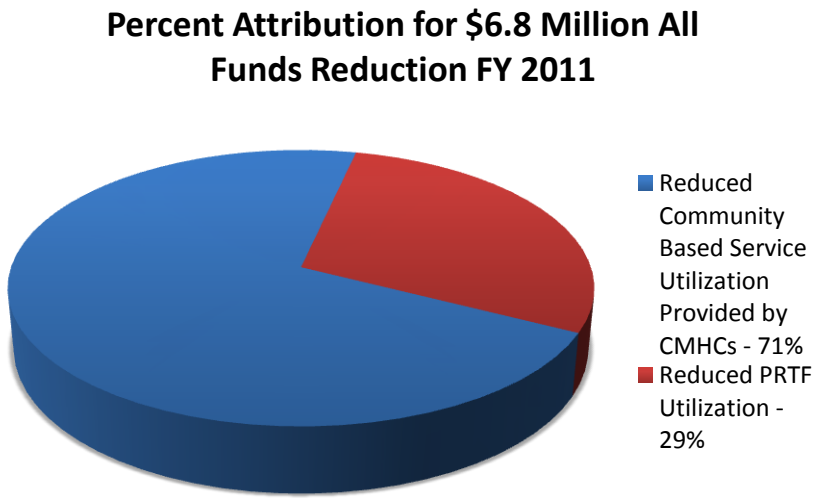
By May 2011, SRS/DBHS began hearing concerns from PRTFs around reduced utilization of PRTFs and sharing of anecdotal information, SRS/DBHS began reviewing all PRTF screening decisions made by CMHCs. It should be noted that KHS assigns care coordination to all children with an SED who are screened out of or discharged from a PRTF who either are PAHP eligible or who KHS anticipates will become PAHP eligible. Those KHS Care Coordinators ensure these children receive needed mental health services. In addition, SRS assigns clinical staff to review the status of all children screened for PRTF services or discharged from a PRTF. **Since the SRS reviews began, the Mental Health Director and SRS leadership have indicated that overall, the reviews showed that the CMHCs were making the appropriate decisions and service delivery was occurring.**

Secretary Siedlecki further clarified the agency's intent with the policy in June 2011 that children with SED should receive the right service at the right time by the right provider in the right amount so they experience recovery and live safe healthy and successful lives in family homes. Children whose psychiatric treatment cannot be safely and effectively served in the community can and should be screened and provided access to PRTFs.

It should also be noted that since this policy change and implementation of such began, SRS convened an Advisory Group to recommend any needed changes in how PRTF admission and discharge decisions are made.

Slowing the Growth in Medicaid Mental Health

Tied to the letter of directive from SRS referenced above, KHS was given a target of $6.8 million AF for FY 2011 for reduced expenditures. The results are reflected in the pie chart below:



Providers within the KHS network were given spending targets for their Medicaid expenditures for the remainder of FY 2011. As it related to PRTFs, KHS (with SRS approval) instructed its provider network to not restrict access to community-based mental health services for children and adolescents screened and diverted or discharged from a PRTF.

Even with the Medicaid reductions in play, data shows the CMHCs were serving more children in the first quarter of FY 2012 than they were in first quarter of FY 2011.

What the Data Shows

The following data comes from Kansas Health Solutions. It is the same data that would be available to SRS. This data reflects the following:

- 80% of screens result in an admission
- 4% of all screens are appealed
- The appeals process appears to be working
- Screens are occurring timely
- Services are being provided timely when diversion occurs

PRTF Screens, Admissions and Diversions

	Screens	Admissions	% Admissions	Diversions	% Diversions
FY10	3494	2984	85%	510	15%
FY11	3172	2585	82%	587	19%
FY12 (thru 12/31)	1091	875	80%	216	20%

Screens Appealed

	Screens	Screen Appeals	% Appealed	% Overturned
FY10	3494	39	1%	51%
FY11	3172	66	2%	32%
FY12 (thru 12/31)	1091	49	4%	45%

I did ask KHS about trends they are seeing with the overturned appeals. One trend is related to dual diagnosis (MI/MR) or autism spectrum. Kansas Health Solutions has engaged its provider network on continuing education around these two issues. There has been a recent training hosted by Dr. Rob Fletcher of the National Association of Developmental Disabilities (NADD) on dual diagnosis issues and clinical diagnoses of such; and another one later this month with Dr. Valerie Gaus on autism spectrum.

Timeliness of Screens

	Screens	% Achieving Standard
FY11	3172	97%
FY12 (thru 12/31)	1091	98%

Total number of PAHP Members diverted at PRTF Initial screen (March 1, 2011 through November 30, 2011)

Service Provision	Number of Members	Percentage
Within 10 days of diversion	181	77%
Between 11-30 days of diversion	43	18%
Greater than 30 days of diversion	5	2%
With no service provision	7	3%
Total	236	100%

Of the seven Members with no service provision by a CMHC, six were in a juvenile detention facility at the time of their screen and one was at home with family and has never been registered for outpatient mental health services under the PAHP contract.

Of the five Members with service delivery by a CMHC occurring greater than 30 days, three were in detention at the time of the screen and two were in an inpatient facility at the time of the screen.

Occasionally, community based services may not occur for children diverted from PRTF placement within 10 days. This is due to a variety of factors, but can most often be attributed to where the child is in residence at the time of the screen. The majority of these cases (70%) are due to a child residing in an inpatient facility or juvenile detention center. In these cases, should the child be diverted from a PRTF placement, they will continue to receive care from the facility, rather than community based services from the CMHC.

