

**Nursing Facility for
Mental Health
(NFMH) Workgroup
Report
March 3, 2016**



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Overview of the NFMH Workgroup

The main purposes of the workgroup included:

1. Reviewing current practices and procedures around NFMHs and provide recommendations for improvements.
2. Identifying service gaps for individuals who exhibit high acuity for mental health services and make recommendations on the services, resources and supports needed.

The tasks identified on the charter included:

1. Review current NFMH systems including current practices of Screens-for-Continued-Stay, admissions and discharges, and identify strengths, barriers and challenges from systems perspectives.
2. Make recommendations to increase collaboration, improve consumer outcomes and processes through the following practices for Screens-for-Continued-Stay process, admission and discharge processes, and other issues identified in task 1.
3. Make recommendations on how to increase mental health services and resources in NFMHs within current structure paradigm for example, how to increase mental health training for NFMH's.
4. Identify services needed for individuals with high mental health needs who do not require Nursing Home care. Review additional needs identified in the Adult Continuum Meetings and create a recommendation on how the needs could be met.
5. Identify ways to increase collaboration between Behavioral Health (BH) providers to include State Mental Health Facilities, Community Mental Health Centers, NFMHs, Consumer-Run Organizations and Managed Care Organizations.

The process of the workgroup:

The group met seven times. During these meetings the following occurred:

- Established group member expectations.
- Overview of the NFMH system.
- Analyzed the strengths and barriers of the following processes: Screens-for-Continued-Stay, admission, and discharges.
- Identifying additional systems issues that needed to be analyzed and improved which included crisis services and education and training.
- Brainstormed recommendations for all five areas of concern: Screens-for-Continued-Stay, admission, discharges, crisis services, and education and training.

- Established final recommendations for Screens-for-Continued-Stay, admissions and discharges with measurable outcomes and projected due dates.
- Identified the needs of individuals who need services but do not need a nursing home placement.
- Identified the services that could support the above mentioned individuals.

Executive Summary

The Nursing Facility for Mental Health workgroup was tasked with reviewing and making recommendations on how to improve services in the current paradigm of service delivery and review ways in which service provision could be improved, enhance services, and improve collaboration among providers. The key recommendations for this task included:

- Develop a policy for Screens-for-Continued-Stay (SCS) for CMHCs as well as enhance internal SCS policy.
- Develop a new Screens-for-Continued-Stay tool based on policy.
- Develop training for providers and staff on new policy and new screening tool.
- Develop policy and procedure for standardized information NFMHs need from referral sources such as CMHCs/State Mental Health Hospitals, to include resources not available or needed in the community.
- Develop policy and procedure to standardize admissions process with NFMHs to include person-to-person interviews and timelines for an admission decision and protocol to communicate the decision utilizing televideo whenever possible.
- Develop a fact sheet regarding NFMHs for discharge planners and referral sources.
- Review policy regarding Pre-Admission Screen and Resident Review (PASRR) timeframe starting prior to discharge.
- Increase information sharing between PASRR and SCS.
- Update discharge guide developed and utilized by The Wyandot Center for utilization statewide.
- Increase billable codes 120 days prior to discharge to include: peer support, SBIRT, psychosocial groups, attendant care.
- Coordinate with KDHE and determine if a policy could be developed that allows presumptive approval from date leaving facility for anyone leaving an IMD environment
- Develop standardized training and staff working in NFMHs on issues such as MH first aid and CPI as well as other training on trainingteams.org in addition to Strengths Based Case Management, WRAP, IDDT
- Develop a way for peer specialists and CROs to be paid to provide support in the facilities.
- Develop a list of places available when a crisis occurs.
- Develop a process for crisis services to be accessed/provided for individuals in the NFMH. Partner with CMHC to provide crisis services, including beds and figure out

payment mechanism. To include the creation of additional crisis stabilization units with medical and MH abilities to help stabilize people up to 14 days.

