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# HMA

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HEALTH MANAGEMENT ASSOCIATES

*Behavioral Health Needs Assessment  
for Metropolitan Kansas City*

JANUARY 29, 2009

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics  
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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## EXECUTIVE SUMMARY

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Communities across the nation are faced with the challenge of ensuring that citizens with behavioral health issues have access to the services they need. Behavioral healthcare is too often underfunded, fragmented, and not integrated with other services. Major issues include:

- *Inadequate service capacity.* In many communities, individuals face long waits for services, often resulting in exacerbation of the problems for which they sought help.
- *Gaps in services.* In most communities, some critical services are not available at all. This is especially true for some of the newer, evidence-based and promising practices.
- *Poor coordination among providers.* Behavioral health systems are complex. Inadequate attention to coordination of services often results in individuals “falling through the cracks.”
- *Inadequate integration of physical and behavioral health services.* Many people with behavioral health challenges also face major physical health issues, which often go untreated.

Stakeholders in the Kansas City metropolitan area have been working to understand and address these issues and to identify community solutions to ensure that residents have behavioral health services that are adequate and accessible, and that services are provided in a way that promotes coordination and integration of care. To support the community’s efforts to address these issues, the Mid-America Regional Council (MARC), the region’s council of government and planning organization, asked Health Management Associates (HMA) to provide planning support to the community as it seeks to identify the gaps and develop a plan to respond to them.

Specifically, HMA was asked to:

- Review existing needs assessments that have been completed for the Kansas City metropolitan region in the areas of mental health, substance abuse, developmental disabilities, with a focus on the needs of the uninsured and medically underserved populations;
- Identify services currently available in metropolitan Kansas City and the gaps in services that exist in the region;
- Through a series of interviews, focus groups and surveys, highlight the perceptions of key stakeholders about the strengths and weaknesses of the current system, the unmet needs in behavioral health services and issues of coordination of behavioral health and physical healthcare services;
- Collect and compile information on national models of behavioral health practice and behavioral/physical health integration that might inform the Kansas City community’s efforts; and
- Make recommendations for community initiatives for consideration by stakeholders.

### ***Methodology***

HMA's approach to identify unmet needs and service gaps in the community relied on information from a variety of sources, including:

- Review of existing needs assessments;
- Stakeholder input, including focus groups and key informant interviews;
- Survey of providers about barriers to services;
- Survey of community mental health centers (CMHCs) about available services; and
- Review of information about nationally recognized best practice models.

Our findings and recommendations were developed based on a review of all these data sources. Our recommendations represent findings where there was a strong consensus or alignment among the various sources of information.

HMA reviewed approximately a dozen recent reports that ranged from strategic planning documents for individual providers to broad health assessments covering one or more counties the region. The majority of the reports reviewed cover Jackson County, Missouri, while a handful of reports address services provided in other counties in the region. These reports used widely varying methodologies and had widely varying objectives, making it difficult to draw a comprehensive picture of the need for services across the region. Nevertheless, the reports provide important insight into key areas of unmet need.

Information about perceived strengths, weaknesses and unmet needs of the service delivery system constituted a second part of the project. To gather input and recommendations from key stakeholders, including consumers, providers, advocates and community leaders, HMA conducted focus groups and key informant interviews.

HMA facilitated two focus groups for consumers to gather obtain their perceptions on the service delivery system and two focus groups for providers, to identify gaps in services. After identifying some preliminary findings, HMA facilitated three additional focus groups, one attended by consumers and advocates, a second for community mental health center executive directors and a third for other stakeholders, to review our preliminary findings.

In addition to the focus groups, HMA interviewed eighteen key informants to benefit from their insights about and knowledge of the system, particular services and target populations.

Additional information came from a survey MARC issued to 139 behavioral health providers and safety net organizations in metropolitan Kansas City. The purpose of the survey was three fold: 1) to gather information about patient/client access to health and behavioral healthcare across the age spectrum; 2) to determine the gaps in the existing health and behavioral healthcare system for the uninsured and medically underserved; and 3) to identify barriers that prevent uninsured and medically underserved people from receiving the care they need.

Additional information was gathered from seven of the CMHCs that have collaboratively targeted the range of services they provide to the metropolitan Kansas City region. Using that as a basis, HMA asked CMHCs to complete a follow up survey to gain a more complete picture of the available vs. unavailable behavioral health services that in the Kansas City region, with particular emphasis on the availability of evidence-based and promising practices.

HMA also reviewed several regional and/or national models that have the ability to improve local, regional and state mental health systems' capacity and/or effectiveness. The description of models is organized into six categories:

- Models that help increase access to housing services;
- Models that help increase access to transportation services;
- Models that improve coordination and /or collaboration of service providers;
- Models that promote integration of mental health and substance abuse or physical health services;
- Models that address funding silos; and
- Models that encourage recovery and patient-centered planning.

Each of the models profiled has achieved some measure of quantifiable improvement and each addresses at least one, if not more, of the issues identified as a need within the Kansas City Region by key stakeholders. The profiles included under each model were selected because each contains elements that could inform future efforts in the Kansas City Region to strengthen the mental health service system.

### ***Findings***

The findings were developed from a review of the various data sources used by HMA in this study and represent areas where there was consensus or alignment among the various sources of information. Following are the findings of the needs assessment:

1. There are opportunities across the Kansas City region to increase consumer involvement and to support consumer run services.
2. There is a shortage of safe, appropriate and affordable housing for low-income individuals with behavioral health needs.
3. There are insufficient residential services for individuals needing long-term structured residential supports to meet demand.
4. Funding for mental health services is not commensurate with need.
5. The Kansas City region has inadequate capacity to meet the needs of consumers with serious mental illnesses who need acute care services.
6. The lack of access to services outside normal business hours is a barrier to care for some consumers.
7. Consumers, particularly adult consumers, with behavioral health issues need assistance in securing physical healthcare services.
8. Some subpopulations were reported to face greater challenges in accessing services.
9. There is a lack of available substance abuse treatment services in the Kansas City region.
10. The Kansas City region has some of the critical elements of a crisis response system but would benefit from a community effort to improve availability and coordination of these services.

11. While the Kansas City region has made significant strides in developing healthcare resources and information for the area, there remains a lack of information regarding behavioral health disorders, resources for obtaining behavioral health services, and management of behavioral health illnesses.
12. The Kansas City Region does not currently collect key metrics to determine the effectiveness and availability of behavioral health services.
13. There is a need to ensure that mental health and other services offered by safety net providers are coordinated.
14. There are a high percentage of individuals in the criminal justice system who have behavioral health diagnoses and will need comprehensive services to be able to successfully re-enter the community.
15. Transportation is a major barrier to care.
16. The Kansas City region has become increasingly culturally diverse in recent years, prompting the need for strategies to address cultural and linguistic barriers to care.
17. Siloed funding across behavioral health and other programs used by behavioral health consumers makes it difficult to offer the type of flexible and unique services required by consumers and creates barriers to access to services as consumers must navigate multiple program eligibility requirements.

### ***Recommendations***

Based on the findings, the report includes the following recommendations. Each recommendation is tied to one or more finding in the report:

1. **Embed recovery practices and principles in the behavioral health service delivery system.** The region's healthcare leaders should create a coalition to ensure that the principles and strategies associated with recovery are embedded in the service delivery system. The coalition should include significant representation from the consumer and family member community as well as service providers, local officials and other stakeholders. The stakeholders group convened by MARC may form the basis of such a coalition.
2. **Implement a community-wide initiative to address the critical need for housing for individuals with behavioral health disorders.** Improving the availability of housing for people with behavioral health disorders is a major issue for the community, largely because housing is often a prerequisite for successful engagement in community-based behavioral health services. To address this, we recommend a coalition of consumers, advocates, county officials and other key stakeholders be charged with evaluating the feasibility of establishing a "housing first" approach in the Kansas City region. This type of housing program can be started as a modest initiative with a limited number of units and expanded as resources allow.
3. **Address the critical gaps in services and service capacity.** While the Kansas City region has a basic foundation of needed services, there remain critical gaps. These gaps can be viewed as occurring in three areas: gaps where services are not available, gaps due to lack of capacity in certain services and gaps where certain populations need either additional services or assistance in access existing services. A concerted community

effort is needed to begin to address those gaps that were noted as priorities as this has the potential to significantly improve the overall service delivery system.

4. **Ensure that behavioral health services are a central component of community efforts to coordinate and manage healthcare and social services.** While the Kansas City community has already taken steps to create linkages and coordination of various safety net services, it is critical that future activities include behavioral health services. Given that behavioral health needs drive a substantial amount of physical health utilization and expenditures, inclusion of behavioral health and community health collaborations is essential.
5. **Expand strategies to improve the integration of behavioral health and physical healthcare services.** Existing efforts to integrate physical and behavioral healthcare should be reviewed to determine the most effective approach for expanding integrated care across the region. A broad-based community initiative, coordinated with these ongoing strategies, should be undertaken to improve the integration of physical health and behavioral health services. Strategies to determine what entities will be responsible for providing and managing care, such as the Four Quadrant model, should be developed.
6. **Develop a region-wide plan to improve transportation to increase individuals' access to behavioral health services.** Lack of reliable and accessible transportation was repeatedly cited as a barrier to services. We recommend that MARC, which already plays a major role in coordinating the region's transportation initiatives, convene a group to address the specialized transportation needs of individuals with behavioral health needs. The group should review possible models of transportation supports, including those profiled in this report, and develop a plan to implement those that are considered to be the most feasible for the region. Urban communities which already have a relatively robust transportation infrastructure should consider options that build on existing transportation approaches (such as the half fare program), while rural areas will likely require more tailored approaches that create new means of transportation such as vouchers or volunteer drivers, or expand the use of telemedicine to avoid the need for transportation.
7. **Address the barriers created by siloed funding by developing approaches to increase flexibility through the use of regional or statewide funding strategies, such as braided or blended funding pools.** Tackling funding silos is often one of the most challenging, but also most critical, components of achieving system reform and improvement. However, there are a number of avenues that the Kansas City region can pursue. Some of these would require significant statewide policy changes, such as pursuing Medicaid waivers that combine multiple federal, state and local funds while others can be done without a Medicaid waiver if community providers across multiple systems can agree to blend some portion of their funds. Regardless of whether a Medicaid waiver is part of the strategy to address funding silos, doing so has the effect of creating more efficient and flexible delivery systems that enable communities to stretch limited resources.
8. **Develop a process to regularly collect, distribute and evaluate key measures of the region's behavioral health system performance.** As a means of assessing the performance of the system of care, the community should establish a series of metrics to assess the success of the service delivery system and serve as a guideline for change

when needed. These suggested measures would offer a baseline against which to judge the impact of any future changes to the delivery system. Additionally, regular monitoring of these measures can help the community proactively identify areas where attention is needed and where the community may want to develop a collaborative solution.

## BACKGROUND/OVERVIEW

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### *Description of project*

Across the nation, states and local communities are struggling to ensure that citizens with behavioral health issues have access to the services they need.<sup>1</sup> Behavioral healthcare is too often underfunded, fragmented, and not integrated with other services. Major issues include:

- *Inadequate service capacity.* In many communities, individuals face long waits for services, often resulting in exacerbation of the problems for which they sought help;
- *Gaps in services.* In most communities, some critical services are not available at all. This is especially true for some of the newer, evidence-based and promising practices;
- *Poor coordination among providers.* Behavioral health systems are complex. Inadequate attention to coordination of services often results in individuals “falling through the cracks.”
- *Inadequate integration of physical and behavioral health services.* Many people with behavioral health challenges also face major physical health issues, which often go untreated.

These problems are particularly acute for individuals with complex needs such as dual diagnoses of mental illness and substance abuse, mental illness and a developmental disability, individuals with a behavioral health disorder and a co-occurring medical problem, or people with behavioral health disorders with criminal justice involvement.

Stakeholders in the Kansas City metropolitan area have been working to understand and address these issues and to identify community solutions to ensure that the region’s behavioral health services are adequate and accessible, and are provided in a way that promotes coordination and integration of care. To support the community’s efforts to address these issues, the Mid-America Regional Council (MARC), the region’s council of government and planning organization, asked Health Management Associates (HMA) to provide planning support to the community as it seeks to identify the gaps and develop a plan to respond to them.

Specifically, HMA was asked to:

- Review existing needs assessments that have been completed for the Kansas City metropolitan region in the areas of mental health, substance abuse, developmental disabilities, with a focus on the needs of the uninsured and medically underserved populations;
- Identify services currently available in metropolitan Kansas City and the gaps in services that exist in the region;
- Through a series of interviews, focus groups and surveys, highlight the perceptions of key stakeholders about the strengths and weaknesses of the current system, the unmet

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<sup>1</sup> For the purpose of this study, the term behavioral health encompasses mental health, substance abuse and developmental disabilities.

needs in behavioral health services and issues of coordination of behavioral health and physical healthcare services;

- Collect and compile information on models able to strengthen behavioral health services that can inform the Kansas City community's efforts; and
- Make recommendations for community initiatives for consideration by stakeholders.

### ***Overview of service delivery system***

The focus of this study is the Kansas City metropolitan area, defined as an eleven county region straddling the border of Kansas and Missouri. Kansas Counties in the region are Johnson, Wyandotte and Leavenworth; Missouri Counties includes Bates, Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray.<sup>2</sup> With a population of nearly 1.8 million people, the region has experienced consistent growth over the past decades. Jackson County, Missouri is the region's largest county; Johnson County, Kansas has experienced the fastest growth. The region includes densely urban areas, such as Kansas City, Missouri, sub-urban areas, and rural communities. The population of the area is growing, particularly those counties surrounding the urban core.<sup>3</sup> Finding regional solutions to addressing the behavioral health needs of this large, diverse area requires an appreciation of the current service delivery system, including the policies and practices of the Missouri and Kansas systems, the existing services infrastructure and the coordination initiatives that are currently in place.

### **Kansas and Missouri state systems**

***Kansas.*** In Kansas, mental health and substance abuse services are both overseen by the Department of Social and Rehabilitation Services, but are delivered under two distinct funding and management systems.

Mental health services are delivered through 26 community mental health centers (CMHCs). CMHCs are responsible for providing a core array of mental health services in the areas they serve and act as gatekeeper for state mental health hospital admissions. CMHCs receive county, state and federal grant funds to support the services they provide to people unable to pay in other ways. They also bill for services through the Medicaid program for the services they provide to eligible beneficiaries. In 2006, CMHCs served 119,400 individuals (15 percent seriously and persistently mentally ill (SPMI), 42 percent Non-SPMI, 23 percent with serious emotional disturbances (SED) and 20 percent Non-SED). Starting in 2007, Kansas implemented managed care for Medicaid outpatient mental health services. Kansas Health Solutions, a CMHC-sponsored non-risk managed care organization (MCO), oversees a provider network providing all ambulatory Medicaid mental health services covered under the contract between Kansas Health Solutions and the State of Kansas.

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<sup>2</sup> The eleven county region defined in the RFP for this project is broader than the MARC Region, which consists of only eight counties.

<sup>3</sup> Mid-America Regional Council, *Regional Data Snapshot*, September 2005. Found at <http://www.marc.org/regionalsnapshot.pdf>. Please note that the data included here focus on the eight counties in the MARC service area. The U.S. Office of Management and Budget identifies the Kansas includes additional counties in it Metropolitan Statistical Area (MSA).

In 2007, Kansas also implemented managed care for substance abuse treatment. The Department of Social and Rehabilitative Services awarded a managed care contract to Value Options (VO - Kansas) to manage substance abuse services for approximately 280,000 Medicaid beneficiaries as well as individuals eligible under the Substance Abuse Prevention and Treatment block grant. (Block grant eligibility is limited to those with clinical need and income under 200 percent of the Federal Poverty Limit). VO-Kansas continues to use the Integrated Data System developed by the state to ensure a uniform process to register clients, approve treatment services and monitor operations. This is an objective, scientific instrument for treatment placement, continuing care, and discharge to ensure that decisions about care are driven by clinical needs and objectives, and are standardized statewide. The VO-Kansas provider network includes over 100 licensed substance abuse providers covering approximately 200 service locations.

**Missouri.** The Missouri Department of Mental Health (DMH) manages the public mental health delivery system. For the provision of community-based services, Missouri's 114 counties and the City of St. Louis are subdivided into 25 mental health service areas. In FY 2006, the State of Missouri spent at least \$2.07 billion on mental health services. Over half of these expenditures (\$1.1 billion), serving 144,644 consumers, flowed through DMH. The agency with the next largest percentage of total mental health expenditures (41 percent) was the MO HealthNet (Medicaid) Division Fee for Service (\$855 million) within the Department of Social Services, serving 305,566 consumers. MO HealthNet Children's Services Division's Comprehensive Psychiatric Rehabilitation program accounted for \$69 million in expenditures.

With an annual budget of \$1.1 billion (53 percent state general revenue, 43 percent federal, 4 percent other funds), DMH contracts with over 1,600 providers. DMH provides services for persons with substance abuse, psychiatric and MR/DD disorders. In FY2006, most expenditures were for persons with psychiatric or mental retardation and developmental disabilities disorders. Specifically 7 percent of funds were expended for substance use services, 38 percent for psychiatric services, 43 percent, were for mental retardation and developmental disabilities services, and 12 percent was expended for persons with dual diagnoses.

Key differences between the two states make developing a regional approach challenging. However, the region can also benefit from efforts to replicate policy improvements and/or service delivery advances from one state to another. Critical differences between the states that can impact the Kansas City region's efforts to strengthen behavioral health services include:

- **Medicaid Eligibility.** The eligibility process in Kansas does not require a separate determination process from disability determination for supplemental security income. Missouri's Medicaid eligibility requires a separate Medicaid application. This added administrative barrier in Missouri likely leads to fewer Medicaid eligible individuals securing benefits.
- **Per Capita Mental Health Expenditures.** Kansas spends approximately 30 percent more per capita on state mental health expenditures than does Missouri. In 2005, Kansas's per capita state mental health agency expenditures were \$93 compared to \$72 for Missouri.
- **Medicaid Waivers.** Kansas has pursued Medicaid waivers, particularly 1915(c) waivers that allow for greater flexibility in what services can be provided, and to whom, to a greater degree than has Missouri.

- **Service Integration.** Missouri appears to have taken greater strides in developing strategies to enhance coordination between behavioral health and physical healthcare services than Kansas.

Please see **Appendix C** for additional comparative information about Kansas' and Missouri's systems.

### **Community Mental Health Centers**

Community Mental Health Centers (CMHCs) play a significant role in the delivery of behavioral health services, particularly for indigent and uninsured individuals. Nine community mental health centers serve the Kansas City area.

In Kansas, twenty-seven CMHCs are licensed by the state and serve as local mental health authorities for designated areas. Kansas CMHCs serving counties in the Kansas City region are Johnson County Mental Health Center, Wyandot Center and The Guidance Center.

- *Johnson County Mental Health Center* is licensed by the state of Kansas and offers a range of mental health services at four locations: Shawnee, Olathe, Overland Park and Mission. Information about the Center's services can be found at <http://mentalhealth.jocogov.org>.
- *Wyandot Center* serves as the designated community mental health center for Wyandotte County. Services are provided at several locations in Kansas City and in Bonner Springs. Information about the Center services can be found at <http://www.wyandotcenter.org/AboutUs/index.html>.
- *The Guidance Center* is the community mental health center for Leavenworth County in the region, as well as Acheson and Jefferson Counties. Information about the Center's services can be found at <http://www.theguidance-ctr.org>.

The State of Missouri has divided the state into 25 service areas. Community mental health centers serve as administrative agents (or affiliates) of the state in the delivery mental health services in their designated service area. Missouri CMHCs serving the Kansas City metropolitan area are:

- *Comprehensive Mental Health Services*, based in Independence, serves communities in eastern Jackson County. Information about services can be found at <http://www.thecmhs.com>.
- *Pathways Community Behavioral Healthcare* provides a range of mental health and substance abuse services to a 35-county region of the state, including several counties in the region: Bates, Cass, Johnson and Lafayette. Information about services can be found at <http://www.pathwaysonline.org>.
- *ReDiscover*, headquartered in Lee's Summit, serves part of Jackson County, including the communities of South Kansas City, Grandview, Raytown, Lee's Summit, Midtown Kansas City. Information about center services can be found at <http://www.rediscovermh.org/programs.html>.
- *Swope Health Services* serves part of Jackson County. In addition to serving as a community mental health center with a broad array of services for adults with mental

illnesses, children and adolescents with emotional disturbance, and individuals with addictions, Swope is a federally qualified health center (FQHC). See [www.swopehealth.org/Services/Health\\_Behavioral.aspx](http://www.swopehealth.org/Services/Health_Behavioral.aspx).

- *Tri-County Mental Health Center* serves Clay, Platte, and Ray Counties. The center has locations in Kansas City, Excelsior Springs, North Kansas City, Richmond and Platte City. <http://www.tri-countymhs.org/Services/Programs.html>.
- *Truman Medical Center Behavioral Health* serves part of Jackson, County. Like Swope, Truman Medical Center is an FQHC. In addition, it provides inpatient services. Information about services can be found at [http://www.trumed.org/trumedweb/bh/bh\\_services.asp](http://www.trumed.org/trumedweb/bh/bh_services.asp).

Of these, four (Comprehensive, ReDiscover, Swope and Truman) serve parts of Jackson County.

### **Other services/providers**

- In addition to community mental health centers, the Kansas City metropolitan area includes a wide array of providers of behavioral health, healthcare and social services. Many of these organizations might be considered to be “niche” providers, in that they serve individuals with specific needs or provide a piece of the services continuum. These providers include non-profit providers, consumer and advocacy organizations that also offer services, providers who deliver health and social services such as homeless or domestic violence services, and providers who serve clients with specific diagnoses such as substance abuse or developmental disabilities.

