

## **COMMUNITY MENTAL HEALTH REGION 5 ENGAGEMENT AND RECOVERY SERVICES PLAN FY2014**

### **Introduction**

The State of Kansas designated Community Mental Health Region 5 service area includes 22 rural and frontier counties in eastern Kansas. The region covers 14,431.8 square miles, includes a population of 335,998 citizens and has a population density of 23.28 people per square mile. The region's population exceeds the state average for percentage of individuals living below poverty level (14.07% compared to 12.6%). In fact, fifteen of the 22 counties have a population range of 13.3% to 21.2% living below poverty level. The region's mental health safety net system charged with insuring mental health care is accessible and affordable to all citizens is comprised of the following seven centers: Crawford County MHC, MHC of East Central Kansas, Elizabeth Layton Center, Four County MHC, Labette Center for Mental Health, Southeast Kansas MHC and Spring River Mental Health & Wellness.

With a regional annual allocation of \$1,010,606 or \$3.01 per person per year, the seven mental health centers have committed to a collaborative effort involving shared clinical expertise, pooled physical and financial resources, and interagency technical assistance focused toward enhanced service program access and improved patient recovery outcomes. The following proposal details the collective effort and commitment of the region's centers in identifying community need(s) and designing interventions to further promote recovery.

### **Statement of Need**

Mental illness is one of the leading causes of disability in the United States. New State-level data released by the Substance Abuse and Mental Health Services Administration (SAMHSA) in May 2012 showed a national incidence rate of mental illness at 19.8 percent and a national incidence rate of serious mental illness (SMI) of 4.6 percent. By comparison, the incidence rate of mental illness specific to Kansas was found to be 20.6 percent with a 4.46 percent incidence rate of SMI in Kansas. Of greatest concern was the national finding that only 60 percent of adults with SMI received treatment in the past 12 months.

Locally the Region 5 centers report similar experiences with incidence rates and service engagement. For example, in Montgomery County, Kansas, service data from Four County MHC indicated that despite providing active care to 10 percent of the general population at any given time and having served 17 percent of the county's population (1 of every 6 citizens) at some point in the past three years, approximately half of the crisis contacts in their emergency services department are delivered to individuals who had not sought care in the past 12 months.

Challenges to service delivery are numerous. The region, as described in the introduction, is rural or frontier so a combination of miles to travel and low population density present a treatment access barrier. Add to that a higher than average percent of the population living below poverty level, societal bias or stigma regarding acknowledgment of mental health conditions, the fact that a common symptom of mental illness is often a lack of insight into the need for treatment and it should come as no surprise that many who could benefit from some level of treatment simply do not seek it.

One of the historic gaps or weaknesses in the Region 5 service delivery system is the shortage of available healthcare providers specialized in psychiatry, specifically child psychiatry. Widening that gap was the elimination of Family Centered System of Care (FCSC) funding at the end of fiscal year 2013. The discontinuation of FCSC funding eliminated 2.1 FTE mission-critical psychiatric positions along with 6 parent support, 2 peer support, 4 crisis-focused Attendant Care, 2 part-time In-home Family Therapy, 3.7 psychosocial group, and 4 crisis case management positions. The service needs exposed by the dissolution of these positions were identified by all centers as high-priority.

Additionally, in a comprehensive effort to best understand the entire service delivery system's gaps or weaknesses, identify opportunities, and evaluate the unique needs of the communities being served the Region 5 centers studied data from the following sources: 1) KDADS regional stakeholder meetings, 2) CMHC community needs assessments, 3) Client/patient satisfaction surveys, 4) Community partner satisfaction surveys, 5) Hospital & PRTF placement data, 6) feedback from adult and youth consumer organizations and 7) Children's Client Status Report Outcome Measures.

Review of the above described data and feedback resulted in a consensus opinion that not all service needs can or will be met with the financial resources presently available. Therefore, intensive discussion focused on establishing priority efforts around those professional services, interventions, community-based supports, and innovative approaches that could achieve the highest levels of adaptive, independent functioning for the largest number of individuals and/or families. It was agreed that **child and family services** needed to be a primary focus along with concurrent efforts **enhancing psychiatry access** and **increasing post-crisis treatment engagement** by those individuals needing stabilization. Secondary to this focus should emerge **decreased hospital/PRTF re-admission rates**, improved **stability in residential status** of both adults and children, **improved community satisfaction**, and a **decrease in re-occurrence of crisis related events**.

