Strategic Framework for Modernizing the Kansas Behavioral Health System:

2021 High-Priority Update

Working Groups Report to the 2021 Special Committee on Kansas Mental Health Modernization and Reform

December 15, 2021

Acknowledgments

The working groups (*Appendix E*, page E-1) would like to thank the following individuals who provided topic-specific expertise: Jane Adams, Wyatt Beckman, Randal Bowman, The Honorable Glenn Braun, Andrew Brown, Scott Brunner, Dr. Rachel Brown, Darla Carra-Denton, Gail Cozadd, Marley A. Doyle, MD, Sheriff Jeff Easter, Richard Falcon, Sarah Fertig, Reverend David C. Fulton, David Fye, Lindsay Galindo, Koleen Garrison, Lauren Grace, John Hess, PhD, Dorothy Hughes, PhD, MHSA, David Jordan, Shawn Jurgensen, Kathy Keck, Kyle Kessler, Tanya Keys, Dr. Nicole Klaus, Monica Kurz, Jennifer Marsh, The Honorable Timothy McCarthy, Amber McMurray, Max Mendoza, Craig Neuenswander, EdD, Ericka Nicholson, Melissa Patrick, Nanette Perrin, PhD, Jack Pitsor, The Honorable Nicholas St. Peter, Angie Salava, Dr. Mark Schmidt, Rennie Shuler-McKinney, Lisa Southern, Representative Kristey Williams, Ron Wilson, Kyle Zebley, and Heidi Zimmerman.

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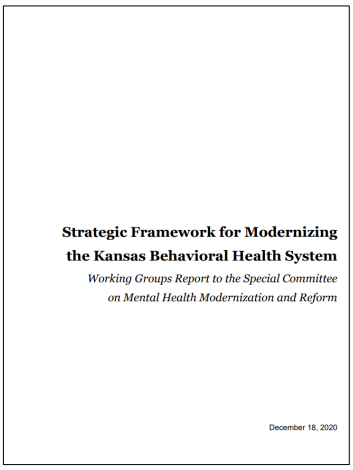
Background/Introduction



To access the 2020 report, visit https://bit.ly/3GabNV6

The Legislative Coordinating Council approved six days for the 2021 Special Committee on Kansas Mental Health Modernization and Reform (Special Committee) to:

- Ensure that both inpatient and outpatient services are accessible in communities;
- Review the capacity of the current behavioral health workforce;
- Study the availability and capacity of crisis centers and substance abuse facilities;
- Assess the impact of recent changes to state policies on the treatment of individuals with behavioral health needs; and
- Make recommendations on steps needed to make Kansas a nationwide leader on behavioral health delivery, specifically focusing on how Kansas should modernize its behavioral health delivery system.

The 2021 Special Committee convened three working groups to revisit recommendations from the 2020 report, *Strategic Framework for Modernizing the Kansas Behavioral Health System*. The working groups were asked to revise, update, and add to the recommendations as necessary to address topics directed to them by the Special Committee. The three working groups convened were Services and Workforce, System Capacity and Transformation, and Telehealth.

Navigating this Report: This report should be read in concert with the *2020 Strategic Framework for Modernizing the Kansas Behavioral Health System*. New recommendations and revisions to 2020 recommendations are noted in the 2021 report summary (page 4) and should be read with the 2020 *Strategic Framework*. Revisions to previous recommendations are noted by red underlined text.

Recommendations from 2020 considered complete are documented in *Appendix B* (page B-1).

High-priority recommendations from 2020 and 2021 are included in *Appendix D* (page D-1), designated as:

Immediate Action are those that the working groups believe can be initiated and completed in the next two years.

Strategic Importance are those that should be initiated in the near term but will be completed in the longer term.

In addition to high-priority recommendations, the group also offered one high-priority discussion item to urge the Special Committee to consider the potential contribution of Medicaid expansion to a modernized behavioral health system.

Working Group Process

In 2020, three working groups had met to develop the bulk of the recommendations in the 2020 *Strategic Framework*, with a fourth working group convened with a subset of the other three to focus on cross-cutting issues related to tele-behavioral health.

In 2021, to review and update the recommendations, the 2021 Special Committee on Kansas Mental Health Modernization and Reform (Special Committee) considered lessons learned in the 2020 working group process and, after discussion, again convened three working groups. The Special Committee then assigned topics based on the 2020 recommendations and new areas of focus for consideration or emphasis in 2021.

- Services and Workforce:
    - Ongoing topics: Workforce, community engagement, prevention and education, treatment and recovery, and special populations
    - New topics: Trauma-informed care, social isolation, stigma and the Autism waiver
    - 2020 Recommendation 2.4 Suicide Prevention
    - Heightened focus on issues related to maternal mental health, rural populations, veterans, people of color, older adults, low-income families and health care workers
- System Capacity and Transformation:
    - Ongoing topics: Funding and accessibility, data systems, legal system and law enforcement, and system transformation
    - New topics: K-12 mental health intervention teams/behavioral health services in schools, outcomes data, specialty courts, and competency evaluation and restoration
    - 2020 Recommendation 4.1 988 Suicide Prevention Lifeline funding
- Telehealth
    - New topic: Issues related to payment parity (including for behavioral health services delivered via telehealth)

Each working group met virtually four to five times (*Figure 1,* page 3) and completed surveys between meetings used to assist in the development and prioritization of recommendations.

In addition, presentations during meetings of the Special Committee were used to gather testimony and ideas that informed the development of new and revised recommendations, including for K-12 behavioral health services, outcomes and funding; specialty courts; suicide

prevention; trauma-informed care; the behavioral health workforce; telehealth; and mobile crisis response. The Special Committee also heard updates on the work of the Autism Task Team and the Governor's Commission on Racial Equity and Justice that were used to inform recommendations and other language in this report.

Figure 1. **Working Group Process Diagram**

Special Committee on Kansas Mental Health Modernization and Reform		
Workgroup #1 **Services and Workforce**	**Workgroup # 2** **System Capacity and Transformation**	**Workgroup # 3** **Telehealth**
• **Meeting #1, Oct. 14, 2021,** Review and revise previous recommendations • **Meeting #2, Nov. 3, 2021,** Identify new recommendations based on charge • **Meeting #3, Dec. 2, 2021,** Prioritize recommendations • **Meeting #4, Dec. 6, 2021,** Ratify *Strategic Framework* update	• **Meeting #1, Oct. 14, 2021,** Review and revise previous recommendations • **Meeting #2, Nov. 1, 2021,** Special focus on legal system and law enforcement recommendations • **Meeting #3, Nov. 10, 2021,** Identify new recommendations based on charge • **Meeting #4, Dec. 2, 2021,** Prioritize recommendations • **Meeting #5, Dec. 6, 2021,** Ratify *Strategic Framework* update	• **Meeting #1, Oct. 13, 2021,** Review and revise vision and previous recommendations • **Meeting #2, Oct. 20, 2021,** Overview of Kansas Telemedicine Act, revisions to previous recommendations and discussion on new topic • **Meeting #3, Nov. 15, 2021,** Presentations and discussion on new topic, and review of data • **Meeting #4, Dec. 2, 2021,** Finalize recommendation language and characterization • **Meeting #5, Dec. 6, 2021,** Ratify *Strategic Framework* update

Note: Surveys were administered between working group meetings.

All working group decisions were reached based upon consensus. Each working group adopted the following meeting commitments: to come ready to discuss and compromise, keep remarks succinct and on topic, not to hesitate to ask clarifying questions, and to start and end meetings on time. As members discussed each topic and recommendations, decisions were made based on proposals offered by the working group and adopted by verbal agreement or absence of objections.

In order to guide discussion and ensure consistency across working groups and reports, the Recommendations Rubric from 2020 was adopted for use again in 2021 (*Appendix C,* page C-1*)* as a tool to assist in ranking and modifying existing recommendations or when writing new recommendations. Using the rubric, working groups were able to assign numeric values to recommendations based on a 1-10 scale for both ease of implementation and potential for high impact.

New and Revised Recommendations for Special Committee Consideration

The following recommendations were added by the 2021 working groups of the Special Committee on Kansas Mental Health Modernization and Reform ("New Recommendations") or are revisions the 2021 working groups proposed to recommendations from the 2020 *Strategic Framework* ("Revised Recommendations").

New Recommendations

Expand Mental Health Intervention Team Program. Expand the Mental Health Intervention Team grant program to additional school districts. Support continuity and provide a way for students to access services when schools are not open by extending the times of services at schools, utilizing community mental health centers (CMHCs), or utilizing other mental health providers. ***(Recommendation 2.6; Immediate Action)***

Trauma-Informed Care. Under the auspices of the Governor's Behavioral Health Services Planning Council (GBHSPC), convene a workgroup of providers who have implemented trauma-informed practices to make recommendations for a pilot program or other initiative to expand trauma-informed practices statewide. ***(Recommendation 4.5; Immediate Action)***

Promote Social Isolation as a Public Health Issue. Create strategies to disseminate the importance of social isolation as a public health issue, using social media and media campaigns, educating providers, and encouraging adoption of a screening tool. ***(Recommendation 4.6; Strategic Importance)***

Normalize Behavioral Health Discussions. In lieu of discussing stigma, build on recent success stories (e.g., 988 lifeline, mobile crisis, certified community behavioral health clinics) to publicize behavioral health as health, creating a culture in which mention of depression, anxiety, post-trauma, addiction and other common illnesses become as mentionable as diabetes, heart disease and migraines. ***(Recommendation 4.7; Immediate Action)***

Medicaid Postpartum Coverage. Request Robert G. Bethell Home and Community Based Services and KanCare Oversight Committee review of extending the Medicaid postpartum coverage period to 12 months postpartum. This supports access to behavioral health treatment and other preventive care, thus improving health outcomes for both the mother and child. ***(Recommendation 6.6; Immediate Action)***

Outcomes Data. Work with the State Epidemiological Outcomes Workgroup (SEOW) to establish an annual legislative report on state behavioral health outcomes using existing data and outcome measures. ***(Recommendation 7.6; Strategic Importance)***

Regional Specialty Courts/Venue Transfer. Explore creation of regional specialty courts across Kansas. Consider implications related to venue transfer for access to regional specialty courts. ***(Recommendation 8.5; Strategic Importance)***

Specialty Court Coordinators. Provide funding for judicial districts that meet qualifying criteria to hire specialty court coordinators. ***(Recommendation 8.6; Immediate Action)***

Competency Evaluations and Restoration. Provide funding for community mental health centers to conduct mobile competency evaluation and competency restoration. ***(Recommendation 8.7; Immediate Action)***

Telemedicine Committee. The Legislative Coordinating Council shall establish a Special Committee on Telemedicine Modernization. ***(Recommendation 10.6; Strategic Importance)***

Revised Recommendations

Access to Psychiatry Services. Request a Legislative Post Audit to review Kansas behavioral health recipients of National Health Service Corps (NHSC) and State Loan Repayment Program (SLRP) for the past 10 years; review professions awarded, communities in which those providers were located, number of years they participated in the program, and number of years they continued to practice in their position after they exited the program; expand the analysis to the behavioral health professions served in these programs (not just psychiatry); review best practices from other states regarding recruitment and retention of licensed behavioral health professional staff to Urban, Rural, and Frontier communities for possible, if successful, implementation in Kansas; review medical school and residency training location of psychiatrists and child and adolescent psychiatrists currently practicing in Kansas, as well as current practice locations of residents and fellows in child psychiatry who completed residency or fellowship in Kansas within the last 10 years; review existing research regarding where fellows practice in relation to where they trained; and look at the University of Kansas program that incentivizes medical students to end up practicing in Kansas to see if it is effective. ***(Revision of 2020 Recommendation 1.2; Immediate Action)***

Workforce Investment Plan. The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include:

- The state should establish a Kansas university partnership to develop the comprehensive investment plan, including a focus on high school internships, mentorship and free continuing education courses, building on the model the Special Committee heard about in Nebraska;
- Seed university programs to develop and expand bachelor's and graduate programs in behavioral health;
- Create a pool of funds that behavioral health providers could access to support retention and recruitment;
- Develop a career ladder for clinicians, such as through the development of an associate-level practitioner role; and

- Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ+ and the ability to work with those with limited English proficiency.