## **METHODOLOGY**

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HMA used a “convergent” approach to identify unmet needs and service gaps in the community that relied on information from a variety of sources, including:

- Review of existing needs assessments;
- Stakeholder input, including focus groups and key informant interviews;
- Survey of providers about barriers to services; and
- Survey of CMHCs about available services.

Our findings and recommendations were developed based on a review of all these data sources and represent areas where there was a consensus or alignment among the various sources of information.

The methodology used in this needs assessment had several advantages, including building on previous behavioral health needs assessment information. First of all, this report summarizes the findings of previous needs assessments and builds on the matrix developed by the CMHCs to outline their available services. Use of these existing source materials prevented this effort from being redundant with previous initiatives. In addition, an effort was made to gather information from a range of perspectives, including consumers, providers and other stakeholders. And finally, the methodology incorporated a variety of approaches to gathering information, including surveys, interviews and focus groups.

However, by its nature, the methodology had limitations. For example, since much of the information is based on individual perception, many of the findings were dependent on who responded to surveys or who chose to participate in focus groups. The Findings section of the report reflects some findings with a stronger evidence base than others. While both data-based and perception-based information are legitimate, findings that are largely based in perception may lead to recommendations that vary from those where there is a strong data base supporting an unmet need or gap in service.

In addition, because much of the information gathered was based on perception, the results of this study reflect the priorities of those who chose to participate in the various opportunities for input. Because of the active participation in the needs assessment process from consumers, CMHCs and other stakeholders who participate in MARC, the results reflect more directly the behavioral health needs of those eight counties (Johnson, Leavenworth and Wyandotte in Kansas; and Cass, Clay, Jackson, Platte and Ray in Missouri) than of the larger region.

### ***Review of existing needs assessments***

As part of this project, HMA was asked to review and synthesize existing needs assessments that have been completed for the Kansas City metropolitan region in the areas of mental health, substance abuse, developmental disabilities and physical healthcare with a focus on the needs of the uninsured and medically underserved population.

HMA reviewed approximately a dozen recent reports that ranged from strategic planning documents for individual providers to broad health assessments covering one or more counties in the region. The majority of the reports reviewed cover Jackson County, Missouri, while a

handful of reports address services provided in other counties in the region. These reports had widely varying methodologies and objectives, making it difficult to draw a comprehensive picture of the need for services across the region. Nevertheless, the reports provide important insight into key areas of unmet need and help to inform many of the findings reached during this process. Major findings from the needs assessments are summarized below.

Among the key findings from existing needs assessments:

*Mental Health.* Focus group participants in Cass and Lafayette Counties noted that mental health services (including inpatient services) were insufficient to meet community needs.<sup>4</sup> Allen, Johnson and Wyandotte Counties are each served by a community mental health center; users of community-based mental health supports in these counties report being very satisfied with the services received.<sup>5</sup> In Allen County, residents enjoy a better overall mental health status than in surrounding counties, despite absence of practicing psychiatrists in the County. In Johnson County, the Johnson County Mental Health Center (JCMHC) indicates that its number of psychiatrists has grown at half the rate of its growth in services provided.<sup>6</sup> The JCMHC also reports a 52 percent increase over the last 10 years in the number of mental health crisis contacts and a need for inpatient hospital beds that outstrips supply. Wyandotte County residents have higher rates of depression and suicide than surrounding counties; the County appears to have too few psychiatrists available to meet the demand.<sup>7</sup>

Residents of Clay, Platte and Ray Counties reported the greatest needs for youth to be counseling/therapy, substance abuse services, crisis response availability for youth and their families, suicide prevention targeted to youth, and care management. For adults, the greatest needs were substance abuse services, counseling/therapy, access to medication and housing; for older adults, the greatest needs were coordinated care for those with co-occurring mental illness and Alzheimer's disease or dementia, a medical home, counseling/therapy, coordination of physical health and mental health services and housing.<sup>8</sup>

In Jackson County, families and consumers rated overall care at the four community mental health centers as good or very good, but the ease of accessing therapy or other services was rated as "difficult" or "occasionally easy."<sup>9</sup> In general, Eastern Jackson County has fewer mental health services available than the Kansas City region. Community agency staff reported significant difficulties in obtaining beds for patients, as well as difficulties in obtaining crisis services and medications.<sup>10</sup>

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<sup>4</sup> Healthcare Foundation of Greater Kansas City. *Health Assessment of Cass, Jackson and Lafayette Counties*. January 4, 2005.

<sup>5</sup> A. Wellever. *Allen, Johnson and Wyandotte Counties Health Assessment (prepared for the REACH Foundation)*, Kansas Health Institute, August 2004.

<sup>6</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*

<sup>7</sup> A. Wellever.. August 2004.

<sup>8</sup> Tri-County Mental Health Services, *Needs Assessment of the Northland*, 2008.

<sup>9</sup> C. Rinck and T. Graybill, *Jackson County Mental Health Needs Assessment: Comparison of Kansas City and Eastern Jackson County (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

<sup>10</sup> C. Rinck and T. Graybill, *Jackson County Mental Health Needs Assessment: Cross-Cutting Issues (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005

Several studies noted specific areas of need among targeted populations, including children, seniors and the incarcerated. These areas of need included crisis beds for children (Jackson County),<sup>11</sup> general mental health and substance abuse services for children (Cass and Lafayette Counties),<sup>12</sup> general mental health services for seniors (Allen and Johnson Counties),<sup>13, 14</sup> and better services targeted toward the offender population (Jackson and Johnson Counties).<sup>15, 16</sup> In addition, local data indicate that Hispanics are underrepresented among users of Jackson County mental health levy providers and that many levy providers do not have the ability to serve non-English speaking clients.<sup>17</sup>

*Substance Abuse.* The number of individuals in Missouri receiving both substance abuse and mental health treatment has doubled, from 6.9 percent in 1999 to 14 percent in 2002. Several studies reviewed for this project looked at the availability of substance abuse services in the region. The studies described a mental health/substance abuse system that is often fragmented and over-stretched. One study found that Jackson County has a significantly higher rate of hospitalization due to alcohol and substance abuse disorders compared to statewide average.<sup>18</sup> Service providers in Jackson County noted it is very difficult to find programs that cover co-occurring disorders, especially if the individual is uninsured or undocumented (nearly half said access to drug treatment centers was “difficult” or “impossible.” Lack of detox beds and supportive services (e.g. housing) were also cited.<sup>19</sup> Interview and focus group participants in Cass, Lafayette and Johnson Counties noted that substance abuse services for children and teens were lacking.<sup>20, 21</sup>

Timely access to substance abuse services was cited as a significant problem for the homeless population in Jackson County.<sup>22</sup> Specifically:

- Two-thirds of homeless shelters noted difficulties in obtaining detox services;
- Shelters noted they lacked staff to work with individuals with co-occurring disorders; and

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<sup>11</sup> C. Rinck and T. Graybill, *Jackson County Mental Health Needs Assessment: Children and Senior Services* (presented to the Mental Health Strategic Planning Task Force). University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

<sup>12</sup> Healthcare Foundation of Greater Kansas City. January 4, 2005.

<sup>13</sup> A. Wellever.. August 2004.

<sup>14</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*

<sup>15</sup> C. Rinck and T. Graybill, *Jackson County Mental Health Needs Assessment: Homelessness and Incarceration* (presented to the Mental Health Strategic Planning Task Force). University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

<sup>16</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*

<sup>17</sup> Mattie Rhodes Center, *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri*. June 2003.

<sup>18</sup> Healthcare Foundation of Greater Kansas City. January 4, 2005.

<sup>19</sup> C. Rinck and T. Graybill, *Jackson County Mental Health Needs Assessment: Substance Abuse and Mental Illness* (presented to the Mental Health Strategic Planning Task Force). University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

<sup>20</sup> Healthcare Foundation of Greater Kansas City. January 4, 2005.

<sup>21</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*.

<sup>22</sup> C. Rinck and T. Graybill, *Jackson County Mental Health Needs Assessment: Substance Abuse and Mental Illness* (presented to the Mental Health Strategic Planning Task Force). University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

- Some mental health providers will not accept individuals with co-occurring disorders until the substance abuse issue has been addressed.

Specific recommendations for improving substance abuse services in the region included better coordination of mental health and substance abuse systems (including incorporation of shelters and the correctional system in discussions regarding service system improvements).

*Developmental Disabilities.* Several studies addressed access to services for people with developmental disabilities. In Lafayette County, focus group respondents cited a need for additional services for people with developmental disabilities.<sup>23</sup> Interviews with community stakeholders in Johnson County indicated a need for better services for individuals with dual mental health/development disability diagnoses, particularly children with autism spectrum disorder.<sup>24</sup>

Key areas of unmet need identified in Jackson County include services for seniors, support with social relationships, employment and housing and transportation.<sup>25</sup> Families in Jackson County reported a need for more respite services and more services for children transitioning from school to adulthood. Families in Jackson County expressed a desire for service coordination to be more relationship-based, as characterized by staff actively listening to and working with families to connect individuals to needed services.

Specific recommendations for Jackson County include:

- Expand and enhance the array of housing and employment options;
- Provide relationship-based service coordination;
- Increase availability of continuing education;
- Increase availability of accessible and flexible transportation;
- Increase support and services for individuals with disabilities; and
- Improve dissemination of information.

### ***Stakeholder input***

Information about perceived strengths, weaknesses and unmet needs of the service delivery system constituted a second part of the project. To gather input and recommendations from key stakeholders, including consumers, providers, advocates and community leaders, HMA conducted focus groups and key informant interviews.

On October 7 and 8, 2008, HMA facilitated four focus groups. Two were held with consumers of mental health services and two were held with providers of services.

### ***Consumer focus groups***

The purpose of the consumer focus groups was to understand what services participants used and where they received services, where there are gaps in services, and what barriers participants faced in getting, keeping and using the services they need. To aid in participation, transportation

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<sup>23</sup> Healthcare Foundation of Greater Kansas City. January 4, 2005.

<sup>24</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*

<sup>25</sup> R. Jensen et al. *Needs Assessment: Developmental Disability Services of Jackson County (prepared for Empowering Individuals Through Advocacy and Support)*. UMKC Institute for Human Development. August 2007.

was provided for each individual who agreed to participate in a group and each participant received a gift card.

The first consumer focus group was hosted by Mental Health America of the Heartland, in Kansas City, Kansas and involved thirteen consumers of services, eleven of whom were male and two were female; nine from Missouri and four from Kansas. Most identified themselves as having dual mental health and substance abuse diagnoses, some had co-occurring medical issues.

The second consumer focus group was hosted by the Mattie Rhodes Center in Kansas City, Missouri. This group involved ten consumers, all from Missouri. Several had mental illness diagnoses, some had experienced domestic violence as well. Five participants reported co-occurring mental illness and substance abuse diagnoses.

While participants in both focus groups expressed appreciation for the services they had received or are currently using, they expressed concerns as well. Among the concerns expressed by participants:

- Transportation is problematic and is frequently a barrier to care;
- Access to medication, particularly on the weekends, is difficult;
- There are not enough evening and weekend services;
- Calls to the crisis hotline generally result in responses by the police, which deters people from calling; and
- The region's behavioral health system does not consistently reflect a recovery-oriented philosophy, where consumers are viewed as equal partners. Several consumers noted that they do not feel a sense of partnership with providers. One participant described the situation as "you get what they want to give you".

### ***Provider Focus Groups***

The purpose of the provider focus groups, which were hosted by MARC, was to discuss the major gaps in services from the perspective of those providing services. Among the gaps in services raised by these groups were:

- Services for older adults;
- Early childhood mental health services;
- Services for individuals with traumatic brain injury;
- Services for non-English speaking individuals and populations with different cultural norms;
- Services for veterans;
- Housing services and services for those who needed long term residential supports;
- Transportation;
- Prevention services;
- Services for individuals with criminal justice involvement, particularly younger males with dual diagnoses of mental illness and substance abuse;
- Access to medications;

- Services for individuals with co-occurring mental illness and developmental disabilities; and
- Inpatient, particularly acute care, and outpatient services.

In addition to gaps in services, provider focus group participants also concerns about other system-related issues, including:

- Challenges related to workforce recruitment and retention;
- Difficulties in coordination of care, particularly barriers to sharing information across providers; and
- Problems of funding “silos,” which make services integration more difficult.

### ***Focus Groups’ Review of Preliminary Findings***

In addition, on November 7, MARC hosted and HMA facilitated three additional focus groups, one attended by consumers and advocates, a second for community mental health center executive directors and a third for other stakeholders, to review our preliminary findings. Participants were asked to reflect on each proposed finding and to provide further information. These sessions provided much additional information for the project. This final report reflects the input received during those sessions.

### ***Key informant interviews***

In addition to the focus groups, HMA interviewed 18 key informants to benefit from their insights about and knowledge of the system, particular services and target populations. The list of key informants is contained in **Appendix A**.

The need to make the system more recovery-oriented was addressed by some key informants. It was reported that, while there has been progress made to promote recovery orientation in service delivery system (particularly in Kansas), more needs to be done. The need for more consumer drop-in centers, peer support programs and other consumer-run organizations and stable funding to support these was cited. Concerns were raised about the lack of an adequate voice for consumers and family members in the service delivery system. It was noted that the move to a recovery-oriented system was more of a cultural change for the community than a technological change. This means that more training opportunities need to be available as well.

The lack of affordable housing was cited as a major need by several key informants. However, there were differing views on the need for “transitional” housing. While some individuals supported this approach, other key informants advocated a model that promotes de-linking services from housing with development of services such as crisis respite, in-home counseling and peer support, and employment assistance. One noted that consumers see transitional housing as “another hoop to jump through” before being able to live on their own.

Some key informants discussed the fragmentation of the service delivery system. This was particularly emphasized with regard to individuals leaving hospitals or jail.

One key informant estimated that 60 percent of the municipal jail inmates have a mental illness and that, of these, 80 percent have co-occurring substance abuse and 86 percent are homeless. While people entering the system are screened and services are available, the lengths of stay are usually short, requiring that follow up services be available. Priorities among these are supportive housing and access to a psychiatrist to ensure that medications and treatment started

in the jail are continued. The in-jail services and aftercare services that are available rely on grant funds.

Another transition issue that was raised relates to the lack of smooth transition of individuals leaving inpatient services to ensure that they receive the ongoing community services they need. It was noted that because of the limited number of inpatient beds in the community, hospital lengths of stay are very short, and people leave the hospital with intensive services needs. One key informant suggested strengthening the liaison between the hospitals and CMHCs as an important strategy. Another key informant identified the major need in this area to be crisis beds, step-down (transitional) beds and partial hospitalization.

Many people who present for services at homeless providers, domestic violence shelters, and other “niche” providers often have behavioral health issues as well. An additional fragmentation issue was addressed by another key informant who indicated that the community needed better tools to support collaboration between the CMHCs and these niche providers.

The need for additional crisis services was discussed by several key informants. One suggested expansion of crisis respite services (currently available in much of the region but often accessible only to established clients) to new clients who would benefit from this as an alternative to hospitalization. Another suggested more use of mobile crisis services and a better coordinated crisis hotline system. Challenges in serving individuals with complex needs, particularly those with aggressive behavior, those who need involuntary hospitalization or who have forensic involvement were cited by several key informants. One informant identified the lack of a cohesive safety net, with lack of funding of services as the core of the problem.

The challenge of integration of physical and behavioral health services was cited as an issue as well. Notable exceptions exist, particularly at Truman Behavioral Health and Swope, as well as the Veterans’ Administration, all of which offer both medical and behavioral health services. At Truman, for example, medical and behavioral health services are co-located. There are behavioral health staff in the primary care and specialty clinics, who are able to make “cross-referrals”. The goal is to move to a truly integrated care model such as a collaborative practice approach. Beyond these examples, some key informants cited significant problems for consumers attempting to access physical and dental health services.

There are a range of services available for individuals with developmental disabilities, yet gaps in needed services remain. Concerns were raised about the lack of specialized community resources to address the needs of individuals with co-occurring developmental disabilities and behavioral health disorders (particularly mental health problems). Needed services include structured residential services and short term residential services to address behavior crises. For individuals with developmental disabilities, an additional gap in the service delivery system is supported community employment for people with developmental disabilities. For people with developmental disabilities, medical care is generally available, but there is a lack of providers of dental care available to serve this population.

Several key informants identified transportation as a significant barrier for people seeking services throughout the Kansas City region.

### ***Survey of providers***

In September 2008, MARC issued a survey to 139 CEOs of behavioral health providers and safety net organizations in metropolitan Kansas City. The CEO of each agency was asked to

complete the survey and forward it to appropriate staff members for completion as well. The purpose of the survey was three fold: 1) to gather information about patient/client access to health and behavioral healthcare across the age spectrum; 2) to determine the gaps in the existing health and behavioral healthcare system for the uninsured and medically underserved; and 3) to identify barriers that prevent uninsured and medically underserved people from receiving the care they need.

MARC received 88 responses to the survey (a 63 percent response rate), which were reviewed and summarized by HMA. Nine counties in the region were represented in the service areas of the survey respondents, though Jackson County is perhaps over-represented in the survey. Survey respondents served the entire age spectrum of clients, from young children to seniors. The survey findings provide an additional viewpoint – that of behavioral health providers – on access to services for vulnerable populations. Key survey findings are summarized below and are also detailed throughout this report. Where informative, we have done additional analysis to break out survey responses by the counties primarily served by the respondent’s organization.<sup>26</sup>

Survey respondents were asked to indicate how much of a problem it is to get certain types of care for their uninsured or medically underserved clients with serious mental illness, developmental disabilities and substance abuse. With few exceptions, providers indicated that access to most services for this population was either a small or big problem.

Regardless of the consumer population that provider respondents served, housing, employment and residential hospitalization services were cited as difficult to access by a very large number of respondents. Interestingly, other areas of need identified in previous needs assessments and focus groups conducted for this project, while still prominent, were considered less serious by survey respondents. For example, access to acute hospitalization services ranked 8<sup>th</sup> among services for individuals with serious mental illness and developmental disabilities, with 58 percent and 63 percent of respondents, respectively, indicating that it is a “big problem.” Crisis support services ranked second to last for individuals with serious mental illness and third to last for individuals with developmental disabilities (32 percent and 57 percent of respondents, respectively, indicated it is a “big problem”). Ease of access varied, in many cases, by the age group of the client and by the provider’s service area, as discussed later in this report.

The table below summarizes the services deemed most problematic by survey respondents.

**Top Five Percent of Respondents Citing Service as a “Big Problem”**

<b>Services for Individuals with Serious Mental Illness</b>	<b>Percent of Respondents Citing as “Big Problem”</b>
Housing Assistance	76%
Residential Hospitalization	75%
Supported Housing	71%
Employment	65%
Transition Services from School to Work	64%
<b>Services for Individuals with Developmental Disabilities</b>	
Residential Hospitalization	85%

<sup>26</sup> Note that survey respondents were asked to indicate the counties where they provide services and could select as few as one or as many as nine counties. As a result, geographic analysis of responses is inherently weighted by the number of counties in which each respondent provides services and, therefore, does not necessarily sum to the total, non-weighted results.

Supported Housing	75%
Housing Assistance	74%
Supported Employment	74%
Case Management and Attendant Care	72%
<b>Services for Individuals with Substance Abuse</b>	
Long-term Residential	82%
Transitional Living	72%
Medical Detoxification Program	60%
Psychiatric Services, including Medicaid Management	60%
Short-term Residential	58%

Notes: Excludes “do not know” responses

### Survey of CMHCs

Seven of the community mental health centers in the Kansas City area worked together to identify the range of services CMHCs provide to the community and incorporated this information into a template.<sup>27</sup> Using that as a basis HMA asked CMHCs to complete a follow-up survey to gain a more complete picture of the behavioral health services that are, and are not, available in the Kansas City region, with particular emphasis on the availability of evidence-based and promising practices. The survey focused on:

- Mental health crisis emergency services;
- Housing and residential;
- Mental health and substance abuse outpatient treatment;
- Mental health recovery/maintenance services;
- Vocational/employment services; and
- Other key services and best practices.

*Crisis/Emergency.* All centers reported having crisis intervention teams, and mobile crisis outreach teams. Most centers offered hotline and crisis respite services. Some have liaisons in hospital emergency rooms. There is more limited availability of crisis stabilization services.

*Housing/Residential.* All CMHCs reported offering supportive housing services. There is more limited availability of transitional housing options, residential treatment and other services such as crisis residential services.

*Outpatient Services.* All Centers reported offering care management, counseling and therapy, diagnosis and assessment services, medication management and substance abuse counseling/therapy. It was reported that demand for these services exceeds availability.

*Day Treatment and Partial Hospitalization Services* are available at some centers as is Intensive Outpatient (IOP) for addictions. Availability of Assertive Community Treatment (ACT) is limited in the region.

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<sup>27</sup> Participating Centers included Johnson County, Wyandot Center, Comprehensive Mental Health Services, ReDiscover, Swope Health Services, Tri-County Mental Health Center and Truman Behavioral Health.

*Recovery/Maintenance Services.* All centers in the region report offering peer support, psychosocial rehabilitation and community psychiatric supportive treatment. Family psycho-education, illness management and substance abuse relapse prevention are available at some or most centers.

*Vocational/Employment Services.* All centers report offering supported employment services.

*Other key services/best practices.* Among the other key services, all centers offer school-based and in-home services. Key youth services such as multisystemic therapy and functional family therapy are not widely available. Only one center reports telemedicine capability.