Therefore, Region 5 centers will promote community-based recovery and reduce both acute and chronic out-of-home placements through the collaborative use of at least 6 crisis-diversion beds, shared access to psychiatric specialists, enhanced outreach and patient engagement, expanded community involvement and training (i.e., MHFA), and shared training and service resources specific to those Evidence-based Practices identified as viable to effectively close treatment gaps across the region.

In addition, all centers are committed to delivery of parent support, peer support, intensive case management, crisis stabilization, developing specialists in engagement or patient navigation, and further developing the evidenced-based or emerging practices represented across the region (see chart below). The scope of delivery of these services will be a very fluid dynamic across the region with each participating center engaging in ongoing needs assessments with community stakeholders and consumer advocacy groups. As the unique needs of newly engaging patient populations emerge (presently unknown individuals) each center will enhance those services most likely to meet the needs of the most vulnerable and serve the largest number of identified patients.

A collaborative relationship beyond those Centers within Region 5 will be explored with the Mental Health Association of South Central Kansas. A system of care expanding housing options and enhancing basic independent living success will be developed in those communities lacking adequate resources and where geographically within Region 5 the MHA of South Central Kansas seeks joint

ventures. Those services assessed to be outside the bounds of financial viability due to present funding limitations of this initiative are identified on the chart below with a designation of “X”.

<b>Evidence Based/Promising Practice</b>	<b># of CMHCs</b>	<b>Evidence Based/Promising Practice</b>	<b># of CMHCs</b>
Beating the Blues	2	Mental Health First Aid (MHFA)	4
Strength Based Case Management	3	Parent Child Interaction Therapy	1
Supported Employment	2	Conscious Discipline	1
Positive Behavioral Support	2	IDDT	2
Dialectical Behavioral Therapy	2	The Incredible Years	1
Suicide Prevention QPR Training	1	Guiding Good Choices	1
Kansas Partnership of Families	1	Active Parenting Now	1
Aggression Replacement Training	1	Crossroads of Parenting & Divorce	1
Matrix Model	2	Love & Logic	1
Project Before	1	Thinking for Change	3
Recognizing & Responding to Suicide Risk (RRSR)	1	Strengthening Families	1
SOAR Case Management	6	FFT, FCT, & Multi-systemic Therapy	X
SUD Treatment and Recovery	3	Home-based Family Therapy (HBFT)	X

### **Regional Recovery Initiative Design**

The Region 5 initiative design will be multi-faceted out of a desire to create the greatest impact for the largest number of individuals while taking advantage of the many unique resources represented across the seven provider agencies. The value of effective child and family services is well documented if society hopes to see another generation of healthy, well-adjusted, and productive citizens. Intact families and predictable home environments are pivotal for children’s sense of security and perception of environmental mastery. The three primary goals detailed in the Implementation Plan section below were selected for their over-arching ties to child and family functioning: 1) Reducing inpatient bed day utilization is achieved through enhanced crisis services, enhancing community collaboration among all natural resources, and can serve to re-unite family members within their natural home; 2) Objective demonstration of treatment efficacy serves the interest of children as well as the adults active in their lives and upon whom they are dependent; and 3) Stabilizing the long-term placement of children not only enhances their over-all emotional well-being and bonding but it enhances both social and academic developmental opportunities.

An important exercise to improve collaboration within the region and its respective communities is an inventory of the many unique service programs represented across the seven participating agencies. This will be completed within the 1<sup>st</sup> Qtr FY14. Through examination of EBP treatment resources and other treatment programming Region 5 intends to match services found in one area with similar service needs not yet met in another. This too will be completed within 1<sup>st</sup> Qtr FY14. As implementation progresses there will need to be both administrative and clinical service coalitions developed among the regional provider agencies so the system of care increases in consistency and implements practices/ programs in an informed manner, congruent with each unique community’s emerging needs. This will begin 2<sup>nd</sup> Qtr FY14 and continue throughout the year as each center responds to stakeholder feedback collected on a quarterly basis.