(Revision of 2020 Recommendation 1.4; Strategic Importance)

Addressing Inpatient Capacity by Implementing a Regional Model. Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings, supplementing the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Ongoing analysis should be conducted to identify geographic areas of need and gaps in levels of care. ***(Merger of 2020 Recommendations 2.2 and 9.1; Immediate Action)***

Reimbursement Rate and Review. Implement an immediate increase of 10-15 percent for reimbursement rates for all providers of behavioral health services. After increasing reimbursement rates, establish a working group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population. ***(Revision of 2020 Recommendation 2.3; Immediate Action)***

Support Kansas Suicide Prevention Plan. In support of the 2021-2025 Kansas Suicide Prevention Plan: Standardize definitions of data collected related to suicide data and making suicide a reportable condition; propose policy to ensure consistent data collection across the state, including for diverse populations (include demographics); leverage the Kansas Suicide Prevention Coalition to enable collaboration among all agencies engaged in suicide prevention; designate the Kansas Department for Aging and Disability Services (KDADS; the single state authority for federal mental health and substance use disorder programs) as lead agency for implementation of the State Suicide Prevention Plan and collaborate with the Youth Suicide Prevention Coordinator in the office of the Attorney General; add $1,500,000 state general funds (SGF) to KDADS budget to implement additional recommendations and strategies from the State Suicide Prevention Plan, including $250,000 for the Kansas Suicide Prevention Coalition, $90,000 for a full-time state suicide prevention coordinator (population-wide), and the remainder for providing grant opportunities for local communities and implementing a statewide media campaign; require KDADS to submit an annual report on the progress from collaborating state agencies and the coalition as to the status and effectiveness of state suicide prevention policies and interventions as well as any updates to the State Suicide Prevention Plan to the Governor's Behavioral Health Services Planning Council and its Prevention Subcommittee. ***(Revision of 2020 Recommendation 2.4; Immediate Action)***

Foster Homes. The State of Kansas should invest in foster home recruitment and retention by:

- Increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth;
- Supporting families navigating child welfare and Medicaid programs;

- Continuing investment in recruiting, preparing and supporting families to serve high-acuity and older youth, and in recruiting, preparing, retaining and supporting African-American families;

- Providing in-home therapeutic parenting services for families to meet high-acuity needs; and

- Ensuring services are available across the continuum of care for youth discharged from inpatient or Psychiatric Residential Treatment Facilities (PRTF) settings.

(Revision of 2020 Recommendation 3.3; Strategic Importance)

Community-Based Liaison. Expand locations where community-based liaisons are available to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and co-occurring conditions. ***(Revision of 2020 Recommendation 3.4; Strategic Importance)***

988 Suicide Prevention Lifeline Funding. Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources. The Legislature should consider House Bill (HB) 2281 in the 2022 session to ensure funds are available in July 2022. (***Revision of 2020 Recommendation 4.1; Immediate Action***)

Behavioral Health Prevention. Increase state funds for behavioral health prevention efforts to support additional evidence-based primary prevention and grant opportunities for community prevention activities. ***(Revision of 2020 Recommendation 4.4; Strategic Importance)***

Statewide Psychiatric Access Program. Fully fund a statewide psychiatric access program that includes linked specialty teams with high levels of expertise (e.g., psychiatrists, child and adolescent psychiatrists, peripartum psychiatrists, child psychologists, pediatricians, resource specialists, and patient and family advocates) to provide multi-disciplinary consultations, training, and resource and referral support to health care providers across the lifespan. Ensure continuation of current pregnant/postpartum and pediatric programs starting July 2023 (FY 2024). Expand current programs to include specialty teams for children (through 21 years of age) with Intellectual/Developmental Disability (I/DD) and children (through 21 years of age) with Autism Spectrum Disorder starting July 2024 (FY 2025), and for adults with mood disorders starting July 2025 (FY 2026). (***Revision of 2020 Recommendation 5.3; Immediate Action***)

Correctional Employees. Expand training provided in state correctional facilities, local jails and detention centers to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services. (***Revision of 2020 Recommendation 8.1; Immediate Action***)

Law Enforcement Referrals. Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to inpatient, residential and

outpatient services for this population. (***Revision to 2020 Recommendation 8.3; Immediate Action***)

Defining Crossover Youth Population. Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population. Coordinate with juvenile corrections advisory boards to ensure local implementation aligns with statewide policy team recommendations. (***Revision to 2020 Recommendation 8.4; Strategic Importance***)

Integration. Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. For example, adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions. (***Revision to 2020 Recommendation 9.3; Immediate Action***)

Family Psychotherapy. Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care. This would allow therapists/practitioners to have discussions without the child present. (***Revision to 2020 Recommendation 9.5; Strategic Importance***)

Telehealth Quality Assurance. Develop quality assurance standards to ensure high-quality telehealth services are provided, including establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies; allowing telehealth supervision hours to be consistently counted toward licensure requirements; allowing services to be provided flexibly utilizing the Kansas Telemedicine Act; and improving provider and patient education around telehealth literacy in relation to privacy, efficacy, access and cybersecurity practices. (***Revision to 2020 Recommendation 10.1; Immediate Action***)

Telehealth Reimbursement Codes. As Centers for Medicare and Medicaid Services (CMS) rules allow, maintain Medicaid reimbursement codes added during the public health emergency for telehealth services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services. (***Revision to 2020 Recommendation 10.2; Immediate Action***)

Telehealth for Crisis Services. Continue coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities. Engage professional associations statewide to adopt appropriate education for providers, practitioners and law enforcement officers on using telehealth for crisis services. (***Revision to 2020 Recommendation 10.3; Immediate Action***)

Telehealth Originating and Distant Sites. The following item should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations: examine issues related to providers practicing, and patients receiving, services across state

lines, such as by exploring participation in interstate licensure compacts. (***Revision to 2020 Recommendation 10.4; Strategic Importance***)

Child Welfare System and Telehealth. Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Explore how the unique needs of parents of children in the child welfare system can be met via telehealth. (***Revision to 2020 Recommendation 10.5; Strategic Importance***)

Data Profile

The following process measures were identified in 2020 to monitor the progress on the work completed by this committee and its convened working groups:

- Number of recommendations implemented and
- Number of recommendations implemented with identified key collaborators.

The high-level data profile presented in *Figure 3* (page 10) has been updated based on data availability to provide a systemic assessment of the state's behavioral health system. As before, it includes only a subset of the wide range of data that are available about the Kansas behavioral health system.

Future use of measures can incorporate data by race/ethnicity, gender, age and geography, where available, and could include measures related to other factors that influence behavioral health risk and outcomes, including housing quality, social support, and employment opportunities.[1] Please see **Recommendation 7.6 Outcomes Data** for a proposed approach that would be responsive to the Legislature and could incorporate those key concepts.

The table on page 10 provides only new data available in 2021.

Figure 3. **Select Measures to Assess the Kansas Behavioral Health System**

MEASURES								
Measure:	**Number**				**Percent**			
Kansas counties recognized as a Mental Health Professional Shortage Area *Lower number/percentage of counties is better.*	99 (2020)				94.3% (2020)			
MEASURES COMPARING KANSAS AND U.S.								
Measure:	**Kansas current (year)**	**Kansas previous (year)**			**U.S. current (year)**	**U.S. previous (year)**		
Statewide age-adjusted mortality rate for suicide per 100,000 population *Lower rates are better.*	22.4 (2018)	21.6 (2017)			14.2 (2018)	15.2 (2017)		
Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities (i.e., criteria for and predictors of clinical depression) *Lower percentage is better.*	32.5% (2019)	24.8% (2017)			36.7% (2019)	31.5% (2017)		
Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling *Higher percentage is better.*	49.2% (2019-2020)	55.9% (2018-2019)			52.3% (2019-2020)	53.2% (2018-2019)		
MENTAL HEALTH IN AMERICA RANKINGS of 50 States and Washington D.C. by Report Year								
Select Measure: *States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes.*	**2022**	**2021**	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
Kansas rankings: Overall	#41	#29	#42	#24	#19	#21	#15	#19
Kansas ranking: Adult (prevalence and access to care)	#42	#38	#43	#28	#22	#23	#16	#23
Kansas ranking: Youth (prevalence and access to care)	#33	#26	#37	#21	#19	#18	#15	#8
Kansas ranking: Adults with mental illness who report unmet needs	#49	#51	#46	#29	#39	#38	#28	#51
Kansas ranking: Youth with at least one major depressive episode who did not receive mental health services	#17	#18	#47	#40	#29	#12	#12	NA

Note: The Mental Health in America overall ranking uses national data from surveys including the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). The overall ranking is comprised of 15 measures for adults and youth around mental health issues, substance use issues, access to insurance, access to adequate insurance, as well as access to and barriers to accessing mental health care. A rank of 1-13 indicates lower prevalence of mental illness and higher rates of access to care, and an overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. Data in each reporting year come from previous reporting periods. For example, in the 2022 report, most indicators reflect data from 2018-2019, while the 2021 report includes data from 2017-2018 and so forth. The baseline report year is 2015. For more information, go to https://mhanational.org/sites/default/files/2022StateofMentalHealthinAmerica.pdf

Source: Data as reported by the Kansas Department of Health and Environment (KDHE) and Kansas Health Institute (KHI) summary of data from the 2015-2022 Mental Health in America Rankings.

Recommendations

The following section provides additional background for each new and revised recommendation identified by a working group, organized by topic. Only new recommendations and revised recommendations from 2020 are included in this section. All other recommendations from the 2020 report not referenced here remain in progress, except for those specifically identified as complete (*Appendix B*, page B-1).

The reasons working groups proposed revisions are noted in the rationale section of the tables below, and new recommendations and recommendations that were significantly revised were also characterized to capture factors related to ease of implementation and potential for high impact. For recommendations with less significant modification, only the rationale for revision was required.

Workforce – Revised Recommendations

Workforce Recommendation 1.2: **Access to Psychiatry Services [Revised; Immediate Action]**

Recommendation: Request a Legislative Post Audit to review Kansas behavioral health recipients of National Health Service Corps (NHSC) and State Loan Repayment Program (SLRP) for the past 10 years; review professions awarded, communities in which those providers were located, number of years they participated in the program, and number of years they continued to practice in their position after they exited the program; expand the analysis to the behavioral health professions served in these programs (not just psychiatry); review best practices from other states regarding recruitment and retention of licensed behavioral health professional staff to Urban, Rural, and Frontier communities for possible, if successful, implementation in Kansas; review medical school and residency training location of psychiatrists and child and adolescent psychiatrists currently practicing in Kansas, as well as current practice locations of residents and fellows in child psychiatry who completed residency or fellowship in Kansas within the last 10 years; review existing research regarding where fellows practice in relation to where they trained; and look at the University of Kansas program that incentivizes medical students to end up practicing in Kansas to see if it is effective.
Rationale for Revision: The working group believed the previous version of the recommendation ("Require a study to be conducted by KDHE with an educational institution[s], to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses.") lacked specificity. Working group members suggested that this recommendation could be effectively implemented through a request for a Legislative Post Audit. Working group members volunteered to assist in developing the request. Although Legislative Post Audit review is not guaranteed, it would significantly streamline this recommendation. The revised recommendation also provides information about the scope of the review. The effectiveness of the recommendation long-term will require action to be taken on the findings.

Ease of Implementation *(Score 1-10): 8*	**Potential for High Impact** *(Score 1-10): 6*
• If performed as a Legislative Post Audit, ease of implementation would be high with little to no additional cost. • Taking action on findings will require additional activity.	• Implementing strategies from the report could impact frontier and rural communities that struggle to recruit psychiatric providers. • Potential for high impact may depend on actionability of the Legislative Post Audit's results.
Measuring Impact: • Percent or number of mental health care professionals participating in the Kansas State Loan Repayment Program. • Number of Kansas counties recognized as a Mental Health Professional Shortage Area. • Number of adult and child/adolescent psychiatry residents in Kansas.	
Action Lead: Legislature	**Key Collaborators:** KDHE, KDADS, universities

Return to Figure A-1 and Figure D-1.

Workforce Recommendation 1.4: **Workforce Investment Plan [Revised; Strategic Importance]**

Recommendation: The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include:

- The state should establish a Kansas university partnership to develop the comprehensive investment plan, including a focus on high school internships, mentorship and free continuing education courses, building on the model the Special Committee heard about in Nebraska;
- Seed university programs to develop and expand bachelor's and graduate programs in behavioral health;
- Create a pool of funds that behavioral health providers could access to support retention and recruitment;
- Develop a career ladder for clinicians, such as through the development of an associate-level practitioner role; and
- Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ+ and the ability to work with those with limited English proficiency.

Rationale for Revision: The working group highlighted a dire need for investment in the behavioral health workforce, requiring immediate steps toward long-term action. Behavioral workforce shortages have significantly reduced access to behavioral health services for many across the state, and working group members specifically identified challenges in recruitment and retention as key to solving this problem. The working group embraced a "grow your own" approach, in which the workforce reflects the diversity of the community. Although working group members noted challenges associated with a long-term commitment to recruitment and

<table>
<tr><td colspan="2">retention including, but not limited to, potentially high costs, creation of new programs, and the work of multiple legislative sessions, this recommendation has a high potential for impact. Working group members said many Kansans will benefit from implementation of this recommendation, particularly in rural areas where there exists a critical shortage of psychiatrists and behavioral health workers, as well as other populations that lack access to behavioral health services. The working group called for the creation and funding of a Kansas organization modeled after the Behavioral Health Education Center of Nebraska (BHECN) at the University of Nebraska that was presented to the Special Committee.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 1</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td>Could include program changes and pilot programs.
Cost will be a barrier to implementation.
Could involve changes in a legislative session, federal approval process, agency budget development and grant cycles.</td><td>Would impact a large population.
Would impact multiple populations, including those in foster care, those with limited English proficiency, children and those with low income.</td></tr>
<tr><td colspan="2">Measuring Impact:
Workforce retention rates.
Number of behavioral health providers practicing in Kansas by age, race/ethnicity, language and sexual orientation.
Number of students enrolling in post-secondary behavioral health education/training programs in Kansas schools.
Number of community colleges offering a behavioral health track associate degree.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, Kansas Behavioral Sciences Regulatory Board (BSRB), Legislature, providers, clinics, educational institutions</td></tr>
</table>

Return to Figure A-1 and Figure D-2.