- Implement Common Ground model in NFMHs.
- Consider Outpatient Treatment Orders for individuals with a history of non-med compliance.
- Open trainingteams.org to NFMH staff.
- Create standards for mental health training needed to work in NFMHs.
- Create NFMH-specific training. For example NFMHs asking MCOs, CMHCs and SMHHs for mental health-specific training.
- Share training calendars/events among SMHHs, CMHCs, and KDADS.
- Quarterly meetings with CMHCs and NFMHs.
- Inviting NFMHs to quarterly mental health reform meetings.
- Develop/find a training for guardians possibly partnering with Kansas Guardianship Program. Also help guardians understand role of NFMHs and community resources available. Utilizing NFMHs to disseminate information.
- Education for KDADS surveyors to be aware of special populations in mental health facilities.

The second focus of the workgroup was to examine specific groups of individuals and their presenting conditions that make it either difficult to serve in an NFMH setting or inappropriate for them to be in a nursing home setting. Additionally, to identify what services those individuals would need in order to successfully live in the community and to make recommendations on how to increase and/or create an appropriate level of care for those individuals. **The group recognized that all recommendations should consider the impact of the Institute for Mental Disease (IMD) rule.**

- Develop long term program/s with licensed mental health techs (LMHT), people trained in managing challenging behaviors, psycho social group, CPI de-escalation, behavior support plans/psychiatric advanced directives, psychologist, ARPN, medication reviews recommendations made from data, human rights committee.
- Increase transitional living/group home facilities statewide.
- Develop programs/services/policies that support treatment for individuals with MH and SUD need.
- Internal team to look at NFMH surveying/licensing's processes including Informal Dispute Resolution (IDR) process to include mental health expertise and another NFMH.

RESULTS AND RECOMMENDATIONS

Screens-for-Continued-Stay Process

Strengths

- Person with lived experience attends the Screens-for-Continued-Stay (SCS) and completes the strengths assessment.
- Attempt to evaluate need for continued stay and make sure folks don't linger.
- Payment for screens.
- Gives choice to live in different locations if wanted.

Barriers

- NFMH staff not involved in process.
- MCOs are not part of the process.
- Guardians are not always involved or are a barrier
- Inconsistency among screeners (could also be a training issue).
- The number of years a person has been in the NFMH decreased the person's hope for discharge as well as a recommendation for discharge.
- Individual's history going into NFMH makes it difficult to find appropriate community support with intense 24-hour structure in a less restrictive community setting.
- No one gets out or recommended for discharge.
- Due to the screens being annual, the screener only sees the person once per year and doesn't see the true strengths and challenges of the individual.
- In addition to the concerns about an "annual screen", the nature of having Screens-for-Continued-Stay once a year is not rehabilitative in nature.
- Recommendations don't have a specific implementation plan, follow-up, and discharge plan with accountability on who will assist an individual reach the goals identified.
- Recommendations should include consideration for individuals who have co-occurring issues.
- Individuals don't want to work on tasks recommended during SCS.
- Number of courtesy screens in rural areas.
- Time consuming to do screens.
- Lists of individuals on the screening lists are inaccurate.
- Rural areas are difficult to find someone with lived experience.
- Potential conflict of interest because CMHC does the screen and then might place the person in their services which generate money for the agency.
- Guardians are not aware of other services available in the community and need training.
- Guardians fearful for deterioration and want what's best for individuals.
- Training is a joke.
- Stigma of what an NFMH is creates a barrier.
- Screens are not taken serious by CMHC or facilitators.

Brainstorm recommendations

- Develop a policy on Screens-for-Continued-Stay (SCS)
- Review Screening Tool completed by CMHC and update process to include NFMH input, guardian input, MCO involvement and who will follow up with recommendations; also change the name of tool to reflect discharge and frequency of tool. Scoring would determine re-evaluation, SUD.