All provider agencies have committed to examining what they can do to serve difficult to treat patients from anywhere in the region. For example, if a patient from one area of the region has proven difficult to maintain in the community and has consequently been hospitalized with an extended length of stay, the varied or unique community resources from another area will be made available and that patient may be offered community care outside of their traditional “county of responsibility.”

All providers are also committed to enhanced outreach efforts and development of patient navigator or engagement specialist roles. Outreach activities performed by all centers within the region will include but not be limited to: participation in discharge planning, wellness drop-ins at the home, telephone contacts, follow-up with collaterals, service participation contracting, and treatment barrier assessments and referrals (transportation, etc...).

In an effort to increase treatment need awareness, improve community access, and enhance the community stakeholder’s understanding and satisfaction with available mental health services the Region 5 centers will be committing a minimum of eleven (11) staff to a Mental Health First Aid initiative that will reach approximately 500 participants.

**Implementation Plan**

<b>GOAL #1: Region #5 will collaborate to reduce both acute and chronic regional bed day utilization at Osawatomie State Hospital as compared to the average of the past 3 fiscal years. (FY 11-13)</b>	
<b>Objective #1</b>  Evaluate and develop a community-based discharge plan for OSH admitted patients with a length of stay exceeding 6 months.	<b>Activities:</b>  <ul style="list-style-type: none"> <li>➤ Each CMHC will participate in case review of long-term OSH admissions to evaluate the unique community-based service array they may offer the patient that the county of responsibility may not be able to provide.</li> <li>➤ Share prospective discharge plan details with county of responsibility CMHC to insure collaboration, comprehensiveness of plan, and on-going patient safety.</li> <li>➤ Liaison and case managers from all involved centers will review case progress at least monthly to discuss progress and recommend course</li> </ul>

	<p>corrections once discharge is implemented</p> <ul style="list-style-type: none"> <li>➤ Share regional resources such as crisis beds to reduce admissions and increase post-crisis treatment engagement.</li> <li>➤</li> </ul> <p><b>Stakeholder involvement:</b> Region #5 CMHCs EDs &amp; Clinical/CSS/Medical Directors, KDADS field staff, CDS &amp; CSS case managers, OSH hospital staff, law enforcement, other healthcare providers.</p> <p><b>Progress:</b> To be measured semi-annually and reported to regional center, stakeholders, and governing boards.</p>
<p><b>Objective#2</b></p> <p><b>Decrease reoccurrence of screening events provided by Region 5 crisis staff.</b></p>	<p><b>Activities:</b></p> <ul style="list-style-type: none"> <li>➤ Share regional resources such as crisis beds to reduce admissions and increase post-crisis treatment engagement.</li> <li>➤ Each center will provide intensive outreach and follow-up.</li> <li>➤ Address psychosocial stressors occurring in addition to mental health symptoms that may be precipitating crisis reaction in patients.</li> </ul> <p><b>Stakeholder involvement:</b> Region #5 CMHCs EDs &amp; Clinical/CSS/CBS Directors, KDADS field staff, agency case managers, local hospital ER staff, law enforcement, other healthcare providers and natural community supports.</p> <p><b>Progress:</b> To be measured semi-annually and reported to regional center, stakeholders, and governing boards.</p>

**GOAL #2: Region 5 patients who are newly admitted into outpatient services following a hospital discharge or crisis screening will demonstrate improvement (increased score on the DLA 20) after 90 days of treatment. (FY 14 is a baseline year)**

**Objective #1:**

Adaptive independent functioning as measured by the DLA-20 will be improved in the above described patients.

**Activities:**

- All regional centers will train staff in use of DLA-20 by June 30, 2014.
- DLA-20 will be utilized as a standardized methodology for establishing level of functioning at admission to services.
- A train the trainer event will occur for centers in the region by June 30, 2014

**Stakeholder involvement:** Region #5 CMHCs EDs & Clinical/CSS/CBS/Medical Directors, KDADS field staff, agency case managers, OSH hospital staff, law enforcement, other healthcare providers and natural community supports.

**Progress:** To be measured quarterly and reported to regional center, stakeholders, and governing boards.

**Objective #2:**

Active engagement of patients identified through psychiatric hospital discharge or mental health crisis screening assessment as measured by documentation of service delivery.