Workforce – Other Issues

Workforce issues were discussed as potential barriers in relation to recommendations in other topic areas, highlighting how essential addressing workforce shortages will be in accomplishing many of the recommendations from the working groups.

The Services and Workforce working group considered modifying 2020 **Recommendation 1.3 Provider MAT Training**, “Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT.” The working group opted to add report language emphasizing that many of the individuals who need MAT often are uninsured and lack the ability to pay for the treatment. The working group discussed the need to ensure funding sustainability for MAT once federal opioid response grants end. The working group also was interested in ensuring that the certified community behavioral health clinic (CCBHC) model Kansas adopts will allow CCBHCs to collaborate with SUD providers to ensure access to MAT and other

treatment. The group also discussed requiring KanCare managed care organizations to report regularly to the Robert G. (Bob) Bethell Committee on Home and Community Based Services and KanCare Oversight regarding network adequacy for MAT services. The state also can use the KanCare 3.0 contracting process to emphasize the need to expand access to and capacity of MAT services.

In addition, the Services and Workforce working group noted that 2020 **Recommendation 1.5 Family Engagement Practices** will require more funding than initially allocated for implementation. Working group members also said the processes ultimately implemented in support of the recommendation should be flexible, simple and user-friendly to access.

Funding and Accessibility – New Recommendation

Funding and Accessibility Recommendation 2.6: **Expand Mental Health Intervention Team Program [New; Immediate Action]**

Recommendation: Expand the Mental Health Intervention Team grant program to additional school districts. Support continuity and provide a way for students to access services when schools are not open by extending the times of services at schools, utilizing Community Mental Health Centers, or utilizing other mental health providers.
Rationale: The 2018 Legislature created the Mental Health Intervention Team Pilot Program "to improve social-emotional wellness and outcomes for students by increasing schools' access to counselors, social workers and psychologists statewide." In Fiscal Year 2022, 55 school districts are participating. Working group members said there is a significant need to expand the program to more school districts as for most children, schools are their first access point for services and the program can support continuity of care. The program also helps reduce transportation as a barrier to accessing behavioral health services. Working group members also noted there should be an expectation for schools to seek out additional funding to supplement the program beyond the funding provided by the state. The working group members called for future investigation into a long-term plan for this program, including the possibility of incorporating the Mental Health Intervention Team program into the school finance formula for future sustainability. In the short-term, working group members recommend expanding the pilot program to other school districts interested in participating. Implementation of this recommendation has high potential for impact, particularly for youth at high risk for suicide. Increased access to this program could also reduce foster care entrance rates as children receive better access to essential mental health services. In addition to community mental health centers, working group members anticipate students would also receive services through the mobile crisis response team and 988 prevention lifeline when schools are not open, reiterating the importance of supporting continuity between the Mental Health Intervention Team program and other mental health providers.

Ease of Implementation *(Score 1-10): 7*	**Potential for High Impact** *(Score 1-10): 9*
• Cost will be a barrier to implementation, although schools could participate financially in the cost of the building liaison. • Will require an expansion to the pre-existing pilot program in the short term. Long-term implementation will require more resources.	• Would impact foster children, rural communities, urban communities, limited English proficient persons, low-income individuals, children, and students. • Serves those disproportionately affected.
Measuring Impact: • Number of school districts participating in the Mental Health Intervention Team Program. • Data elements currently collected by the Kansas State Department of Education (KSDE) for Mental Health Intervention Team participants.	
Action Lead: KSDE	**Key Collaborators:** KDADS, DCF

Return to Figure A-1 and Figure D-1.

Funding and Accessibility – Revised Recommendations

Funding and Accessibility Recommendation 2.2: **Addressing Inpatient Capacity [Revised; Immediate Action]**

Recommendation: Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings, supplementing the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Ongoing analysis should be conducted to identify geographic areas of need and gaps in levels of care.
Rationale for Revision: The working group combined 2020 Recommendations 2.2 Addressing Inpatient Capacity and 9.1 Regional Model to acknowledge the intended effect of regional facilities on inpatient capacity needs across the state. Working group members expressed concern that there can be significant changes in where gaps in capacity exist from year to year. Working group members proposed that rather than identifying a specific region for added capacity, it would recommend that, as capacity is added, ongoing analysis should be used to identify and address gaps.

Ease of Implementation *(Score 1-10): 3*	**Potential for High Impact** *(Score 1-10): 10*
• Cost will be a barrier to implementation. • Contracting cycles will impact implementation	• Would impact a large population. • Could produce cost savings via reduction in transportation costs and lower costs in other systems, including emergency medicine and corrections.

Measuring Impact: • Number of private hospitals enrolled in KanCare as State Institution Alternatives. • Number of new private psychiatric hospital (PPH) beds licensed in Kansas. • Number of new state mental health hospital (SMHH) beds added at state hospitals. • Increases in community-based treatment service delivery or utilization like supported employment and supported housing.	
Action Lead: KDADS	**Key Collaborators:** Legislature, local units of government, law enforcement

Return to Figure A-1 and Figure D-1.

Funding and Accessibility Recommendation 2.3: **Reimbursement Rate Increase and Review [Revised; Immediate Action]**

Recommendation: Implement an immediate increase of 10-15 percent for reimbursement rates for all providers of behavioral health services. After increasing reimbursement rates, establish a working group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population.
Rationale for Revision: Working group members clarified that the recommendation has applied to Medicaid rates and noted the importance of funding for providing services to the uninsured. They also asked to update the recommendation language and clarify that it applies to all providers of behavioral health services.

Return to Figure A-1 and Figure D-1.

Funding and Accessibility Recommendation 2.4: **Suicide Prevention [Revised; Immediate Action]**

Recommendation: In support of the 2021-2025 Kansas Suicide Prevention Plan: standardize definitions of data collected related to suicide data and making suicide a reportable condition; propose policy to ensure consistent data collection across the state, including for diverse populations (include demographics); leverage the Kansas Suicide Prevention Coalition to enable collaboration among all agencies engaged in suicide prevention; designate KDADS (the single state authority for federal mental health and substance use disorder programs) as lead agency for implementation of the State Suicide Prevention Plan and collaborate with the Youth Suicide Prevention Coordinator in the office of the Attorney General; add $1,500,000 SGF to KDADS budget to implement additional recommendations and strategies from the State Suicide Prevention Plan, including $250,000 for the Kansas Suicide Prevention Coalition, $90,000 for a full-time state suicide prevention coordinator (population-wide), and the remainder for providing grant opportunities for local communities and implementing a statewide media campaign; require KDADS to submit an annual report on the progress from collaborating state agencies and the coalition as to the status and effectiveness of state suicide prevention policies and interventions as well as any updates to the State Suicide Prevention Plan to the Governor's Behavioral Health Services Planning Council and its Prevention Subcommittee.

<table>
<tr><td colspan="2">Rationale for Revision: The Special Committee heard a presentation on the 2021-2025 Kansas Suicide Prevention Plan in its October meeting. Afterwards, the working group proposed a revision to the previous recommendation related to suicide prevention in Kansas to support and affirm the recommendations within the Kansas State Suicide Prevention Plan. While KDADS was identified as the lead agency because of its role as the state authority for mental health and substance use disorder programs, the working group clarified that the state suicide prevention coordinator would be separate from but complement the youth suicide prevention coordinator in the Office of the Attorney General, and that both require funding. Additionally, the working group clarified that one recommended source for the critically needed $1.5 million would be the telecommunications surcharge for the 988 suicide prevention lifeline (Recommendation 4.1). The implementation of Recommendation 4.1 will determine access to that funding stream, but regardless of the source, funding is needed. Affected communities can be engaged in the discussion of data collection and reporting to provide context for the data.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 5</td><td>Potential for High Impact (Score 1-10): 10</td></tr>
<tr><td>Cost is a barrier to implementation of this recommendation.
Many portions of this recommendation are already in progress but require continued funding to operate.</td><td>Would impact children (including those in foster care), frontier communities, rural communities — particularly those in the agricultural sector — and veterans.</td></tr>
<tr><td colspan="2">Measuring Impact:
Percent change in the age-adjusted mortality rate for suicide per 100,000 population.
Subsets of data: suicide rate by gender, age group, socio-demographics (marital status, veteran, and education), race/ethnicity, occupational classification, cause of death (firearm, suffocation, etc.), and circumstances (mental health, substance use disorder, and interpersonal problems).
Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE, Office of the Attorney General, Kansas Suicide Prevention Coalition</td></tr>
</table>

Return to Figure A-1 and Figure D-1.

Funding and Accessibility – High-Priority Discussion

Funding and Accessibility High-Priority Discussion Item: **Medicaid Expansion [High-Priority Discussion]**

Rationale (2020): Medicaid expansion has been recommended by previous task forces, including the Mental Health Task Force, the Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force. Medicaid Expansion was flagged by the working group as a high priority discussion when considering opportunities to modernize the behavioral health system due to the opportunity that it represents to improve access to behavioral health services at all levels of care and allow investment in workforce and system capacity. Expanding Medicaid under the terms of the Affordable Care Act would provide insurance coverage to an estimated 130,000 to 150,000 Kansans. Working group members noted that many of these individuals may already be utilizing services within the behavioral health system, but in many cases those services are uncompensated or subsidized by state grants. Ninety percent of Medicaid expansion costs would be covered by the federal government. Other Kansans with behavioral health needs may be foregoing care completely until they reach a crisis. The Working group considered Medicaid expansion as a high priority discussion item for the Special Committee, as the Kansas Legislature is the body to determine whether expansion will move forward.	
Action Lead: Legislature	**Key Collaborators:** Working group members

Return to Figure A-1 and Figure D-3.

Community Engagement – Revised Recommendations

Community Engagement Recommendation 3.3: **Foster Homes [Revised; Strategic Importance]**

Recommendation: The State of Kansas should invest in foster home recruitment and retention by:

- Increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth;
- Supporting families navigating child welfare and Medicaid programs;
- Continuing investment in recruiting, preparing and supporting families to serve high-acuity and older youth, and in recruiting, preparing, retaining and supporting African-American families;
- Providing in-home therapeutic parenting services for families to meet high-acuity needs; and
- Ensuring services are available across the continuum of care for youth discharged from inpatient or PRTF settings.

(Revised)

Rationale: Previous language for this recommendation was originally developed by the Child Welfare System Task Force.[2] Providing additional training and support to foster homes (including kinship placements and adoptive homes) caring for youth with behavioral health needs, particularly SED youth, could improve retention of foster homes as well as incentivize placement of youth who may be more difficult to place otherwise. This year, working group members felt the recommendation should be modified to include ways to improve systems to support foster families. Based on discussions with the Department for Children and Families, items two through five were added as top priorities. Additionally, working group members discussed the importance of treating foster families as families when implementing recommendations. The addition of these new elements to the recommendation does increase the difficulty of implementation, but working group members noted the high potential for impact and importance of these changes to the foster care system.	
Ease of Implementation *(Score 1-10): 5*	**Potential for High Impact** *(Score 1-10): 7*
• Would require program change. • Could require a legislative session, regulatory process and contracts to implement.	• Would have a high impact on a small population (foster care youth). • Could produce savings through reductions in hospitalizations and residential care.
Measuring Impact: • Placement stability rate for children entering care. • Percent or number of foster youth on the SED waiver.	
Action Lead: Kansas Department for Children and Families (DCF)	**Key Collaborators:** KDADS

Return to Figure A-1 and Figure D-2.

Community Engagement Recommendation 3.4: **Community-Based Liaison [Revised; Strategic Importance]**

Recommendation: Expand locations where community-based liaisons are available to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and co-occurring conditions.
Rationale for Revision: Initially the working group discussed revising the recommendation to identify funding alternatives to fee-for-service reimbursement for these activities. In discussion, the group identified that the upcoming adoption of the certified community behavioral health clinic (CCBHC) model would address the concern, but only for those providers who qualify as CCBHC. The modified language, developed after review by KDADS, was intended to signal support for expanding the availability of the service to other geographic locations and provider types, including SUD providers.

Return to Figure A-1 and Figure D-2.