Based on this survey of these CMHCs, areas where there are gaps in essential services, at least in some areas, include:

- Crisis stabilization services and crisis residential services, which are widely considered a core component of an effective continuum of crisis care.
- Transitional housing, which is often critical to help consumers leaving inpatient facilities to successfully transition to community-based care.
- Key evidence-based services, such as Assertive Community Treatment for adults or Multi-Systemic Therapy (MST) for youth.
- Telemedicine, which can be a valuable tool in overcoming barriers to care that result from an inadequate supply of providers in certain areas or for serving clients who have transportation barriers to local providers.

**Appendix D** contains the matrix and the responses by CMHC for each category of service.

## OVERVIEW OF NATIONAL, STATE AND REGIONAL MODELS TO IMPROVE BEHAVIORAL HEALTHCARE

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Following is a discussion of several regional and/or national models that have the ability to improve local, regional and state mental health systems' capacity and/or effectiveness. The description of models is organized into six categories:

- Models that help increase access to housing services;
- Models that help increase access to transportation services;
- Models that improve coordination and /or collaboration of service providers;
- Models that promote integration of mental health and substance abuse or physical health services;
- Models that address funding silos; and
- Models that encourage recovery and patient-centered planning.

Each of the models profiled has achieved some measure of quantifiable improvement and each addresses at least one, if not more, of the issues identified as a need within the Kansas City region by key stakeholders. The profiles included under each model were selected because each contains elements that could inform future efforts in the Kansas City region to strengthen the behavioral health service system.

### *Increasing access to housing for high need consumers*

Adequate, affordable and integrated housing is an essential component for consumers with mental illness to be able to successfully participate in and benefit from mental health treatment. The lack of affordable housing and accompanying support services often causes people with serious mental illnesses to cycle between jails, state hospitals, shelters and the street.<sup>28</sup> People with serious mental illnesses also make up a large percentage of the homeless population<sup>29</sup> as a result both of the symptoms of their illness and the gap between typical rents and Supplemental Security Income (SSI), which is often the only source of income with people with serious mental illnesses. Data from the U.S. Department of Housing and Urban Affairs regarding national average cost for rental units in 2006 found that a person with mental illness would have needed to pay 113 percent of his or her monthly income to rent a modest one-bedroom apartment.<sup>30</sup> People with co-occurring mental illness and substance use disorders are especially vulnerable to lack of housing. Besides making up a significant percentage of the homeless and chronically homeless<sup>31</sup> they are also likely to have acute and chronic physical health problems; exacerbated

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<sup>28</sup> A. O'Hara, "Housing for People with Mental Illness: Update of a Report to the President's New Freedom Commission," *Psychiatric Services*, Vol. 58, No. 7, July 2007.

<sup>29</sup> M. Bert, "What will it Take to End Chronic Homelessness?" Washington, DC, Urban Institute Press, 2001.

<sup>30</sup> "Priced Out in 2006," Boston, Technical Assistance Collaborative, Inc., 2007.

<sup>31</sup> M. Bert, "What will it Take to End Chronic Homelessness?" Washington, DC, Urban Institute Press, 2001.

psychiatric symptoms and a higher likelihood of victimization and incarceration.<sup>32</sup> Securing safe and stable housing is often a necessary prerequisite for a consumer to benefit from community-based mental healthcare. However, declines in federal support for housing programs, the historic tendency of mental health system to view housing as outside of their responsibility, and categorical or “siloed” funding streams have left many people with serious mental illnesses without access to housing that can support their needs.

As the consumer recovery movement in mental health has developed, it has also influenced the approach to developing housing for people with mental illness. While historically housing for people with mental illness has been in segregated, congregate residential settings, such as group homes, research has shown that people with mental illness not only prefer to live in housing that is integrated in the community, but also that consumer preference is an important predictor of housing success.<sup>33, 34</sup> The approach of making housing available without preconditions of sobriety or engagement in mental health services is widely referred to as “housing first” and is considered a best practice by both mental health and housing experts.<sup>35, 36</sup>

### **Profile: Pathways to Housing, New York, New York**

Founded in 1992, Pathways to Housing, a not-for-profit organization, works with individuals who have been turned away from other programs because of active substance use/abuse, refusal to participate in psychiatric treatment, histories of violence or incarceration, or other behavioral problems. Currently over 500 individuals in New York City receive permanent housing through the Pathways program. Pathways began housing 50 people in its first year, and has grown steadily over time.

Pathways to Housing separates housing from treatment. The program offers clients immediate access to housing without requiring sobriety or psychiatric treatment first. Unlike traditional housing programs, Pathways’ admission requirements are minimal: to be eligible, clients must be homeless, have a psychiatric disability, and elect to participate in the program.

Housing provided by Pathways is permanent and independent—regular apartments are scattered throughout residential buildings in various neighborhoods. Research has shown that this model is preferred by most consumers,<sup>37</sup> and is often a critical component in forming the connections necessary for full recovery. Through Pathways, consumers have access to an entire team of mental health and rehabilitation specialists, including a psychiatrist and peer counselor, as well as support with any housing issues that arise. Clients can consult their team 24 hours a day, seven days a week. Staff members make house calls once a week. Clients are offered a wide

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<sup>32</sup> A. O’Hara, “Housing for People with Mental Illness: Update of a Report to the President’s New Freedom Commission”, *Psychiatric Services*, Vol. 58, No. 7, July 2007.

<sup>33</sup> A. O’Hara, “Housing for People with Mental Illness: Update of a Report to the President’s New Freedom Commission”, *Psychiatric Services*, Vol. 58, No. 7, July 2007.

<sup>34</sup> S. Tsemberis, L. Gulcur, M. Nakae, “Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis,” *American Journal of Public Health* Vol. 94: 651-656, 2004.

<sup>35</sup> U. S. Department of Housing and Urban Development, Office of Policy and Research, “Strategies for Reducing Chronic Homelessness,” Washington, D.C., January 2004. Available at:

<http://www.huduser.org/Publications/PDF/ChronicStrtHomeless.pdf>

<sup>36</sup> SAMHSA’s National Registry of Evidence-Based and Promising Practices, available at:

[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=195](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=195)

<sup>37</sup> W. Fakhoury, A. Murray, G Shepherd, et al, “Research in Supported Housing,” *Social Psychology and Psychology Epidemiology* Vol. 37: 301-315, 2002.

range of support and clinical services that include psychiatric and substance abuse treatment, comprehensive healthcare, supported employment services, and family reconnection.

Using government subsidies, Pathways moves clients into apartments rented from private landlords, which means there is minimal start-up time. Pathways' Housing Division serves as a liaison between the tenant and landlord, making sure rent issues, apartment repairs and emergencies are addressed in a timely manner. Since landlords receive a steady rental income stream combined with a stable tenancy, securing landlord participation has been relatively easy. To ensure housing is integrated, Pathways does not rent more than 20 percent of units in any one building. Pathways depends on a range of funding, including grants and government support (66 percent), Medicaid<sup>38</sup> (24 percent), client rent (7 percent), housing service fees (2 percent), and individual contributions (1 percent).

The Pathways model has demonstrated positive outcomes, in both housing retention rates and reductions in treatment costs. Consumers in the Pathways program spent significantly less time in psychiatric hospitals and incurred fewer treatment costs than prior to joining the program.<sup>39</sup> Participants spent approximately 80 percent of their time in stable housing, versus 30 percent for participants in a comparison group, who were assigned to traditional programs that made treatment and sobriety prerequisites for housing. Additionally, from baseline to 2-year follow-up, participants in the comparison group reported significantly higher use of substance abuse treatment programs and a significantly larger proportion of time in psychiatric institutions than participants assigned to the Pathways Model.<sup>40</sup>

The costs of providing housing in the Pathways model, compared to alternative housing or treatment costs demonstrate the ability for the model to achieve cost effectiveness.

### **Daily Cost Comparisons**

Program	Daily Cost
Pathways Housing	\$57
New York City Shelter	\$73
New York City Jail	\$164
State Psychiatric Hospital	\$467
New York City Psychiatric Hospital	\$1,185

*Source: Pathways to Housing, Annual Report, 2007*

The Pathways model has been designated by the Substance Abuse and Mental Health Services Administration as an evidence-based practice<sup>41</sup> and was highlighted in the U.S. Department of Housing and Urban Development's 2007 report on successful programs.<sup>42</sup> The Pathways model has been replicated in Washington, D.C and Philadelphia. In addition, other communities (e.g. Cincinnati, Columbus, Denver, Salt Lake City, Minneapolis) have adopted the "housing first"

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<sup>38</sup> Although Medicaid cannot be used for room or board, Pathways uses Medicaid to fund some of the Medicaid-covered services provided to residents.

<sup>39</sup> Pathways to Housing, Annual Report, 2007, available at:

[http://www.pathwaystohousing.org/Articles/PTHPublications/FINAL\\_AnnualReport\\_2007.pdf](http://www.pathwaystohousing.org/Articles/PTHPublications/FINAL_AnnualReport_2007.pdf)

<sup>40</sup> SAMHSA's National Registry of Evidence-Based and Promising Practices, available at:

[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=195](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=195)

<sup>41</sup> SAMHSA's National Registry of Evidence-Based and Promising Practices, available at:

[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=195](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=195)

<sup>42</sup> Available at: <http://www.huduser.org/Publications/pdf/hsgfirst.pdf>

model developed by Pathways, and have used Pathways to provide technical assistance in developing and implementing this approach. The successful replication of the model in other cities is likely due to the fact that the model allows for a quick start up, since existing rental units are used, and can be scaled to begin with a very small number of consumers and grow (or contract) as a community's resources change over time.

### ***Increasing access to transportation services***<sup>43</sup>

Transportation barriers for behavioral health consumers are a problem nationwide. However, some communities have responded by developing innovative transportation programs for consumers with behavioral health disorders. These emerging best practices address barriers of affordability, accessibility, applicability, availability, and awareness by either taking advantage of existing transit opportunities or by providing transportation in situations in which transit is unavailable.

Programs that expand access to public transit can benefit the larger community as well as the target population. Allowing unrestricted access to public transit boosts ridership at non-peak hours, such as during evenings and weekends when many seats are unused, can help a transit agency benefit financially without having to increase capacity. Agencies and government programs also save money when they enable people to use public transit instead of special vehicles. Expansion of public transit benefits people with disabilities by allowing them greater mobility and independence. People can ride when and where they want to alongside other members of the community, rather than being segregated by specialized transportation. The major shortcoming of these initiatives is that they demand the existence of a mature public transit system.

**Expanded Half-Fare Programs.** Expanded half-fare programs, enacted by State law or by local or regional transit authorities, increase the availability of reduced transit fares beyond that required by Federal law. Whenever a public transit authority receives Federal funds, it must offer a half-fare program for off-peak hours on trains, subways, and buses to qualified people with disabilities. Generally, an individual submits an application and verification of his or her disability, and receives a photo identification card. Under Federal qualifications, only people with a disability that interferes with the ability to ride transit unassisted and people receiving Medicare are eligible. Transit systems, however, are permitted to use a broader definition of disability for their half-fare programs. Some communities and States, recognizing that many more people with disabilities face great financial hardships, have expanded their half-fare programs. For example, anyone in Massachusetts who receives services from the Department of Mental Health is eligible for a Transportation Access Pass that entitles the holder to reduced fares on all transit systems in the State. Finally, although federal regulations do not require transit agencies to offer half-fare during peak hours or on express buses and trains, programs can increase people with disabilities' access to transportation by making the half fare option available on regular transit vehicles 24 hours a day.

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<sup>43</sup> This section is excerpt of "Emerging Best Practices for Providing Transportation to Mental Health Consumers, SAMHSA, Center for Mental Health Services, available at: [http://download.ncadi.samhsa.gov/ken/pdf/SMA04-3948/Emerging\\_Best\\_Practices\\_for\\_Providing\\_Transportation\\_to\\_ment.pdf](http://download.ncadi.samhsa.gov/ken/pdf/SMA04-3948/Emerging_Best_Practices_for_Providing_Transportation_to_ment.pdf)

### **Profile: New York State**

In New York State, mental health advocates created a coalition that worked to allow mental health consumers receiving SSI and Medicaid the same right to reduced fares as people receiving Social Security Disability Insurance (SSDI) and Medicare. This coalition succeeded in expanding the existing half-fare program to persons with serious mental illness eligible to receive Supplemental Security Income benefits (New York State Public Authorities Law, Section 1205(8)).

An effective half-fare program also requires a fair, straightforward application process and proactive outreach to educate consumers about the availability of the discount. Initially, the application the New York coalition designed placed extra requirements on mental health consumers—including discussion of an individual’s diagnosis—rather than simply verifying the individual’s disability status with the Social Security Administration. Ultimately, advocates went to court to ensure fair implementation of the law. An out-of-court settlement resulted in a revised application that did not require disclosure of a specific diagnosis. Additionally, the Metropolitan Transit Authority (MTA) agreed to promote the availability of the discounts by sending information to more than 1,200 mental health programs. By the end of 2003, over 6,000 mental health consumers had received half-fare cards under the new standards.

**Medicaid Transit Passes.** Like the half-fare program, Medicaid transit passes make transportation affordable for people with disabilities who are living in areas served by public transit. The passes enable people to obtain transportation for whatever purpose they desire. Each participant simply receives a monthly transit pass that allows him or her unlimited rides on public transit. Funding comes entirely from the State’s Medicaid budget.

States are required to ensure that Medicaid recipients have transportation to services covered by Medicaid, which can include doctor and therapist visits, drug and alcohol programs, and psychiatric rehabilitation. Traditionally, this transportation has been provided either through special Medicaid transportation vans, by taxi, or by private shuttle service. The cost per trip is significant, and for people making several trips per month to doctors and other services, the costs mount quickly. However, issuing monthly transit passes can be more cost effective to a State and provide additional transit options and flexibility to the consumer recipients.

### **Profile: Miami-Dade County, Florida**

In Miami-Dade County, Florida, Medicaid administrators realized that the cost of providing two round trips per month was roughly the same as the cost of a monthly transit pass. A monthly transit pass enables a person capable of using public transit to travel not only to all needed services, but also to anywhere else he or she desires. The Medicaid agency, therefore, established a partnership with the local transit authority to provide transit passes for Medicaid recipients requiring frequent transportation for medical needs. People who sign up for the program receive a transit pass and no longer are eligible for door-to-door transportation for non-emergency services. The Medicaid agency saves money on transportation, and the transit authority benefits from additional sales of monthly passes.

The Metro-Dade Transit Agency (MDTA) handles applications and distribution of passes; the Medicaid agency pays for the passes plus a monthly administrative fee. To keep information confidential, Medicaid codes instead of diagnoses are used in the application process. To save money and to reduce the number of lost or misdelivered passes, MDTA distributes a large

majority of the passes through agencies providing services to Medicaid recipients. MDTA also takes an active role in recruiting agencies that serve Medicaid clients to participate in the program.

**Travel Training.** To increase the number of people with disabilities who use public transit, a number of local transit authorities and private organizations offer travel training programs that help people overcome transportation difficulties. Unlike half-fare and Medicaid transit pass programs, which address affordability issues, travel training programs focus on accessibility and raising awareness of public transit to foster greater independence. Using public transit, rather than demand-response services such as paratransit, gives people greater flexibility to make trips because there is no advance scheduling requirement; it also saves money for both the rider and the transit system.

Although travel training programs traditionally have focused on helping people with physical disabilities or vision impairments, a number of programs now offer training to mental health consumers. Typically, travel trainers work either with individuals or with groups of people enrolled in a particular rehabilitation program. In addition to classroom-style workshops, travel training involves experiential learning, such as taking bus or train trips. Such programs help with skills that include finding the right bus stop, reading a schedule, calling in for information, recognizing landmarks for the purpose of disembarking, and transferring to other vehicles. Travel training programs can be conducted by the transit system or by a nonprofit organization under contract with the transit system. Some communities have initiated a peer-to-peer model for travel training by hiring people with disabilities and older adults who used public transit as peer instructors.

**Providing Specialized Transportation and Using Consumer-Run Programs.** Programs expanding access to public transit have many advantages in terms of flexibility and cost, but the transportation that they provide is only as good as the local transit system. In many parts of the country, especially in rural areas, public transit either does not exist or has limited hours or routes. Even in areas served by public transit, a transit system may not meet an individual's needs or in some way may be inaccessible. For these reasons, many communities have created specialized transportation programs for people considered to be "transportation disadvantaged," a category that generally includes people with disabilities, older adults, and people of limited income. Additionally, some communities have responded to the lack of transportation for consumers with mental illnesses by starting peer-run transportation initiatives where they have secured funding to employ consumers to transport other consumers whenever necessary.

### **Profile: Peer Transportation Services (PTS), West Virginia**

A consumer-run program that exemplifies an inclusive approach to peer transportation is Peer Transportation Services (PTS), a project of the West Virginia Mental Health Consumers' Association. Much of West Virginia is rural with no public transportation; some small urban areas have only limited public transportation. Often, the public transportation operates on a very limited schedule, leaving people who cannot afford a car with few transportation options. PTS serves adult mental health consumers who have no other means of transportation. PTS operates as a typical demand-response transportation service. Users are required to make reservations a week in advance (when possible), and a consumer employee of PTS will transport the person using one of the program's vehicles.

PTS does not charge a co-payment for its services, which are available for a wide variety of purposes, such as grocery shopping, social outings, family events, and meetings of the mental health planning council. Many people use PTS to reach doctors' offices and community mental health centers, and to access nonclinical services they consider essential to recovery, such as drop-in centers, peer support groups, Wellness Recovery Action Plan (WRAP) classes, and 12-step groups. Typically, PTS does not provide transportation to Medicaid-covered services, but does provide medical transportation to people not covered by Medicaid.

PTS has played an instrumental role in community integration for many people. Several of the sites provide more than 1,000 rides per year to people who otherwise would have no transportation. PTS also arranges social outings, such as trips to yard sales or bowling nights. A growing number of rides are for job interviews and the first few weeks on a job, when meeting transportation costs is still difficult. PTS is exploring additional funding sources for this employment-related transportation. Currently, PTS receives reimbursement for its operating expenses from the State through Community Mental Health Services Block Grant funds administered by the Federal Substance Abuse and Mental Health Services Administration. These funds pay for gasoline and repairs, but PTS is not allowed to use the funds to purchase vehicles so instead relies on donated vehicles. Although the program has been successful, gasoline costs and vehicle repair costs are significant.

**Volunteer-Augmented Programs.** Some programs have made great strides in alleviating local transportation shortages by using differing combinations of paid staff and volunteers, program vehicles and personal vehicles. By using volunteers and personal vehicles, a nonprofit transportation program can provide rides to a broader group of people for a wider variety of purposes than a program that is funded for a specific type of transportation.

### **Profile: The Community Association for Rural Transportation (CART) in Rockingham County, Virginia**

The Community Association for Rural Transportation (CART) in Rockingham County, Virginia has sought to alleviate transportation barriers for people with mental illness in rural areas by relying on volunteer drivers and services. CART is a nonprofit agency with an active board of directors and a large group of volunteer drivers.

In a semi-rural county with several large employers but limited public transportation, CART serves anyone who is 65 or older, has any type of disability, or who has a family income below the Federal poverty level. CART operates as a combination service broker and transportation provider. Some rides are provided by a private taxi service subsidized by CART, and some rides are provided by CART volunteers using either their own vehicles or one of CART's vehicles. CART has a wheelchair accessible vehicle available for volunteers to use and provides thorough training in how to operate it. People can ride CART for any purpose they desire; thus, CART fills the gaps left by programs such as Medicaid transportation.

When someone first calls CART, a staff person completes an intake form that establishes whether the caller is eligible for CART's services, and equally important, whether the caller is eligible for rides from other services, such as Medicaid, the American Cancer Society, or paratransit. CART makes optimal use of its ability to offer rides by not providing rides that could be made available by other means. However, consumers eligible for Medicaid transportation for

medical purposes can use CART for nonmedical purposes. CART holds down costs by setting a weekly limit on nonmedical trips.

Once someone's eligibility for CART services is established, he or she may arrange a ride by calling the participating taxi company or the CART staff, who can arrange a ride through the taxi company or a volunteer driver. Riders make a co-payment of \$3, \$5, or \$10, depending on distance. One-day notice is required for local trips, and 3-day notice is required for trips to medical centers outside of the area. To ensure everyone's safety, CART screens its volunteers by checking driving and criminal records, and by requiring proof of auto insurance. CART provides excess liability insurance to its drivers, which helps to protect volunteers against awards above their own insurance coverage limits. CART also offers mileage reimbursement; however, most volunteers decline the reimbursement and instead deduct the mileage on their tax returns. Volunteers always are free to accept or decline a trip.

In addition to the use of volunteer drivers, another key to CART's flexibility has been its diversified funding sources. Initially funded by a local Disability Services Board, CART has since received funding or vehicles from the county government, the Virginia Department of Rail and Public Transportation, retirement communities, the United Way, the State Department of Aging, the Virginia Health Care Foundation, and the local Area Healthcare Education Center. CART also received a major grant from the Merck & Company Foundation.

**Travel Vouchers.** Some rural areas have initiated travel voucher programs that differ from other programs in that they do not rely on specific forms of transportation. Rather, participants are free to arrange their own rides and to present a voucher that is reimbursed by the sponsoring agency to the ride provider. Rides can be provided by taxi services, public transportation, and even friends and family – all of whom are reimbursed by the agency issuing the voucher. Even a service agency that maintains vans for a particular purpose, such as transporting older adults to senior centers, can offer its vans for other uses that can be reimbursed through these vouchers. Although the sponsoring agency might offer a list of potential transportation providers, the program participant has the flexibility to seek other arrangements if he or she prefers.