We do know that for those in service referenced above, their average length in service was 4.2 months. We also know that for those who do not show in the data set as accessing services after being diverted, most were not PAHP eligible. That does not mean they did not receive services necessarily. It simply means Medicaid did not pay for those services.

Services Most Often Provided to Children Diverted from PRTFs

- Attendant Care
- Community Psychiatric Supportive Treatment
- Psychosocial Rehabilitation
- Targeted Case Management
- Special Family Therapy
- Medication Management
- Wrap Around Facilitation

Diversion Plan Outcomes (March 1, 2011 through November 20, 2011)

- 236 PAHP Members were diverted at PRTF Initial screen between March 1, 2011- November 30, 2011.
- 118 (50%) of which did not have a service within 3 days of diversion.
- Of these 118 Members, 71 were involved with Care Coordination.

The parent or guardian of 49 of these 71 Members answered one or more of Care Coordination's questions regarding the diversion plan (i.e., alternative community service plan) provided at the time of the screen. Below you will find data regarding their responses.

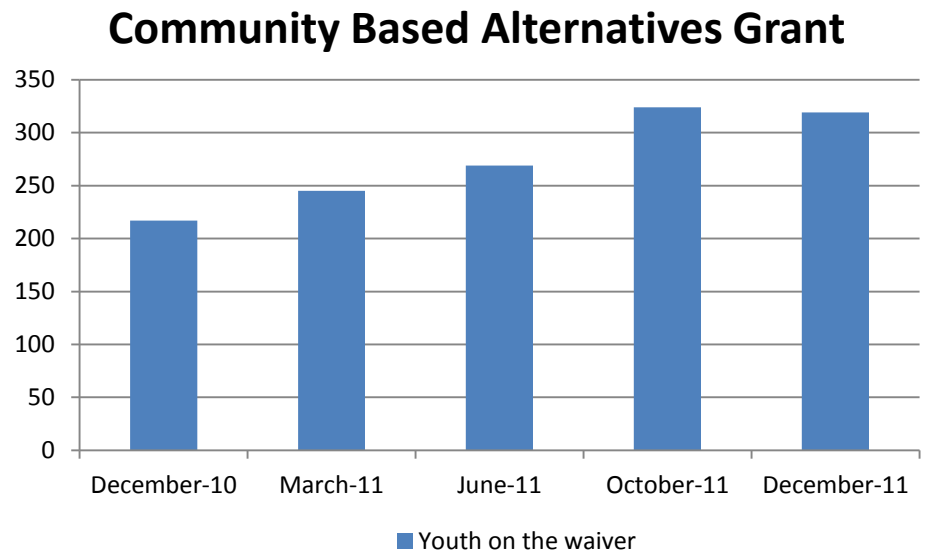
Questions	Yes		No	
	Number of Members	Percentage	Number of Members	Percentage
Did you receive a diversion plan that you understand?	43	88%	6	12%
Do you consider the diversion plan adequate? (Only 46 answered)	36	78%	10	22%
Are you planning/able to follow through with the diversion plan? (Only 45 answered)	41	91%	4	9%

Growth in the PRTF Community Based Alternatives Grant

Kansas has a PRTF Community Based Alternatives (CBA) Grant awarded by CMS to further enhance resources available to CMHCs to keep children out of PRTFs or reduce their stay in a PRTF. The CBA Grant provides a community based service alternative to treatment in a PRTF through both diversion and transition. The goals are to divert children/youth at risk of placement in a PRTF and to transition children/youth residing in a PRTF back into the community. It was anticipated that implementation of the CBA Grant would result in:

1. A decrease in the average length of stay for qualifying youth residing in a PRTF.
2. A decrease in admissions to PRTF.
3. An increase in the number of youth diverted from a PRTF who do not return for an inpatient certification of need within 6 months from beginning the program.

The number of youth on the CBA Grant just prior to the implementation of the policy directive through the end of last month shows a steady increase, as outlined below:



Impact on Children's Psychiatric Inpatient Services

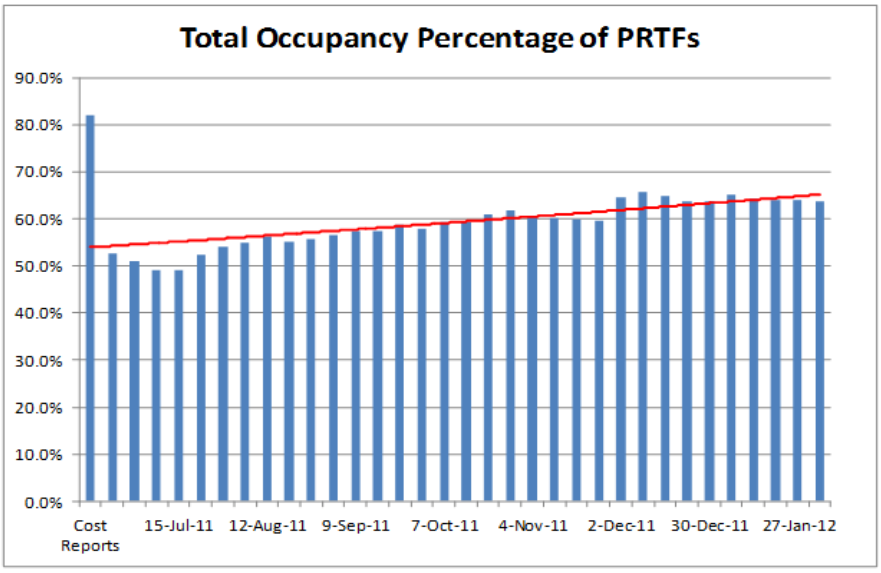
Change in policy could have had a detrimental effect on inpatient services. However, data reveals that did not occur. Of the 202 kids screened between May 30, 2011 and December 30, 2011, who were diverted from a PRTF, 12 (6 percent) were admitted to KVC Star or Wheatland after their diversion.