Prevention and Education –New Recommendations

Prevention and Education Recommendation 4.5: **Trauma-Informed Care [New; Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Under the auspices of the Governor's Behavioral Health Services Planning Council (GBHSPC), convene a workgroup of providers who have implemented trauma-informed practices to make recommendations for a pilot program or other initiative to expand trauma-informed practices statewide.</td></tr>
<tr><td colspan="2">Rationale: The Special Committee discussed the importance of trauma-informed care and strategies to prevent trauma and adverse childhood experiences. Materials provided for the working group included national and state resources.[3,4,5] Three distinct recommendations were proposed for the topic of trauma-informed care, including a) "Launch pilot projects with select behavioral health providers to increase their understanding and adoption of trauma informed practices. Take the lessons learned from these pilots and conduct a feasibility study as to the strategies needed to take it statewide."; b) "All KDADS funded agencies will train all staff in the basics of trauma-informed care upon hire with annual update. KDADS can work collaboratively with CMHCs or utilize curriculum from the Substance Abuse and Mental Health Services Administration (SAMHSA) to disseminate to the funded agencies."; and c) "Create a common language across all agencies and communities in Kansas to think about a trauma-informed approach in all aspects of care." The working group survey revealed similar support for each concept, and ultimately the working group selected an option that will build upon what providers who have adopted trauma-informed practices have learned and disseminate learnings across systems to support trauma-informed communities.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 7</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td>Implementation will require creation of a pilot program.
Cost may be a barrier to implementation dependent on provider capacity.</td><td>Implementation will benefit a large population.
Increased behavioral health workforce capacity for implementing trauma-informed practices will help address inequities, particularly for those children in foster care.</td></tr>
<tr><td colspan="2">Measuring Impact:
Establishment of workgroup in first quarter of 2022.
GBHSPC to assess baseline and future measures of trauma-informed practices adoption.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: GBHSPC</td></tr>
</table>

Return to Figure A-1 and Figure D-1.

Prevention and Education Recommendation 4.6: **Promoting Social Isolation as a Public Health Issue [New; Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Create strategies to disseminate the importance of social isolation as a public health issue, using social media and media campaigns, educating providers, and encouraging adoption of a screening tool.</td></tr>
<tr><td colspan="2">Rationale: The Special Committee discussed social isolation, particularly as experienced by older adults, people of color, and rural residents, both before and during the pandemic. The working group received materials related to social isolation and its link to serious health conditions[6] and how social isolation affects Kansas older adults[7,8]. The recommendation was developed by combining two initial proposed recommendations from working group members: a) “Treat social isolation similar to other public health issues. Create strategies to disseminate the importance of social isolation on health through public service announcements (with suggestions on where to go), educate providers on this issue and encourage adoption of a screening tool. For each group, identify primary places that are frequented and target strategies for each.”; and b) “We must have open conversations about loneliness and its impact on physical health, mental health and the potential for suicide. This needs to be community wide. Perhaps look at social media/media campaign to address.” Screening tools that have been identified by the National Academies of Sciences, Engineering and Medicine as likely to have greatest success in clinical settings include the Berkman–Syme Social Network Index (for measuring social isolation) and the three-item UCLA Loneliness Scale (for measuring loneliness).[9]</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 3</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td>Cost will be a barrier to implementation.
Implementation could require the creation of a pilot program or new program over many years.</td><td>Implementation of this recommendation will benefit a large population of the general public including, but not limited to, older adults, people of color, and low-income families.
High potential for cost savings for the general public and safety net programs due to early identification of and intervention for mental health problems related to social isolation.</td></tr>
<tr><td colspan="2">Measuring Impact:
Number of adopters of screening tool.
Suicide rates.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE</td></tr>
</table>

Return to Figure A-1 and Figure D-2.

Prevention and Education Recommendation 4.7: **Normalize Behavioral Health Discussions [New; Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: In lieu of discussing stigma, build on recent success stories (e.g., 988 lifeline, mobile crisis, CCBHC) to publicize behavioral health as health, creating a culture in which mention of depression, anxiety, post-trauma, addiction and other common illnesses become as mentionable as diabetes, heart disease and migraines.</td></tr>
<tr><td colspan="2">Rationale: The Special Committee raised the issue of stigma related to mental illness and addictions and its impact on access to behavioral health services. The working group was provided with select national materials about stigma,[10] and members proposed two distinct recommendations that, after a survey revealed similar support for each, were combined into one by the working group co-chairs. The original proposed options were to: a) “Publicize help lines to encourage people to get help before they are suicidal or in crisis. Increase access to therapy and medications for the uninsured. Find success stories and promote them publicly.”; and b) “Just talk about mental health (not stigma). Create a culture in which mention of depression, anxiety, post-trauma, and other common illnesses become as mentionable as diabetes, hypertension, and migraines.” After a survey revealed similar support for both concepts, the working group co-chairs proposed combining them. Culturally appropriate outreach campaigns — including social media campaigns and public service announcements — can be designed for accessibility to diverse audiences.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 3</td><td>Potential for High Impact (Score 1-10): 8</td></tr>
<tr><td>Cost may be a barrier to implementation.
May require program change.</td><td>High potential for impact for large population, particularly those in foster care, rural and urban communities, those with limited English proficiency, and low-income individuals.
May produce cost savings for both general public and for safety net programs.</td></tr>
<tr><td colspan="2">Measuring Impact:
Behavioral Risk Factor Surveillance System optional mental illness and stigma module.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: KDHE</td></tr>
</table>

Return to Figure A-1 and Figure D-1.

Prevention and Education – Revised Recommendations

Prevention and Education Recommendation 4.1: **988 Suicide Prevention Lifeline Funding [Revised; Immediate Action]**

Recommendation: Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources. The Legislature should consider HB 2281 in the 2022 session to ensure funds are available in July 2022.	
Rationale for Revision: The working group reaffirmed the importance of funding the 988 Suicide Prevention Lifeline. 988 will go into effect in July 2022 regardless of funding mechanism as per federal requirements. The working group maintains that a telecommunications surcharge remains the best method to ensure 988 has the resources needed to appropriately respond to all calls. The NSPL is a national network of local crisis centers that provides support to people in suicidal crisis or emotional distress. The NSPL will transition from a 10-digit phone number to 988 by July of 2022, making it easier for individuals to know what number to call when in crisis; some phone providers have already begun making this transition.[11] The change is expected to contribute to an increase in the number of individuals using the NSPL, which currently attempts to match callers to in-state crisis centers when possible. Between October 1, 2019, and December 31, 2019, 60 percent of NSPL calls initiated in Kansas were answered by Kansas providers.[12] Increasing the in-state answer rate will ensure that Kansans in crisis are connected to providers who can direct them to local resources.	
Ease of Implementation *(Score 1-10): 5*	**Potential for High Impact** *(Score 1-10): 8*
• Would likely involve a program overhaul, involving additional staff and training. • Sustainability is considered in the recommendation via fee collection. The recommendation does not include funding for a crisis text line. • Will require a legislative session, contracts, grant cycles and systems to implement.	• Will benefit a large population. • Could produce savings in other areas.
Measuring Impact: • National Suicide Prevention Lifeline Answer Rate. • Percent change in the statewide age-adjusted mortality rate for suicide per 100,000 population.	
Action Lead: KDADS	**Key Collaborators:** Crisis centers, CMHCs, Legislature

Return to Figure A-1 and Figure D-1.

Prevention and Education Recommendation 4.4: **Behavioral Health Prevention [Revised; Strategic Importance]**

Recommendation: Increase state funds for behavioral health prevention efforts to support additional evidence-based primary prevention and grant opportunities for community prevention activities.
Rationale for Revision: The original language of the recommendation — "Increase state funds for behavioral health prevention efforts (e.g., substance use disorder [SUD] prevention, suicide prevention)" — was considered overly broad by some working group members, while others said the interpretation of the 2020 recommendation had been interwoven with specific state activities, including the Kansas Suicide Prevention Plan, and did not require more specificity. To reach consensus, the working group asked KDADS to suggest language that would highlight how the recommendation could support expanding prevention opportunities. The new language highlights opportunities to increase evidence-based primary prevention and provide grant funding for community organizations to implement prevention activities.

Return to Figure A-1 and Figure D-2.

Treatment and Recovery – Revised Recommendations

Treatment and Recovery Recommendation 5.3: **Frontline Capacity [Revised; Immediate Action]**

Recommendation: Fully fund a statewide psychiatric access program that includes linked specialty teams with high levels of expertise (e.g., psychiatrists, child and adolescent psychiatrists, peripartum psychiatrists, child psychologists, pediatricians, resource specialists, and patient and family advocates) to provide multi-disciplinary consultations, training, and resource and referral support to health care providers across the lifespan. Ensure continuation of current pregnant/postpartum and pediatric programs starting July 2023 (FY 2024). Expand current programs to include specialty teams for children (through 21 years of age) with Intellectual/Developmental Disability (I/DD) and children (through 21 years of age) with Autism Spectrum Disorder starting July 2024 (FY 2025), and for adults with mood disorders starting July 2025 (FY 2026).
Rationale for Revision: The revision refined the previous version of the recommendation ("Increase capacity of frontline health care providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.") by adding specificity about the KDHE program currently supported by two distinct federal grants, one focused on providers who work with pregnant and postpartum individuals (Kansas Connecting Communities), and another focused on pediatric primary care providers (KSKidsMAP). These grant programs are modeled after two psychiatric access programs developed in Massachusetts, where they proved to be effective.[13,14] While federal grants have covered initial implementation activities (e.g., provider-to-provider consultation), these funds will expire in 2023. Private insurers may also be interested in this service and could be collaborated with to move this recommendation forward.

Ease of Implementation *(Score 1-10): 5*	**Potential for High Impact** *(Score 1-10): 6*
• Cost will be a barrier to implementation. $1.18 million is needed to continue the perinatal and pediatric psychiatric access programs starting in FY 2024. An additional $500,000 (estimated) is needed to expand the psychiatric access programs to include health care providers treating pediatric patients with I/DD and/or autism in FY 2025. An additional $500,000 (estimated) is needed to expand to include adults with mood disorders starting in FY 2026. ▪ SFY2024 - $1.18 million (est.) ▪ SFY2025 - $1.68 million (est.) ▪ SFY2026 - $2.18 million (est.) • Expansion may require creation of a pilot program or program change.	• Potential for impact is dependent on the participation of primary care providers with higher participation rates leading to increased impact. • Recommendation has potential for high impact, particularly for those in foster care, rural communities, those with limited English proficiency or low-income, and those with SUD diagnoses.
Measuring Impact: • Number of pediatric primary care providers who enroll in a pediatric mental health care access program. • Number of perinatal providers who enroll in a perinatal psychiatric access program. • Utilization of Maternal Depression Screening Medicaid codes.	
Action Lead: KDHE	**Key Collaborators:** KU School of Medicine – Wichita and Kansas City

Return to Figure A-1 and Figure D-1.

Special Populations – New Recommendation

Special Populations Recommendation 6.6: **Medicaid Postpartum Coverage [New; Immediate Action]**

Recommendation: Request Robert G. (Bob) Bethell Home and Community Based Services and KanCare Oversight Committee review of extending the Medicaid postpartum coverage period to 12 months postpartum. This supports access to behavioral health treatment and other preventive care, thus improving health outcomes for both the mother and child.
Rationale: Working group members identified that Medicaid postpartum coverage is limited to 60 days in Kansas but had been extended temporarily due to the COVID-19 policy restricting disenrollment during the public health emergency. Kansas now has the option to decide to extend postpartum coverage up to 12 months, and the state's actuaries estimate this action will have no impact or a small positive impact on budget neutrality for KanCare and an estimated annual cost of $10.5 million a year. Working group members noted extended coverage would increase access to behavioral health services.

<table>
<tr><td colspan="2">There was consensus that this would have a positive impact on health but concern from the working group members that more information is needed to determine a cost/impact ratio, including what the cost of doing nothing would include[15, 16]. In a 2021 report, the Commonwealth Fund examines the financial cost of failing to treat maternal morbidity conditions in the United States. Maternal mental health carried the highest cost of the conditions studied with $18.1 billion which authors suggest signals a need for increased access to post-partum behavioral health services.[17] The recommendation was modified to serious consideration by the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 10</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td>Requesting Bethell Committee review has a high ease of implementation; however, should the Bethell Committee decide to pursue this recommendation either through a state plan amendment or a 1115 waiver, implementation may be more difficult.
The estimated cost of $10.5 million SGF, because of other savings, would have no effect on budget neutrality or could produce net savings.</td><td>The recommendation has potential for very high impact, particularly for pregnant and postpartum mothers.
The recommendation could address disparities in maternal health outcomes among people of color and low-income populations.
There is a potential for cost savings in the rest of the health care system as well as the child welfare system.</td></tr>
<tr><td colspan="2">Measuring Impact:
Maternal morbidity rates.</td></tr>
<tr><td>Action Lead: Legislature</td><td>Key Collaborators: KDHE</td></tr>
</table>

Return to Figure A-1 and Figure D-1.

Special Populations – Related Activities

The 2020 *Strategic Framework* included a recommendation to expand the Medicaid waiver for individuals with intellectual or developmental disabilities. The 2021 Special Committee indicated interest in addressing the Autism waiver and services for children and adolescents with autism spectrum disorder. The Special Committee received an update on related recommendations from the Autism Task Team convened by KDADS and DCF in 2021.

The Services and Workforce Working Group also received an update from the Autism Task Team on its work and recommends that Special Committee members and readers of this report reference the Autism Task Team recommendations that will be published in January 2022. Key recommendations may include expanding access to autism services via telehealth, developing systems that allow for individualized budget authority, incentivizing providers to serve rural and underserved communities, and exploring options to expand services for youth with autism.