The sponsoring agency issues travel vouchers with carbon duplicates to eligible participants who, in turn, present vouchers to the persons providing the rides. The person providing the ride then submits the voucher to the sponsoring agency for reimbursement, usually based on a fixed rate per mile. Depending on their funding sources, sponsors of voucher programs have a great deal of flexibility in determining who is eligible to receive travel vouchers as well as the purposes for which the vouchers may be used. Voucher programs offer participants flexibility because they allow participants to take advantage of whatever transportation opportunity is available. They also encourage social service agencies to use their vehicles to serve more people. Additional information on establishing a voucher program is provided in, "Making Transportation Work for People with Disabilities in Rural America", available online at <http://rtc.ruralinstitute.umd.edu/Trn/TrnManual.htm>.

### *Addressing funding silos*

Individuals with behavioral health disorders often need access to a broad range of services beyond direct mental health, substance abuse or developmental disability services. These may include physical health services, social services (such as job training), and housing assistance. Since funding is typically siloed, there is often a lack of coordination among service providers.

Additionally, the variety of organizations that must be involved in providing supports and services to consumers with behavioral health disorders creates a system that is frequently complex and challenging for both consumers and providers to navigate.

A number of communities have attempted to improve coordination either by developing platforms for coordination of safety net providers or by creating models to overcome funding silos (either by braiding or blending funding streams) to achieve a more coordinated service system for clients with mental health needs. The Wraparound Milwaukee project is perhaps the best known of these efforts.

### **Profile: Wraparound Milwaukee, Milwaukee Wisconsin**

Wraparound Milwaukee was created in 1995 to integrate services and funding for children with serious emotional disorders and their families. The project was developed out of a federal grant designed to foster the development of more comprehensive, community-based care for children with serious emotional needs and their families. Over time, Wraparound Milwaukee has become recognized as a unique system of care for children with serious emotional, behavioral, and mental health needs and their families and in 2004, was named an exemplary program by the President's New Freedom Commission on Mental Health.

The primary focus of Wraparound Milwaukee is on children who have serious emotional disorders who are identified by the child welfare or juvenile justice system as being at risk for residential or correctional placement. Wraparound Milwaukee serves about 1,000 children a year over age five. A combination of several state and county agencies, including child welfare, Medicaid, juvenile probation services, and the county mental health agency, finance the system. Their dollars create a pooled fund that supports Wraparound Milwaukee, which is administered by the Milwaukee County Behavioral Health Division in the County Department of Health and Human Services, which functions as a management services organization (or managed care entity).<sup>44</sup> The program's \$30 million budget is funded by pooling child welfare and juvenile justice funds (that were redirected from institutional care) and by a set monthly fee for each Medicaid-eligible child (based on historical Medicaid costs for psychiatric hospitalization or other similar services).<sup>45</sup> Milwaukee Wraparound is designed to be accountable and at risk for service use, dollars spent, and clinical results achieved. The project has broad flexibility as to what can be provided, largely as a result of blended funding and case rate and capitation financing arrangements.

Wraparound Milwaukee was designed to reduce the use of institutional-based care such as residential treatment centers and inpatient psychiatric hospitals while providing more services in the community and in the child's home. As a result, the services offered in the program are designed to prevent or avoid more inpatient care. The top five services utilized in 2007, excluding care coordination, were One to One Crisis Stabilization/Supervision, In-Home

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<sup>44</sup> B. Stroul, S. Pires, M. Armstrong, J. McCarthy, K. Pizzigati, & G. Wood, "Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan" (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. # 235-02), 2008. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health.

<sup>45</sup> Department of Health and Human Services, "President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America, Final Report," DHHS Pub. No. SMA-03-0383, July 3, 2003. <http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/Study03-exp-fr-field.pdf>

Therapy (Lead- Medicaid), Outpatient Therapy (Individual/Family/Group), Transportation Services, and Youth Support Services (Mentoring/Academic Support/Supervision-Observation/Tutoring). In addition, 54 percent of the youth/families utilized Discretionary Funds in some capacity,<sup>46</sup> demonstrating the degree of flexibility used by the program.

Outcomes of the program include a reduced rate of juvenile delinquency, improved school attendance, better clinical outcomes, lower rate of hospitalization, and reduced costs of care. The following table demonstrates the potential savings available by diverting children from inpatient care or more expensive forms of care.

<b>PROGRAM</b>	<b>APPROXIMATE AVERAGE COST PER MONTH/PER YOUTH</b>
<i>Wraparound Milwaukee</i>	\$3,850
<i>Group Homes</i>	\$5,433
<i>Corrections</i>	\$7,770
<i>Residential</i>	\$8,520
<i>Psychiatric Inpatient Hospital</i>	\$40,083

Source: *Wraparound Milwaukee Quality Assurance/Improvement Semi-Annual Report, July1 – December 31, 2007.*

### **Profile: NorthSTAR, Multi-County Region in North Texas**

The NorthSTAR program is a behavioral health managed care project that uses a 1915(b) waiver to both restrict the provider network and provide flexibility in how services are paid for that removes the funding silos that typically accompany behavioral health service systems. The NorthSTAR program provides an integrated system of care for mental health and chemical dependency services to both Medicaid and indigent (non Medicaid) consumers who live in the seven county region of the Dallas metropolitan area. The program is an innovative managed care initiative blending the funding of several state and local agencies to create a single system of public behavioral healthcare for Medicaid and indigent clients. By eliminating siloed eligibility criteria and administrative structures, individuals in need of behavioral health services contact a single entity which is contracted to insure an accessible provider network. This simplified the process for consumers by eliminating the need to seek services from multiple agencies or change providers should they lose Medicaid eligibility.

Historically, the systems were under-funded and operated independently with their own eligibility criteria, programs and benefits; and consumers were left to their own devices to navigate the systems. The program relies on braided funding streams from state and local funds, Medicaid (TANF/SSI), federal Substance Abuse Block Grant and federal Mental Health Block Grant dollars to help overcome traditional funding silos.

Through blended funding mechanisms, the program has delivered services more efficiently than other models in the state that lack the benefit of braided funding. Additionally, over the four-year waiver period from 1999-2003, NorthSTAR resulted in Medicaid cost savings of about \$20 million, most of which was achieved in administrative savings.

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<sup>46</sup> *Wraparound Milwaukee Quality Assurance/Improvement Semi-Annual Report, July1 – December 31, 2007,* <http://www.milwaukeecounty.org/ImageLibrary/User/trandall/QA/SEMIANNUALQAREPORT20072ndHALF.doc>

NorthSTAR instituted a “no wrong door” approach for eligibility to reduce time on waiting lists for services. Waiting lists for services for uninsured/non-Medicaid consumers have been eliminated. During the first full year of operation, use of behavioral health services by the uninsured population increased 46 percent from 9,190 individuals to 13,433 individuals and new providers emerged to offer specialty care services, giving consumers greater choice and control over how where they received services.

Blending state, local and Medicaid funds also enhanced care coordination and continuity of care for clients who cycle on and off Medicaid, by allowing them to retain the same provider network and receive an almost identical array of services, regardless of their payer source. The integrated system of care resulted in streamlined policies and eligibility criteria across payer sources. Through use of electronic systems, providers no longer have to bifurcate services based on a consumers’ payer source.

### *Encouraging recovery and patient-centered planning*

In recent years, services for adults with mental illnesses and youths with serious emotional disturbance have evolved to embrace the expectation that recovery from mental illness is possible and that service delivery systems must be transformed to support recovery. A recovery philosophy has been described as the single most important goal for the mental health service delivery system.<sup>47</sup> The term resiliency is used to describe similar principles for children and adolescents with serious emotional disturbance. A critical component underlying successful implementation of recovery and resiliency values is consumer/family member involvement in treatment and decision making. Consumers and family members are becoming increasingly active partners in the design, delivery and oversight of services, and mental health systems are increasingly emphasizing the role of “person-centered planning”, an approach with roots in developmental disabilities services which is a family of tools and approaches designed to ensure that the priorities of the individual and those who support them form the basis for individualized plans leading to rehabilitation, recovery and community inclusion. Person-centered planning addresses the consumer’s goals, and the role of systems and communities in supporting achievement of these goals.

Despite a variety of national reports (e.g. the President’s New Freedom Commission) citing the need for person-centered planning, most mental health systems are still struggling to effectively put person-centered planning into practice. Moreover, many systems claim to have adopted a person-centered approach, but evaluation of the actual process often shows that those systems have not fully adopted the key components of a person-centered, recovery focus, often because of a lack of provider training and a clear commitment at the leadership level to making the cultural change necessary. The profile of the Western New York Care Coordination Program below illustrates how one region was able to take the philosophy of recovery and person centered planning and successfully embed these concepts into the service delivery structure and achieve measureable improvements as a result.

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<sup>47</sup> U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “National Consensus Statement on Mental Health Recovery,” 2004. Available at <http://mental.health.samhsa.gov/scripts/printpage.aspx>

**Profile: Western New York Care Coordination Program, Erie, Genesee, Monroe, Onondaga and Wyoming Counties, New York**

The Western New York Care Coordination Program (WNYCCP) is a collaborative initiative by six county governments, the New York State Office of Mental Health, providers, and consumers to transform community systems serving people diagnosed with serious mental illness.<sup>48</sup> The program is designed to transform the local service system to a “person-centered, recovery focused systems that supports people in defining and achieving a satisfying life.”<sup>49</sup> Service delivery is based upon an individual services plan developed in partnership with consumers and their families. Planning for the program began in 2000 and implementation occurred in 2002.

The idea for the program took hold after New York State’s attempt to create Special Needs Plans to provide managed care for the behavioral health population failed, but the regional collaboration and the drive to better manage care for this population remained. WNYCCP is targeted to adults diagnosed with serious mental illness with a high need for clinical and support services. These are persons with histories of repeated hospitalization or incarceration, frequent crises, absence of a constructive social or family network, a lack of daily structure, and difficulties engaging in treatment, taking prescribed medications and self-monitoring. Eligibility for the program is not limited to Medicaid clients; about 15 percent of the program’s population is non-Medicaid.<sup>50</sup> When need exceeds funded slots, applicants are placed on a waiting list.

WNYCCP is led by a Steering Committee composed of county representatives, peers/family members, and providers as well as nonvoting representatives from the NYS Office of Mental Health. Project management is provided by Coordinated Care Services, Inc. (CCSI), a non-profit management services organization. The Steering Committee makes decisions at the policy level regarding the Program’s values, goals, objectives and initiatives. Implementation decisions are made at the county level. The Director of Community Services of each participating county takes the lead in implementation of WNYCCP initiatives in that county. Each county has a local advisory group, including consumers and providers, who work with the County Mental Health Department to implement the program. Program goals include:

- Alignment of the interests of providers and consumers based on the principles of person-centeredness, person-centered planning and recovery;
- Empowerment of recipients through individual service planning that promotes choice;
- Coordination of services delivered by multiple providers;
- Creation of a rehabilitation and recovery model of services;
- Implementation of evidence-based best practices;
- Allocation of resources based on individual need;
- Improved information systems that provide timely, useful information;
- Performance measured by outcomes; and
- Increased accountability.

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<sup>48</sup> For detailed information about the program, please see: <http://www.carecoordination.org/>

<sup>49</sup> N. Adams, Presentation to National Association of State Mental Health Program Directors, Winter 2006 Meeting, “Person-Centered Treatment Planning: A Core Construct in Transforming Our Systems of Care” available at: <http://www.nasmhpd.org/wcomm1206.cfm>

<sup>50</sup> Telephone interview with Phillip Endress, Commissioner of Mental Health for Erie County, December 12, 2008.

WNYCCP has launched a number of initiatives to support the program's goals. A select few are summarized below:

*Care Coordination.* To improve care coordination for enrolled consumers, each participating county has a Single Point of Access process which links to a variety of care coordination programs including Programs of Assertive Community Treatment (PACT) and Intensive Case Management (ICM). Care coordinators differ from traditional case managers by their added authority to: help recipients develop an Individual Services Plan (ISP); ensure consistency between the ISP and treatment plans developed by providers; coordinate crisis response; and access a pool of funds available to purchase nontraditional services or programs needed to support individuals in their recovery.

*Culture Change.* Despite the care taken to develop a template for individual service planning that focused on the interests of individual recipients, a review of the first set of Individual Services Plans developed by Care Coordinators revealed little change from the previous system's use of a "provider knows best" case management system.<sup>51</sup> The program's leaders believed that the philosophy and technology of person-centered planning, which had been developed within the developmental disabilities field, could be adapted to the adult mental health field. An intensive training initiative was developed with the help of individuals experienced in person-centered planning. A substantial investment was made in person-centered training, with 6-14 days of training supported by the Office of Mental Health. The Program's training emphasized in concrete ways what did and (did not) constitute person-centered planning (PCP) and worked to dispel many common myths about why providers could not be expected to follow the PCP model, (e.g. false perceptions that funding and licensure restrictions would impede person-centered planning). The ultimate goal of the training was to help providers see their role differently, with less focus on *managing* consumers' needs and more emphasis placed on *collaborating* with consumers to develop a plan of care that met the individual's unique needs.

*Adherence to Fidelity Standards.* A key component of the program's success involves developing fidelity standards for the participating CMHCs to ensure that services are being delivered as intended. The program regularly conducts fidelity reviews that consist of consumer reviews and medical record reviews. In order to ensure continued improvement, the minimum standards to meet fidelity are regularly raised. Additionally, the program publishes the CMHCs' fidelity scores as a means to incentive improved performance. A new focus of the fidelity measures is to incentivize CMHCs to help consumers "graduate" from the program to less intensive services. The length of stay within the program is now under two years for a set of very high need clients that had previously been expected to need intensive services indefinitely.<sup>52</sup>

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<sup>51</sup> Department of Mental Health, Government of Erie County New York, "Western New York Care Coordination Program," available at: [http://www.erie.gov/health/mentalhealth/pdfs/WNY\\_CCP\\_Project\\_Description.pdf](http://www.erie.gov/health/mentalhealth/pdfs/WNY_CCP_Project_Description.pdf)

<sup>52</sup> Telephone interview with Phillip Endress, Commissioner of Mental Health for Erie County, December 12, 2008.

### WNYCCP Outcomes: 2003-2007

Measure	Outcome
Gainful activity	Increased 27%
Arrests	Decreased 18%
Suicide attempts	Decreased 66%
Emergency room visits	Decreased 55%
Days spent in hospital	Decreased 58%
Medicaid costs – per person	Decreased 6% (while state average increased 8%)

Source: Presentation by Neal Adams, National Association of State Mental Health Program Directors, Winter 2006 Meeting, "Person-Centered Treatment Planning: A Core Construct in Transforming Our Systems of Care."

A key aspect of the program's funding involves an agreement between the six counties and the State Mental Health agency to use a percentage of state funds for mental health in a more flexible manner to give Care Coordinators flexibility to purchase services and supports when individuals need them. The Care Coordination Fund is designed to provide Care Coordinators with enhanced service dollars to purchase services and supports essential for the individual's recovery that are not available through traditional sources. Local Government Units participating in the Western New York Care Coordination program are allowed to transfer portions of traditional funding streams into the Care Coordination funding stream. The remaining funding comes from Medicaid reimbursement for Intensive Case Management. As the State's resources have declined with budget shortfalls, some of the participating Counties are now reallocating existing local funds to ensure the program continues,<sup>53</sup> proving evidence of local commitment to the model.

### *Improving coordination / collaboration of care across service systems*

There are a number of models around the country that have applied a similar principle – creating a collaboration of safety net providers to better manage limited resources in serving low income and uninsured patients. Those models that include primary care, mental health, and substance abuse have the ability to identify ways to more effectively manage resources so that agencies and providers can better share resources and collaborate on community-wide goals. For example, these collaborations can identify ways to better utilize the advantageous pricing for psychiatric medications using the 340B program, develop community-wide protocols for directing clients to a medical home for either behavioral health or primary care, and develop ways of sharing staff resources across programs to better address the needs of consumers with dual disorders. The following example is profiled because it has achieved significant benefits for people with behavioral health needs.

### **Profile: Indigent Care Collaboration, Austin, Texas**

The Indigent Care Collaboration (ICC), is an alliance of healthcare safety net providers that work together to increase access, improve quality and facilitate financing solutions to provide care to the region's medically indigent. A fundamental component to the ICC's approach is the inclusion

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<sup>53</sup> Telephone interview with Phillip Endress, Commissioner of Mental Health for Erie County, December 12, 2008.

of behavioral health as a core service and an understanding that a growing need for behavioral health services is at the base of a substantial proportion of primary care and other visits to healthcare providers.

The ICC was established in 1997 and is led by all of the safety net providers in a three-county region (Travis, Williamson and Hays). The ICC members collaboratively address multiple healthcare issues to the benefit of the medically indigent and the community at large. The goal of the ICC is to develop joint projects to increase access, improve quality, lower costs of providing care to the region's medically indigent, and to form a platform to create more coordinated and integrated system of services.

The ICC was launched as part of a grant project to increase local collaboration of safety net providers. Grant funds provided for critical start up costs and allowed the initiative to prove its value to the community as a whole and to the individual safety net providers. By the time grant funding ended, the member organizations had recognized the value of the collaborative and began paying membership dues to support ongoing costs of the collaborative. The ICC has created a number of tools and program to help strengthen the public safety net. Those programs with direct advantages to consumers with behavioral health needs are described below:

***Master Patient Index, known as I-Care***

A web-based Master Patient Index/Clinical Data Repository stores specific confidential patient health information as it is contributed by each ICC member. The goal of the system is to better coordinate the needs of the consumers served by the ICC's providers by improving continuity of care, reducing duplicate procedures and reducing the time spent in seeking healthcare services. The I-Care system allows participating safety net providers to build shared longitudinal electronic health records for uninsured and other low income patients to improve care continuity and delivery.

This has particular benefits for extending resources available for consumers with mental illnesses, specifically around securing the most advantageous price for psychiatric medications under the 340B drug program. The 340B drug program is a federal program designed to provide low-cost prescriptions to patients. Entities that can participate in the 340B drug pricing program are generally limited to FQHCs, FQHC look-alikes, certain DSH hospitals, Ryan White Aids Clinics, certain family planning programs. Only patients of these covered entities may access 340b pricing. In general, local mental health centers (unless they have FQHC status) do not have access to 340B pricing.

Using the ICC's shared patient index, the local FQHC and community mental health center have collaborated to identify shared clients so that these clients can get their medications through the FQHC and thus get the 340B pricing on the psychiatric medications. This collaboration opportunity only applies to shared clients of both the FQHC and the local mental health authority, since federal rules require that 340B pricing is only available for consumers who are patients of a covered entity. However, with greater coordination, there is the possibility of finding legitimate ways of expanding the pool of clients considered to be clients to the FQHC and to therefore achieve additional costs savings on medications.

Additionally, availability of the Master Patient Index has allowed for care improvements that require system coordination and data sharing. The region's main safety net hospital uses the Patient Index to regularly review patients with high Emergency Department utilization to determine whether behavioral health concerns were a contributing factor in the patient's use of

the ED and to develop a plan of care that recognizes the behavioral health need. The Patient Index is also used by the local mental health center to inform the psychiatrist and case worker of recent medical events, and gives the psychiatrist clinical information to inform medication decisions and indicates which patients are stable and established with primary care clinics, and thus could be referred back to their PCP for ongoing care.<sup>54</sup>

### ***Common Eligibility Program, known as Medicaider***

The ICC uses a common eligibility program through which uninsured residents are screened for eligibility for all major programs, such as Medicaid, CHIP, Supplemental Security Income and other federal, state and local programs. Medicaider is an off the shelf integrated eligibility and enrollment system designed for use by multiple providers and includes eligibility information for multiple program. The ICC contracted with Network Sciences LLC to customize the tool with the addition of criteria for eligibility for Title V, Title XX, and local funding programs, including hospital-based charity care programs. In addition to assisting in the determination of public funding eligibility, these customizations will make it possible for the ICC members to direct patients to whichever charity care program or programs they may benefit from. A study by the ICC as of October 2004 suggested that by directing patients to available third party reimbursement, over \$7 million in uncaptured revenue could be available to ICC members.<sup>55</sup>

Obtaining and maintaining Medicaid or other third party coverage is typically challenging for people with mental illness. The inability to complete the benefit application process is often made more challenging by the symptoms of mental illness. As a result, many consumers with mental illness fail to receive coverage from programs for which they are eligible. This limits the benefits available to the individual and reduces revenue for the provider system that is already strained by the burden of caring for unfunded patients. By developing multiple points to capture eligibility information and direct clients to available programs, a common eligibility tool increases the chances that clients with behavioral health needs will access third party coverage, which increases their likelihood of receiving necessary services and brings more resources into an underfunded system.

### ***Integrating mental health and primary care***

The need to develop better linkages and coordination between the behavioral health and physical health systems has become a major theme in recent years. The lack of effective linkages has financial costs for public systems and quality of life costs for people with behavioral health disorders. Reports from state agencies indicate that persons with serious mental illnesses die 25 years earlier than the general population.<sup>56</sup> Additionally, the presence of a mental illness often causes increased utilization of medical services, resulting in increased costs. Patients seen in primary care settings with mild to severe depression use between two and three times the amount of primary care services than non-depressed clients.<sup>57</sup> Both the high cost of care and premature

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<sup>54</sup> I-CARE use cases, available at: <http://www.icc-centex.org/library/ICare%20UseCase%20Summaries%20v2.pdf>

<sup>55</sup> Information accessed from the Indigent Care Collaboration website on October 23, 2008, <http://www.icc-centex.org/programs.cfm>

<sup>56</sup> R. Manderscheid, "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death among Public Mental Health Clients in Eight States," *Preventing Chronic Disease: Public Health Research, Practice and Policy* Vol. 3, 2006.

<sup>57</sup> G. Simon, "Psychiatric Disorder and Functional Somatic Symptoms as Predictors of Health Care Use," *Psychiatric Medicine* 10:49-60, 1992.

mortality underscore the need for improved integration between the mental health and primary care systems.