Challenges Implementing the Directive

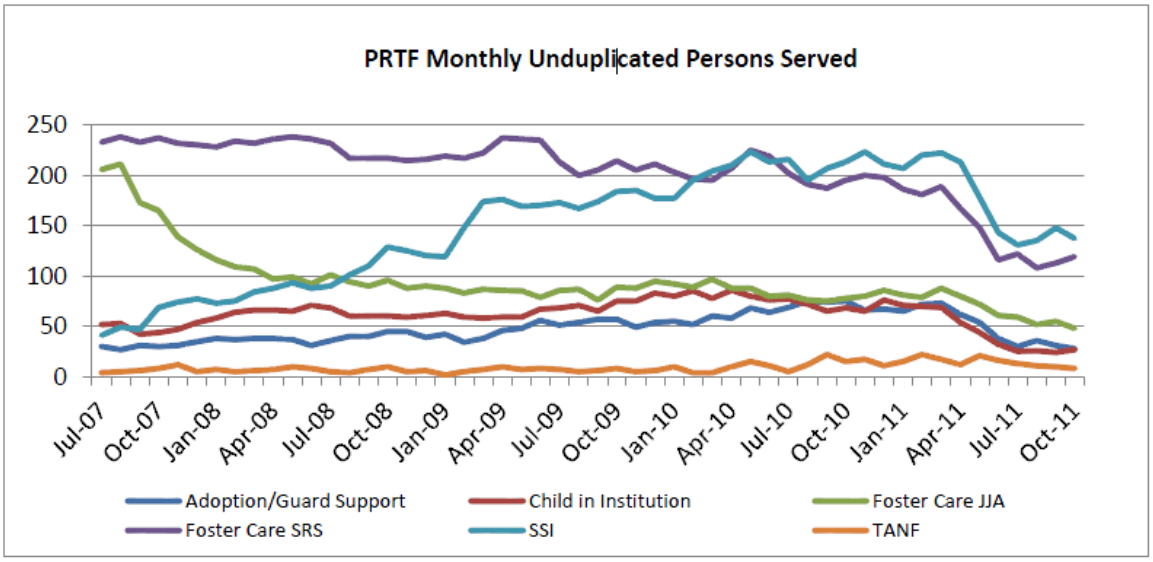
- Internal controls at some of the CMHCs were initiated in the beginning of implementing this directive that likely contributed to the sharp downturn of use of residential services and some of those internal controls were modified as more clarification was provided by SRS related to the directive.
- In some instances, children who are developmentally delayed and do not have a psychiatric diagnosis present for admission and do not meet medical necessity. It should be noted that it can be challenging to effectively diagnose persons with a developmental disability who also have a mental illness. This can create frustration in both systems in determining the most appropriate level of service in the least restrictive setting.
- Increases in requests from JJA where they (JJA) indicate they have no foster homes to access and YRC2 is not an appropriate placement (reference to foster homes here are those not part of the SRS foster care system that include CINC kids).
- You may hear frustrations today directed at the CMHCs. It is important to understand the process used by the CMHC. A clinician from a CMHC completes the PRTF screen with the support of the Community Based Service Team, which includes the family, child welfare case managers, JJA custodial case managers and mental health providers. The team may also include a medical director, but does use information/recommendations from a medical director. The final determination is made by the CMHC Screener. It is a treatment team that is involved in discharge decisions from a PRTF. The treatment team determines that the child can be safely and effectively served with community mental health services; family or guardian requests discharge; or a change in the child's status warrants discharge to a different level of service. **The point being made here is that it is a team of professionals involved in helping to reach the correct decision, not just one person.**

