KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

Testimony presented to the Senate Ways and Means Subcommittee on Social Services
Re: Osawatomie and Larned State Mental Health Hospitals

Amy A. Campbell – February 16, 2017

Thank you for the opportunity to address your committee today on behalf of the Kansas Mental Health Coalition. The Kansas Mental Health Coalition is dedicated to improving the lives of Kansans living with Mental Illnesses and Severe Emotional Disorders. We are consumer and family advocates, provider associations, direct services providers, pharmaceutical companies and others who share a common mission. At monthly roundtable meetings, participants develop and track a consensus agenda that provides the basis for legislative advocacy efforts each year. This format enables many groups, that would otherwise be unable to participate in the policy making process, to have a voice in public policy matters that directly affect the lives of their constituencies. The opportunity for dialogue and the development of consensus makes all of us stronger and more effective in achieving our mission.

Today, I am speaking to you on behalf of the Kansas Mental Health Coalition. I also serve as a co-chair of the Adult Continuum of Care Task Force. This committee serves under the auspices of the Governor's Behavioral Health Council (GBHSPC) in an advisory role to the Secretary of the Kansas Department for Aging and Disability Services (KDADS). The ACC Task Force is working to develop specific plans for the implementation of the recommendations from the 2015 Adult Continuum of Care Committee Report. The Executive Summaries of two ACC reports are attached.

The Moratorium on Admissions at Osawatomie State Hospital: A Crisis for Communities

The state's psychiatric inpatient system is broken. Simply put, it does not have the capacity to meet the current demand to serve Kansans who need inpatient treatment. Osawatomie State Hospital has lost its CMS accreditation, costing the State of Kansas close to $1 million per month in reimbursements and DSH payments. The fact is, mental health advocates have been warning of the potential crisis for ten years, and needed investments in facilities, technology, training and salaries were repeatedly delayed.

Why this matters: Kansans who experience a mental health crisis need the care and treatment required to help stabilize them and allow them to return to the community. Of those who use our state hospitals, more than 70 percent do not have Medicaid or other forms of reimbursement, limiting their access to private hospital beds. All this underscores the need to support a state mental health hospital system as a safety net for those who experience a mental health crisis. Without that safety net, many of these individuals will become involved with law enforcement or be seen in emergency rooms, shifting the cost to other systems. Whether public or private, underfunded inpatient facilities are not safe for patients or staff and they do not produce lasting recovery for patients.

The moratorium on admissions means that people who are in crisis and at risk of harming themselves or others must wait for needed treatment. There are no voluntary admissions under the moratorium, so every case must go through the legal process for involuntary commitment. Kansas law enforcement organizations and community hospitals identify the moratorium at Osawatomie State Hospital as a crisis that needs to be resolved as soon as possible.

Those who are involuntarily committed must wait for bed space to open up for their admission. Individuals are held in a variety of settings – placing community providers and law enforcement in the position of attempting to protect and care for them in surroundings that are not built for such situations.

Local law enforcement officials confirm that under these circumstances, they have made the difficult decision to walk away from some cases where interventions might have been best, but simply can't be managed if it will require taking officers off the street.

The lack of capacity in community based mental health services and in the state hospital system exacerbate the mental health crisis of the individual through increased use of criminal charges for minor offenses to resolve immediate problems of disorder. This results in citizens being incarcerated that could be better served by mental health services. Incarceration in these situations needlessly compounds the person's ability to function in the community and places them in a setting where they are, at best, receiving minimal mental health services with diminished probability of stabilization.

Solutions Must Include Attention to the Behavioral Health Continuum of Care

Kansas should restore inpatient capacity to 206 beds for Osawatomie and end the moratorium. The Coalition considers 206 beds a minimum to meet the public need today. The moratorium is harmful to people and communities today. As we pursue this immediate goal, we must also fill the gaps in our behavioral health continuum of care. An ideal number of state hospital beds for Kansas simply can't be determined until the overall continuum of care is addressed. It is important to remember that adding beds is not dependent on recertification.