**Activities:**

- CMHC staff will deliver outreach contact with patient within 24 hours of discharge and/or initial crisis contact.
- Follow-up outpatient appointments will be scheduled within 72 hours of outreach contact.
- Clinical outreach and follow-up will occur for any missed appointment after a hospitalization or crisis screening.
- Patients will be offered or referred to an array of community-oriented

	<p>support services to meet non-mental health needs.</p> <p><b>Stakeholder involvement:</b> Region #5 CMHCs Clinical/CSS/CBS/Medical Directors, KDADS field staff, agency case managers, other healthcare providers, patients, patient families, and other natural community supports.</p> <p><b>Progress:</b> To be measured semi-annually and reported to regional center, stakeholders, and governing boards.</p>
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**Goal # 3: Increase residential stability of SED youth as evidenced by consistent in-home placement and reduced psychiatric hospital re-admission.**

<p><b>Objective # 1:</b></p> <p><b>Increased number of days of in home placement for children with SED within a 90 day period. (FY 2014 is baseline data)</b></p>	<p><b>Activities:</b></p> <ul style="list-style-type: none"> <li>➤ Monitor AIMS and CSR data provided by KDADS field staff.</li> <li>➤ Ensure wrap-around of community-based services as appropriate.</li> <li>➤ Connect youth and family to natural support services in community as appropriate.</li> <li>➤ Provide intensive services such as crisis case management, In-home Family therapy, etc... to patient and families identified to be at risk.</li> <li>➤ Collaborative utilization of child psychiatry resources (i.e., case conference and/or telemedicine sessions)</li> </ul> <p><b>Stakeholder involvement:</b> Region #5 CMHCs Clinical/CDS/CBS Directors, KDADS field staff, agency case managers, other healthcare providers, patients, patient families, Child-Welfare contractors and natural community supports.</p> <p><b>Progress:</b> To be measured semi-annually and reported to regional center, stakeholders, and</p>
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	governing boards.
<p><b>Objective # 2:</b></p> <p>Provide adult Mental Health First Aid Sessions and expand provision of Children’s MH First Aid educational sessions to support and improve parenting skills.</p>	<p><b>Activities:</b></p> <p>The region will offer this training to the local communities; targeting a total of 18 training sessions by June 30, 2014.</p> <p><b>Stakeholder involvement:</b> CMHC staff, Faith-based organizations, LEO, District Courts and Attorneys, PCP’s, community self-referrals, FQHC’s, Probation/Community Corrections, JJA.</p> <p><b>Progress:</b></p>
<p><b>Objective # 3:</b></p> <p>Actively reduce rates of youth re-admission within both 30 days and 90 days throughout the region.</p>	<p><b>Activities:</b></p> <ul style="list-style-type: none"> <li>➤ Monitor AIMS and CSR data provided by KDADS field staff.</li> <li>➤ Ensure wrap-around of community-based services as appropriate.</li> <li>➤ Connect youth and family to natural support services in community as appropriate.</li> <li>➤ Provide intensive services such as crisis case management and/or Family Care Treatment to patient and family identified to be at risk.</li> </ul> <p><b>Stakeholder involvement:</b> Region #5 CMHCs Clinical/CDS/CBS/Medical Directors, KDADS field staff, agency case managers, other healthcare providers, patients, patient families, and other natural community supports.</p> <p><b>Progress:</b> To be measured semi-annually and reported to regional center, stakeholders, and governing boards.</p>

**Regional Structure**

Four County MHC will serve as the Regional Center for all Region 5 provider organizations. Through the previously described regional meetings and interagency coalitions the regional providers will be able to collectively “keep pace” toward achieving the identified goals and outcomes. Each provider participated in several hours of community examination and service goal formulation. The “buy-in” is strong with each member organization and each of the three implementation goals spans multiple needs for each community.

Each provider organization has agreed to sign a Memorandum of Understanding or similar contract with the regional center for purposes of engaging in this regional business collaborative. Along with such an understanding will be, where appropriate, HIPAA-compliant Business Associate Agreements allowing for exchange of confidential information and the collective assurance that PHI from one organization will be treated with the same discretion as if from their own organization. Data points and/or aggregate data that can be de-identified prior to transfer will be modified accordingly to further protect patient confidentiality.