There are a wide variety of models currently being used to integrate mental health and physical healthcare. In general, the majority of models fall into one of four categories, although in many instances, a particular model may have elements of more than one approach:

1. Co-located services, where physical health and mental healthcare are delivered in the same setting;
2. Collaborative care, where the treatment team consists of both mental health and primary care providers;
3. Mental healthcare embedded in the physical healthcare setting; and
4. Physical healthcare embedded in the mental healthcare setting.

Additionally, some models have focused solely on merging primary care with mental healthcare, while others are broader and also include substance abuse, and occasionally, other conditions, such as developmental disabilities.

As communities seek to develop or enhance integration of primary care and behavioral health, the selection of which model to choose should be driven by available resources and the needs and utilization patterns and preferences of the targeted population. For example, efforts that seek to provide integrated services to the non-SMI population will likely need a different structure than those targeting the SMI population. Additionally, while the co-located model has been shown to increase the opportunities for consultation between mental health and primary care providers, it does not ensure that providers will collaborate in the treatment of shared clients and the amount of coordination that actually occurs can vary greatly.<sup>58</sup>

A critical component of building an effective integrated approach involves determining who will provide and manage the care. The Four Quadrant model, created under the auspices of the National Council for Community Behavioral Healthcare, offers a framework to make determinations about what type of care individuals need and where that care would be delivered most effectively.<sup>59</sup> The model was designed to serve as a template for coordinated planning in local systems, allowing for considerations of local resources and developing alternative methods (such as telemedicine) where specialty care may be required.<sup>60</sup> The Four Quadrant model has been used in a number of integrated care systems as a way to define responsibilities of the parties and organize care around the consumer's needs.

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<sup>58</sup> Hogg Foundation for Mental Health, "Connecting Body and Mind: A Resource Guide to Integrated HealthCare in Texas and the United States," 2008.

<sup>59</sup> B. Mauer, "Behavioral health/primary care integration: The four quadrant model and evidence-based practices." [www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant/pdf](http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant/pdf).

<sup>60</sup> J. Parks and D. Pollack, "Integrating Behavioral Health and Primacy Care Services: Opportunities and Challenges for State Mental Health Authorities," National Association of State Mental Health Program Directors, November 26, 2004.

### Four Quadrant Model

<p><b>Quadrant II</b> High BH, Low PH</p> <ul style="list-style-type: none"><li>• Community mental health or primary care as the medical home</li></ul>	<p><b>Quadrant IV</b> High BH, High PH</p> <ul style="list-style-type: none"><li>• Co-managed care between community mental health and primary care</li></ul>
<p><b>Quadrant I</b> Low BH, Low PH</p> <ul style="list-style-type: none"><li>• Primary care as the medical home</li></ul>	<p><b>Quadrant III</b> Low BH, High PH</p> <ul style="list-style-type: none"><li>• Primary care as the medical home</li></ul>

There are a multitude of examples of local and regional integration efforts. Those profiled below were selected to show the breadth of variation possible, including an example that focuses on integration and co-location, one that employs the four quadrant model and one that utilizes “reverse integration” where primary care is delivered in community mental health centers.

### Profile: Marillac Clinic, Grand Junction, Colorado

Marillac is a safety net clinic providing comprehensive medical, mental health, dental, vision and pharmacy services to the low income (under 200 percent federal poverty level) uninsured population. Marillac has a \$5.6 million budget and approximately 90 employees. The clinic is licensed as a community health center, but does not have FQHC status. The Integration project began under a Robert Wood Johnson grant. After a decade of ongoing evaluation and modification, Marillac Clinic has developed an innovative model of collaborative care that fully integrates mental health services in a primary care setting.

Patients at Marillac who require mental health services are identified either through physician referral or by a health history questionnaire that is completed by all first-time patients. Mental health treatment begins with an informal introduction to a counselor at the time of referral, and an immediate follow-up visit is scheduled. The clinic employs a full-time case manager to handle scheduling and evaluation for mental health services. Between August 2000 and July 2004, Marillac Clinic provided integrated mental health services to 3,077 unduplicated patients.

The model relies heavily on creating an environment where mental health and medical practitioners are co-located in a way that allows for spontaneous contact which fosters collaboration. Both medical exam rooms and mental health practitioner rooms are in the same area of the clinic, and share front office, reception and other clinic functions. The model also relies on changing the usual culture of mental health treatment, where sessions are not interrupted for consultations with other practitioners. The “mantra” in the Marillac clinic is that “no session is un-interruptible.” In this way, the clinic has made mental health treatment conform to the manner in which primary care is more typically delivered.

Marillac partners with a local hospital, St. Mary’s, which allows for data exchange and evaluation of the program’s impact. St. Mary’s Hospital began tracking ER utilization and hospitalization for integrated care recipients from Marillac in 2001 to document the program’s impact on uncompensated care. In 2001, 22 percent of patients receiving mental health services used the ER at least once, and 9 percent were hospitalized at least once. By 2005, the number of patients who used the ER had dropped to 13 percent, and only 4 percent of patients had experienced a hospitalization in the previous year. Reduced utilization of the ER has translated into significant savings for St. Mary’s Hospital (\$228,000 over four months in 2004). As a result,

the hospital recently elected to fund integrated healthcare by donating 10 percent of the documented cost savings to Marillac Clinic.<sup>61</sup>

In addition to cost savings, a 2001 study documented patient satisfaction at the clinic. Ninety percent of patients reported a preference for collaboration between their medical and mental health providers. Increased patient satisfaction is also reflected in the no-show rates for mental health services. When the clinic first began to offer counseling in 1994, it had a no-show rate of 75 to 90 percent. Data collected in 2006 showed that the no-show rate had fallen to less than 10 percent.<sup>62</sup>

However, since Marillac is not an FQHC and does not accept insured patients, its funding mechanisms may be more flexible than many urban clinics. Additionally, Marillac project staff have pointed out that entities relying solely on fee-for-service revenue may face greater challenges in developing fully integrated models. Because Marillac can combine its funds and blend them “upstream,” clinic staff are not as constrained by concerns over coding and billing, which maximizes the time spent focusing on patient treatment. According to the Executive Director, having one bottom line for both mental and physical health helps foster integration.<sup>63</sup>

### **Profile: Washtenaw Community Health Organization, Ypsilanti, Michigan**

The Washtenaw Community Health Organization (WCHO) is a service organization that administers primary care, mental health, substance abuse and developmental disability services in southeastern Michigan. In 2000 the organization began to integrate mental health, substance abuse, primary and specialty healthcare services for Medicaid, low-income and indigent consumers. The Project serves an urban population of all age groups and all levels of need and covers approximately 22,700 individuals<sup>64</sup> in seven clinics.

The project is supported by a braided funding system that combines Medicaid, Medicare, local tax dollars, mental health block grant funds, substance abuse block grant funds, state funds and private funds. All funding flows through the WCHO, which contracts with a community mental health agency that serves as the primary implementer of the initiative.

The program uses the four quadrant model to determine whether a behavioral health case manager or primary care provider will have chief responsibility for overseeing the consumer’s care. The program’s staff reports that on-site co-location is critical; in clinics where mental health and primary care is not co-located, there is a significant reduction in follow through on referrals from primary care to mental health and vice versa.<sup>65</sup>

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<sup>61</sup> “Care that Pays for Itself: Community Initiatives to Reduce the Cost of Uncompensated Health Care,” LBJ School of Public Affairs, Policy Research Report, No. 151, 2006.

[http://www.stdavidsfoundation.org/downloads/collaborations\\_lbj\\_prp.pdf](http://www.stdavidsfoundation.org/downloads/collaborations_lbj_prp.pdf)

<sup>62</sup> Presentation by Steve Hurd, Executive Director, Marillac Clinic, Care that Pays for Itself” Conference, Sponsored by LBJ School of Public Affairs, March 24, 2006

<sup>63</sup> Presentation by Steve Hurd, Executive Director, Marillac Clinic, Care that Pays for Itself” Conference, Sponsored by LBJ School of Public Affairs, March 24, 2006.

<sup>64</sup> Health Management Associates, “Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives,” Prepared for the Robert Wood Johnson Foundation, February 2007.

<sup>65</sup> Presentation by Kathleen Reynolds to Hogg Foundation for Mental Health, Integrated Health conference, September 8, 2008

The project has showed an overall decline in cost of care and a positive return on investment: The longest operating of the clinics in the project has achieved cost savings of \$2,000 per month, per person.<sup>66</sup> In addition, treatment outcome data indicate that clients in the program have also experienced reductions in unemployment, homelessness and legal issues.<sup>67</sup>

### **Profile: Vermont Medical Home Project, Vermont**

The Office of Vermont Health Access (OVHA) developed a Medical Home Project (MHP) in 2003 as a result of concerns related to research on poor health and high mortality rates of people with serious mental illness. The project's funding was largely supported by a grant from the Center for Health Care Strategies to integrate primary care with community mental health services.

The Medical Home Project employed a "reverse integration" strategy and made Community Mental Health Centers (CMHCs) the service location and targeted consumers with serious and persistent mental illnesses. The project served 200 adult and elderly Medicaid-eligible consumers who were being treated in a CMHC due to severe and persistent mental illness and who were identified as having diabetes.

The project used grant funds to test three different approaches to achieving integration. These approaches included: 1) hiring a registered nurse to work on site at the CMHC; 2) contracting with a registered nurse employed by a local FQHC to work on site at the CMHC; and 3) training community mental health case management staff to provide primary care case management. The state determined that the first approach was most effective and the third approach was considered not effective. In the first two approaches, the nurses collaborated with other CMHC staff, including the case manager and staff psychiatrist. Services provided by the RNs began as hands-on interventions with consumers and dealt with obesity, uncontrolled diabetes and encouraging lifestyle changes. Over time, however, as the consumers in the project became more medically stable, the role of the nurses evolved to also include acting as a coach for the CMHC case managers to help them be better able to address the physical health needs of the CMHC's clients.

The role of nurses in the first two approaches included a variety of responsibilities, including:

- Educating consumers about lifestyle choices;
- Linking consumers to medical homes or other services;
- Advocating for consumers, including accompanying them to medical appointments;
- Encouraging consumers to make and continue to make lifestyle changes; and
- Monitoring consumers' blood pressure, blood sugar and other vital signs as necessary.<sup>68</sup>

Rates of hospitalization, use of emergency rooms and standard health measures regarding diabetes were evaluated after six months. OVHA reported a three fold increase in office visits for

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<sup>66</sup> Presentation by Kathleen Reynolds to Hogg Foundation for Mental Health, Integrated Health conference, September 8, 2008.

<sup>67</sup> Health Management Associates, "Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives," Prepared for the Robert Wood Johnson Foundation, February 2007.

<sup>68</sup> Presentation by Liz Reardon and Jane Winterling, to Hogg Foundation for Mental Health, Integrated Health conference, September 8, 2008.

primary care services in the center where the RN was a mental health center employee, with smaller increases reported in the other staffing models. There were increased numbers of patients who had an A1C completed to monitor the patient's diabetic condition. While use of emergency room services and hospital admissions declined, total Medicaid primary care spending on patients with diabetes increased over the short term, especially regarding prescription drugs to treat diabetes and other medical conditions. In general, the sickest patients at the beginning of the pilot saw the most improved results after six months, and the State believed that these results suggest that unmet physical healthcare needs were being better addressed.<sup>69</sup>

Additionally, the mental health center, which had employed its own RN under the pilot, chose to continue the RN on staff after the end of the grant. The center believed that overall results were improving for their patients involved in the project, since the improvement in physical healthcare supported more effective self-management for mental health conditions.<sup>70</sup>

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<sup>69</sup> Health Management Associates, *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives*, Prepared for the Robert Wood Johnson Foundation, February 2007.

<sup>70</sup> Health Management Associates, *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives*, Prepared for the Robert Wood Johnson Foundation, February 2007.

## **DISCUSSION OF KEY FINDINGS**

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The following findings are those that HMA believes offer a comprehensive assessment of areas where behavioral health services in the Kansas City region can be strengthened. These findings were developed from a review of the various data sources used by HMA in this study (i.e. focus groups, individual interviews, provider survey, national research, etc.) and thus represent findings where there was consensus or alignment among the various sources of information that we gathered. The findings are not grouped by priority order. However, where key informants appeared to have different perspectives regarding the priority of an issue, we have noted those differences.

The description of each finding includes key information gleaned from previous needs assessments, input from stakeholders, responses from provider surveys as well as relevant national research on the topic.

**Finding 1: There are opportunities across the Kansas City region to increase consumer involvement and to support consumer run services.** In recent years, recovery has become a central theme in the design and implementation of mental health services. A focus on recovery involves a fundamental shift in values to a consumer-centric approach. Consumer involvement in the planning, implementing and evaluating of services is a key component of a recovery-focused system. Recovery oriented services that involve consumers and families provide benefits to the consumers as well as to service delivery systems. For consumers receiving services, recovery-oriented services improve social functioning, self-esteem and social support as well as improve quality of life. They also result in reduced use of hospital and crisis services. Systems benefit from cost savings due to reduced hospitalization and shorter inpatient stays and improvements in the overall effectiveness of the service delivery system.<sup>71</sup>

Many stakeholders cited the benefits of the recovery philosophy and of person-centered planning and indicated that these concepts would be critical to strengthening the mental health service system in the region. However, stakeholders also noted that the commitment of service providers to these concepts is inconsistent across the region. This problem is also often found in other communities, where recovery based principles and practices are lauded, but are often not successfully embedded in the actual delivery of services.

**Finding 2: There is a shortage of safe, appropriate and affordable housing for low-income individuals with behavioral health needs.** Stable and safe housing is a prerequisite to ensuring that consumers with behavioral health needs are able to engage in and benefit from treatment. In both interviews and focus groups, the lack of affordable housing options for low income people with behavioral health disorders was repeatedly noted as an area that compromised the community's ability to effectively serve consumers with behavioral health needs. While there is a general lack of housing for this population, it was repeatedly noted that there is a particular shortage of transitional housing that has appropriate supports to help consumers reintegrate into the community and which is of long enough duration to allow for successful reintegration strategies. The populations most affected by this lack of transitional housing are clients leaving

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<sup>71</sup> Presentation from NASMHPD Forensic Directors Meeting, September 2007, available at [http://www.nasmhpd.org/general\\_files/meeting\\_presentations/Forensic%20Powerpoints%20for%20Website%2007/McCormick%20Presentation.pdf](http://www.nasmhpd.org/general_files/meeting_presentations/Forensic%20Powerpoints%20for%20Website%2007/McCormick%20Presentation.pdf).

the state hospital or criminal justice involvement. In many cases, a consumer's history or diagnosis can negatively effect his or her ability to secure appropriate housing, since some housing providers exclude consumers with a criminal record, others exclude individuals with substance abuse or are in a location (e.g. across from a liquor store) that is not conducive to someone in the early stages of substance abuse recovery.

This issue was addressed, albeit indirectly, in previous needs assessments. The Kansas Department of Social and Rehabilitative Services (SRS) formed a Hospital and Home Initiative Core Team to determine if the State had sufficient inpatient mental health beds. One of the Team's findings was that individuals in state hospital faced delays in state hospital discharge due to a lack of safe and affordable housing and adequate transportation.<sup>72</sup> Focus group participants indicated poverty/lack of income was a chief (although not the only) reason that people with mental illnesses had difficulty finding safe, stable and appropriate housing. Stakeholders, especially consumers, noted that the "housing first" philosophy is critical to establishing effective housing solutions. Additionally, responses from the provider survey also addressed this housing issue. The need for housing assistance for consumers with mental illnesses or developmental disabilities was cited as a "big problem" by a majority of the respondents (76 percent of providers serving consumers with mental illness and 74 percent serving the developmentally disabled population).

The need for more affordable and appropriate housing for people with behavioral health needs is national in scope. Across the country, housing that people with Supplemental Security Income (SSI) can afford remains in short supply compared with the need. There is a significant gap between typical rents and SSI, which is often the only source of income for people with serious mental illnesses. (In 2009 SSI will be \$674 per month for an individual.)<sup>73</sup> Data from the U.S. Department of Housing and Urban Affairs regarding national average cost for rental units in 2006 found that a person with mental illness would have needed to pay 113 percent of his or her monthly income to rent a modest one-bedroom apartment.<sup>74</sup> People with co-occurring mental illness and substance use disorders are especially vulnerable to lack of housing. Besides making up a significant percentage of the homeless and chronically homeless<sup>75</sup> population they are also likely to have acute and chronic physical health problems; exacerbated psychiatric symptoms; and a higher likelihood of victimization and incarceration. Additionally, individuals attempting to exit homelessness have been negatively affected by national trends in the reduced availability of housing vouchers, public housing, and units in Section 8 projects that would help narrow the gap between incomes and housing costs.<sup>76</sup>

**Finding 3: There are insufficient residential services for individuals needing long-term structured residential supports to meet demand.** While this sub-population is likely small, these consumers typically need more care and supports than most community housing options offer and thus may account for a large percentage of utilization of behavioral health and other social service interventions. A number of these individuals currently reside at the Western

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<sup>72</sup> Hospital and Home Initiative: Executive Summary and Action Plan. Kansas SRS Hospital and Home Core Team. June 3, 2008.

<sup>73</sup> Social Security Online: <http://www.ssa.gov/OACT/COLA/SSI.html>

<sup>74</sup> "Priced Out in 2006," Boston, Technical Assistance Collaborative, Inc., 2007.

<sup>75</sup> M. Bert, "What will it Take to End Chronic Homelessness?" Washington, DC, Urban Institute Press, 2001.

<sup>76</sup> A. O'Hara, "Housing for People with Mental Illness: Update of a Report to the President's New Freedom Commission", *Psychiatric Services*, Vol. 58, No. 7, July 2007.

Missouri Mental Health Center (WMMHC); concerns were raised about ensuring that their needs are addressed in the planning for the potential transfer of the state hospital. As both Missouri and Kansas follow the national trend of shifting behavioral health resources from inpatient facilities to community-based services, this population is at increased risk of facing difficulties securing coordinated care in the community for their intense and complex needs.

Almost all the stakeholders noted that there is a small population that needs long-term, intensive services that offer fairly substantial levels of supervision and programming and also noted that some of this population has co-occurring substance abuse or medical issues. In provider surveys, the majority of respondents cited both supported housing and residential hospitalization as a “big problem.”

Finally, recent research also supports the belief that there is a subset of behavioral health consumers who need intensive supports to avoid rehospitalization or other involvement with acute and expensive services. A recent study<sup>77</sup> examined outcomes during a one-year follow-up for persons who were discharged from a locked intermediate care facility then spent 90 or more days in locked or highly structured institutions that provided 24-hour care (including jail) or had five or more acute hospitalizations. The study’s authors concluded that the high rate of recidivism suggests that there is a subset of the population with high needs that require intensive supports for effective transition from more structured, intermediate inpatient services to lower levels of community-based care.

**Finding 4: Funding for mental health services is not commensurate with need.** Like communities across the country, the Kansas City region is faced with more demand for mental health services than can be provided with existing resources.

This issue, not surprisingly, has been addressed in previous needs assessments. For example, the Johnson County Mental Health Center strategic plan noted the need for increased funding for services to keep pace with expanding demand.<sup>78</sup> Stakeholders in general, and providers in particular, noted the challenges of meeting the growing need for mental health and other behavioral health services with existing resources. Many stakeholders also noted that changes in state policy have resulted in less care being delivered in inpatient facilities with a commensurate increase in the responsibilities of community-based providers. That shift in service delivery often means that community-based providers are serving not only more individuals, but also individuals who have a higher level of acuity and who, in years past, would have been served by inpatient facilities. Within the provider survey, the lack of funds was cited as a “big problem” by the vast majority of providers responding to the survey, regardless of whether they were serving consumers with mental illnesses, substance abuse disorders or developmental disabilities.

There are a variety of factors that have stressed public mental health systems’ ability to meet demand with existing resources. These include:

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<sup>77</sup> R. Lamb and L Weinberger, “One-Year Follow-Up of Persons Discharged From a Locked Intermediate Care Facility,” *Psychiatric Services*, Vol. 56, No. 2, February 2005.

<sup>78</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*

- Increases in the number of uninsured individuals as the prevalence of private insurance has declined. National data shows that one in four uninsured adults have a mental illness, substance abuse disorder or co-occurring disorder.<sup>79</sup>
- States' reliance on Medicaid. In recent decades, states have aggressively pursued federal matching funds for mental health services that were previously funded with state and local dollars. While refinancing services allowed States to obtain federal match for services, it also had the effect of shifting public mental healthcare toward Medicaid-covered people and services, often to the detriment of individuals who for various reasons are not eligible for Medicaid. As a result of this trend, States across the Country have seen a reduction in the availability of discretionary funds available for traditional mental health safety-net functions.<sup>80</sup>
- Limitations in Medicaid benefits. While Medicaid is the largest payer of mental health services, there are a number of services traditionally delivered by public mental health systems that are not eligible for Medicaid reimbursement, such as non-medical support (e.g. housing, educational or vocational services). Assuming federal rules related to targeted care management and rehabilitative services go into effect as planned in 2009, States' use of Medicaid to fund mental health services will be further narrowed.
- State mental health funding has increased, but primarily for Medicaid-covered services. From Fiscal Year 2001 to Fiscal Year 2005, state mental health authority-controlled expenditures for mental health services increased from \$23.1 billion to \$29.4 billion, an increase of 27.9 percent.<sup>81</sup> However, the increase is due largely to active efforts by states to shift programs into Medicaid that were previously funded solely by state or local dollars.<sup>82</sup> As a result state spending uninsured consumers has sharply diminished.<sup>83</sup>

**Finding 5: The Kansas City region has inadequate capacity to meet the needs of consumers with serious mental illnesses who need acute care services.** This issue is often framed around problems securing inpatient bed capacity, since this is the location in the service system where a lack of capacity is typically most apparent. However, this issue involves more than inpatient psychiatric bed capacity. The lack of capacity for inpatient beds is often a symptom of inadequate capacity in other areas of the service system, such as outpatient care, crisis systems, respite care and transitional housing, all of which impact whether a consumer will need inpatient care and for how long. In the Kansas City region, like other communities across the country, the lack of access to inpatient and other acute care services shifts the burden of care to local emergency departments, homeless services, jails and other community resources. As a result, where capacity is a problem at the most acute (and frequently the most expensive) levels of care,

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<sup>79</sup> M. Giliberti et al., *Coverage for All: Inclusion of Mental Health and Substance Use Disorders in State Healthcare Reform Initiatives*, National Alliance on Mental Illness and National Council for Community Behavioral healthcare, June 2008.