In the midst of this gloomy picture, the Secretary of the Kansas Department on Aging and Disability Services and his staff have energetically pursued CMS recertification for Osawatomie State Hospital and important improvements in training, staffing and treatment delivery at both state hospitals. The improvements accomplished to date are admirable. There is still a lot of work to be done and we hope the 2017 Legislature will actively support the agency to achieve facility improvements and staffing goals. These problems have been exacerbated over many years, and they can't be fixed with any quick short-term strategies. The State's ability to address overall behavioral health treatment delivery for Kansans is limited while we struggle to deal with the immediate crisis.

For instance, the decision to separate Osawatomie into two unique hospitals raises a number of concerns. The agency is wise to minimize the investment in recertification if these efforts may be unsuccessful. But if Adair Acute Care at Osawatomie State Hospital is recertified, Kansas will still be unable to recoup federal Medicare and DSH funds for the majority of the beds at Osawatomie – referred to as the state licensed beds or non-certified beds. There are higher costs of duplicate administration. More importantly, will the two hospitals be comparable in quality and care? Will there be disadvantages regarding treatment quality or employee safety? Through the Adult Continuum of Care Committee, we have had opportunities to ask these questions, and the agency is aware of the concerns.

The Adult Continuum of Care Task Force and multiple prior reports have asserted the needs for higher levels of community based care, including crisis stabilization services, mental health and addictions treatment and detox services (inpatient and outpatient), and multiple levels of housing.

As we move forward through the complexities of recertification and planning for our hospitals, a parallel effort must be implemented to create and sustain the community programs that assist individuals in establishing and maintaining recovery in the community.

A 2014 Transitional Care Services Needs Assessment reports that only 6 of the 26 community mental health centers reported "adequate" housing resources in their communities. Housing resources evaluated in the survey included interim housing, structured care environments, transitional housing beds, short term respite care, rapid re-housing, professional resource family care, and vouchers for hotels.

Our current Task Force has been frustrated by the lack of progress since the 2015 report. In spite of good work by KDADS officials to support Rainbow Services Inc. and a promising grant for transition beds in Topeka, the continuum has eroded.

The current moratorium on admissions at Osawatomie State Hospital and the resulting waiting list exacerbate the current crisis. The four percent reimbursement cuts, cancellation of health homes and cancellation of the Medicaid hospitalization screening policy have reduced personnel and programs at the CMHCs. Recently, KDADS cancelled the University of Kansas contract supporting evidence based programs and reduced the Wichita State University contract supporting consumer programs and training.

Recommendations

1) **The Kansas Legislature should support and fund high-quality psychiatric inpatient services to meet the needs of all Kansans who require this care.** The Committee recommends funding the agency request for LSH at 7.4 million All Funds and 7.3 million State General Funds above the Governor's recommendation. The funding will be required to pay for the CMS recoupment of funds for disallowed payments associated with billing for SPTP patients and for $500,000 to replace the data storage system at the hospital. Recognize that this funding is necessary for funding current operations and not for expansion.

2) **Restore the 206 beds at Osawatomie State Hospital.** Beds must be restored to end the moratorium. This is priority one for communities and law enforcement. Alternatively, the committee could endorse the recommendations of the Special Committee on Osawatomie and Larned State Hospitals and requests the agency end the moratorium on admissions at OSH by re-opening or contracting for an additional 20 beds before the end of the current fiscal year – but 20 beds will not likely change the situation for voluntary admissions, which are denied now. The waiting list requires that individuals in crisis may be held in emergency rooms or jails that are not equipped for "psychiatric boarding." This creates an unsafe situation for people and the staff who try to serve them. The funding will be required to fill the gap created by the loss of Medicare and Medicaid reimbursement, as well as to cover the increasing percentage of people served at the hospital who do not have a payor source.

3) **The budget should not reduce the budgeted bed capacity at OSH.** The OSH budget reduces the budgeted bed capacity for FY2017, FY2018, and FY2019. There is no corresponding reduction to FTEs, but the change is more than symbolic. For one thing, it reverses the State's promise to provide 206 beds at OSH after the closure of Rainbow Mental Health Facility. It also significantly changes the cost per bed.

   Please do not approve changing the budgeted bed capacity to 146 beds at Osawatomie. Although we acknowledge the staffing and physical limitations that prevent re-opening 60 beds today, it should be the goal of the agency to operate 206 beds at OSH until there is evidence that the need for inpatient treatment at OSH has diminished. Assessing the need of inpatient beds should provide for both involuntary and voluntary admissions.