The working group also refers readers to the recommendations of the Governor's Commission on Racial Equity and Justice, which were presented to the Special Committee in November 2020[18] prior to their adoption. Many of the recommendations align with those made by the working groups of the Special Committee in 2020 and 2021, including regarding a statewide needs assessment, expanded telehealth access, suicide prevention, school-based mental health services, workforce, and 12-month postpartum Medicaid coverage. The Commission also adopted a number of recommendations related to social determinants of health and early childhood mental health services.

Data Systems – New Recommendations

Data Systems Recommendation 7.6: **Outcomes Data [New; Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Work with the State Epidemiological Outcomes Workgroup (SEOW) to establish an annual legislative report on state behavioral health outcomes using existing data and outcome measures.</td></tr>
<tr><td colspan="2">Rationale: The working group was assigned this topic by the Special Committee for 2021. The working group acknowledged legislative concerns about lags in data availability and discussed how to address concerns for the need for current data. Working group members proposed that outcome indicators be selected in advance and analyzed in collaboration with the State Epidemiological Outcomes Workgroup (SEOW). Examples could include hospital admissions and key social determinants of health, including housing and employment stability. The SEOW was created to integrate efforts around data collection, bringing together a diverse group of data experts to support the state's prevention infrastructure. It meets quarterly and maintains a wide array of behavioral health indicators. When available, all indicators report data related to prevalence, treatment and consequences by age, gender, race and ethnicity.[19]</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 6</td><td>Potential for High Impact (Score 1-10): 5</td></tr>
<tr><td>• Cost will be a barrier to implementation.
• Implementation may require program overhaul, creation of a pilot program, and/or program change.</td><td>• Benefits a large population.
• Will impact foster care children, rural communities, urban communities, limited English proficient persons, low-income individuals, and children.
• Will assist in measurement of disparities.</td></tr>
<tr><td colspan="2">Measuring Impact:
• Data provided to Legislature and used for policy decision making.
• Use in production of disparities analysis.</td></tr>
<tr><td>Action Lead: State Epidemiological Outcomes Workgroup</td><td>Key Collaborators: Legislative Health Committees</td></tr>
</table>

Return to Figure A-1 and Figure D-2.

Interactions with Legal System and Law Enforcement – New Recommendations

Interactions with Legal System and Law Enforcement Recommendation 8.5: **Regional Specialty Courts/Venue Transfer [New; Strategic Importance]**

<table>
<tr><td colspan="2">Recommendation: Explore creation of regional specialty courts across Kansas. Consider implications related to venue transfer for access to regional specialty courts.</td></tr>
<tr><td colspan="2">Rationale: Specialty courts — including veterans courts, drug courts and mental health courts — are designed to provide individualized and rehabilitative treatment, and to reduce recidivism. In addition to the 2020 Recommendation 8.2 related to specialty courts, the working group proposed a new recommendation related to regional specialty courts and venue transfer to address the need for services and supports, particularly in rural and frontier areas of Kansas that may lack resources. In order to pursue a regional court model, legislative action permitting venue transfer will be required. Working group members also discussed the challenges of limited funding for specialty courts and how state-level funding may not necessarily be the best solution. Working group members called for specialty court funding from multiple funding streams. Ultimately the group decided to refer the issue to the judicial branch’s Specialty Courts Committee.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 3</td><td>Potential for High Impact (Score 1-10): 10</td></tr>
<tr><td>• Will require legislative change.
• Cost will be a barrier.</td><td>• Could produce savings in correctional system costs.
• Would impact disproportionately affected populations</td></tr>
<tr><td colspan="2">Measuring Impact:
• Recidivism rates.
• Number of judicial districts with access to specialty courts.
• Individuals referred for services.
• Individuals receiving treatment.</td></tr>
<tr><td>Action Lead: Specialty Courts Committee (judicial branch)</td><td>Key Collaborators: Office of Judicial Administration, Legislature</td></tr>
</table>

Return to Figure A-1 and Figure D-2.

Interactions with Legal System and Law Enforcement Recommendation 8.6: **Specialty Court Coordinators [New; Immediate Action]**

<table>
<tr><td>Recommendation: Provide funding for judicial districts that meet qualifying criteria to hire specialty court coordinators.</td></tr>
<tr><td>Rationale: Working group members said because specialty courts require substantial work, related recommendations will necessitate the funding of coordinator positions to facilitate the workload. To expand current specialty court capacity or create new specialty courts, funding will be required to ensure the specialty courts function as intended and can access the full range of wrap-around services proposed. In testimony to the Special Committee, judges</td></tr>
</table>

described the effectiveness of specialty courts in reducing recidivism. They also described the need to rely on grant funding to originate specialty courts and concern about what happens after grants expire. HB 2361,[20] which passed the House in 2021 and has been referred to the Senate Judiciary Committee, would, among other actions, establish the Specialty Court Funding Advisory Committee within the judicial branch to evaluate resources available for people assigned to specialty courts and for the operation of specialty courts; secure funding to operate courts; and recommend to the Judicial Administrator the allocation of resources among the various specialty courts.	
Ease of Implementation *(Score 1-10): 4*	**Potential for High Impact** *(Score 1-10): 9*
• Will require funding. • Related legislation has passed one chamber of the Legislature.	• Could produce savings in correctional costs.
Measuring Impact: • Number of judicial districts with access to specialty courts. • Recidivism rates. • Number of individuals in court system receiving treatment.	
Action Lead: Judicial Branch	**Key Collaborators:** Legislature

Return to Figure A-1 and Figure D-1.

Interactions with Legal System and Law Enforcement Recommendation 8.7: **Competency Evaluation and Restoration [New; Immediate Action]**

Recommendation: Provide funding for community mental health centers to conduct mobile competency evaluation and competency restoration.
Rationale: KDADS provided the working group with an update on the current status of competency evaluations and competency restoration. This update highlighted the limited capacity and long wait periods — with an average wait time for a competency evaluation of 170 days for males, with some waiting up to 360 days to complete. Additionally, KDADS highlighted the potential for mobile competency evaluations to help reduce long waiting periods but said this will not serve everyone. The working group called for immediate action to remedy unjust waiting periods and proposed other options for increasing capacity be explored including the potential for telehealth and Osawatomie State Hospital (OSH) or CMHCs to assist in the completion of competency evaluations. Implementation will be impacted by community mental health center interest in participating and funding. Working group members explained a first step would likely involve developing a pilot program for those CMHCs interested in conducting competency evaluations or restoration. Although the working group acknowledges that only a small portion of the overall state population will benefit from implementation, working group members noted the current due process issues with the long wait times for competency evaluations. Improving access to competency evaluations will have a very high impact on those currently affected.

Ease of Implementation *(Score 1-10): 8*	**Potential for High Impact** *(Score 1-10): 8*
• Cost will be a barrier. • Recommendation does not currently include strategies for continuity. • Implementation will likely require a pilot program.	• Will not benefit a large population, but will have a substantially high impact on those who have long waiting periods for competency evaluations. • Will impact foster children, rural and urban communities, limited English proficient persons, low-income individuals and children. • Will produce cost savings in other areas
Measuring Impact: • Number of days people wait for competency evaluations. • Number of days people wait for competency restoration services.	
Action Lead: KDADS	**Key Collaborators:** CMHCs, prosecutors, defense counsel, Office of Judicial Administration

Return to Figure A-1 and Figure D-1.

Interactions with Legal System and Law Enforcement – Revised Recommendations

Interactions with Legal System and Law Enforcement Recommendation 8.1: **Correctional Employees [Revised; Immediate Action]**

Recommendation: Expand training provided in state correctional facilities, local jails and detention centers to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services.
Rationale for Revision: The working group recommended revising the language of the recommendation to clarify that training should include staff of local as well as state facilities. Trainings throughout the justice system should be offered on a consistent and ongoing basis.

Return to Figure A-1 and Figure D-1.

Interactions with Legal System and Law Enforcement Recommendation 8.3: **Law Enforcement Referrals [Revised; Immediate Action]**

Recommendation: Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to inpatient, residential and outpatient services for this population.

Rationale for Revision: The working group revised the recommendation to ensure it is interpreted broadly to include funding to support access to residential services as well as inpatient and outpatient services.

Return to Figure A-1 and Figure D-1.

Interactions with Legal System and Law Enforcement Recommendation 8.4: **Defining Crossover Youth Population. [Revised; Strategic Importance]**

Recommendation: Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population. Coordinate with juvenile corrections advisory boards to ensure local implementation aligns with statewide policy team recommendations.
Rationale for Revision: Since the previous 2020 Special Committee meetings, the Kansas Department of Corrections (KDOC) completed this work and established statewide recommendations for working with crossover youth. Ideally, these recommendations are implemented by local Juvenile Corrections Boards, which operate in each judicial district. However, working group members advised that local agencies have not uniformly adopted these recommendations. The working group proposed re-opening this recommendation and adding the new language to clarify expectation that local agency responses align with statewide policy team expectations.

Return to Figure A-1 and Figure D-2.

System Transformation – Revised Recommendations

System Transformation Recommendation 9.3: **Integration [Revised; Immediate Action]**

Recommendation: Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. For example, adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions.
Rationale for Revision: The revision clarifies that adopting coding practices that facilitate integration of primary medical and behavioral health care is one critical step toward the goal of providing best-practice, whole-person care, and that other strategies can and should be considered.

Return to Figure A-1 and Figure D-1.

System Transformation Recommendation 9.5: **Family Psychotherapy [Revised; Strategic Importance]**

Recommendation: Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care. This would allow therapists/practitioners to have discussions without the child present.
Rationale for Revision: State staff reported that one element from the previous version of this recommendation ("Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility (PRTF).") — the provision about using the code for children in PRTFs — would not be approvable by the CMS, as it is considered content of service for the PRTF per diem. KDHE and KDADS staff anticipate the state plan amendment necessary to allow billing of 90846 in other settings will be submitted by January 2022. Services in evidence-based programs that can be billed using the code include Parent Management Training of Oregon (PMTO), Emotion Focused Family Therapy, and Brief Solution Focused Therapy.

Return to Figure A-1 and Figure D-2.

Telehealth – Revision to Vision Statement

A modernized behavioral health system will deliver technologically current telehealth services, with the Kansas Telemedicine Act as a foundation, as a strategy to provide meaningful access to care across rural, frontier and urban areas and regardless of socioeconomic status. These services will be high-quality, integrated with other modes of care delivery and ensure consumer choice and privacy, in addition to supporting the full spectrum of behavioral health care.

Telehealth – New Recommendation

Telehealth Recommendation 10.6: **Telemedicine Committee [New; Strategic Importance]**

Recommendation: The Legislative Coordinating Council shall establish a Special Committee on Telemedicine Modernization.
Rationale: The working group called for the conversation on telehealth modernization to be continued beyond the 2021 Special Committee on Kansas Mental Health Modernization and Reform. Having received clarification on the Kansas Telemedicine Act, working group members noted a continued need for education and discussion about telemedicine rates and usage. However, the working group determined that telehealth usage remains unpredictable due to the pandemic, and more data collection is needed to better understand the future of telemedicine in Kansas prior to making decisions related to telehealth rates or payment parity.

The working group charges this new Special Committee on Telemedicine Modernization with the development of guidelines and standards for quality assurance as one of their first acts (See Recommendation 10.1).	
Ease of Implementation *(Score 1-10):* 2	**Potential for High Impact** *(Score 1-10):* 10
• The creation of the committee will likely have a high ease of implementation, but the decisions this committee will make may be highly challenging.	• Implementation of this recommendation has a strong potential for high impact, particularly among populations with limited mobility and those lacking vehicle transportation. • Potential for cost savings depending on decisions made by this committee.
Measuring Impact: • Statutory change. • Increase in telehealth accessibility and affordability based on review of telehealth claims data.	
Action Lead: Legislative Coordinating Council (LCC), Legislature	**Key Collaborators:** Providers, consumers, Legislature, private insurers, employers (particularly self-insured), KDHE, KDADS, regulatory boards

Return to Figure A-1 and Figure D-2.