<sup>80</sup> R. Frank, H. Goldman and M. Hogan, "Medicaid and Mental Health: Be Careful What You Ask For," *Health Affairs*, Vol 22, No 1 2003.

<sup>81</sup> National Association of State Mental Health Program Directors National Research Institute, *FY 2005 State Mental Health Revenue and Expenditure Study Results*, November 2007. Retrieved from <http://www.nri-inc.org/projects/Profiles/RevExp2005/FY2005%20Revenues%20&%20Expenditures%20Study%20Results.pdf> .

<sup>82</sup> J. Buck, "Datapoints: Spending for State Mental Health Care," *Psychiatric Services* 52:1294, October 2001.

<sup>83</sup> R. Frank, H. Goldman and M. Hogan, "Medicaid and Mental Health: Be Careful What You Ask For," *Health Affairs*, Vol 22, No 1 2003.

it should be seen as a symptom of underlying problems in overall system capacity and effectiveness.

The need for acute care services was addressed in previous needs assessments. For example, the Jackson County Mental Health Needs Assessment found that the County had 658 inpatient psychiatric beds in 1990; by 2002, the number had dropped to 399.<sup>84</sup> Additionally, the Johnson County Mental Health Center reported in their 2005-2006 Strategic Plan that state hospital bed utilization in 2004 was 135 percent of the number of beds allocated to the County by the state and that the number of psychiatric beds in community hospitals continues to decline.<sup>85</sup> Stakeholders also noted the need for additional acute care resources, and stated that the need exists regardless of whether a consumer had private insurance, public insurance or was uninsured. Provider survey responses found that the majority of survey respondents (58 percent) reported that finding acute beds for consumers with serious mental illness is a “big problem.” Moreover, the problem appears, from the survey responses, to be more severe among providers serving the more rural counties surrounding Kansas City.

Nationally, the rate of inpatient mental health beds per 100,000 civilian population declined by 45 percent between 1990 and 2004.<sup>86</sup> Additionally, while publicly run beds have been declining since the 1970s, starting in the mid 1990s, private inpatient psychiatric beds also began to decline significantly.<sup>87</sup> While these declines in inpatient capacity have been offset, in varying degrees, by additional outpatient capacity, many systems across the country are struggling to ensure acute care services, and have seen a rise in the number of consumers with behavioral health needs entering hospital emergency departments (EDs) for care. The burden of treating people with behavioral health disorders is considerable – psychiatric patients remain in hospital EDs more than twice as long as other patients, with over 40 percent spending nine or more hours in the ED.<sup>88</sup>

**Finding 6: The lack of access to services outside normal business hours is a barrier to care for some consumers.** While the lack of availability of evening and weekend clinical services for treatment, medication and crisis intervention was noted by several informants, mostly consumers of services, some providers noted that they either currently offer these services or have offered them in the past but discontinued them because of insufficient utilization. Further exploration is needed to determine if the reports of need for after hours care involves availability (or lack thereof), the choice of location for after hours care, or the degree to which the after hours care is sufficiently promoted to consumers. In addition, providers noted that despite calls for greater afterhours care, past attempts to establish afterhours care have had mixed results. For example, Swope representatives said that they did not find clients used much of the after hours care made available.

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<sup>84</sup> Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Cross-Cutting Issues (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development, September 1, 2005.

<sup>85</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*.

<sup>86</sup> National Center for Health Statistics, Health, United States, 2007: Chartbook on Trends in the Health of America (National Center for Health Statistics, 2007), available at: <http://www.cdc.gov/nchs/data/hus/hus07.pdf>.

<sup>87</sup> E. Salinsky and C. Loftis, “Shrinking Inpatient Capacity: Cause for Celebration or Concern,” National Health Policy Forum, George Washington university, Issue Brief no. 823, August 2007.

<sup>88</sup> Eileen Salinsky and Christopher Loftis, “Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?” *National Health Policy Forum*, Issue Brief No. 823 (August 1, 2007).

**Finding 7: Consumers, particularly adult consumers, with behavioral health issues need assistance in securing physical healthcare services.** Securing primary healthcare for people with serious mental illnesses was noted as a problem by both stakeholders and provider survey respondents. Specialty services, such as dental and vision, were noted as particularly difficult to obtain.

Stakeholders repeatedly noted the need to ensure consumers, particularly adults with serious mental illnesses, had access to physical healthcare services. Stakeholders also noted that a critical component of mental health consumer's ability to secure necessary physical health services also involved having access to case management services to help in obtaining and navigating the service system. Finally, stakeholders noted that there is more integration work being done in Missouri on this issue than in Kansas. Responses to the provider survey also indicated that this is a large need, with the majority (57 percent) of survey respondents citing access to primary care and specialty care services for individuals with mental illness or substance abuse as a "big problem." Survey respondents indicated that this issue is more of an issue for the adult population than for children. While primary and specialty care access is an issue for consumers with developmental disabilities, the provider survey responses indicate that it is less acute than for the population with mental health or substance abuse needs.

Services for people with mental illnesses and substance abuse disorders have traditionally been separate from primary care. However, the need to better address the physical health needs of consumers with serious mental illness is now widely accepted. The extent of behavioral health diagnoses within primary care settings emphasizes the need for integrated care. Substance abuse and mental health disorders, taken together, are by far the most frequently diagnosed encounters at health centers, outnumbering hypertension and diabetes.<sup>89</sup> Some of the most powerful evidence documenting the need to secure primary care services for consumers with serious mental illnesses comes from an analysis of data from state agencies which found that persons with serious mental illnesses die 25 years earlier than the general population, largely due to untreated or poorly managed physical health problems.<sup>90</sup>

**Finding 8: Some subpopulations were reported to face greater challenges in accessing services.** These groups include:

- Individuals with complex needs, often including: co-occurring substance abuse, development disability or medical diagnosis, and a history of criminal justice involvement and/or physical aggression;
- Young adults transitioning from children's services, which have broader eligibility criteria and a richer service array than do adult mental health services;
- Individuals with developmental disabilities who also have significant mental health and/or behavioral problems;
- Latinos and other non-English speaking populations;
- People in rural areas of the region;

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<sup>89</sup> Based on 2004 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

<sup>90</sup> R. Manderscheid, "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death among Public Mental Health Clients in Eight States," *Preventing Chronic Disease: Public Health Research, Practice and Policy* Vol. 3, 2006.

- Single females and children; and
- Individuals with history of trauma.

**Finding 9: There is a lack of available substance abuse treatment services in the Kansas City region.** Gaps in substance abuse treatment appear to exist across levels of care (inpatient vs. community). According to information published by the Journal of American Medical Association, roughly half of the individuals with mental disorders also suffer from a substance abuse problem.<sup>91</sup> Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness. Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs. Research has shown that approaches like Integrated Dual Disorder Treatment (IDDT) reduce relapse, duplication of services and costs, and improve continuity of care.<sup>92</sup>

Stakeholders noted that coordination of mental health and substance abuse services, and improved use of evidence-based treatment options could yield higher rates of recovery. Providers noted that there is a fundamental barrier to securing substance abuse treatment for adult men, in that those who are alcohol-addicted must have committed a crime in order to be eligible for treatment.

Previous needs assessments have addressed this issue. For example, the Jackson County Needs Assessment found that the number of individuals in Missouri receiving both substance abuse and mental health treatment has doubled, from 6.9 percent in 1999 to 14 percent in 2002.<sup>93</sup> Stakeholders noted that it is very difficult to find programs that cover co-occurring disorders, especially if the consumer is uninsured or undocumented. Stakeholders also noted that while social detox services are available in the region, medical detox services are not available.

**Finding 10: The Kansas City region has some of the critical elements of a crisis response system but would benefit from a community effort to strengthen these services.** The concerns raised about crisis services are critical to investigate, since crisis services are often the last attempt to provide alternatives to the most expensive part of the treatment continuum – inpatient care or criminal justice involvement. Additionally, crisis services are often a consumer’s first interaction with the mental health system, and thus a consumer’s impression of services is likely to influence how successfully he or she will engage in follow-up services. Finally, lack of access to crisis services can result in significant risk to the individual and sometimes to others in the community. Left untreated, these issues can result in individuals going to jail or becoming homeless as a result of worsening symptoms of serious mental illness. Optimizing the system’s response for people experiencing a mental health crisis will require a coordinated effort of many community systems, including law enforcement, first responders, hospital emergency departments, as well as the behavioral health system. Developing the capacity to provide crisis respite and other services that ensure that a continuum of care between outpatient and inpatient is an area of particular need, both to divert consumers from inpatient care and to create an effective source of care for clients leaving inpatient facilities.

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<sup>91</sup> From [http://www.addictionsearch.com/treatment\\_articles/article/dual-diagnosis-and-treatment-substance-abuse-and-cooccurring-mental-health-disorders\\_71.html](http://www.addictionsearch.com/treatment_articles/article/dual-diagnosis-and-treatment-substance-abuse-and-cooccurring-mental-health-disorders_71.html).

<sup>92</sup> From <http://www.ohiosamickoe.case.edu/dualdisorders.html>.

<sup>93</sup> R. Jensen et al. *Needs Assessment: Developmental Disability Services of Jackson County (prepared for Empowering Individuals Through Advocacy and Support)*. UMKC Institute for Human Development. August 2007

Several recent needs assessments have cited lack of adequate crisis services as a serious problem.<sup>94</sup> Specifically, the Johnson County Mental Health Center reports a 52 percent increase over the last 10 years in its number of mental health crisis contacts.<sup>95</sup> Stakeholders also noted concerns about access to crisis hotlines, mobile crisis response services, and inpatient crisis stabilization beds. In focus groups, some consumers noted specific dissatisfaction with the way after-hours crisis services are provided. For example, in Missouri, the crisis line is answered in St. Louis by clinicians who have the ability to do a “warm transfer” to a local provider. Some stakeholders (consumer and advocates) felt that the line would be more effective if answered locally. However, only a minority (between 28 percent and 38 percent) of providers responding to the provider survey reported crisis services were a “big problem”. Only in Wyandotte County did more than half of the providers serving the County report access to crisis services as a “big problem”. Finally, in the survey of CMHCs, both crisis residential and crisis stabilization services were absent in many parts of the region.

The need to articulate what crisis services should be offered by public entities and to establish clinical guidelines around the provision of those services is a critical element of ensuring that the public mental health system can ensure that this critical function is both effective and consistently available. Efforts to develop a sound crisis service continuum and to establish standards associated with the various components of a continuum have already been developed by various entities and could inform any regional efforts to strengthen the region’s crisis system. These relevant sources include:

- The American Psychiatric Association’s Task Force on Psychiatric Services has developed recommended crisis service standards. These standards can be found in the *Report and Recommendations Regarding Psychiatric Emergency and Crisis Services* of the APA Task Force on Psychiatric Emergency Services (2002), available at: [http://archive.psych.org/edu/other\\_res/lib\\_archives/archives/tfr/tfr200201.pdf](http://archive.psych.org/edu/other_res/lib_archives/archives/tfr/tfr200201.pdf)
- The State of Texas recently conducted a comprehensive redesign of public crisis services. This effort involved identifying the core elements of an effective public mental health crisis system and establishing standards of care for each service. The report and related measures can be found at: <http://www.dshs.state.tx.us/mhsacsr/default.shtm>.

**Finding 11: While the Kansas City region has made significant strides in developing healthcare resources and information for the area, there remains a lack of information regarding behavioral health disorders, resources for obtaining behavioral health services, and managing behavioral health illnesses.** A cataloguing of services throughout the community, including locations, and procedures for accessing services would be an important aid for the community.

Stakeholders noted that there is a need to help consumers navigate a system that includes a wide variety of providers, including public and private providers, and providers offering a comprehensive array of services as well as those offering limited or niche services. Lack of

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<sup>94</sup> See, for example, Christine Rinck and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Cross-Cutting Issues* (presented to the Mental Health Strategic Planning Task Force). University of Missouri – Kansas City, Institute for Human Development, September 1, 2005 and Rinck, Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Children and Senior Services* (presented to the Mental Health Strategic Planning Task Force). University of Missouri – Kansas City, Institute for Human Development, September 1, 2005.

<sup>95</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*.

knowledge about available services was cited as a “big problem” by the vast majority (72 percent) of respondents caring for individuals with mental illness, developmental disabilities or substance use disorders.

**Finding 12: The Kansas City Region does not currently collect key metrics to determine the effectiveness and availability of behavioral health services.** Such measures are important to determine impact of any changes to the service system and can help pinpoint areas where community collaboration and attention is necessary to correct problems. Additionally, private funders are often very responsive to projects that have in place a commitment to tracking and measuring results.

**Finding 13: There is a need to ensure that mental health and other services offered by safety net providers are coordinated.** While informal efforts to coordinate care exist throughout the community, their effectiveness could be enhanced with the adoption of a common eligibility tool and a system to track consumers as they engage with providers across the service delivery system to coordinate care and to identify and pursue opportunities to minimize duplication of services or to deliver care more efficiently.

Stakeholders noted the likelihood of duplicating services or not having access to information such as prescription information or diagnosis or assessment history that would make treatment more effective. While all stakeholders agreed that this was an issue worthy of addressing, various constituencies gave it different levels of priority, with providers indicating they felt it was not a priority, while other stakeholders indicated that there was a significant need to enhance coordination across the various service providers. Additionally, stakeholders noted the need to improve coordination of care for individuals leaving inpatient psychiatric facilities. Stakeholders indicated that information such as mental health assessment and treatment history does not adequately follow clients from state inpatient psychiatric facilities to community mental health centers. This causes delays in treatment and can lead to duplication of services and is often an area of the service system where consumers “fall through the cracks.” CMHC staff noted that in many cases they are not informed of an admission or discharge so their ability to manage a consumer’s care is compromised. Additionally, there is a need to establish greater accountability of both the quality and timeliness of care provided to clients upon discharge from state hospitals.

A number of regional programs have been developed across the country to create more coordinated care among safety net providers. These initiatives focus on developing better-organized and coordinated service systems and tend to be designed to:

- Provide enrollees with a medical home;
- Offer some form of case management; and
- Produce patient information that can be shared among public and private providers.

The level of involvement of mental health providers varies, but at least some of these collaborations have explicitly included mental health representatives to ensure coordination across both mental health and physical health. The profile of the Indigent Care Collaboration in the Regional Models section provides more information on how mental health can be incorporated into these efforts.

**Finding 14: There are a high percentage of individuals in the criminal justice system who have behavioral health diagnoses and will need comprehensive services to be able to**

**successfully re-enter the community.** The Kansas City Missouri Correctional Institution (MCI) reports that there are a high percentage of individuals involved in their system who have a behavioral health disorder - approximately 60 percent of MCI's inmates have a mental illness and 80 percent of inmates have substance abuse problem. In addition, some studies indicate that approximately 86 percent are homeless or have only marginal housing supports.<sup>96</sup> This information points to the need for enhanced coordination between the jail and the mental health system. Significant efforts have been undertaken to coordinate mental health services for individuals at MCI. Funding from the Jackson County Community Mental Health Fund and the Healthcare Foundation of Greater Kansas City has enabled MCI to address the needs of individuals with mental illnesses. In addition, Kansas City has both mental health courts and drug courts to address the special needs of individuals who encounter the justice system with significant mental health and/or substance abuse issues. While there are limited strategies to divert individuals from the justice system prior to incarceration or to address recidivism, the community has made some infrastructure developments (e.g. mental health court, Partners in Crisis collaborative) on which to build a coordinated approach to the needs of individuals with behavioral health disorders who are known to the criminal justice system.

Previous needs assessments have addressed this issue. The Johnson County Mental Health Center's Strategic Plan for 2005-2006 indicated a need for more mental health services for the offender population, especially offenders with mental health and substance abuse issues.<sup>97</sup> While all stakeholders agreed that this was an issue worthy of addressing, various constituencies gave it different levels of priority, with providers indicating they felt this coordination was already occurring, while other stakeholders indicated that there was a significant need to enhance coordination for this population.

Nationally, individuals with mental illness are significantly overrepresented among the segment of the population in contact with the criminal justice system. Approximately 5 percent of the U.S. population has a serious mental illness; however, approximately 16 percent of the population in prison or jail has a serious mental illness.<sup>98</sup>

**Finding 15: Transportation is a major barrier to care.** Accessible transportation is necessary for people with disabilities to go to work, get an education, receive medical care, and to have an active, inclusive role in society. Across all available data sources, transportation was considered a key barrier to care. This is especially an issue in suburban and rural communities, where public transportation is lacking, although it was also noted as an issue in urban areas, particularly during "non-peak" times of day.

Several previous needs assessments have addressed this issue. The needs assessment for Jackson County around consumers with developmental disabilities found that accessible, affordable transportation was a key area of unmet need.<sup>99</sup> The Hospital and Home Initiative formed by Kansas to design the future mental health system found that lack of adequate transportation led

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<sup>96</sup> MCI survey of incarcerated women.

<sup>97</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*.

<sup>98</sup> Council of State Governments, "Criminal Justice / Mental Health Consensus Project – Full Report," June 2002, available at [http://consensusproject.org/downloads/Entire\\_report.pdf](http://consensusproject.org/downloads/Entire_report.pdf).

<sup>99</sup> R. Jensen, et al. *Needs Assessment: Developmental Disability Services of Jackson County (prepared for Empowering Individuals Through Advocacy and Support)*. UMKC Institute for Human Development. August 2007.

to delays in discharge for state psychiatric hospitals.<sup>100</sup> Stakeholders repeatedly noted that transportation was a major barrier to care and contributed to consumers' difficulty in accessing services and likely increased no-show rates. Stakeholders also noted that the way transportation is funded in the Access to Recovery Program (ATR) appears to be effective. ATR is a federally funded program that allows participating providers to reimburse transportation using either a mileage standard or a straight reimbursement for public transportation costs. The majority of respondents to the provider survey also noted that lack of transportation for consumers with mental illness, developmental disability and/or substance abuse is a "big problem".

Transportation was also one of the most frequently cited "greatest barriers to accessing available care" among respondents. Transportation issues were perceived to be even more acute by providers serving consumers with mental illness in the predominantly rural counties. Providers serving Cass, Clay, Leavenworth, Miami, Ray and Platte Counties cited transportation as a "big concern" 100 percent of the time, compared to a rate of approximately 93 percent for providers serving clients in the more urban areas of Jackson, Wyandotte and Johnson Counties. The same pattern exists for providers serving consumers with developmental disabilities and/or substance abuse disorders.

**Finding 16: The Kansas City region has become increasingly culturally diverse in recent years, prompting the need for strategies to address cultural and linguistic barriers to care.**

One of the challenges of growing diversity is to ensure that services are culturally and linguistically appropriate.

Previous needs assessments have addressed the changing demographics of the region. The Jackson County needs assessment found that while Hispanics make up only 5.3 percent of the population in Jackson County, compared to 12.5 percent nationally, the Hispanic population in the county is growing rapidly, doubling between 1990 and 2000 and that Hispanics are under-represented among users of Jackson County mental health levy providers. Local data also indicate that many mental health levy providers do not have the ability to serve non-English speaking clients.<sup>101</sup> While stakeholders noted the need for Spanish-language therapists and other providers, the need for other languages was noted as well. Although many providers who responded to the survey noted the lack of access to culturally or linguistically appropriate services as a problem and that language and culture posed a significant barrier to care, these issues were cited far less frequently than other barriers, such as transportation, funding and public awareness.

**Finding 17: Siloed funding across behavioral health and other programs used by behavioral health consumers makes it difficult to offer the type of flexible and unique services required by consumers and creates barriers to access to services as consumers must navigate multiple program's eligibility requirements.** The problems associated with siloed funding are not unique to the Kansas City region and are experienced by most communities. Stakeholders repeatedly noted the challenges consumers face in navigating a behavioral health system that due to its funding is inherently complex and fragmented.

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<sup>100</sup> Hospital and Home Initiative: Executive Summary and Action Plan. Kansas SRS Hospital and Home Core Team. June 3, 2008

<sup>101</sup> Mattie Rhodes Center, *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri*. June 2003

Previous needs assessments have noted the fragmentation of the system and the difficulty consumers can face in accessing services. Additionally, providers in the focus groups discussed the challenges they face in trying to provide services tailored to a consumer's needs that are outside of the narrowly defined services allowed for in various programs. The need for greater flexibility was a key and often repeated comment.

A number of programs have been developed in various parts of the country (three are profiled in this report<sup>102</sup>) that seek to address funding silos to create greater flexibility and coordination of care. While in many cases this type of flexibility requires a Medicaid waiver, programs have been developed that provide flexibility across regional providers without the requirement of a waiver.

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<sup>102</sup> See profiles for NorthSTAR, Wrap Around Milwaukee and Western New York Care Coordination Program.

## **RECOMMENDATIONS**

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The findings in this report provide behavioral health stakeholders in the Kansas City region with numerous opportunities to build on and enhance the existing system of care. The following recommendations are offered to provide a pathway by which the community can take critical next steps in improving the service delivery system. The recommendations offered are those we believe are appropriate for multi-county or regional participation and have the potential to result in significant impact for the community. Each recommendation is associated with one or more findings in this report.