4) **Pursue recertification or accreditation as possible.** We agree with the agency that certification and/or accreditation of Adair Acute Care Hospital is also very important, and asks the agency to present a plan to HSSBC to recertify all of the beds at OSH by May 1. It is understood that certification requires minimum staffing levels and remodeling that could cost around $700,000 per 30 bed unit.

5) **Provide ongoing funding and support to replicate throughout the state the crisis stabilization services established recently at the former Rainbow Mental Health Facility serving Wyandotte and Johnson Counties and fund them into the future**. The KDADS budget included a request from the agency for $2 million which was not funded by the Governor.

6) **Empower the Kansas Department on Aging and Disability Services to produce a long-term plan to implement the recommendations of the Adult Continuum of Care Committee.** The ACC Report builds on the work of at least five working groups or task forces dating back more than a decade. Strategic planning could help us to make the current hospital crisis a temporary situation and move our State forward in developing a balance between our inpatient resources and the community programs that make up our continuum of care.

7) **Provide for continued public/private partnerships for local psychiatric inpatient beds to alleviate the growing demand for state psychiatric hospital beds**. The percentage of uninsured served within more intensive community treatment programs means that these programs struggle for sustainability. The positive outcomes of these programs are well documented.

Any proposal for privatization of state hospital inpatient services should be evaluated on its potential to improve the current behavioral health system in Kansas overall and not to simply replace the State's role in operating the hospitals. Privatization efforts across the country have not succeeded in erasing the challenges Kansas faces today. However, Kansas has had positive public/private partnerships for smaller children's hospital units and adult diversion beds, which may provide an example for opportunities.

The Coalition will eagerly participate in public discussions regarding the merits of any proposals that emerge.

Thank you for the opportunity to speak to you today. Please feel free to contact me at any time to discuss these issues further.

Amy A. Campbell, Kansas Mental Health Coalition, PO Box 4103, Topeka, KS 66604 785-969-1617

History

The system: The Department for Aging & Disability Services (KDADS) operates two mental health hospitals: Osawatomie State Hospital (OSH) and Larned State Hospital (LSH). Together, these hospitals have approximately 310 beds. Over the last decade admissions to both hospitals have risen consistently.

Some history: In the 1950s, Kansas had more than 5,000 state hospital beds. Today, 94% of those beds no longer exist. This dramatic reduction in beds reflects a change in public mental health services from offering care and treatment through long-term institutionalization to providing care in the community with a goal of helping individuals live independent and fulfilling lives. Despite this shift, hospitals remain a critical part of the public mental health system. They not only help stabilize people experiencing a mental health crisis, but relieve the burden placed on local criminal justice systems, hospital emergency rooms, and other public safety agencies.

The two State Mental Health Hospitals: Larned State Hospital and Osawatomie State Hospital, have the capacity to serve an average daily census of 310 persons. However, due to construction, Osawatomie State Hospital was forced to reduce their beds to 146, which puts the statewide capacity at 250 persons. This gave OSH a capacity of 146 available beds to serve a population area of well over 1.5 million people. (Closing Rainbow Mental Health Hospital in 2014 reduced the number of state hospital beds by 20.) Meanwhile, community based treatment options have not expanded to meet the outpatient, residential, housing, employment, and peer support needs of Kansans who need services for mental illness and/or addictions treatment.

Development of Local, Accessible, Crisis Stabilization Services Statewide: In April, 2014, KDADS implemented a contract with the Wyandot Center, in partnership with Johnson County Mental Health Center and the Heartland Regional Alcohol and Drug Assessment Center, which established the former Rainbow

Mental Health Facility as a crisis stabilization center (Rainbow Services Inc., also known as RSI). This partnership effort includes 24-hour intake, assessment, and triage service; crisis observation beds; a short term crisis stabilization unit; and substance abuse sobering and detoxification services. The facility has capacity to serve up to 30 people in a 24-hour period, including 10 crisis stabilization beds for short-term stays. It also includes a strong focus on connecting individuals to community services and avoiding admissions to Osawatomie State Hospital. RSI provides a model for replication across the state of crisis stabilization services which could and should be available to all Kansas residents. Since opening in April, 2014, admissions to Osawatomie State Hospital from Wyandotte and Johnson Counties have been reduced by 40% compared to the same time period in the previous year.