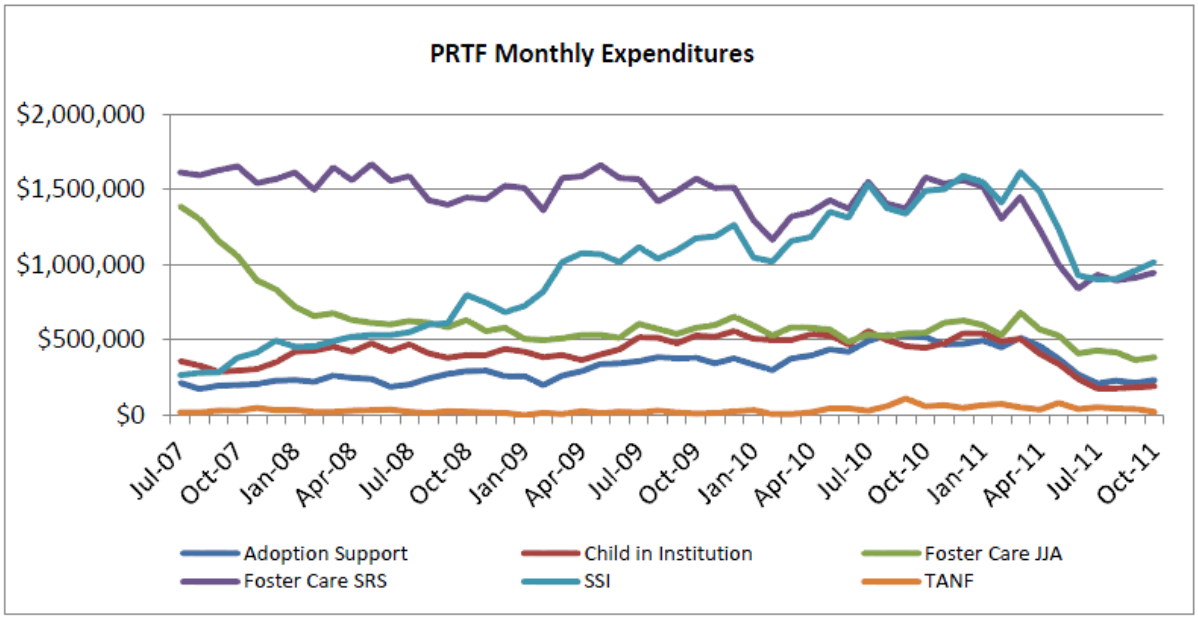
PRTF Occupancy Trends

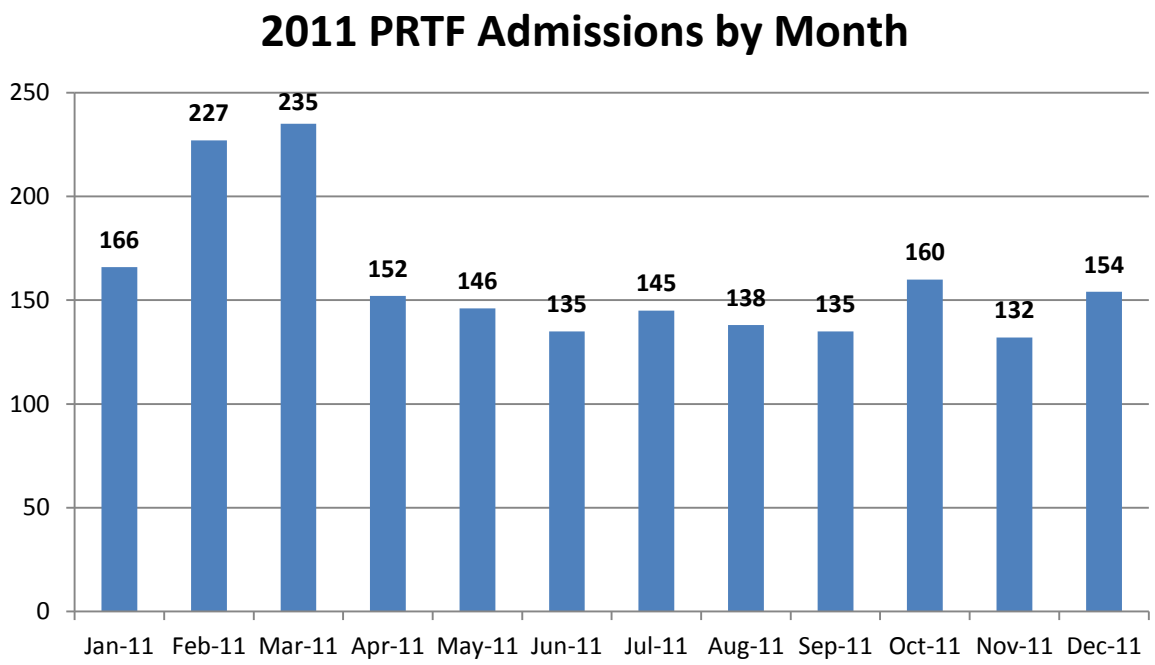
In looking at total occupancy percentages for PRTFs, occupancy averaged 82% as verified by the cost reports submitted by PRTFs for the period July 2010 to December 2010 and as low as 49% after the policy implementation. As of January 27th, 2012, average occupancy was back up to 63%. **There has been a steady climb since the low, and it appears to be trending upwards.** This data is based on PRTF cost reports that are self reported to SRS.

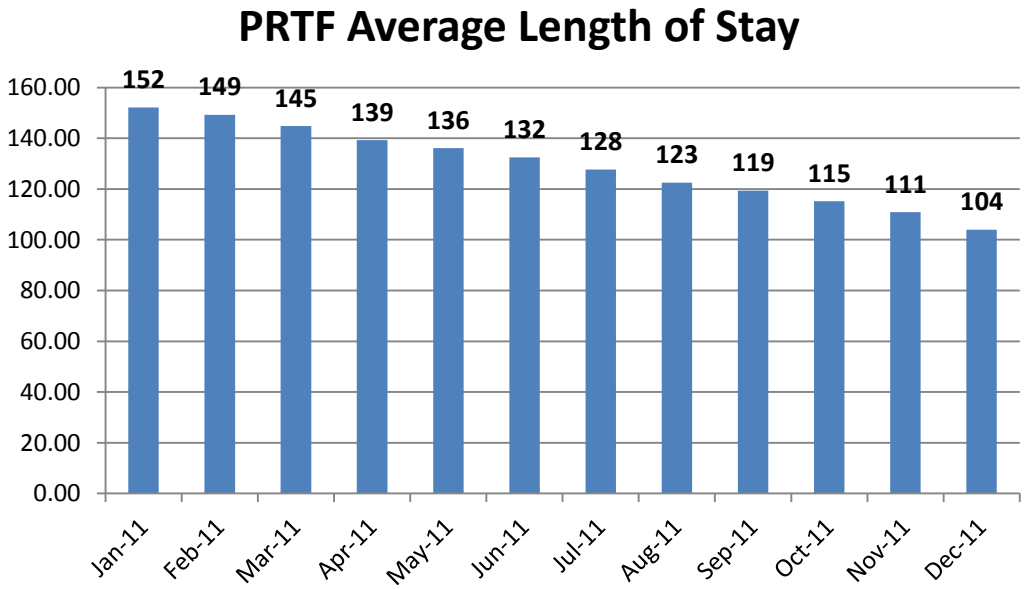


The policy change does appear to have worked in meeting the intent as we know it today – utilization of PRTFs across all population groups has since aligned and overutilization has been addressed; admissions appear to have stabilized; and average lengths of stay is declining. Logically, that has driven monthly expenditures on PRTFs down. The unintended consequence must also be stated, that PRTF facilities downsized and some even had to close.