- Training for screeners with NFMHs, CMHCs and MCOs on tool, policies, value of document and process.
- Require a policy for SCS to be done in NFMH care plan/personal lifestyle design/icare plan meetings with CMHC, resident, guardian and family.
- Identifying needs based on dispositions, i.e. discharge tool developed, continued stay and what they need to work on.
- Develop a plan of support to ensure person needs are met/feedback loop, i.e visits back to NFMH, peer supports.
- Review discharge plan and who will assist individual on reaching goals.
- Discharge planning should start at the time of admission.
- Training on community resources for personal care planning, CMHCs, NFMHs, SUD (Substance Use Disorder) and guardians.
- Get access to resource tools made available from other initiatives such as prevention efforts.
- Define role of NFMH Liaison.
- Develop a policy/procedure that allows for increased MCO involvement (similar to Kansas Department of Corrections (KDOC)).
- Develop a process to utilize peer support/peer mentoring/recovery coaches and opportunities for people with lived experience connections with Consumer-Run Organizations.
- Develop a new code for KDHE for a suspended Medicaid status instead of terminating eligibility for people going in and out of facilities.
- Consider Telemedicine for consumer in NFMHs/CMHCs/MCOs.

Final recommendations for continued stay screens

- 1.) Develop a SCS policy conducted by the CMHC to include:
 - a. Identify and define roles of essential/key participants, i.e. individual, peer support, CMHC, NFMH, guardians, MCO's and SUD when appropriate.
 - b. Clearly identify the role of the CMHC liaison.
 - c. Incorporate the SCS process during an icare plan or personal lifestyle plan.
 - d. Consider tele video options for CMHC's to have more frequent engagement with individuals.
 - e. Include section for discharge recommendations for each SCS and who will help the individual achieve the goals.
 - f. Consider changing the name of the SCS to a more strength based name such as Community Preparation Plan (CPP).
- 2.) Develop an internal SCS Policy to include:
 - a. Aligning SCS/ CPP and Pre-admission Screen and Resident Review (PASRR).
 - b. Allow for increased MCO involvement in screening/discharge process (similar to KDOC) .
 - c. Develop a new code for KDHE to suspend Medicaid status or apply and determine eligibility prior to discharge.
 - d. Clear expectations of KDADS review process to include what portions can be shared and with who.
- 3.) Develop new CPP tool based on policy.
 - a. The new tool should be electronic and accessible to multiple users.
- 4.) Develop Training for new policy and tool
 - a. Train individuals, CMHCs, NFMH, MCO's, guardians, peer support, SUD, and KDADS.

Next steps/action plan for continued stay screens

- Establish SCS policy teams by 4/1/16 and have a policy to KDADS by 5/1/16 for final approval by KDADS/KDHE by 6/15/16.
- Establish a team by 4/1/16 to develop new screening tool (currently SCS) based on policy and recommendations from NFMH workgroup. The recommended tool should be completed by 5/1/16 for final approval by KDADS 6/15/16.
- Establish a team to develop training based on new policy and screening tool by 6/15/16 to have training materials prepared and approved for implementation by 7/15/16 taking in consideration the time needed for KDADS/KDHE approval.
- Complete initial training to providers by 8/1/16. The training will be available electronically.

Admissions

Strengths

- Person receiving needed help.
- PASRR letter is clear on what individuals needs to work on.
- Timeframes of process.
- Team makes decision with various input.
- Process goes quickly.
- MCO's being involved.

Barriers

- Not clear who will help the person with the tasks listed on the PASRR letter.
- Team recommendations aren't always the final decision.
- Hard for process to go quick enough for acute hospitalizations.
- MCO not involved in the process.
- For temporary stays PASRR getting completed.
- Regular NFs won't take if a Level II is completed.
- NFMHs don't all do personal interviews to determine admission.
- Potential liability for CMHC.
- Challenging for CMHCs to get PASRR done in short time frame.
- No payer source.
- Approval timeframe from PASRR starts at time of PASRR approval and not admission into a facility and sometimes it takes time to find placement after PASRR approval.
- Diagnosis and medications are not given to NFMH at time of admissions from community.
- Not being able to fill medication due to no insurance or written scripts.
- Treatment facilities changing discharge orders upon discharge.
- PRN medications not given at time of discharge/admission.
- Once admitted into NFMH, CMHC case manager trying to direct care.
- Physical health conditions medication concerns might not be able to determine by NFMH.
- Regulations of Adult Care Homes.
- Physical and mental health needs.
- PASRR Recommendations become outdated for individuals with a permanent letter.