Executive Summary – 2015 Adult Continuum of Care Committee Report

Kansas has identified the need to move beyond a mental health system that is stretched beyond its ability to provide the right care at the right time in the right place for Kansas citizens since 2006. The health and safety of our citizens, families and communities are at risk in a system where we must desperately seek alternative placements in order to avoid unacceptable hospital census numbers.

Recovery and independence are best achieved through an array of psychiatric and SUD services and supports that provide quality care, individual choice, and treatment options that are specific to the needs of the individual. As the public mental health system struggles to meet the critical needs of increasing numbers of Kansans, we must address the available continuum of care now rather than later.

Why do we need a continuum? Providing the right care in the right setting at the right time enhances patient care and improves health outcomes for Kansans. It assures the effective use of resources and promotes individual recovery. It is this committee's unanimous assessment that the continuum in Kansas is insufficient to serve the needs of the population and makes it impossible for the state mental health hospitals to reduce capacity or pursue a more specialized role than as a broad safety net setting. The 60 beds at Osawatomie State Hospital must come back into service as soon as the federally ordered renovations are complete.

While the current shortage of state mental health hospital beds has placed a significant strain on state hospitals, community hospitals, community mental health centers, and housing resources; it also presents an opportunity for Kansas to evaluate the strengths and weaknesses of our current adult continuum of care.

The committee endorses the report and recommendations of the Hospital and Home Core Team and asserts that the gaps in our continuum of care present a past, present and future barrier to achieving the Core Team goals for the state hospitals. One of those goals is for the state mental health hospitals to become more of a tertiary care hospital setting with a focus on treatment of chronic mental illness. The Hospital and Home Core Team also developed recommendations regarding screening and discharge processes. This committee did not attempt to repeat that work in the short time available, but hopes to build on that report with further recommendations focusing on the continuum.

To move our mental health system toward better health outcomes and the best chance of recovery for Kansans facing behavioral health issues, particularly chronic mental illness and chronic substance use disorders, we must bridge some of the gaps in our continuum of care. The State's innovation and investment in Rainbow Services Inc. (RSI) is an excellent step forward to strengthen at least one level of the continuum that has needed attention. The successes of RSI to date can be replicated in other communities if we can stimulate the partnerships and community support established there. But there is more work to be done to assure the sustainability of RSI, through funding, policy and statutory initiatives. The committee encourages the Department to lead those efforts and transfer lessons learned to invest in RSI model services in other Kansas communities.

In addition to recommending expansion of the RSI model to other communities, the committee recommends strategies to boost other levels of the continuum. When the continuum of care offers multiple levels of treatment addressing varied individual needs, such as those with chronic mental illness co-occurring with substance use disorders, developmental disabilities, and traumatic brain injuries, people are less likely to require referral to treatment at a state mental health hospital. Further, Kansas lacks appropriate treatment for transitional age youth, forensic, and geriatric populations, which are sometimes grouped together.

Executive Summary – January 5 2017 Update to the Adult Continuum of Care Report

The ACC Task Force endorses the 2015 Report. These recommendations do not replace the recommendations of the 2015 Report and interested parties should read the full 2015 Report to provide context to this document.

The members of the ACC Task Force are discouraged at the continued erosion of the Kansas behavioral health continuum of care since the last report. While there have been positive developments, including Rainbow Services, Inc., and the creation of new crisis services in Wichita and Topeka, the overall system has degraded and cannot meet the statewide need.

Kansans who need treatment through the behavioral health system are currently all too often unable to get the help they need. Community resources are strained, affecting both mental health treatment and substance use disorders treatment.