Telehealth – Revised Recommendations

Telehealth Recommendation 10.1: **Quality Assurance [Revised; Immediate Action]**

Recommendation: Develop quality assurance standards to ensure high-quality telehealth services are provided, including: • Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies. • Allowing telehealth supervision hours to be consistently counted toward licensure requirements. • Allowing services to be provided flexibly utilizing the Kansas Telemedicine Act. • Improving provider and patient education around telehealth literacy in relation to privacy, efficacy, access and cybersecurity practices.
Rationale for Revision: The working group identified key barriers for implementation of the previous 2020 recommendation of Telehealth Quality Assurance, including confusion with the Kansas Telemedicine Act and gaps in provider training around maintaining a standard of care in a telehealth setting. To address this, the working group proposed increased provider and patient education around the appropriate use of technology to ensure the same quality of care of both in-person and telehealth visits and improve e-health literacy in relation to privacy, efficacy, and

access. Working group members also called for increased training in relation to cybersecurity best-practices and for the creation of consistent guidelines in collaboration with licensing and regulatory agencies. This recommendation scores high for ease of implementation because many providers are already familiar with telehealth services and the trainings needed for further provider and patient education are widely available. The only potential challenge to implementation that the working group identified was that some providers may have limited information technology (IT), creating challenges for their capacity to carry out telehealth services.	
Ease of Implementation *(Score 1-10): 9*	**Potential for High Impact** *(Score 1-10): 8*
• Implementation will likely require program change. • Providers' IT systems may be a challenge for implementation.	• Recommendation has potential for high impact, particularly for those in foster care, rural communities, and those with limited mobility.
Measuring Impact: • Trends in telehealth utilization rates.	
Action Lead: Special Committee on Telemedicine Modernization (established through Recommendation 10.6)	**Key Collaborators:** KDHE, KDADS, providers, BSRB, private insurers, regulatory bodies, Kansas Insurance Department, state associations, health care provider associations, providers' professional associations across continuum of care, Legislature

Return to Figure A-1 and Figure D-1.

Telehealth Recommendation 10.2: **Reimbursement Codes [Revised; Immediate Action]**

Recommendation: As CMS rules allow, maintain Medicaid reimbursement codes added during the public health emergency for telehealth services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.
Rationale for Revision: Many of the reimbursement codes added during the pandemic that were intended to prevent loss of facility fees remain in use. The working group identified these code expansions as key to improved provision of telehealth services to patients during the pandemic. In order to ensure this continued access, the working group revised this recommendation to call for maintenance of the current codes as permitted by CMS rules. Working group members do note that should the state choose to allow facility fees for behavioral telehealth providers, other providers may ask for the same accommodation. For a long-term solution, working group members encourage the exploration of new or different codes to help in long-term prevention of providers losing revenue by providing telehealth services if CMS rules were to change.

Ease of Implementation *(Score 1-10): 10*	**Potential for High Impact** *(Score 1-10): 10*
• Implementation will require program maintenance as Medicaid already does this currently.	• This recommendation will benefit a large population.
Measuring Impact: • Number of telehealth codes open for Medicaid reimbursement pre- and post-pandemic. • Utilization of these telehealth codes.	
Action Lead: KDHE Division of Health Care Finance	**Key Collaborators:** KDADS, managed care organizations, CMHCs, provider and payer professional associations, Medicare/Medicaid and insurance representatives, hospital advisory boards, patient advocacy groups, Legislature, CMS

Return to Figure A-1 and Figure D-1.

Telehealth Recommendation 10.3: ***Telehealth for Crisis Services*** **[Revised; Immediate Action]**

Recommendation: Continue coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities. Engage professional associations statewide to adopt appropriate education for providers, practitioners and law enforcement officers on using telehealth for crisis services.
Rationale for Revision: The Medicaid state plan amendment to allow coverage of mobile crisis services was submitted to CMS in October, with a proposed effective date of October 1, 2021. In recognition of the work done to allow for the use of telehealth for crisis services, the working group revised the recommendation to call for continued services and a stronger emphasis on training around best practices for law enforcement and provider use of telehealth in crisis response. The working group called for KDHE to engage professional associations to adopt education to provide this training. One potential way professional associations could pursue this education with minimal administrative burden is through the integration of telehealth for crisis services training into continuing education requirements. Although working group members said that many such training courses already exist for law enforcement and practitioners, variation across the state may make this more challenging for some to adopt compared to others.

Ease of Implementation *(Score 1-10): 6*	**Potential for High Impact** *(Score 1-10): 9*
• Implementation may require program change.	• This recommendation could impact a large population, with a particularly significant impact for homeless and limited English proficient individuals and children in foster care.
Measuring Impact: • Number of telehealth crisis codes open for Medicaid reimbursement. • Utilization of these telehealth crisis codes.	
Action Lead: KDHE	**Key Collaborators:** KDADS, KDOC, DCF, local law enforcement, providers, affected licensing agencies and professional associations, BSRB, nursing/physician representation, emergency medical services (EMS), behavioral health practices, Legislature

Return to Figure A-1 and Figure D-1.

Telehealth Recommendation 10.4: ***Originating and Distant Sites*** **[Revised; Strategic Importance]**

Recommendation: The following item should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations: • Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts. *(Some 2020 language removed)*
Rationale for Revision: The working group expressed concerns about provider confusion around the Kansas Telemedicine Act in relation to Originating and Distant Sites and existing inter-state compacts. Generally, behavioral health providers must have a state license to practice within the state that the originating site is located, even when the distant site is out of state. With a compact, licensed behavioral health providers in one compact state can practice or be a distant site in any other compact state. Most compacts are specific to licensure category. For example, the American Counseling Association's work with the Council of State Governments (CSG) National Center on Interstate Compacts on an interstate compact for licensed counselors is expected to cover licensed professional counselors and is hoped to include 10-12 initial states by 2023. Use of these compacts could greatly benefit a large population, particularly those in rural areas of Kansas where access to providers is limited. The working group called for further examination of these issues to further the modernization of telehealth in Kansas.

Ease of Implementation *(Score 1-10): 10*	**Potential for High Impact** *(Score 1-10): 10*
• Implementation may require program change.	• Implementation of this recommendation has a high potential for high impact because of its potential to increase access to care.
Measuring Impact: • Number of contracts with providers outside of state. • Use of compacts.	
Action Lead: Legislature	**Key Collaborators:** KDHE, KDADS, providers, health care providers' professional associations, insurance agencies, Medicare/Medicaid, BSRB, licensing boards, professions' regulatory boards

Telehealth Recommendation 10.5: ***Child Welfare System and Telehealth*** **[Revised; Strategic Importance]**

Recommendation: Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Explore how the unique needs of parents of children in the child welfare system can be met via telehealth.	
Rationale for Revision: Working group members identified an opportunity for telehealth to aid in addressing the unique needs of parents of children in the child welfare system. They recommend further exploration of how telehealth could help address these needs. The working group also identified this as an issue that telehealth could help address and requested greater effort towards maintaining contact and continuation of therapy for these children.	
Ease of Implementation *(Score 1-10): 10*	**Potential for High Impact** *(Score 1-10): 10*
• Implementation could require program change.	• Implementation will significantly impact children, those in foster care, and low-income individuals.
Measuring Impact: • Utilization of telehealth across foster children eligibility groups. • When a child comes into care or goes to a new placement, the CMHC will provide therapy within 72 hours of receiving the request. • Percentage of child in need of care (CINC) children/adolescents, age 17 or younger, that received crisis intervention services 30 calendar days prior to a screen resulting in inpatient psychiatric admission, excluding PRTF (i.e., CINC crisis intervention rate). • The percentage of CINC children/adolescents that received therapeutic intervention services (includes more than initial assessment and diagnosis such as peer support, psychosocial individual/group, community psychiatric support and treatment, therapy and/or intake) within 30 calendar days prior to a screen resulting in an inpatient psychiatric admission, excluding PRTF (i.e., CINC therapeutic intervention rate).	

Action Lead: KDHE	**Key Collaborators:** KDADS, DCF, child welfare and advocacy organization representatives, school health professionals, BSRB, foster care contractors, CMHCs

Return to Figure A-1 and Figure D-2.

Appendix A. Summary of All Recommendations from 2020 and 2021, As Revised

Figure A-1. **Working Group High-Priority Recommendations by Topic**

WORKFORCE
Immediate Action
Recommendation 1.1 Clinical Supervision Hours. Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers***. (Complete)***
Recommendation 1.2 Access to Psychiatry Services. Request a Legislative Post Audit to review Kansas behavioral health recipients of National Health Service Corps (NHSC) and State Loan Repayment Program (SLRP) for the past 10 years; review professions awarded, communities in which those providers were located, number of years they participated in the program, and number of years they continued to practice in their position after they exited the program; expand the analysis to the behavioral health professions served in these programs (not just psychiatry); review best practices from other states regarding recruitment and retention of licensed behavioral health professional staff to Urban, Rural, and, Frontier communities for possible, if successful, implementation in Kansas; review medical school and residency training location of psychiatrists and child and adolescent psychiatrists currently practicing in Kansas, as well as current practice locations of residents and fellows in child psychiatry who completed residency or fellowship in Kansas within the last 10 years; review existing research regarding where fellows practice in relation to where they trained; and look at the University of Kansas program that incentivizes medical students to end up practicing in Kansas to see if it is effective. ***(Revised)***
Recommendation 1.3 Provider MAT Training. Increase capacity and access to medication-assisted treatment (MAT) in Kansas through provider training on MAT. ***(In progress)***
Strategic Importance
Recommendation 1.4 Workforce Investment Plan. The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include: • The state should establish a Kansas university partnership to develop the comprehensive investment plan, including a focus on high school internships, mentorship and free continuing education courses, building on the model the Special Committee heard about in Nebraska; • Seed university programs to develop and expand bachelor's and graduate programs in behavioral health;

- Create a pool of funds that behavioral health providers could access to support retention and recruitment;
- Develop a career ladder for clinicians, such as through the development of an associate-level practitioner role; and
- Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency.

(Revised)

Recommendation 1.5 Family Engagement Practices. Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families. ***(In progress)***

FUNDING AND ACCESSIBILITY

Immediate Action

Recommendation 2.1 Certified Community Behavioral Health Clinic Model. Support expansion of the federal Excellence in Mental Health Act and then pursue participation. If participation in the Excellence in Mental Health Act is not possible, pursue a state plan amendment or change to the 1115 Waiver to allow interested providers to gain access to the Certified Community Behavioral Health Clinic (CCBHC) model. ***(In progress)***

Recommendation 2.2 Addressing Inpatient Capacity by Implementing a Regional Model. Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings, supplementing the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Ongoing analysis should be conducted to identify geographic areas of need and gaps in levels of care. ***(Revised)***

Recommendation 2.3 Reimbursement Rate Increase and Review. Implement an immediate increase of 10-15 percent for reimbursement rates for all providers of behavioral health services. After increasing reimbursement rates, establish a working group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population. ***(Revised)***

Recommendation 2.4 Suicide Prevention. In support of the 2021-2025 Kansas Suicide Prevention Plan: standardize definitions of data collected related to suicide data and making suicide a reportable condition; propose policy to ensure consistent data collection across the state, including for diverse populations (include demographics); leverage the Kansas Suicide Prevention Coalition to enable collaboration among all agencies engaged in suicide prevention; designate KDADS (the single state authority for federal mental health and substance use disorder programs) as lead agency for implementation of the State Suicide Prevention Plan and collaborate with the Youth Suicide Prevention Coordinator in the office of the Attorney General; add $1,500,000 SGF to KDADS budget to implement additional

recommendations and strategies from the State Suicide Prevention Plan, including $250,000 for the Kansas Suicide Prevention Coalition, $90,000 for a full-time state suicide prevention coordinator (population-wide), and the remainder for providing grant opportunities for local communities and implementing a statewide media campaign; require KDADS to submit an annual report on the progress from collaborating state agencies and the coalition as to the status and effectiveness of state suicide prevention policies and interventions as well as any updates to the State Suicide Prevention Plan to the Governor's Behavioral Health Services Planning Council and its Prevention Subcommittee. ***(Revised)***

Recommendation 2.5 Problem Gambling and Other Addictions Fund. Recommend the State continue to incrementally increase the proportion of money in the Problem Gambling and Other Addictions [Grant] Fund that is applied to treatment over the next several years until the full fund is being applied as intended. ***(In progress)***

Recommendation 2.6 Expand Mental Health Intervention Team Program. Expand the Mental Health Intervention Team grant program to additional school districts. Support continuity and provide a way for students to access services when schools are not open by extending the times of services at schools, utilizing Community Mental Health Centers, or utilizing other mental health resources. ***(New)***

High-Priority Discussion

Medicaid Expansion. In addition to these recommendations for immediate action and of strategic importance, the working group also puts forward the issue of Medicaid expansion as a high-priority discussion item for the Special Committee. The recommendation discussed by the working group related to Medicaid Expansion reads, "Recommend a full expansion of Medicaid in order to increase access to health care for uninsured, low-income Kansans."

More information is available in the Funding and Accessibility section, and can be accessed by selecting the link above.