Brainstorm recommendations

- Education for discharge workers to understand NFMHs/regulation/specialty.
- Develop a standardized admissions process including a standardized packet of information essential for NFMHs to receive prior to admission - to include what PRNs have been successful for person at facility as well as behavior supports that work for the person.
- Develop standard for how long NFMHs have to respond to admission request.
- Use technology to see facility and do phone interview.
- Virtual tours of facilities.
- MCO, NFMH, and CMHC involvement with transitions into facilities.
- Requiring/requesting referring facilities to send at least two weeks or regular meds script and PRN scripts.
- Utilize CMHC case managers and health home to help give the most accurate, up-to-date

info.

- Develop a provisional determination for PASRR to begin when the discharge occurs not from date of assessment being done.

Final recommendations

- 1) Develop policy and procedure for standardized information NFMHs need from referral source such as CMHC/SMHH. Any policy for admission should include a section that explains what community resources were considered and why community living with supports is not feasible.
- 2) Develop policy and procedure to standardize admission process with NFMH to include person-to-person interview and timeline for an admission decision and protocol to communicate the decision utilizing tele video whenever possible.
- 3) Develop a fact sheet regarding NFMHs for discharge planners and referral sources.
- 4) Review policy regarding PASRR timeframe starting prior to discharge.
- 5) Increase information sharing between PASRR and SCS.

Next Steps/Action Plan

- NFMHs, SMHHs and KDADS meet to create standardized referral packet by 4/15/16
- NF/NFMHs and KDADS to form a workgroup to develop policy and procedure to be developed to standardize the admission process to NFMHs by 5/15/16.
- Develop a NFMH fact sheet/brochure/on KDADS website by 5/15/16.
- KDADS internal team to meet and review policy regarding PASRR timeframe starting prior to discharge by 5/1/16.
- KDADS internal team meet to determine plan to improve information-sharing between PASRR and SCS by 5/1/16.

Discharge process

Strengths

- Looking for least restrictive setting to meet the person's needs.
- Listening to where the person wants to be to meet their needs for example if they express being near a church or other social outlet is important to them to help find a placement within access.
- Working with the MCO 120 days prior to discharge to get services in place.
- If a person is discharging that means their mental health is improving.
- The use of supportive housing funds to help with discharge items such as food and household items.
- "How to leave" an NFMH guide that is used at one CMHC.
- Proper supports in place before the person leaves – holistic - primary care, BH, CRO, family connections, peer supports, etc.
- Involvement of the individuals doctors, pharmacy, guardian and anyone else the individual identifies as a support person.

Barriers

- Person wants to discharge to a different community and how the initial intake will get paid for.
- Peer supports lacking in the CMHCs.
- Lack of access to appropriate treatment for individuals with co-occurring disorders.
- Not being able to apply for services/Medicaid while still in services at NFMH.
- Limited service codes available 90 days prior to discharge but then if individual is not approved for Medicaid the CMHC is left to pay for services.
- If a person doesn't qualify for Medicaid.
- Unclear on who is helping the person get ready for discharge from the PASRR and Screens-for-Continued-Stay recommendations, the consumer doesn't know who's helping them.
- Consumer refusing services/medications for planned and unplanned discharges.
- Some individuals at NFMH have lost all hope and don't believe they can be discharged.
- NFMH/CMHC not coordinating discharge communication.
- Revolving door for consumers because the right supports are not put in place and are not person centered. This can include not planning for food, money and social supports needed.
- Few long term transitional care options available from NFMH.
- Different opinions of when someone is "ready for discharge."
- Defining what recovery looks like.
- When the MCO is not involved in the discharge process (not all NFMH/CMHCs open to working with MCO and difference approaches by MCOs) lack of education among systems.
- Lack of NFMH staff education on what services are available by the CMHC.
- NFMH administrators who do not believe individuals can be discharged.
- Discharges are difficult when guardians don't agree with the plan.
- Difficulty finding housing.