The Osawatomie State Hospital moratorium is a crisis that must be ended and the Task Force supports restoring OSH to 206 beds. The 2015 Report recommended restoring 60 beds to Osawatomie State Hospital as soon as the federally ordered renovations are complete. In the months after that report was released, two major events occurred. First, due to the planned safety renovations and shortage of staff, KDADS initiated a moratorium on admissions. Second, CMS decertified Osawatomie State Hospital. Today, due to decertification and lack of staffing, Osawatomie continues to operate only 146 beds and continues under the moratorium. Until the gaps identified in our continuum of care have been addressed and community resources exist to serve Kansans who have serious mental illness and addictions, Kansas will be unable to implement any strategy for our state mental health hospitals that includes a data supported number of hospital beds.

Kansans who experience a mental health crisis need the care and treatment required to help stabilize them and allow them to return to the community. Of those who use our state hospitals, more than 70 percent do not have Medicaid or other forms of reimbursement, limiting their access to private hospital beds. All this underscores the need to support the state mental health hospital system as a safety net for those who experience a mental health crisis. Without that safety net, many of these individuals will become involved with law enforcement or be seen in emergency rooms, shifting the cost to other systems. Whether public or private, underfunded inpatient facilities are not safe for patients or staff and they do not produce lasting recovery for patients.

The moratorium on admissions means that people who are in crisis and at risk of harming themselves or others must wait for needed treatment. There are no voluntary admissions under the moratorium, so every case must go through the legal process for involuntary commitment. Kansas law enforcement organizations and community hospitals are on the front line of this crisis.

Those who are involuntarily committed must wait for bed space to open up for their admission. Individuals are held in a variety of settings – placing community providers and law enforcement in the position of attempting to protect and care for them in surroundings that are not built for such situations and delaying the initiation of treatment. Local law enforcement officials confirm that under these circumstances, they have made the difficult decision to walk away from some cases where interventions might have been helpful, but simply can't be managed if it will require taking officers off the street.

The lack of capacity in community based mental health services and in the state hospital system exacerbates the mental health crisis of the individual through increased use of criminal charges for minor offenses to

resolve immediate problems of disorder. This results in citizens being incarcerated that could be better served by mental health services. Incarceration in these situations needlessly compounds the person's ability to function in the community and places them in a setting where they are, at best, receiving minimal mental health services with diminished probability of stabilization.

While community mental health centers serve all Kansans regardless of their ability to pay. The depth in the array of treatments needed for many Kansans, especially those at risk, is not broadly available across Kansas communities.

The Secretary of the Kansas Department on Aging and Disability Services and Osawatomie State Hospital staff have energetically pursued CMS recertification for Osawatomie State Hospital and important improvements in training, staffing and treatment delivery at both state hospitals. The improvements accomplished to date are admirable but many challenges remain, including facility improvements and staffing goals. These problems have been exacerbated over many years, and they will not be fixed with any quick short-term strategies. The State's ability to address overall behavioral health treatment delivery for Kansans is limited while we struggle to deal with the immediate crisis.

The Task Force worked to develop recommendations to move Kansas beyond this crisis and to improve the overall continuum of care. Information was gathered from within the Task Force and outside our state system with the goal of addressing the larger issues of access to care and the role of the state hospitals. The 2015 Report identified multiple levels of our continuum of care that need attention (see page 6 of the 2015 Report). The Task Force examined the roles of Community Mental Health Centers (CMHCs), Substance Use Disorder (SUD) providers, Supported Housing and Nursing Facilities for Mental Health (NFMHs) today and the barriers that can prevent these agencies from providing the appropriate treatment at the appropriate time. The excellent programs that strive to transition people who have been discharged from the hospitals to the community are hampered by the lack of community housing options and Medicaid payment restrictions.

Kansas must, in the immediate future, implement regulations and funding strategies to incentivize the treatment and services necessary to fill the gaps of our continuum of care. Without access to the services necessary, people will continue to suffer the life threatening trauma of serious mental illness and addictions without the services that might prevent unnecessary incarceration or hospitalization. Without the resources for treatment at the right time and in the right setting, which include housing and employment support, we will continue to overuse more restrictive and expensive resources.

The Task Force is aware that KDADS has issued a Request for Proposals for privatization of Osawatomie State Hospital. The Task Force did not provide input to the RFP. In the absence of information regarding the proposals, the Task Force does not support private contracts for operating our state hospitals today, and priorities that need to be addressed in potential privatization contracts must be outlined for the Task Force to support a privatization recommendation.