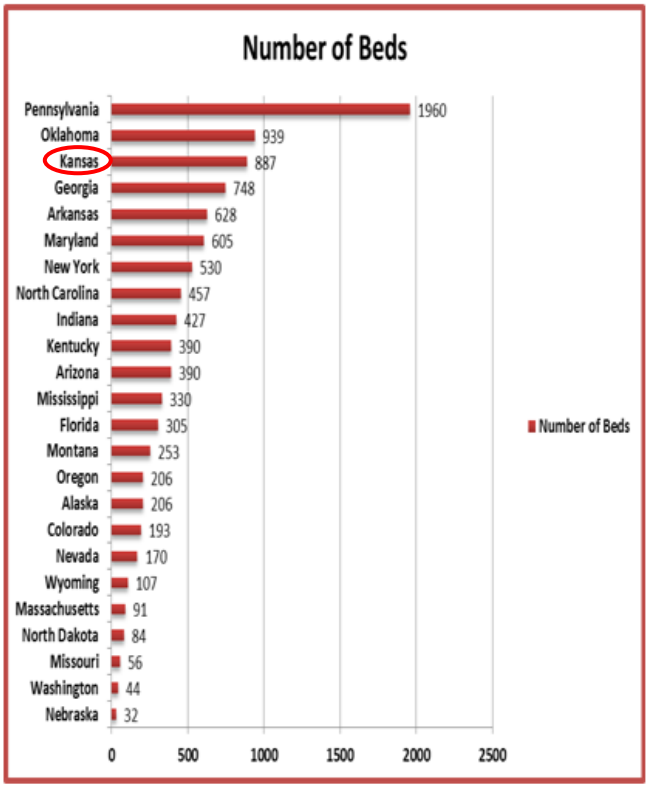


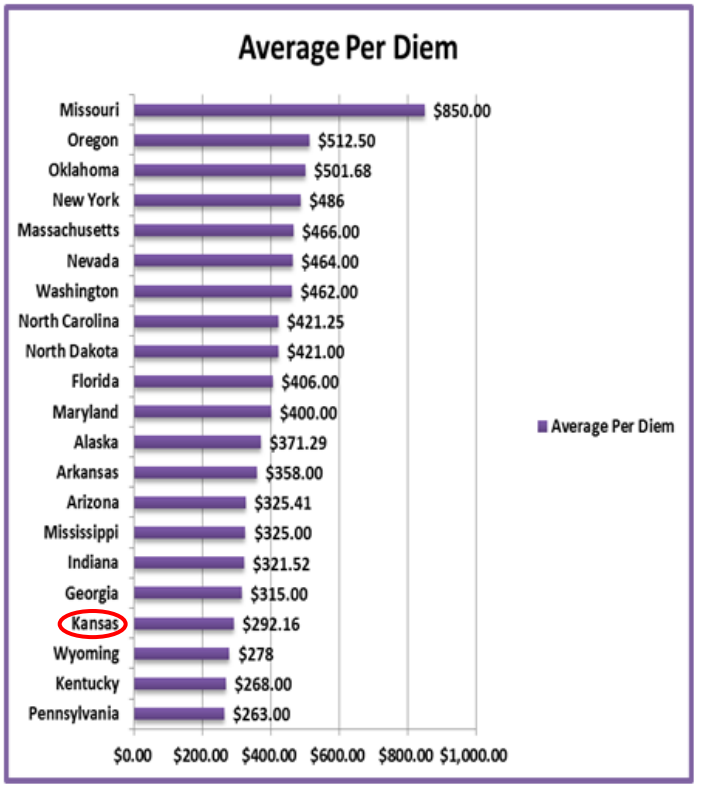


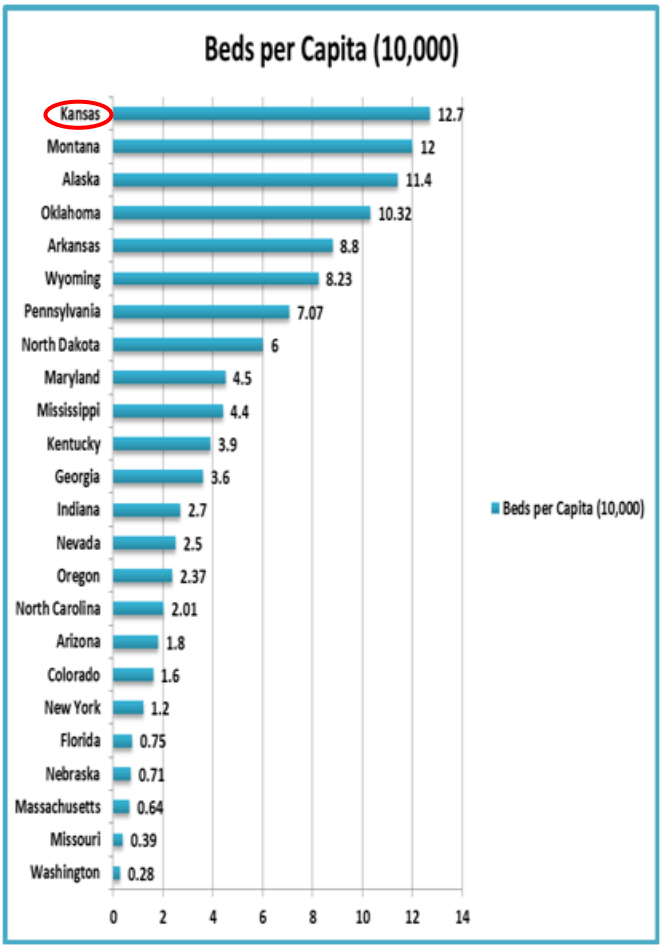


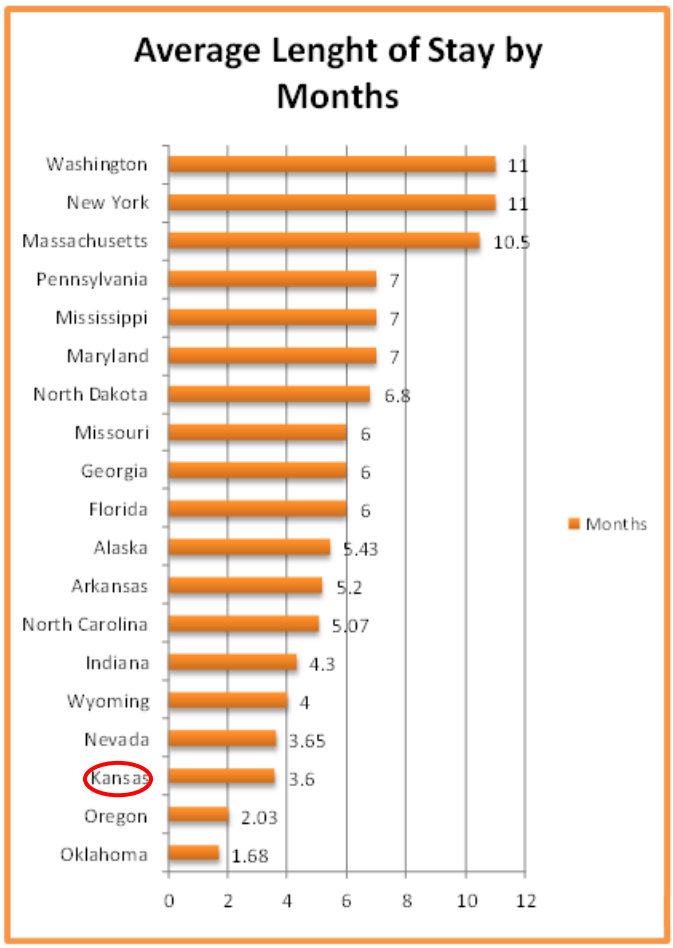
Capacity Adequacy

Georgetown University conducted a study (February 2011) from States who self reported having PRTFs. Twenty-five (25) States elected to provide the information. In looking at Kansas' ranking among the 25 States, Kansas ranks third highest in the number of PRTF beds, at 887, with the low being 32 and the high being 1,960. Kansas is fourth from the bottom in average per diem, at $292, with the low being $263, and the high being $850. Kansas ranks the highest among beds per capita (10,000), at 12.7, with the low being .28. Kansas ranks third lowest in average length of stay by months, at 3.6 months, with the low being 1.68 and the high being 11.


Number of Beds
Pennsylvania 1960
Oklahoma 939
Kansas 887
Georgia 748
Arkansas 628
Maryland 605
New York 530
North Carolina 457
Indiana 427
Kentucky 390
Arizona 390
Mississippi 330
Florida 305
Montana 253
Oregon 206
Alaska 206
Colorado 193
Nevada 170
Wyoming 107
Massachusetts 91
North Dakota 84
Missouri 56
Washington 44
Nebraska 32
0 500 1000 1500 2000 2500
Number of Beds


Average Per Diem
Missouri $850.00
Oregon $512.50
Oklahoma $501.68
New York $486
Massachusetts $466.00
Nevada $464.00
Washington $462.00
North Carolina $421.25
North Dakota $421.00
Florida $406.00
Maryland $400.00