Brainstorm recommendations

- Update how to discharge guide originally created by Sherrie Walkins-Alvey.
- Things to include: transferring to a different CMHC.
- Verify all benefits available prior to discharge.
- List of expectations person can achieve prior to discharge.
- Complete Screening and Brief Intervention and Referral to Treatment (SBIRT) on all people leaving NFMH.
- Coordinate with KDHE/DCF and determine if a policy could be developed that allows presumptive approval from date leaving facility for anyone leaving an IMD environment.
- Discharge begins from day one, NFMH review goals quarterly in care plan meetings and include CMHCs liaison, MCOs, peers and natural supports.
- Provide SOAR training for NFMHs and SMHHs.
- Assuring the NFMHs are aware who the NFMHs liaison is and their role.
- Increase long term transitional housing programs 6-12 months.
- Identify and utilize pool of successful peers who can be resources for others in NFMH with CMHCs.
- Review billable codes 120 days prior to discharge.

Final recommendations

- 1) Update discharge guide to include:
 - a. Transferring to a different CMHC.
 - b. Verify all benefits available prior to discharge (SOAR).
 - c. List of expectations person can achieve prior to d/c.
 - d. Complete Screening and Brief Intervention and Referral to Treatment (SBIRT) on all people leaving NFMH.
 - e. CMHC educating person and guardian of community resources needed.
 - f. Identify and utilize pool of successful peers who can be resources.
 - g. Develop a process to utilize peer support /peer mentoring/recovery coaches and opportunities for people with lived experience connections with CROs.
 - h. Develop a plan of support to ensure person needs are met/feedback loop i.e visits back to NFMH, peer supports.
- 2) Increase billable codes 120 days prior to discharge to include: peer support, SBIRT, psychosocial groups, attendant care.
- 3) Coordinate with KDHE and determine if a policy could be developed that allows presumptive approval from date leaving facility for anyone leaving an IMD environment.

Next steps/action plan for the discharge process

- Establish group by 4/1/16 and update the discharge guide originally created by Sherrie Watkins-Alvey by 5/15/16.
- KDADS to work with KDHE/MCOs to review recommendation to increase billable codes 120 days prior to discharge by 6/1/16.
- KDADS will coordinate with KDHE and determine if a policy could be developed that allows presumptive approval from date leaving facility for anyone leaving an IMD environment by 6/1/16.

Crisis services

Strengths

- Services available to all people in catchment area.
- The same psychiatrist covers CMHC and NFMH.
- When a screen occurs and the person gets the help they need (state hospital screen).
- The NFMH receiving assistance promptly when requesting help in a crisis.
- Improvements due to training of law enforcement and having some CIT trained officers.

Barriers

- Finding appropriate places for individuals with TBI, I/DD and/or dementia diagnosis and individuals with Veteran's benefits.
- Getting help for people who leave against medical advice (AMA).
- Person screened into a SMHH are often not able to return to the NFMH.
- Lose Medicaid if at SMHH for more than 21 days.
- No crisis services available for veterans - only scheduled crisis appointments.
- Some regulations required of the NFMH such as having to report theft, behavior plans and med compliance.
- Crisis services are not the same across CMHCs. Some CMHCs have mobile crisis services and others do not.
- Crisis services from CMHC are not always available on site.
- Relationships between law enforcement/CMHC/NFMHs.
- The amount of time for NFMH to receive assistance in crisis situations/response time for help.
- Helping individuals who become medication resistant.
- CMHC doesn't respond when NFMH has a crisis except for sending a screener.
- Not enough facility based crisis services
- Lack of understanding of what NFMH staff is trained for. They are not LMHT but CMA/CNAs.
- Lack of MH training for staff in NFMH.
- Lack of CIT trained officers- training needed for law enforcement such as MH first aid, CIT, etc.