### **Recommendation 1: Embed recovery practices and principles in the behavioral health service delivery system.**

Stakeholders should create a coalition to ensure that the principles and strategies associated with recovery are embedded in the service delivery system. The coalition should include significant representation from the consumer and family member community as well as service providers, local officials and other stakeholders. The stakeholders group, convened by MARC, may form the basis of such a coalition.

Because a focus on recovery involves both consumer involvement and implementation of evidence-based and other best practices, we recommend that the coalition 1) review existing processes to ensure that consumers and family members play a key role in the decisions that impact them, both at the individual and the systems level; and 2) evaluate the services array to ensure that key recovery-oriented evidence-based and promising practices are available region-wide.

To enhance consumer and family member involvement in the planning, governing, and evaluation of services, the coalition should consider strategies to increase consumer and family member participation on governing boards, agency advisory committees and key services planning groups. Consideration should be given to involving consumers in planning and implementing service evaluations such as consumer report cards.

Ensuring that the services array includes practices that promote recovery is another important strategy. Both peer support services and person-centered planning are effective practices to promote recovery. In addition, recovery oriented practices can be valuable tools to help address some the existing concerns identified by stakeholders during this needs assessment. For example, peer support strategies to ensure that individuals leaving inpatient facilities are provided with a peer support connection to help create a more effective connection to community-based services.

The Western New York Care Coordination program described earlier provides a model for organizational principles and strategies to accomplish this recommendation and provider training resources as well.

This recommendation relates to Finding 1.

### **Recommendation 2: Implement a community-wide initiative to address the critical need for housing for individuals with behavioral health disorders.**

Improving the availability of housing for people with behavioral health disorders was repeatedly cited as a major issue for the community, largely because both informants to this process, as well as national experts believe housing is often a prerequisite for successful engagement in

community-based behavioral health services. To address this, we recommend a coalition of consumers, advocates, county officials and other key stakeholders be charged with evaluating the feasibility of establishing a “housing first” approach in the Kansas City region. Consideration should be given to replicating the Pathways model, profiled in this report, or using the principles of this model to implement an approach customized to the needs of the Kansas City region. The coalition should take advantage of the technical assistance provided by Pathways.

This type of housing program can be started as a very small initiative with a limited number of units and expanded as resources allow. Foundations should be considered key partners in the planning of this program and approached for start-up funds. The community should create a process to measure outcomes (i.e. length of housing retention, impact on psychiatric inpatient utilization, etc) and cost effectiveness of this approach, which will be critical to securing additional support for program expansion.

This recommendation relates to Findings 2 and 5.

**Recommendation 3: Address the critical gaps in services and service capacity.**

While the Kansas City community has a basic foundation of needed services, there remain some critical gaps. These gaps can be viewed as occurring in three areas: gaps where services are not available, gaps due to lack of capacity in certain services and gaps where certain populations need either additional services or assistance in access existing services. While there were many gaps noted during this process, those that appear the most pressing are listed below and should be given initial priority:

Additional services or expanded service capacity should be developed in the following areas:

- Structured residential services for individuals with complex needs, particularly those with dual diagnoses, a history of aggressive behavior and those with forensic involvement. Creating this type of residential service will alleviate some of the demand for more acute services, such as inpatient hospitalizations and will also likely lessen the criminal justice involvement for this population.
- Evidence-based practices that focus on consumers with intensive needs. While services such as Assertive Community Treatment for adults or Multi-Systemic Therapy for youth are available in some parts of the region, they are not widely available. Efforts should be made to expand access to these types of evidence-based services across the region.
- Substance abuse services, particularly detox programs and services for women and youth.
- Crisis services, particularly around expansion of community- based crisis stabilization services, such as crisis respite services.

Need for focused assistance to certain populations:

- Young adults transitioning from children’s services to adult services, which tend to have both more narrow service offerings and more narrowly drawn eligibility criteria.
- Non-English speaking populations.
- Older adults.
- Individuals with developmental disabilities who also have mental health or substance abuse disorders.

Finally, there should be a community-wide review of ways to both increase after hours care where it is most needed and to promote its availability among consumers.

To address this recommendation, the Stakeholder Group convened by MARC should implement a five-year plan to address these gaps in services. For each service area, the plan should articulate an incremental implementation strategy, name a “lead” entity; identify the services linkages that must be in place to ensure continuity of care and efficiency; and the cost of implementation. In addition, the Stakeholder Group should ensure that services are responsive to the growing diversity in the Kansas City metropolitan area and that planning for services includes representation of the ultimate users of services.

The Stakeholder Group should also be charged with identifying efficiencies (e.g. opportunities to decrease behavioral health consumers’ use of the region’s emergency departments for care that can more appropriately and more cost-effectively be provided in alternative settings) that can be achieved by streamlining the operation of existing services. Any savings that accrue from these efficiencies or other changes in the service delivery system should be directed to financing efforts to fill these gaps in the services array.

This recommendation relates to Findings 3, 6, 8, 9, 10, 14 and 16.

**Recommendation 4: Ensure that behavioral health services are a central component of community efforts to coordinate and manage healthcare and social services.**

While the Kansas City community has already taken steps to create linkages and coordination of various safety net services, it is critical that future activities include behavioral health services. Given that behavioral health needs drive a substantial amount of physical health utilization and expenditures, inclusion of behavioral health and community health collaborations is essential. A successful collaborative effort will ensure that behavioral health providers are actively working with physical health and other social service providers to jointly collect data, develop community-wide initiatives to enhance coordination and jointly review data to refine strategies. Thus, existing community coalitions, such as KC Care Link, should be expanded to include behavioral health providers and consumers.

Inclusion of behavioral health services into larger community health coordination efforts should also ensure that behavioral health is also fully integrated into community efforts to develop health information technologies<sup>103</sup>. Ensuring that consumers’ medical information can be shared across physical and medical providers is a critical component of developing effective care management strategies and reducing duplication. While attention needs to be paid to confidentiality concerns, these are not, and should not be allowed to become, a barrier to this level of coordination.

Examples of activities that should be addressed by a community coalition include:

- Developing strategies that ensure that referrals between service providers result in successful access to services. This may include developing strategies to enhance

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<sup>103</sup> There are a number of state and regional initiatives that can inform sharing of patient information across providers, including the Indigent Care Coalition profiled in this report. Another promising approach, although still in development form and therefore not profiled in this report, is the efforts by the State of Texas to develop a shared patient record across substance abuse and mental health providers. This platform has been successfully developed to improve patient record keeping and billing for substance abuse providers and expansion to mental health providers is now being developed. For more information, see: <http://www.dshs.state.tx.us/cmbhs/default.shtm>

information sharing, not just among community mental health centers, but between CMHCs and other community providers as well.

- Implementing strategies that help consumers navigate the system successfully, including use of peer supports.
- Identifying the critical junctures at which individuals need support to navigate the system (such as inpatient discharge and jail release), and develop targeted strategies to ensure that people are linked with and access the services they need; and
- Ensuring that critical non-clinical supports (such as access to SSI, child care assistance, domestic violence services) are available and accessible and well-integrated with clinical services.
- Including behavioral health services in any reference or educational materials developed to help consumers or other community members navigate the region's health and/or social services system.

The Stakeholder Group convened by MARC is a logical group to give responsibility for mapping the connectivity between and among services and to develop broadly acceptable processes and protocol to ensure that these linkages are successful.

This recommendation relates to Finding 11 and 13.

**Recommendation 5: Expand strategies to improve the integration of behavioral health and physical healthcare services.**

The Kansas City region, particularly on the Missouri side, has undertaken a variety of initiatives to enhance integration of physical and behavioral healthcare. These efforts should be reviewed to determine the most effective approach for expanding integrated care across the region. A broad-based community initiative, coordinated with these ongoing strategies, should be undertaken to improve the integration of physical health and behavioral health services. Strategies to determine what entities will be responsible for providing and managing care, such as the Four Quadrant model, should be developed. To help ensure that this process is reflected in community-wide activities related to health system improvement, existing community coalitions that include behavioral health stakeholders, as discussed in Recommendation 3, should help inform how the integration strategies are implemented.

Any integration efforts should capitalize on the financial advantages enjoyed by FQHCs and FQHC look-alikes, such as 340B medication pricing and cost-based reimbursement for services. These financial advantages can yield both savings over care provided in other settings and bring in additional federal funds to the region that can be used to help support broader integration efforts. This is not to say that integration efforts should exclusively focus on FQHCs, but that they should be certain to ensure that FQHCs play a key role.

This recommendation relates to Finding 7.

**Recommendation 6: Develop a region-wide plan to improve transportation to increase individuals' access to behavioral healthcare services.**

Lack of reliable and accessible transportation was repeatedly cited as a barrier to services. To address this barrier, we recommend that MARC, which already plays a major role in coordinating the region's transportation initiatives, convene a group to address the specialized

transportation needs of individuals with behavioral health needs. We recommend that the group review possible models of transportation supports, including those profiled in this report, and develop a plan to implement those that are considered to be the most feasible for the region. Urban communities which already have a relatively robust transportation infrastructure should consider options that build on existing transportation approaches (such as the half fare program), while rural areas will likely require more tailored approaches that create new means of transportation such as vouchers or volunteer drivers, or expand the use of telemedicine to avoid the need for transportation.

This recommendation relates to Finding 15.

**Recommendation 7: Address the barriers created by siloed funding by developing approaches to increase flexibility through the use of regional or statewide funding strategies, such as braided or blended funding pools.**

Tackling funding silos is often one of the most challenging, but also most critical, components of achieving system reform and improvement. However, there are a number of avenues that the Kansas City region can pursue. Some of these would require significant statewide policy changes, such as pursuing Medicaid waivers that combine multiple federal, state and local funds.<sup>104</sup> Others would still likely require statewide participation, but can be done without a Medicaid waiver if community providers across multiple systems can agree to pooling some percentage of service funds to be used for agreed upon array of flexible services. The Western New York Care Coordination program profiled earlier provides an example for this type of non-waiver strategy. Regardless of whether a Medicaid waiver is part of the strategy to address funding silos, doing so has the effect of creating more efficient and flexible delivery systems that enable communities to stretch limited resources.

This recommendation relates to Findings 4 and 17.

**Recommendation 8: Develop a process to regularly collect, distribute and evaluate key measures of the region's behavioral health system performance.**

As a means of assessing the performance of the system of care, the community should establish a series of metrics to assess the success of the service delivery system and serve as a guideline for change when needed.

The following measures are suggested as possible metrics to assess the baseline and continuing performance of the Kansas City region regarding the area's ability to meet the behavioral health needs of its citizens. These suggested measures would offer a baseline against which to judge the impact of any future changes to the delivery system. Additionally, regular monitoring of these measures can help the community proactively identify areas where attention is needed and where the community may want to develop a collaborative solution.

1. Readmissions to state psychiatric hospitals within 7 days and within 30 days.
2. Readmission to non-state psychiatric hospitals within 7 days and within 30 days.
3. Number of clients with more than 3 admissions to state psychiatric hospital within 180 days.

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<sup>104</sup> See the description of the NorthSTAR program provided in this report. Additional information is also available at: <http://www.dansatx.org/whatisnorthstar.htm>

4. No-show rates for community mental health center services: -
  - a. All clients
  - b. Clients with first appointment following discharge from a state psychiatric hospital
  - c. SMI clients
  - d. Non-SMI clients
5. Wait time
  - a. Length of time from assessment to first appointment
  - b. Length of wait for a select number of critical services
6. Percentage of CMHC clients who used peer support in the previous 12 months
7. Percentage of CMHC clients with a primary care visit in the previous 12 months
8. Percentage of CMHC clients with more than 2 ED visits within the previous 23 months
9. Utilization of best practices, such as ACT and MST

These measures should be collected by a single entity that has the community-wide credibility as an objective and trusted source of information, such as MARC. Once the data collection process is fully developed, the measures should be published for the community. This process of making the data public will ensure attention is paid to areas where improvement is needed and will act as a strong incentive for continued commitment to system improvement.

This recommendation relates to Finding 12.

## **APPENDICES**

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### ***Appendix A – Key Informant Interviews***

Bruce Eddy, Executive Director, Jackson County Community Mental Health Fund

Alan Flory, Chief Executive Officer, ReDiscover Community Mental Health Center

Nancy Leazer, Superintendent of Corrections, Kansas City Municipal Correctional Institution

John Wickizer, Correctional Supervisor, Kansas City Municipal Correctional Institution

Mike Barnett, Qualified Mental Health Professional, Kansas City Municipal Correctional Institution

Stephanie Boyer, Drug Court Coordinator, Kansas City Municipal Correctional Institution

Rebecca Wood, Public Administrator, Jackson County

David Wiebe, Director, Johnson County Mental Health Center

Anne Lessor, Director, Kansas City Homeless Coalition

Marsha Morgan, Chief Operating Officer, Truman Behavioral Health

Susan Lewis, Director, Mental Health America of the Heartland

Randy Johnson, Senior Director, Advocacy and Recovery Services, Mental Health America of the Heartland

Guyla Stidman, Executive Director, NAMI-KC

Jake Jacobs, Director, EITAS-Developmental Disability Services of Jackson County

Diane McFarland, Director, Missouri Department of Mental Health Transformation

Mary Ellen O'Brien Wright, Medicaid Infrastructure Grant Program Director, Kansas Department of Social and Rehabilitative Services

Deborah Stidham, Kansas Department of Social and Rehabilitative Services

Rick Shults, Kansas Department of Social and Rehabilitative Services

Sandy Harshman, Kansas Department of Social and Rehabilitative Services

***Appendix B – Focus Group Participants***

Craig Kindigar, ReStart, Inc

Vicki Cederburg, The Family Conservancy

Sarah Thibault, KC Rescue Mission

Terry Trafton, Truman Medical Center Behavioral Health

Nancy Micolaus, EITAS

Charles Megerman, KC Community Center

Dorothy Loyd, Cornerstones of Care

Rebecca Wood, Public Administrator

Ron Griffin, NCADD

Bruce Eddy, Jackson County Community Mental Health Fund

Jen Boyden, NAMI-KC

Randy Johnson, Mental Health America Heartland

Sheryl Dysvick, Shelfield Place

Steve Jolly, Research Psychiatric Center

Pat Larson, KC Free Health Clinic

Caroline Germann, Veronica's Voice

Judge John Williams, KC Municipal Court

Iberty Gedeon, Mattie Rhodes Center

Susan Crane Lewis, Mental Health America Heartland

Marsha Morgan, Truman Medical Center Behavioral Health

Tom Cranshaw, Tri-County Mental Health Services

John Fierro, Mattie Rhodes Center

David Wiebe, Johnson County Mental Health Center

Ashley Drake, NAMI KC

Nancy Leazer, MCI

Joann Werner, Tri-County Mental Health

Andrea Perdomo-Moralfs, Mattie Rhodes Center

Jacqui Moore, MARC, Jackson County MHB

William Kyles, Comprehensive Mental Health Services

Gloria Joseph, Swope Health Services

Cathy Hiersteiner, Metropolitan Organization to Counter Sexual Assault

Ron Griffin, NCADD

Larry Aaron, NAMI

George Norman, Westerns District Drug and Alcohol Abuse

Rita Witt, Hope House

Mary Ellen Schaid, Gillis Home for Children

Nancy White, Truman Medical Center

Betsy Topper, REACH Foundation

Daniel Williams, Truman Medical Center

Judy Thompson, Catholic Charities

Marilyn Wheery, Swope Health Center

Marsha Morgan, Truman Behavioral Health

*Note: HMA agreed not to disclose the names of the consumers who participated in the two consumer focus groups.*

**Appendix C – Overview of State Systems**

	<b>Kansas</b>	<b>Missouri</b>
Total Population <sup>105</sup>	2,709,400	5,790,190
Total Medicaid Spending, FY '06	\$2,077,616,164	\$6,477,005,485
Total Medicaid Enrollment, FY '05 <sup>106</sup>	352,200	1,206,400
Medicaid Enrollment as Percent of Total Population, <sup>107</sup>	13%	14%
Per Capita Medicaid Expenditures	\$5,899	\$5,369
Medicaid Eligibility, 2008 (as % FPL) <sup>108</sup>	Working Parents = 34%; Pregnant Women/Infants = 150%; Children Age 1-5 = 133%; Children Age 6-19 = 100%	Working Parents = 39%; Pregnant Women/Infants = 185%; Children Age 1-5 = 150%; Children Age 6-19 = 150%
How is Medicaid eligibility linked to disability status?	In the majority of states, disability determination for SSI automatically makes an individual eligible for Medicaid (these states are referred to as 1634 states). Kansas is a “SSI criteria” state, which means that the State uses the same Medicaid eligibility criteria for their aged, blind, and disabled SSI recipients as are used for the SSI program, but require that these individuals apply to the State separately from their application for SSI to determine their Medicaid eligibility based upon that application. <sup>109</sup>	Missouri is a “209b” state, which means Medicaid eligibility requires a separate application from disability determination. Section 209b states exercise an option that allows states to use their 1972 financial and non-financial standards instead of the federal SSI standards to determine eligibility for the disabled. If a state uses its more restrictive 1972 financial eligibility standards, it must also allow disabled individuals to "spend down" into Medicaid eligibility by deducting incurred medical expenses from income. <sup>110</sup>
SCHIP Eligibility (based on family of 3), 2008 <sup>111</sup>	200%	300% ( <i>Missouri does not have a separate SCHIP program</i> )

<sup>105</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>106</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>107</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>108</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>109</sup> Medicaid Eligibility – States with Own Criteria retrieved from [http://www.workworld.org/wwwwebhelp/medicaid\\_eligibility\\_states\\_with\\_own\\_criteria.htm](http://www.workworld.org/wwwwebhelp/medicaid_eligibility_states_with_own_criteria.htm)

<sup>110</sup> Medicaid Eligibility – States with Own Criteria retrieved from [http://www.workworld.org/wwwwebhelp/medicaid\\_eligibility\\_states\\_with\\_own\\_criteria.htm](http://www.workworld.org/wwwwebhelp/medicaid_eligibility_states_with_own_criteria.htm)

<sup>111</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

	Kansas	Missouri
State Psychiatric Hospital Beds, 1998 <sup>112</sup> <sup>113</sup>	592	1,411
County and State Psychiatric Hospitals, Inpatient Census, 2000 <sup>114</sup>	459	1,408
State Mental Health Agency, Mental Health Services Expenditures, FY '05 <sup>115</sup>	\$253,700,000	\$414,012,967
State Mental Health Agency, Per Capita Expenditures, FY '05 <sup>116</sup>	\$93	\$72
Priority/Target Population for Non-Medicaid, State-Funded Mental Health Services	<p>The Rehabilitation Act, Public law 93-112, established policy which prioritized services for persons with severe disabilities.<sup>117</sup></p> <p>Kansas Department of Social and rehabilitation services divide's the state into 6 different regions. Each CMHC provides a complete range of outpatient services to <i>the adult mental health target population (SPMI)</i>, <i>children mental health target population (SED)</i> as well as others needing less intensive mental health services.<sup>118</sup></p>	<p>Missouri's mental health system is committed to serving four target populations: persons with serious and persistent mental illness, persons suffering from acute psychiatric conditions, children and youth with serious emotional disturbances, and forensic clients. In addition, CPS has identified four priority groups within the target populations: (1) individuals in crisis, (2) people who are homeless, (3) those recently discharged from inpatient care, and (4) substantial users of public funds. These target populations currently constitute the majority of clientele whom the division serves both in inpatient and ambulatory settings.</p> <p>The division divides Missouri into 25 service areas. Each service area has a community mental health center which provides psychiatric services to individuals in need and is designated as the division's administrative agent.</p>

<sup>112</sup> Number of state and county psychiatric inpatient beds. Includes state and local hospital beds only. Inpatient beds in for-profit hospitals are not included in data.

<sup>113</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>114</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>115</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>116</sup> State Medicaid Fact Sheet, The Kaiser Commission on Medicaid and the Uninsured, Extracted October 9, 2008 from <http://www.kff.org/MFS/>.

<sup>117</sup> History of the Kansas Department of Social and Rehabilitation Services (SRS) retrieved on October 14, 2008 from <http://www.srskansas.org/25Anniv.htm>.

<sup>118</sup> Kansas Uniform Application - State Plan Community Mental Health Services Block Grant, Fiscal Year 2009.

	Kansas	Missouri
		These administrative agents serve as the primary entry and exit point for state mental health services. The agents are responsible for the assessment and services provided to both adults and children in their assigned areas and for providing follow-up services for individuals released from state operated inpatient hospitals. <sup>119</sup>
Medicaid Covered Mental Health Services	The following services constitute the array of Medicaid funded Community Mental Health Services provided by the mental health managed care program: <sup>120</sup>  Outpatient Therapy Community Psychiatric Supportive Treatment (CPST) Psychosocial Rehabilitation Peer Support Crisis Intervention Targeted Case Management. Attendant Care Case Conference	Programs and Services: <sup>121</sup>  Access Crisis Intervention Outpatient Community-Based Services Targeted Case Management Day Treatment/Partial Hospitalization Residential Care/Community Placement Inpatient (hospitalization) Respite Treatment Family Homes Program Community Psychiatric Rehabilitation (CPR)
Medicaid Buy-In	Yes  Enrollment as of November 2008 is 1,087 <sup>122</sup>	Yes  Enrollment as of December 2008 is 1,452.  Note, the program was discontinued and reinstated in 2007, with significantly narrower eligibility criteria. <sup>123</sup>
State-specific reporting requirements of CMHCs	CMHCs report demographic, client status and service encounter data through AIMS for adults and children/adolescents. <sup>124</sup> The Automated Management Information System (AIMS) website contains specific Data Reporting Requirements at <a href="http://www.srskansas.org/hcp/MHSIP/MH_SIPAIMS.htm">http://www.srskansas.org/hcp/MHSIP/MH_SIPAIMS.htm</a> .	CMHCs are required to collect, maintain, and report information including but not limited to diagnosis, level of functioning, list of individuals requesting services and disposition of same, outcomes, and quality improvement indicators as may be required and defined by the Division. <sup>125</sup>

<sup>119</sup> The Missouri Budget, Fiscal Year 2007, retrieved October 21, 2008 from <http://oa.mo.gov/bp/budg2007/MentalHealth.pdf>.