COMMUNITY ENGAGEMENT

Immediate Action

Recommendation 3.1: Crisis Intervention Centers. Utilize state funds to support the expansion of crisis centers around the state. ***(In progress)***

Recommendation 3.2 IPS Community Engagement. Increase engagement of stakeholders, consumers, families, and employers through the Kansas Department of Health and Environment (KDHE) or Kansas Department for Aging and Disability Services (KDADS) by requiring agencies implementing the Individual Placement and Support (IPS) program to create opportunities for assertive outreach and engagement for consumers and families. ***(In progress)***

Strategic Importance
Recommendation 3.3 Foster Homes. The State of Kansas should invest in foster home recruitment and retention by: • Increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth; • Supporting families navigating child welfare and Medicaid programs; • Continuing investment in recruiting, preparing and supporting families to serve high-acuity and older youth, and in recruiting, preparing, retaining and supporting African-American families; • Providing in-home therapeutic parenting services for families to meet high-acuity needs; and • Ensuring services are available across the continuum of care for youth discharged from inpatient or PRTF settings. ***(Revised)***
Recommendation 3.4 Community-Based Liaison. Expand locations where community-based liaisons are available to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with SUD and co-occurring conditions. ***(Revised)***

PREVENTION AND EDUCATION
Immediate Action
Recommendation 4.1 988 Suicide Prevention Lifeline Funding. Once the 988 National Suicide Prevention Lifeline (NSPL) phone number is implemented, Kansas should collect fees via phone bills to support increasing the in-state answer rate and ensure that callers are connected to in-state resources. The Legislature should consider HB 2281 in the 2022 session to ensure funds are available in July 2022. ***(Revised)***
Recommendation 4.2 Early Intervention. Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover early childhood mental health screening, assessment, and treatment. ***(In progress)***
Recommendation 4.3 Centralized Authority. Centralize coordination of behavioral health – including substance use disorder and mental health – policy and provider coordination in a cabinet-level position. ***(Complete)***
Recommendation 4.5 Trauma-Informed Care. Under the auspices of the Governor's Behavioral Health Services Planning Council (GBHSPC), convene a workgroup of providers who have implemented trauma-informed practices to make recommendations for a pilot program or other initiative to expand trauma-informed practices statewide. ***(New)***

Recommendation 4.7 Normalize Behavioral Health Discussions. In lieu of discussing stigma, build on recent success stories (e.g., 988 lifeline, mobile crisis, CCBHC) to publicize behavioral health as health, creating a culture in which mention of depression, anxiety, post-trauma, addiction and other common illnesses become as mentionable as diabetes, heart disease and migraines. ***(New)***

Strategic Importance

Recommendation 4.4 Behavioral Health Prevention. Increase state funds for behavioral health prevention efforts to support additional evidence-based primary prevention and grant opportunities for community prevention activities. ***(Revised)***

Recommendation 4.6 Promoting Social Isolation as a Public Health Issue. Create strategies to disseminate the importance of social isolation as a public health issue, using social media and media campaigns, educating providers, and encouraging adoption of a screening tool. ***(New)***

TREATMENT AND RECOVERY

Immediate Action

Recommendation 5.1 Psychiatric Residential Treatment Facilities. Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools. ***(In progress)***

Recommendation 5.3 Frontline Capacity. Fully fund a statewide psychiatric access program that includes linked specialty teams with high levels of expertise (e.g., psychiatrists, child and adolescent psychiatrists, peripartum psychiatrists, child psychologists, pediatricians, resource specialists, and patient and family advocates) to provide multi-disciplinary consultations, training, and resource and referral support to health care providers across the lifespan. Ensure continuation of current pregnant/postpartum and pediatric programs starting July 2023 (FY 2024). Expand current programs to include specialty teams for children (through 21 years of age) with Intellectual/Developmental Disability (I/DD) and children (through 21 years of age) with Autism Spectrum Disorder starting July 2024 (FY 2025), and for adults with mood disorders starting July 2025 (FY 2026). ***(Revised)***

Strategic Importance

Recommendation 5.2 Service Array. Explore options to expand the behavioral health service array, including the expansion of MAT in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured. ***(Complete)***

Recommendation 5.4 Housing. Expand and advance the SSI/SSDI Outreach, Access, and Recovery (SOAR) program (including additional training regarding youth benefits) and the Supported Housing program. ***(In progress)***

SPECIAL POPULATIONS
Immediate Action
Recommendation 6.1 Domestic Violence Survivors. Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies and community providers serving individuals impacted by domestic violence. ***(Complete)***
Recommendation 6.2 Parent Peer Support. Increase access to parent peer support for caregivers and families of youth in the behavioral health system, including ensuring appropriate supports for fathers of dependent children. ***(In progress)***
Recommendation 6.6 Medicaid Postpartum Coverage. Request Robert G. (Bob) Bethell Home and Community Based Services and KanCare Oversight Committee review of extending the Medicaid postpartum coverage period to 12 months postpartum. This supports access to behavioral health treatment and other preventive care, thus improving health outcomes for both the mother and child. ***(New)***
Strategic Importance
Recommendation 6.3 Crossover Youth. Continue to develop linkages between the behavioral health system, juvenile justice system and the child welfare system to increase understanding of treatment options available to youth externalizing trauma in the crossover youth population as current treatment options are not meeting the needs of this population. Then, develop specialty services to meet the needs of this population. ***(Complete)***
Recommendation 6.4 I/DD Waiver Expansion. Fully fund the I/DD waiver and expand I/DD waiver services. Increase reimbursement rates for I/DD services to support workforce expansion. ***(In progress)***
Recommendation 6.5 Family Treatment Centers. Increase the number and capacity of designated family SUD treatment centers as well as outpatient treatment programs across the state. ***(In progress)***

DATA SYSTEMS
Immediate Action

Recommendation 7.1 State Hospital EHR. The new state hospital electronic health record (EHR) system should be interoperable with other data systems in the state. Interoperability should include the ability to automate the current process to reinstate Medicaid benefits following discharge. ***(In progress)***
Recommendation 7.2 Data and Survey Informed Opt-Out. Collect, analyze, use, and disseminate surveillance data to inform prevention. Change legislation regarding public health and behavioral health state surveys, including changing the Kansas Communities That Care (KCTC) and Youth Risk Behavior Surveillance System (YRBSS) surveys from an opt-in consent to an informed opt-out consent, to allow for meaningful data collection. ***(In progress)***
Recommendation 7.3 Information Sharing. Utilize Medicaid funds to incentivize participation in health information exchanges (e.g., LACIE/KHIN). Explore health information exchanges as information source on demographic characteristics, such as primary language and geography for crossover youth and other high priority populations. ***(In progress)***
Recommendation 7.4 Needs Assessment. Conduct a statewide needs assessment to identify gaps in funding, access to SUD treatment providers and identify specific policies to effectively utilize, integrate and expand SUD treatment resources. ***(In progress)***
Strategic Importance
Recommendation 7.5 Cross-Agency Data. Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment. ***(In progress)***
Recommendation 7.6 Outcomes Data. Work with the State Epidemiological Outcomes Workgroup (SEOW) to establish an annual legislative report on state behavioral health outcomes using existing data and outcome measures. ***(New)***

LEGAL SYSTEM AND LAW ENFORCEMENT
Immediate Action
Recommendation 8.1 Correctional Employees. Expand training provided in state correctional facilities, local jails and detention centers to allow employees to better recognize those with substance use disorders, use a trauma-informed approach to identify other mental health needs, and connect those with needs to available services. ***(Revised)***
Recommendation 8.2 Criminal Justice Reform Commission Recommendations. Implement recommendations developed by the Criminal Justice Reform Commission (CJRC) related to specialty courts (e.g., drug courts) and develop a process for regular reporting on implementation status and outcomes. ***(In progress)***

Recommendation 8.3 Law Enforcement Referrals. Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to inpatient, residential and outpatient services for this population. ***(Previous version complete, now revised)***
Recommendation 8.6 Specialty Court Coordinators: Provide funding for judicial districts that meet qualifying criteria to hire specialty court coordinators. ***(New)***
Recommendation 8.7 Competency Evaluation and Restoration: Provide funding for community mental health centers to conduct mobile competency evaluation and competency restoration. ***(New)***
Strategic Importance
Recommendation 8.4 Defining Crossover Youth Population. Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population. Coordinate with juvenile corrections advisory boards to ensure local implementation aligns with statewide policy team recommendations. ***(Previous version complete, now revised)***
Recommendation 8.5 Regional Specialty Courts/VenueTransfer: Explore creation of regional specialty courts across Kansas. Consider implications related to venue transfer for access to regional specialty courts. ***(New)***

SYSTEM TRANSFORMATION
Immediate Action
Recommendation 9.1 Regional Model. *(See revised Recommendation 2.2)*
Recommendation 9.2 Long-Term Care Access and Reform. Reform nursing facilities for mental health (NFMHs) to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care. Increase access to long-term care (LTC) facilities, particularly for individuals with past involvement with the criminal justice system or those with a history of sexual violence. ***(In progress)***
Recommendation 9.3 Integration. Increase integration, linkage, collaboration and identify care transition best practices among mental health, substance abuse, primary care and emergency departments across the state. For example, adopt coding practices that allow for the integration of services across the continuum of care domains (including, but not limited to, primary care, substance use disorder, and mental health) to provide more integrated services to clients with co-occurring conditions. ***(Revised)***

Strategic Importance
Recommendation 9.4 Evidence Based Practices. Kansas should continue and expand support for use of evidence-based practices (EBP) in the state, including for housing and supported employment. Coordinate EBP utilization across systems (e.g., law enforcement, SUD, mental health care) with a goal of implementing programs with fidelity, when possible. ***(In progress)***
Recommendation 9.5 Family Psychotherapy. Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care. This would allow therapists/practitioners to have discussions without the child present. ***(Revised)***

TELEHEALTH
Immediate Action
Recommendation 10.1 Telehealth Quality Assurance. Develop quality assurance standards to ensure high-quality telehealth services are provided, including: • Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies. • Allowing telehealth supervision hours to be consistently counted toward licensure requirements. • Allowing services to be provided flexibly utilizing the Kansas Telemedicine Act. • Improving provider and patient education around telehealth literacy in relation to privacy, efficacy, access and cybersecurity practices. ***(Revised)***
Recommendation 10.2 Reimbursement Codes. As CMS rules allow, maintain Medicaid reimbursement codes added during the public health emergency for telehealth services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services. ***(In progress, now revised)***
Recommendation 10.3 Telehealth for Crisis Services. Continue coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities. Engage professional associations statewide to adopt appropriate education for providers, practitioners and law enforcement officers on using telehealth for crisis services. ***(Complete, now revised)***
Strategic Importance
Recommendation 10.4 Originating and Distant Sites. The following item should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations:

• Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts. ***(Revised)***
Recommendation 10.5 Child Welfare System and Telehealth. Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Explore how the unique needs of parents of children in the child welfare system can be met via telehealth. ***(Revised)***
Recommendation 10.6 Telemedicine Committee. The Legislative Coordinating Council shall establish a Special Committee on Telemedicine Modernization. ***(New)***

Appendix B: Recommendations Considered Complete

Figure B-1. ***Recommendations Reported as Complete by Lead Agency***

Recommendation	Update from Lead Agency
WORKFORCE	
Recommendation 1.1 Clinical Supervision Hours. Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers***. (Complete)***	**BSRB**: The Board requested introduction of HB 2208 during the 2021 Legislative Session, which was enacted by the Legislature. HB 2208 lowered the number of clinical supervision hours required for a clinical level license, from 4,000 hours to 3,000 hours, for the professions of Master's Level Psychology, Professional Counseling, Marriage and Family Therapy, and Addiction Counseling. This action brought the number of supervision hours in line with the reduction in supervision hours for the social work profession in 2019. Normally, for licensees accruing supervision hours, a training plan amendment would have been necessary to use the new standard, but to expedite the process, the Board waived the requirement of updates to training plans and has allowed licensees to use the requirement immediately upon enactment of the bill. A letter on HB 2208 was sent to all licensees under the BSRB and a message was posted to the front page of the BSRB website to provide notice of the changes in the bill.
PREVENTION AND EDUCATION	
Recommendation 4.3 Centralized Authority. Centralize coordination of behavioral health – including substance use disorder and mental health – policy and provider coordination in a cabinet-level position. ***(Complete)***	**Office of the Governor**: KDADS Secretary Laura Howard has been designated the centralized authority.
TREATMENT AND RECOVERY	
Recommendation 5.2 Service Array. Explore options to expand the behavioral health service array, including the expansion of MAT in block grant services. Make the expanded service array available to individuals across the state, such as KanCare enrollees, those with private insurance and the uninsured. ***(Complete)***	**KDADS**: KDADS has explored options and did expand MAT in Block Grant services.