Brainstorm recommendations

- Review regulations about individuals being able to refuse medication.
- Implement Psychiatric Advanced Directives
- Consider long-acting injections for individuals with history of med compliance issues.
- Partner with CMHC to provide crisis services, including beds and figure out payment mechanism.
- Develop a policy or standard regarding crisis services for individuals within NFMH with a feedback loop to KDADS.
- Use tele video to onsite crisis services
- Provide training for NFMHs MH first aid and CPI.
- CIT training for law enforcement
- Define what type of crisis services NFMHs need. Clearly identify what crisis services are available and how they are delivered.
- Develop a WRAP or crisis plan for individuals in the NFMH to help them identify ways to help deescalate to include natural supports.

Final recommendations

1. Develop standardized training and staff working in NFMHs on issues such as MH first aid and CPI as well as other training on training teams.org in addition to strengths-based case management, WRAP, IDDT
2. Develop a way for peer specialists and CROs to be paid to provide support in the facilities.
3. Develop a list of places available when a crisis occurs
4. Develop a process for crisis services to be access/provided for individuals in the NFMH (Partner with CMHC to provide crisis services, including beds and figure out payment mechanism) to include the creation of additional crisis stabilization units with medical and MH abilities to help stabilize people up to 14 days.
5. Implement Common Ground model in NFMHs.
6. Consider Outpatient Treatment Orders for individuals with history of non-med compliance.

Next steps/action plan

- Form a work group to establish standardized training for NFMH staff.
- Form a workgroup to develop a way for peer specialist and CROs to be paid supports in the facility.
- Get a list from Stephanie about places available when crisis occurs.
- Form a workgroup to include KDHE, KDADS, NFMHs, CMHC peer specialists, MCOs to create options for crisis services.
- KDADS to explore how to expand Common Ground to NFMHs either from KU or from CMHCs.
- Educate community partners about the option of Outpatient Treatment Orders

All task to be completed by 6/30/16

Education and training

Strengths

- NFMHs are willing to engage in training.
- Some NFMHs do internal training such as CPI.
- Some CMHCs provide MH 1st aid and diagnosis specific.
- Some NFMHs partnership with I/DD providers for training on specific issues such as dealing with challenging behaviors and de-escalation.

Barriers

- Shared decision/common grounds is not offered to NFMHs.
- No regulation or rule to require MH training.
- Training opportunities such as trainingteams.org are only open to CMHCs.
- Training needs include:
 - Trauma Informed Care
 - CPI training
 - Recovery Oriented Systems of Care
 - What Consumer-Run Organizations (CROs) offer
 - Trainings for guardians /NFMH/SMHH to have a broader understanding of what community resources are available
 - Training to help NFMHs understand what CMHCs can provide and also a training for CMHCs on what NFMHs can offer and provide based on rules and regulations of each system
 - Critical incident debriefing.
- Confusion regarding role of MCO and when they can work with an individual in an NFMH.
- Engaging MCOs in training and education
- Trained peer supports can only get paid through CMHC
- Some NFMHs are not willing to have training basic 101- MH first aid, etc.
- There is no “how to leave NFMH guide/checklist” available for all to use.
- Peer support resources/education in the NFMH.
- NFMH staff are CNA/CMAs and do not have behavioral health or mental health-specific training.
- Cost/staffing barriers to provide training to NFMHs
- Trust/relationship barriers between the NFMH and CMHC.
- NFMHs are not aware of the training that is offered to the public that they could attend.

Brainstorm recommendations

- Open trainingteams.org to NFMHs
- Create standards for mental health training needed to work in NFMH.
- Share training calendars/events among SMHH, CMHC, and KDADS
- Quarterly meetings with CMHC and NFMHs
- Inviting NFMHs quarterly mental health reform meetings.
- Create NFMH specific training
- Develop/or find a training for guardians possibly partnering with Kansas Guardianship Program. Also help guardians understand role of NFMH and community resources available. Utilizing NFMH to disseminate information.
- NFMHs asking MCO's for mental health specific training.