To insure regional providers are adequately resourced to participate in the collective pursuit of all goals and outcomes the regional center will allocate FY14 funding according to the chart below:

<b>Regional Provider</b>	<b>FY2014 Region 5 Allocation</b>
Crawford County MHC	\$130,070.00
East Central Kansas MHC	\$148,752.00
Elizabeth Layton Center	\$87,894.00
Four County MHC	\$221,211.00
Labette County MHC	\$121,880.00
Southeast Kansas MHC	\$178,919.00
Spring River MHC	\$121,880.00
<b>TOTAL</b>	<b>\$1,010,606.00</b>

In addition to a quarterly distribution of the annual allocation detailed above all provider organizations will be encouraged to enter into joint ventures regarding utilization of both financial and programmatic resources. A professional grant writer is employed by the designated regional center and their services will be made available, particularly in pursuit of region-wide funding and program opportunities. Additionally, training resources (staff ) will be shared across the region to insure all centers have proficiency in the DLA-20 as well as have access to all facets of Mental Health First Aid (both adults and children’s training).

Each provider organization within the region has an established Continuous Quality Improvement (CQI) process and several of the designated CQI personnel throughout southeast Kansas meet quarterly to review internal challenges, identify possible solutions, monitor progress, and share successes. This coalition will be expanded to include participation of all regional providers so community partners throughout Region 5 can have a role in providing feedback and shaping future initiatives.

**Performance/Outcome Measures**

Data collection for reporting on performance measures will occur at both the local and state level. The assigned KDADS field staff member for Region 5, Patrick Nickelson, has committed to assist in gathering the reports associated with state hospital bed-day utilization as well as the data needed from the state AIMS and CSR systems. This data will be monitored monthly and compiled for reporting on a quarterly basis. Additionally, each regional provider will compile and report to the regional center on a quarterly basis data unique to their organizational performance as it relates to the DLA-20, Community Satisfaction Survey, and Consumer Satisfaction Survey data. These data sources will be examined quarterly to monitor progress and insure desired goals are being achieved or program efforts are being modified as needed to achieve requisite outcomes.

**Deliverables/Reporting Requirements**

The CMHC region will submit quarterly program and financial reports on the template provided. The report will be submitted to KDADS on or before the 30th day of the month following the quarter.

**Budget Detail Worksheet and Budget Narrative/Justification**

Regional providers will submit to the Regional Center quarterly budget/expense data utilizing the KDADS-approved budget/expense reporting worksheet as follows:

<b>Expense Description</b>	<b>Current Period Expenses</b>	<b>Cumulative Expenses</b>
<i>(List budgeted line items as presented on budget submission.)</i>	KDADS Grant Expenses	KDADS Grant Expenses
Personnel		
Fringe Benefits & Taxes		
Staff Development & Training		
Mileage/Auto Expenses		
Telephone		
Computer & Other Equipment		
Contractual		
Allocated Administrative Costs (to be monitored throughout the year, should be around 10%)		
Flexible Funds (Complete Flexible Funds worksheets for specific breakdown)		
<b>Totals</b>	0.00	0.00
<b>KDADS Grant Award</b>	0.00	0.00
<b>Balance Remaining</b>	0.00	0.00
<b># of Clients Served</b>	0	0
<b>Cost per Client</b>	0	0

The Regional Center will compile the individual budget/expense data into a regional worksheet and submit the same to the State of Kansas within 30 days of the end of each calendar quarter. As illustrated above, the Budget/Expense Detail Worksheet will include an accounting of expenses that fall within the categories of: Personnel, Fringe Benefits & Taxes, Staff Development & Training, Mileage/Auto Expenses, Telephone, Computer & Other Equipment, Contractual, Allocated Admin. Costs, and Flex Funds. The expense funds to be accounted for by each regional provider by the end of FY14 are as follows:

<b>Regional Provider</b>	<b>FY2014 Region 5 Allocation</b>
Crawford County MHC	\$130,070.00
East Central Kansas MHC	\$148,752.00
Elizabeth Layton Center	\$87,894.00
Four County MHC	\$221,211.00
Labette County MHC	\$121,880.00
Southeast Kansas MHC	\$178,919.00
Spring River MHC	\$121,880.00
<b>TOTAL</b>	<b>\$1,010,606.00</b>