Alaska $371.29
Arkansas $358.00
Arizona $325.41
Mississippi $325.00
Indiana $321.52
Georgia $315.00
Kansas $292.16
Wyoming $278
Kentucky $268.00
Pennsylvania $263.00
$0.00 $200.00 $400.00 $600.00 $800.00 $1,000.00
Average Per Diem


Beds per Capita (10,000)
Kansas 12.7
Montana 12
Alaska 11.4
Oklahoma 10.32
Arkansas 8.8
Wyoming 8.23
Pennsylvania 7.07
North Dakota 6
Maryland 4.5
Mississippi 4.4
Kentucky 3.9
Georgia 3.6
Indiana 2.7
Nevada 2.5
Oregon 2.37
North Carolina 2.01
Arizona 1.8
Colorado 1.6
New York 1.2
Florida 0.75
Nebraska 0.71
Massachusetts 0.64
Missouri 0.39
Washington 0.28
0 2 4 6 8 10 12 14
Beds per Capita (10,000)


Average Lenght of Stay by Months
Washington 11
New York 11
Massachusetts 10.5
Pennsylvania 7
Mississippi 7
Maryland 7
North Dakota 6.8
Missouri 6
Georgia 6
Florida 6
Alaska 5.43
Arkansas 5.2
North Carolina 5.07
Indiana 4.3
Wyoming 4
Nevada 3.65
Kansas 3.6
Oregon 2.03
Oklahoma 1.68
0 2 4 6 8 10 12
Months

It should be noted that the definition of a PRTF could vary across States; and that some States keep their numbers down by sending kids out of State to residential treatment. Therefore, fewer beds articulated in the charts above may not necessarily indicate greater utilization of community based services. It does indicate among the States being compared that Kansas pays on the low end for per diem rate, and also has a lower average length of stay than most States in the comparison group.