Final Recommendations

1. Open trainingteams.org to NFMHs.
2. Create standards for mental health training needed to work in NFMH. Create NFMH specific training. For example NFMHs asking MCOs, CMHCs and SMHHs for mental health-specific training.
3. Share training calendars/events among SMHH, CMHC, and KDADS.
4. Quarterly meetings with CMHCs and NFMHs.
5. Inviting NFMH's quarterly mental health reform meetings.
6. Develop/or find a training for guardians possibly partnering with Kansas Guardianship Program. Also help guardians understand role of NFMHs and community resources available. Utilizing NFMHs to disseminate information.
7. Education for KDADS surveyors to be aware of special populations in mental health facilities.

Next Steps/Action Plan

- KDADS will work with Wichita State University to broaden the accessibility of trainingteams.org.
- Form a workgroup (Gary) to develop standard MH training for NFMH staff.
- Explore a centralized location to put training calendars.
- KDADS to coordinate quarterly meetings.
- Invite NFMHs to quarterly mental health reform meetings.
- Create a brochure to help with education and partner with Kansas Guardianship Program. (Deb/Kristin)
- KDADS will work internally to improve process.

All task to be completed by 6/30/16

GAPS IN CURRENT CONTINUUM OF CARE

Specific needs of individuals that currently are not served by the NFMH or who are served but are not in the most appropriate environment.

- ❖ Individuals with severe mental health needs and no/few physical/medical needs.
- ❖ Individuals with high acuity and who require supervision- those who need a 24-hour structure to maintain at baseline.
- ❖ Individuals with low coping skills or problem solving abilities.
- ❖ Individuals who have burnt all their bridges.
- ❖ Individuals who are treatment resistant.
- ❖ Individuals with history of violence or aggression.
- ❖ Uninsured/underinsured individuals with high mental/physical needs who fall through the cracks those who are difficult to serve.
- ❖ Individuals who can't afford needed services.
- ❖ Individuals who have co-occurring SUD/MH only.
- ❖ Individuals with co-occurring Traumatic Brain Injury/IDD/MH/SUD.

- ❖ Individuals with a long history of MI and now have dementia individuals with water intoxication.
- ❖ Individuals who have sex-offending backgrounds.
- ❖ Individuals with criminal court backgrounds.
- ❖ Individuals who display extreme acting out behaviors that are not tolerated in the community.
- ❖ Veterans who are unable to access mental health service.
- ❖ Individuals with mental health needs who also have required skilled care.

TYPES OF SERVICES AND SUPPORTS NEEDED FOR THE ABOVE IDENTIFIED INDIVIDUALS TO SUSTAIN COMMUNITY LIVING

- Section of individual apartments that individuals could access help by phone 24/7 and a Case Manager available during the day (i.e. Tanglewood).
- Section of individual apartments and staff are onsite 24/7 (MHA type program).
- Group home with 24 hours supports, psychosocial groups etc (Evergreen).
- Long-term transitional living programs such as Greensburg Program.
- Adult day services and programming for individuals who live with family/friends.
- Adult respite.
- "Assisted living" like facilities that specialize in MH.
- Assistance with meals and medication.
- Long-term shared living program that is peer led (living room model).
- Long-term shared living program that is staff led.
- Adult "foster care/shared living" program with family and friend short or long term.
- Provide meaningful activities and social connectedness.
- Increase reintegration programs that assist people with MH and SUD needs.
- Integration of care between service sectors, IDD, SUD etc.
- Dual treatment facilities such as PV program (Valley Hope) Shawnee mission.
- Delayed egress or alarmed doors.

RECOMMENDATION TO ADDRESS SERVICE GAP

1. Provide resources to develop long term program/s with licensed mental health techs (LMHT) people trained in managing challenging behaviors, provide treatment, psycho social group, CPI de-escalation, behavior support plans/psychiatric advanced directives, psychologist, ARPN, medication reviews recommendations made from data, human rights committee.
2. Provide resources to increase transitional living/group home facilities statewide.
3. Develop programs/services/policies that support treatment for individuals with MH and SUD need.
4. Internal team to look at NFMH surveying/licensing's processes including Informal Dispute Resolution (IDR) process to include mental health expertise and another NFMH.

**** All recommendations should consider the impact of the Institute for Mental Disease (IMD) rule.***