<sup>120</sup> Kansas 2009 Mental Health Block Grant Application

<sup>121</sup> Programs and Services, Department of Mental Health website, retrieved October 21, 2008 from <http://www.dmh.mo.gov/cps/progs/programs.htm>

<sup>122</sup> Telephone interview with Mary Ellen O'Brien, Medicaid Infrastructure Grant Program Director, Kansas.

<sup>123</sup> Telephone interview with Mary Ellen O'Brien, Medicaid Infrastructure Grant Program Director, Kansas.

<sup>124</sup> Consolidated Contract for Community Mental Health Center, July 2008 version.

<sup>125</sup> CMHC Final Contract, 2008.

	Kansas	Missouri
State-Required Services	<p>“Community Mental Health Centers (CMHCs) participating in the Special Purpose Consolidated Contract (SPCC) must provide all medically necessary services to all persons with mental illness, especially persons in the target populations, who present themselves for service regardless of their ability to pay consistent with K.A.R. 30-60-1 et seq. and K.A.R. 30-61-1 et seq.” “All youth with a SED will have access to a complete array of mental health services and supports provided within a family centered system of care.”<sup>126</sup> In addition, the following link contains a list of the service codes most commonly used by CMHCs:  <a href="http://www.srskansas.org/hcp/MHSIP/AIMS/appendix_c.pdf">http://www.srskansas.org/hcp/MHSIP/AIMS/appendix_c.pdf</a></p>	<p>The contractor shall provide necessary and appropriate services to the target population; Provide service coordination, crisis services (24 hours a day, 7 days a week), medication services, and medication administration services; maintain a certified Community Psychiatric Rehabilitation (CPR) program for both adults and children and youth, and a designated Targeted Case Management (TCM) program for adults and children and youth; and maintain or be responsible for the provision of a 24 hour a day, 7 day a week crisis intervention system available to all persons within the limits of the contractor’s Access Crisis Intervention (ACI) allocation.<sup>127</sup></p>
State Requirements for Follow-Up Care Post Discharge (i.e., timeframe for follow-up, info that follows client from hospital to CMHC)	<p>“The CMHC will: (1) actively participate in admission and discharge decisions and in treatment planning concerning persons from the CMHC’s catchment area who are served in a state mental health hospital, nursing facility for mental health (NF/MH), or psychiatric residential treatment facility (PRTF); (2) offer medically necessary community mental health services and supports to persons discharged from a state mental health hospital, NF/MH, or PRTF and, if the person accepts services, the CMHC will provide such services in a timely manner; (3) cooperate in implementing recommendations made by the Hospital and Home Initiative Core Team within available resources.”<sup>128</sup></p>	<p>CMHCs must provide a continuing care appointment within 14 days for any individual who is not an existing client of the contractor, or sooner if clinically indicated, following discharge for persons who are discharged from a CPS inpatient facility or residential center or from a CPS inpatient facility emergency room.<sup>129</sup></p>

<sup>126</sup> Consolidated Contract for Community Mental Health Center, July 2008 version. .

<sup>127</sup> CMHC Final Contract, 2008.

<sup>128</sup> Consolidated Contract for Community Mental Health Center, July 2008 version.

<sup>129</sup> CMHC Final Contract, 2008.

**Appendix D – Results of Survey of CMHCs**

The community mental health centers in the Kansas City area have worked together to identify the range of services CMHCs provide to the community and have incorporated this information into a template. This survey builds on that original work to identify specific components of key services to develop a comprehensive picture of available and unavailable behavioral health services in the region. Following are results by service area.

**Crisis/Emergency Services**

	Crisis Intervention Teams	Crisis Stabilization	Crisis Respite	Hotline	Mobile Crisis Outreach Teams	Other
Comprehensive	x	x	x	x	x	
Johnson County	x		x	x	x	x Hospital liaisons
ReDiscover	x			x	x	x Hospital liaisons
Swope	x				x	
Tri-County	x	x	x	x	x	
Truman	x		x	x	x	
Wyandot	x		x	x	x	

**Housing/Residential**

	Residential Treatment Center	Supportive Housing	Transitional Housing	Other Residential	Social Detox.
Comprehensive	x	x	x	x	x
Johnson County		x			x
ReDiscover		x	x		
Swope		x			
Tri-County	x	x	x		x
Truman		x	x		
Wyandot		x	x		

**Outpatient Treatment - Mental Health**

	ACT	Case Mgt.	Counseling Therapy	Diagnosis, Assessment, Txt Planning	Day txt	Integrated dual diag. txt	Med. Mgt.	Partial Hospitalization
Comprehensive		x	x	x	x	x	x	x
Johnson County	x	x	x	x		x	x	
ReDiscover		x	x	x	x	x	x	x
Swope		x	x	x	x		x	
Tri-County		x	x	x	x	x	x	x
Truman	x	x	x	x		x	x	
Wyandot		x	x	x		x	x	

Notes:

*ReDiscover reported that demand exceeds availability*

*Swope reported that 1-2 month waits for counseling/therapy, Diagnosis/assessment/treatment planning and medication management*

**Outpatient Treatment - Substance Abuse**

	Continuing Care and Wraparound	Counseling Therapy	Intensive Outpatient (IOP)	Medication assisted txt	Screening and Brief Intervention
Comprehensive	x	x	x	x	x
Johnson County	x	x	x		x
ReDiscover		x	x	x	
Swope	x	x	x	x	
Tri-County	x	x	x	x	x
Truman		x		x	x
Wyandot		x			x

*Note: One center reported a serious shortage of intensive substance abuse treatment.*

**Recovery/Maintenance Services**

	Community Psych. Supportive Txt	Supported employment	Family Psycho-education	Illness Management & Recovery	Peer Support	Psycho-social Rehab.	Sub. Abuse Relapse Prevention
Comprehensive	x	x	x	x	x	x	x
Johnson County	x	x	x	x	x	x	x
ReDiscover	x				x	x	x
Swope	x		x	x	x	x	x
Tri-County	x	x	x	x	x	x	x
Truman	x	x			x	x	x
Wyandot	x		x	x	x	x	

**Other Key Services/Best Practices**

	MST	FFT	Txt Foster Care	School based Services	In Home Services	Tele-medicine
Comprehensive		x	x	x	x	x
Johnson County				x	x	
ReDiscover				x	x	
Swope		x		x	x	
Tri-County				x	x	
Truman				x	x	
Wyandot	x	x		x	x	

*MST – Multisystemic Therapy; FFT – Functional Family Therapy; Txt. Foster Care – Multi-dimensional Treatment Foster Care*

Appendix E - Summary of Previous Needs Assessment Conducted for the Areas within the Kansas City Region

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
Mental Health	<p>MO DMH reduced funding for homeless outreach, cut non-Medicaid services (e.g., supported employment, individual and group therapies) in half, ended funding for school-based intervention projects and eliminated psychiatric medications for individuals in alcohol and drug treatment programs. Also significant budget cuts at Western Missouri Mental Health Center. Psychiatric beds cut from 11.9/10,000 in 1997 to 7.8/10,000 in 2002. High staff turnover noted as serious concern. Community agency staff reported significant difficulties in obtaining beds for patients. Significant challenges also noted in obtaining medications as well as crisis intervention services.<sup>1</sup></p> <p>Families and Consumers rated overall care at the four Community Mental Health Centers in Jackson County as good or very good, though ratings</p>	<p>National studies have found that Latinos are more likely to use mental health services only in a crisis and are more likely to drop out of services sooner and have undesirable treatment outcomes, especially if the mental health system is not culturally and linguistically competent. Local data indicates that Hispanics are under-represented among users of Jackson County mental health levy providers. Local data also indicate that many mental health levy providers do not have the ability to serve non-English speaking clients.<sup>13</sup></p> <p>Report cites a general need (not localized to the Kansas City region) for more culturally and linguistically appropriate care, as well as a need for outcome measures that are appropriate for this population. Report also cites need for additional public and</p>	<p>Lack of crisis beds noted in Jackson County for uninsured children was cited as an important issue, according to child mental health agency staff as was difficult access to CMHCs for uninsured.<sup>16</sup></p> <p>School district staff rate mental health services as “fair” to “good” and crisis services slightly higher (though some were not even aware of crisis services). Improved communication between school district personnel and mental health system was identified as an issue, as was the need to recruit more child mental health professionals.</p> <p>Cass County - Lack of mental health and substance abuse services for children cited as lacking by focus group participants.<sup>17</sup></p> <p>Lafayette County - Lack of mental health and substance abuse services for children cited as</p>	<p>Missouri Division of Senior Services staff rated mental health services in Jackson County between “poor” and “fair.”<sup>20</sup></p> <p>Access to the community mental health system or Western Missouri Mental Health Center was rated as “impossible” or “difficult” by half of survey respondents with Medicaid. Ease of obtaining referrals for social services ranged from “occasionally easy” to “difficult.”</p> <p>Allen County - Anecdotal reports indicate restricted access to geriatric psychiatric services.<sup>21</sup></p> <p>Johnson County - Interviews with community stakeholders indicated a need for more mental health services for seniors.<sup>22</sup></p> <p>Clay, Platte and Ray Counties – Highest ranking needs included coordinated care for</p>	<p>Homeless identified as population in need of more services, as was need to better transition incarcerated individuals into mental health system<sup>24</sup>.</p> <p>46% of survey respondents in Jackson County used ER for mental health issues (compared to 21% for non-homeless).<sup>25</sup></p> <p>Interviews with community stakeholders in Johnson County indicated a need for more mental health services for the offender population, especially offenders with mental health and substance abuse issues.<sup>26</sup></p> <p><b>Recommendations:</b></p> <p>Better coordinate mental health and substance abuse and substance abuse systems; incorporate shelters and correctional system in this discussion.</p> <p>Seek strategies to minimize re-admission rate for those with</p>	<p>Homeless identified as population in need of more services, as was need to better transition incarcerated individuals into mental health system<sup>27</sup>.</p> <p>JCMHC strategic plan includes two objectives: 1) maximize use of current services and resources; and 2) increase funding for services to keep pace with expanding demand. Key strategies under Objective 1 include improving service coordination for persons with concurrent diagnoses, completing development of an EMR and other technologies to increase efficiency; and creating mechanisms to assure that all adults with SPMI and children with SED have access to community-based services when indicated.<sup>28</sup></p> <p><b>Recommendations:</b></p> <p>Develop strategies to streamline the transition from corrections to</p>

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
	<p>somewhat lower for CIT services. Ease of receiving therapy and services was generally “difficult” or “occasionally easy.” Many patients indicate they have gone without their medication and/or have had difficulty obtaining medication. In general, fewer MH resources are available in Eastern Jackson County than in KC.<sup>2</sup></p> <p>The state DMH is in the midst of plan to transition Western Missouri Mental Health Center (75 adult beds, 10 child beds) to Truman to improve reimbursement and reduce costs. The plan calls for the majority of the WMMHC appropriation (approx. \$15M) to be re-directed to community based services (some funds eligible for match). A work group is currently working out details, including uses of redirected funds.<sup>3</sup></p> <p>Wyandotte County residents appear to have a substantial problem with depression and there may be too few psychiatrists to meet the need. Suicide</p>	<p>private financial support of mental health services, and more sophisticated data collection and outcomes monitoring to measure the effectiveness of mental health treatment and prevention efforts<sup>14</sup></p> <p>Need for more interpreters, training for MH providers in cultural competency, more resources for immigrants in Jackson County.<sup>15</sup></p>	<p>lacking by focus group participants.<sup>18</sup></p> <p>Clay, Platte and Ray Counties – Highest ranking needs included counseling/therapy, substance abuse services, crisis response availability for youth and their families, suicide prevention targeted to youth and care management.<sup>19</sup></p> <p><b>Recommendations:</b></p> <p>Look at strategies to increase inpatient beds for children.</p> <p>Develop strategies for recruiting more child mental health professionals.</p> <p>Improve communications between school district personnel and the mental health system.</p>	<p>individuals with co-occurring mental illness and Alzheimer’s disease or dementia, medical homes for older adults, counseling/therapy, coordination of physical health and mental health care, and housing for those with serious mental illnesses.<sup>23</sup></p> <p><b>Recommendations:</b></p> <p>Address communication issues between the Missouri Division of Senior Services and Access Crisis Intervention services.</p> <p>Train Division case managers in mental health issues and train Comprehensive Psychiatric Services case managers in elderly issues.</p>	<p>serious mental illness.</p> <p>Examine strategies to improve and expand detox services.</p> <p>Identify gaps in existing programs for homeless persons and children of persons who are homeless or incarcerated.</p> <p>Develop strategies to streamline the transition from corrections to mental health treatment.</p> <p>Evaluate access to medications for individuals who are incarcerated or homeless.</p>	<p>mental health treatment.</p> <p>Address communication issues between the Missouri Division of Senior Services and Access Crisis Intervention services.</p> <p>Train Division case managers in mental health issues and train Comprehensive Psychiatric Services case managers in elderly issues.</p> <p>Improve communication between school district personnel and the mental health system.</p>

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
	<p>rate is 50% higher than state average. Number of psychiatrists per 10,000 population is 64% lower than Johnson county.<sup>4</sup></p> <p>Cass County - Lack of mental health services (including inpatient) cited as insufficient in focus groups.<sup>5</sup></p> <p>Lafayette County - Lack of mental health services (including inpatient) cited as insufficient in focus groups.<sup>6</sup></p> <p>Allen County - Mental health status of residents overall is better than surrounding counties; less depression and contemplation of suicide. There are no psychiatrists practicing in the county, but it is served by a CMHC.<sup>7</sup></p> <p>Johnson County - County is adequately served by psychiatric providers.<sup>8</sup> However, many indicated long wait times for appointments at the Johnson county Mental Health Center, and more recent data from the Johnson County Mental Health Center indicates that its number of</p>					

	Access/Lack of Services					Coordination
	General	Latino	Children	Seniors	Homeless/Incarcerated	
	<p>psychiatrists has grown at half the rate of its growth in services provided. The JCMHC reports a 52 percent increase over the last 10 years in the number of mental health crisis contacts and significant growth in the number of patients with SPMI. State hospital bed utilization in 2004 was 135% of the number of beds allocated to Johnson County by the state. The number of psychiatric beds in community hospitals continues to decline.<sup>9</sup></p> <p>Allen, Johnson and Lafayette Counties are each served by a CMHC; users of community-based mental health support services appear highly satisfied with the services received.<sup>10</sup></p> <p>SRS formed a Hospital and Home Initiative Core Team to determine if KS has enough inpatient mental health beds and to design the desired future for KS mental health services. The Team found that individuals in state hospitals included a high number of persons with</p>					

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
	<p>addictions and a significant number of persons who were not previously associated with a CMHC. They also found wide variance in the amount of services received prior to admission and after discharge, and delays in discharge due to a lack of safe and affordable housing and adequate transportation.<sup>11</sup></p> <p>Clay, Platte and Ray Counties – Substance abuse services, counseling/therapy, access to medications and housing.<sup>12</sup></p> <p><b>Recommendations:</b></p> <p>Examine strategies to increase number of beds available in Jackson County, including strategies to ensure beds aren't temporarily closed down due to lack of staffing.</p> <p>Examine strategies to reduce staff turnover in the mental health system.</p>					
Substance Abuse/Co-occurring MH/SA	Jackson County has a significantly higher rate of hospitalization due to alcohol and SA disorders compared to statewide		Cass County - Lack of mental health and substance abuse services for children cited as lacking by focus group			MH/SA system in Jackson County seen as fragmented; not coordinated. <sup>34</sup>

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
	<p>average.<sup>29</sup></p> <p>The number of individuals in Missouri receiving both SA and MH treatment has doubled, from 6.9% in 1999 to 14% in 2002. All types of respondents noted it is very difficult to find programs that cover co-occurring disorders, especially if uninsured or undocumented (nearly half said access to drug treatment centers was “difficult” or “impossible.” Lack of detox beds and supportive services (e.g., housing) cited.<sup>30</sup></p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>• Two-thirds of homeless shelters noted difficulties in obtaining detox services;</li> <li>• Shelters noted they lacked staff to work with individuals with co-occurring disorders.</li> <li>• Some mental health individuals will not accept individuals with co-occurring disorders until the substance abuse issue has been addressed;</li> </ul>		<p>participants.<sup>31</sup></p> <p>Lafayette County - Lack of mental health and substance abuse services for children cited as lacking by focus group participants.<sup>32</sup></p> <p>Interviews with community stakeholders in Johnson County indicated a need for more and better substance abuse services, especially for teens, in partnership with schools and courts.<sup>33</sup></p>			<p><b>Recommendations:</b></p> <p>Better coordinate mental health and substance abuse and substance abuse systems; incorporate shelters and correctional system in this discussion.</p>

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
MR/DD	<p>2% of Jackson county population is developmentally disabled; prevalence rate consistent over the years; approximately 24-27% of these individuals are served by DMH/MRDD, and 21% of families of adults with developmental disabilities reported their family member received waiver funding.<sup>35</sup></p> <p>Key areas of unmet need in Jackson County include support with social relationships, employment and housing, as well as accessible, affordable transportation.<sup>36</sup></p> <p>Lafayette County - Lack of services for individuals with MR/DD cited in Lafayette County focus group.<sup>37</sup></p> <p>Interviews with community stakeholders in Johnson County indicated a need for better services for individuals with dual mental health/developmental disability diagnoses, particularly children with autism spectrum disorder.<sup>38</sup></p>		<p>Families in Jackson County reported a need for respite services and more transitional services for children transitioning from school to adulthood.<sup>39</sup></p>	<p>Services for seniors in Jackson County with MR/DD cited as an area of need.<sup>40</sup></p>		<p>Families in Jackson County want service coordination to be more relationship-based as characterized by service coordinators actively listening to and working with families to connect individuals with disabilities to needed services, supports and opportunities. However, the current system makes this challenging.<sup>41</sup></p> <p>Dual diagnosis MH/MRDD population often falls through the cracks and are referred back and forth between Comprehensive Psychiatric Services and the Division of MR/DD.<sup>42</sup></p>

	Access/Lack of Services				Homeless/Incarcerated	Coordination
	General	Latino	Children	Seniors		
	<p><b>Recommendations:</b></p> <p>Expand and enhance the array of housing and employment options.</p> <p>Provide relationship-based service coordination.</p> <p>Increase availability of continuing education.</p> <p>Increase availability of accessible and flexible transportation.</p> <p>Increase support and services for individuals with disabilities.</p> <p>Improve dissemination of information.</p>					

<sup>1</sup> Rinck, Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Cross-Cutting Issues (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

<sup>2</sup> Rinck, Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Comparison of Kansas City and Eastern Jackson County (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.

<sup>3</sup> DMH Psychiatric Acute Care Transformation in Northwest Missouri (NWPACT).

<sup>4</sup> Wellever, Anthony. *Allen, Johnson and Wyandotte Counties Health Assessment (prepared for the REACH Foundation)*, Kansas Health Institute, August 2004.

<sup>5</sup> Healthcare Foundation of Greater Kansas City. *Health Assessment of Cass, Jackson and Lafayette Counties*. January 4, 2005.

<sup>6</sup> Ibid.

<sup>7</sup> Wellever, Anthony. *Allen, Johnson and Wyandotte Counties Health Assessment (prepared for the REACH Foundation)*, Kansas Health Institute, August 2004.

<sup>8</sup> Ibid

<sup>9</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*

<sup>10</sup> Wellever, Anthony. *Allen, Johnson and Wyandotte Counties Health Assessment (prepared for the REACH Foundation)*, Kansas Health Institute, August 2004.

<sup>11</sup> Hospital and Home Initiative: Executive Summary and Action Plan. Kansas SRS Hospital and Home Core Team. June 3, 2008.

<sup>12</sup> Tri-County Mental Health Center, *Mental Health Needs Assessment of the Northland*, 2008.

<sup>13</sup> Mattie Rhodes Center, *Cultural Competency and Mental Health in the Hispanic Community of Jackson County, Missouri*. June 2003.

- <sup>14</sup> Ibid
- <sup>15</sup> Rinck, Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Race and Ethnicity (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.
- <sup>16</sup> Rinck, Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Children and Senior Services (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.
- <sup>17</sup> Healthcare Foundation of Greater Kansas City. *Health Assessment of Cass, Jackson and Lafayette Counties*. January 4, 2005.
- <sup>18</sup> Ibid
- <sup>19</sup> Tri-County Mental Health Center, *Mental Health Needs Assessment of the Northland*, 2008.
- <sup>20</sup> Rinck, Christine and Tracy Graybill, *Jackson County Mental Health Needs Assessment: Children and Senior Services (presented to the Mental Health Strategic Planning Task Force)*. University of Missouri – Kansas City, Institute for Human Development. September 1, 2005.
- <sup>21</sup> Wellever, Anthony. *Allen, Johnson and Wyandotte Counties Health Assessment (prepared for the REACH Foundation)*, Kansas Health Institute, August 2004.
- <sup>22</sup> Johnson County Mental Health Center, *Strategic Plan 2006-2008*.
- <sup>23</sup> Tri-County Mental Health Center, *Mental Health Needs Assessment of the Northland*, 2008.
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