It does beg similar questions we have been asking ourselves in the mental health system around psychiatric inpatient capacity…do we have too many or not enough beds to meet the need?; Is the reimbursement adequate enough to support that needed capacity over time so that there is availability of the service when it is needed? It seems to me that these same questions apply to the PRTF system so that we as a State can guarantee access to that needed service at the time it is actually needed.

Screening Function Performed by CMHCs

You may hear someone advocate in today's hearing that the screening function for PRTFs be taken from the CMHCs and placed elsewhere. **There is no evidence that this function as performed by the CMHCs is broken and in need of being fixed. The CMHCs are the statutory gatekeepers for inpatient services and serve as the local mental health authority. Furthermore, SED children are one of the two federally mandated populations to be served by CMHCs and the Participating CMHC contract with the State of Kansas/SRS requires CMHCs to serve those two federally mandated populations.** Who better than the local CMHC to perform this function as the local CMHC is engaged in the community, is aware of all mental health resources available and has the ability to engage the family in community-based mental health service delivery, and the screener has immediate access to the treaters. **No other organization knows the community resources for mental health better than the local CMHC.**

How would the independent screener know if all CMHC services have been exhausted and aren't working? What would this independent screener's role be in continued review, treatment planning and discharge planning for the youth? Does the independent party take care of finding the placement in PRTF for children they deem appropriate for admission? Is the independent party going to be as available a CMHCs to schedule meetings and screens flexibly with families and agencies? Adding yet another entity to the mix seems to add only more confusion and struggle to the process. Scheduling requires anywhere from 4-10 people schedules at the present time.

CMHCs objectively evaluate, based on clinical need, and determine the best course of treatment for that youth. The SRS Guidance Paper on PRTFs confirms that PRTF admission criteria are solely based on clinical need. The Guidance Paper also states that when it is clinically obvious a child will not be approved for PRTF admission, a CMHC may decline the request for a screen into a PRTF.

Finally and equally important, the SRS Guidance Paper on PRTFs does not recommend changing who currently performs the screens. For all the reasons cited above, we would urge you to NOT accept any *recommendation that would remove the screening function from the CMHCs.*

What the Literature/Research Says

- ✓ Success from residential treatment is correlated primarily with the effectiveness of subsequent follow-up treatment in the community after discharge (Pumariega & Glover, 1998).
- ✓ The field of children's mental health has moved progressively over the last 20 years towards the system of care model, which advocates for individualized, child center, family focused, least restrictive setting. Such care is delivered in the child's normative environment in their community (in their school, home, and neighborhood) by interdisciplinary and interagency teams of professionals…and increasingly delivering evidence-based, community-based interventions in a culturally competent fashion (Pumariega, 2007).

- ✓ A child or youth being sent out of the family for long-term residential treatment often finds their role and position in the family being displaced and sometimes being eliminated after an extended absence…Sending away a child or adolescent for residential treatment sends a false message and gives a false hope to families that is their children who need to change while they do not need to make any accommodations or changes (Pumariega, 2007).
- ✓ Research on children with SED treated within the community has shown this to be an effective context for care. Common goals among community providers appear beneficial for enhancing the coordination of general and mental health care. Specific studies of SED children indicate that coordinated, community-based youth and family service projects may be more effective than overly restrictive settings, such as inpatient hospitalization or residential treatment (Solhkhah R et al, 2007).
- ✓ When systems of care rely too heavily on institutional treatment, they may subject children and families to unnecessary separations and iatrogenic trauma (2011 Inpatient Psychiatric Care for Children & Youth, by Becci Akin, Stephanie Bryson, et al.).
- ✓ An effective child and family mental health service system centers around a family-driven, youth-guided planning model featuring youth and family teams that would design and mange care plans using the Wraparound Care Coordination mode (Mercer 2008). **Kansas uses this approach where these teams have access to an expanded community based mental health services array implemented with fidelity for proven practice elements. These community based programs support the youth remaining in the community, receiving the medically necessary services on any individual bases and provides resources and supports to the families to help maintain the youth in the community, school and home**.

SRS Guidance Paper on PRTFs

As referenced earlier in my testimony, after the policy directive was issued, SRS appointed a PRTF Work Group to further review this policy issue and to provide guidance to stakeholders moving forward. On October 21, 2011, a draft of the PRTF Guidance Paper was issued. Some of the highlights of that Guidance Paper include the following:

- Every child who needs PRTF treatment receives that treatment to the extent needed, and every child who does not need PRTF treatment has access to the full array of community mental health services that are medically necessary.
- One important criterion for admission to a PRTF is, "a clinician/screener, with the assistance of the Community Based Service Team (CBST), has identified and determined that the community based resources used and/or available do not immediately meet the treatment needs of the youth, and that the mental health problem cannot be addressed safely and adequately in the home/community. In the case of a child who has not accessed all the community based resources available in the community, the clinician/screener, with the assistance of the CBST, has determined that the mental health problem is urgent and/or chronic enough that it cannot be addressed safely and adequately in the home or community."
- Children can be discharged from a PRTF before the screening authorized period ends if discharge criteria are met.
- Families are expected to engage in community-based services and work with the CMHC to schedule needed services.
- Children will receive the mental health services that are medically necessary.
- PRTF admission criteria are solely based on clinical need.
- Funding will not be a reason to divert a child from PRTF admission.
- When it is clinically obvious a child will not be approved for PRTF admission, a CMHC may decline the request to complete a screen.
- All screening decisions including a decision to decline providing a screen may be appealed or grieved through KHS or SRS.

- Thirty day treatment reviews will be conducted during treatment team meetings to determine if the child continues to meet medical necessity. If the child has not been discharged after 90 days, a screen for continued stay must be completed, and additional screens completed every 60 days thereafter. Extension screens may be requested up to 30 days prior to the end of an authorization.
- Discharge planning must begin at the time of admission. At the time of discharge, dates and providers of services will be documented for an intake appointment, medication appointment and other identified services by the treatment team.

Moving forward, this Guidance Paper will serve as a valuable resource to guide all stakeholders in understanding the role of a PRTF, the role and expectation of families, rights and responsibilities of families, the screening process, appeals and grievances, alternative community based service planning, continued stay criteria, discharge criteria and provision of community based services.

Summary Conclusions

- PRTFs represent a necessary and important component of the continuum of care for children and adolescents whose behavior cannot be managed effectively in a less restrictive setting. When needed, residential treatment should be kept short-term.
- The policy change does appear to have worked in meeting the intent as we know it today – utilization of PRTFs across all population groups has since aligned and overutilization has been addressed; admissions appear to have stabilized; and average lengths of stay is declining. The unintended consequence must also be stated, that PRTF facilities downsized and some even had to close.
- SRS officials consistently confirm that while there were a handful of instances where there were specific issues tied to a CMHC(s) that once identified, were addressed, they can also say that overall, the agency has been satisfied with what has occurred. The agency also confirms that the reviews by SRS Central Office staff on all CMHC decisions around PRTF screens generally found that the proper decisions were made and that service delivery in the community was occurring.
- We know that individuals with co-occurring developmental disabilities and mental illnesses are a particularly vulnerable population, requiring a coordinated array of treatment interventions and supports. Further cross-systems training on co-occurring illness (MI/DD) would help with to improve service delivery to this challenging population.
- The CMHCs made a renewed effort to identify children/families that with added intervention, residential or inpatient placement could be avoided. The focus has and continues to be trying to keep children and families together in their communities if at all possible. There are those times when residential or inpatient is the treatment option that needs to be chosen. But anytime a community intervention, allowing the child to remain in their home, school and community, is available and effective, it should be the first option. Mental health care in the least restrictive setting is a best practice.
- There is no evidence that the gatekeeping function as performed by the CMHCs is broken and in need of being fixed.
- The Guidance Paper will serve as a valuable resource moving forward.

Desired Recommendations:

The stakeholders have come together to try to achieve consensus in what we all believe to be useful recommendations. For the most part, we all agree on them. The Association asks that the Committee support ALL of the following recommendations:

1. There needs to be meaningful discussions between SRS and systems stakeholders about where in a continuum community-based mental health services, residential services and psychiatric inpatient services fit together.
2. Include language stating that PRTFs are a necessary and vital part of the Kansas children's mental health system's continuum of care.
3. SRS should track resource gaps in the child welfare, mental health and developmental disability systems influencing the need for residential or inpatient care. Our State's financial priority should be to support more robust and less costly community-based treatment services.
4. Encourage the CMHCs and CDDOs to develop a model for collaboration across the mental health and developmental disability systems that address key clinical and philosophical issues that address service delivery issues for persons with co-occurring mental illnesses and developmental disabilities.
5. SRS should fully implementation the recommendations of the PRTF Advisory Committee outlined in the PRTF Guidance Paper. It appears the agency is moving in that direction.
6. SRS should regularly share with stakeholders data they are formally tracking about what is happening to children being diverted from PRTFs as well as when they are discharged. The data should include:
    a) Child's custody status (Parent, SRS, JJA).
    b) Timeliness of access to community-based mental health services when diverted from a PRTF and upon discharge from a PRTF; and identification of barriers for the child in accessing or the provider in providing such services timely.
    c) Array and intensity of community-based mental health services being provided.
    d) Adherence to the immediate provision of service standard for children being discharged from a PRTF as outlined in the PRTF Guidance Paper, and identification of barriers for the child in accessing or the provider in providing such services.
    e) Where each child being discharged from a PRTF is going, and also follow the child for a six month period for their physical location where service delivery is occurring (community, YRC, detention, inpatient).
7. SRS should to "fast track" the implementation of a standardized intake form which could be Used across the CMHC system. We understand that is a process in motion within SRS.
8. Include language that the Committee believes access to all residential care should be completed by one entity regardless of how many managed care contracts may be offered in Medicaid reform, and that the screening should continue to be performed by the CMHC system. Furthermore, all decisions for admission to residential services should be based on medical necessity and not influenced by budgetary decisions.
9. Include language stating that the Kansas mental health system has already suffered significant budget cuts, including $33 million All Funds reduction to Medicaid mental health services. Furthermore, urge the 2012 Legislature to ensure the mental health system isn't receiving a disproportionate cut in any Medicaid reform proposal put forth by the Administration.