SPECIAL POPULATIONS	
Recommendation 6.1 Domestic Violence Survivors. Build awareness of and responsiveness to the behavioral health needs and risks of domestic violence survivors of all ages through data analysis, information sharing, workforce training, and targeted interventions between domestic violence providers, state agencies and community providers serving individuals impacted by domestic violence. ***(Complete)***	**DCF**: DCF administers grants for domestic violence services that provide adults who have been victimized by domestic violence and/or sexual abuse with safety planning, mentoring services, healthy relationship training, conflict resolution training, financial literacy training and responsible parenting skills training. The grants are with Catholic Charities, Family Crisis Center, SafeHome, The Willow, and the YWCA. Since January 2021, DCF has had a contract with KCSDV for a two-part virtual training series called Training Strategies and Skills to Address Domestic Violence in Child Welfare. The participants include employees of DCF, the Child Welfare Case Management providers and other partners. Through August 2021, 205 participants have engaged in the series. DCF anticipates approximately 500 child welfare staff and advocates will participate in this learning opportunity in 2022. DCF also has a training and development contract with KCSDV.
Recommendation 6.3 Crossover Youth. Continue to develop linkages between the behavioral health system, juvenile justice system and the child welfare system to increase understanding of treatment options available to youth externalizing trauma in the crossover youth population as current treatment options are not meeting the needs of this population. Then, develop specialty services to meet the needs of this population. ***(Complete)***	**DCF**: DCF has a dedicated full-time staff position to coordinate the CYPM and participates on the policy team. Through the FFPSA, the DCF budget includes grants for two Evidenced- based programs in mental health: Functional Family Therapy and Multi Systemic Treatment designed to serve families with older youth. In addition, DCF has two smaller grants for an emerging specialty in in-home Behavior Intervention Services for any child in the custody of the Secretary using Adoption and Legal Guardianship Incentive funds.
LEGAL SYSTEM AND LAW ENFORCEMENT	
Recommendation 8.3 Law Enforcement Referrals. Increase utilization and development of evidence-based SUD referral as well as treatment and recovery services among persons with law enforcement contact, which could include securing funding to increase access to inpatient, residential and outpatient	**KDOC**: In cooperation with the healthcare vendor Centurion, KDOC established an SUD assessment and referral system for residents entering the system effective July 1, 2021. If a resident is determined to suffer from Opioid Use Disorder, that resident is eligible for MAT. Processes are also in place among our Parole Officers who routinely make referrals to the RADACs to connect

services for this population. ***(This version complete, revised in 2021)***	those under supervision to recovery services, programs and treatment.
Recommendation 8.4 Defining Crossover Youth Population. Future efforts should include behavioral health within an operationalized definition for youth with offender behaviors at risk of entering foster care, as well as including diverted youth in the definition of the broader juvenile offender population. Coordinate with juvenile corrections advisory boards to ensure local implementation aligns with statewide policy team recommendations. ***(This version complete, revised in 2021)***	**KDOC**: As recommended by the Joint Committee on Corrections and Juvenile Justice Oversight, KDOC has contracted with Georgetown University McCourt School of Public Policy's Center for Juvenile Justice Reform (CJJR) to implement the Cross Over Youth Model through the use of the Evidence Based Fund. There is an established Statewide Policy Team (SPT) that has defined Cross Over Youth for the State of Kansas. Crossover Youth: a young person age 10 or older with any level of concurrent involvement with the child welfare and juvenile justice systems. "Involvement" in the juvenile justice system includes court-ordered community supervision and IIPs. "Involvement" in the child welfare system includes out-of-home placement, an assigned investigation of alleged abuse or neglect with a young person named as the alleged perpetrator, and/or participation in voluntary/preventative services cases that are open for service. The multi-disciplinary collective that became the Kansas State Crossover Youth Practice Model State Policy Team in 2019 continues to hold monthly public meetings under the facilitation of the Statewide Coordinators with the support of CJJR. The team's focus continues to be on intentional interagency collaboration, the facilitation of information sharing, adaptability and accountability, and the active incorporation of youth and family voices in decisions.
TELEHEALTH	
Recommendation 10.3 Telehealth for Crisis Services. Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in	**KDHE:** KMAP Bulletin Nos. 20065 and 20086 state that effective with dates of service on or after March 12, 2020, procedure codes H2011 (Crisis Intervention at the Basic Level); H2011 HK (Crisis Intervention at the Intermediate Level); and H2011 HO (Crisis Intervention at the Advanced Level) will be allowed to be reimbursed via telemedicine (both tele-video and telephone).Billing for these two codes is contingent upon KDADS approval of the individual crisis protocol utilized at a specified CMHCs. In addition, the State has submitted an SPA to allow for delivery of mobile crisis services for youth.

rural and frontier communities. ***(This version complete, revised in 2021)***	

Appendix C. Recommendation Rubric

Figure C-1. **Mental Health Modernization and Reform, Working Group Recommendation Rubric, 2020-2021**

<table>
<tr><td colspan="2">Recommendation:</td></tr>
<tr><td colspan="2">Rationale:</td></tr>
<tr><td>Ease of Implementation (Score 1-10):</td><td>Potential for High Impact (Score 1-10):</td></tr>
<tr><td>Consider:
☐Program Change (Easiest)
☐Pilot Program
☐Program Overhaul
☐New Program (Most difficult)

Will cost be a barrier to implementation?

Does the recommendation include strategies for continuity? (How does it consider sustainability?)

Which of the following mechanisms may affect the achievability of the recommendation?
☐ Legislative session
☐ Federal approval process
☐ Regulatory process
☐ Contracts
☐ Agency budget development
☐ Grant cycles
☐ Systems (e.g., IT)</td><td>Consider:
Will it benefit a large population? ☐Yes ☐ No

Will it significantly impact special populations?
☐Foster care
☐Frontier communities
☐Rural communities
☐Urban communities
☐Limited English Proficient (LEP) persons
☐Low-income individuals
☐Children
☐Veterans
☐Others? (List here)

Does it serve those who have been disproportionately impacted by the issue? (Does it address inequities?)

Could the recommendation produce savings in other areas?</td></tr>
</table>

Figure C-1 (continued). **Mental Health Modernization and Reform, Working Group Recommendation Rubric, 2020**

How does this recommendation contribute to modernization?	
Action Lead: *(Who takes point on this recommendation?)*	**Key Collaborators:** *(Who should be included as decisions are made about how to implement this recommendation?)*
Intensity of Consensus: *(Is there group consensus that this recommendation is important for the modernization and reform of the behavioral health system in the state? Does a wide cross-section of stakeholders feel that this recommendation would be mutually beneficial? To be addressed during final review)*	

Appendix D. UPDATED High-Priority Topic Lists

The working groups have made recommendations related to the following topics for immediate action (*Figure D-1*). **Recommendations for immediate action are those that should be initiated and completed in the next two years.** The full text for each recommendation and working group rationale is available in the body of the report (beginning on page 11).

Figure D-1. **Recommendation Topics for Immediate Action**

Workforce	Funding and Accessibility	Community Engagement
☐ Recommendation 1.1 Clinical Supervision Hours ☐ Recommendation 1.2 Access to Psychiatry Services ☐ Recommendation 1.3 Provider MAT Training	☐ Recommendation 2.1 Certified Community Behavioral Health Clinic Model ☐ Recommendation 2.2 Addressing Inpatient Capacity ☐ Recommendation 2.3 Reimbursement Rate Increase and Review ☐ Recommendation 2.4 Suicide Prevention ☐ Recommendation 2.5 Problem Gambling and Other Addictions Fund ☐ Recommendation 2.6 Expand Mental Health Intervention Team Program	☐ Recommendation 3.1 Crisis Intervention Centers ☐ Recommendation 3.2 IPS Community Engagement
Prevention and Education	**Treatment and Recovery**	**Special Populations**
☐ Recommendation 4.1 988 Suicide Prevention Line Funding ☐ Recommendation 4.2 Early Intervention ☐ Recommendation 4.3 Centralized Authority ☐ Recommendation 4.5 Trauma-Informed Care ☐ Recommendation 4.7 Normalize Behavioral Health Discussions	☐ Recommendation 5.1 Psychiatric Residential Treatment Facilities ☐ Recommendation 5.3 Frontline Capacity	☐ Recommendation 6.1 Domestic Violence Survivors ☐ Recommendation 6.2 Parent Peer Support ☐ Recommendation 6.6 Medicaid Postpartum Coverage
Data Systems	**Legal System and Law Enforcement**	**System Transformation**
☐ Recommendation 7.1 State Hospital EHR ☐ Recommendation 7.2 Data and Informed Survey Opt-Out ☐ Recommendation 7.3 Information Sharing ☐ Recommendation 7.4 Needs Assessment	☐ Recommendation 8.1 Correctional Employees ☐ Recommendation 8.2 Criminal Justice Reform Commission Recommendations ☐ Recommendation 8.3 Law Enforcement Referrals ☐ Recommendation 8.6 Specialty Court Coordinators	☐ Recommendation 9.1 Regional Model ☐ Recommendation 9.2 Long-Term Care Access and Reform ☐ Recommendation 9.3 Integration

	☐ Recommendation 8.7 Competency Evaluation and Restoration	
Telehealth		
☐ Recommendation 10.1 Quality Assurance ☐ Recommendation 10.2 Reimbursement Codes ☐ Recommendation 10.3 Telehealth for Crisis Services		

The working groups have made recommendations related to the following topics (*Figure D-2*) and indicated that they should be considered of strategic importance. **Recommendations of strategic importance are those for which work should start immediately but will be completed in the long-term.** The full text for each recommendation and working group rationale is available in the body of the report (beginning on page 11).

Figure D-2. Recommendation Topics of Strategic Importance

Workforce	Funding and Accessibility	Community Engagement
☐ Recommendation 1.4 Workforce Investment Plan ☐ Recommendation 1.5 Family Engagement Plan	n/a	☐ Recommendation 3.3 Foster Homes ☐ Recommendation 3.4 Community-Based Liaison
Prevention and Education	**Treatment and Recovery**	**Special Populations**
☐ Recommendation 4.4 Behavioral Health Prevention ☐ Recommendation 4.6 Promoting Social Isolation as a Public Health Issue	☐ Recommendation 5.2 Service Array ☐ Recommendation 5.4 Housing	☐ Recommendation 6.3 Crossover Youth ☐ Recommendation 6.4 I/DD Waiver Expansion ☐ Recommendation 6.5 Family Treatment Centers
Data Systems	**Legal System and Law Enforcement**	**System Transformation**
☐ Recommendation 7.5 Cross-Agency Data ☐ Recommendation 7.6 Outcomes Data	☐ Recommendation 8.4 Defining Crossover Youth Population ☐ Recommendation 8.5 Regional Specialty Courts/Venue Transfer	☐ Recommendation 9.4 Evidence Based Practices ☐ Recommendation 9.5 Family Psychotherapy
Telehealth		
☐ Recommendation 10.4 Originating and Distant Site ☐ Recommendation 10.5 Child Welfare System and Telehealth ☐ Recommendation 10.6 Telemedicine Committee		

Figure D-3. High Priority Discussion Item

Medicaid Expansion. In addition to these recommendations for immediate action and of strategic importance, the working group also puts forward the issue of Medicaid expansion as a high-priority discussion item for the Special Committee. The recommendation discussed by the working group related to Medicaid Expansion reads, "Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans."

More information is available in the Funding and Accessibility section, which can be accessed at the link above.

Appendix E. Special Committee and Working Group Membership

2021 Special Committee on Kansas Mental Health Modernization and Reform

- Senator Larry Alley
- Representative Tory Marie Arnberger
- Representative Barbara Ballard
- Representative Will Carpenter
- Senator Renee Erickson
- Senator Michael Fagg
- Senator Tom Hawk
- Representative Brenda Landwehr, Chairperson
- Representative Megan Lynn
- Senator Carolyn McGinn, Vice-chairperson
- Representative Cindy Neighbor
- Representative Adam Smith
- Representative Rui Xu
- *David Long, Committee Assistant*

2021 Special Committee on Kansas Mental Health Modernization and Reform Roundtable

- Jean Clifford, District 5, Kansas State Board of Education
- Wes Cole, Governor's Behavioral Health Services Planning Council
- Sarah Fertig, State Medicaid Director, Kansas Department of Health and Environment
- Coni Fries, Blue Cross and Blue Shield of Kansas City, Vice President Governmental Relations
- Honorable Bruce Gatterman, Chief Justice, Pawnee County
- Erin George, Person with Lived Experience

- Greg Hennen, Executive Director, Four County Mental Health Center, Inc
- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Sheriff Scott King, Sheriff, Pawnee County
- Spence Koehn, Court Services Specialist, Office of Judicial Administration
- Rachel Marsh, Executive Director, Children's Alliance of Kansas
- Laura McCray, President and CEO, Konza
- Sunee Mickle, Vice President Government and Community Relations, Blue Cross and Blue Shield of Kansas
- Honorable Sally Pokorny, Judge, Douglas County
- Kandice Sanaie, Senior Director of State Government Affairs, Cigna
- Don Scheibler, Chief of Police, Hays
- Sherri Schuck, Attorney, Pottawatomie County
- Rennie Shuler-McKinney, Director of Behavioral Health, AdventHealth Shawnee Mission
- Lisa Southern, Executive Director and Clinician, Compass Behavioral Health
- Deborah Stidham, Director of Addiction and Residential Services, Johnson County Mental Health Center
- Kelsee Torrez, Behavioral Health Consultant, Kansas Department of Health and Environment
- Honorable Robert Wonnell, Judge, Johnson County

Services and Workforce Working Group

- Senator Larry Alley
- Charles Bartlett, Co-chair, Director of Adult Services, Kansas Department for Aging and Disabilities Services
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services

- Rachel Brown, Chairperson, Department Psychiatry and Behavioral Sciences, KUMC-Wichita
- Wes Cole, Chair, Governor's Behavioral Health Services Planning Council
- Senator Renee Erickson
- Senator Michael Fagg
- Sarah Fertig, State Medicaid Director, Kansas Department of Health and Environment
- Erin George, Person with Lived Experience
- Gary Henault, Director of Youth Services, Kansas Department for Aging and Disabilities Services
- Greg Hennen, Executive Director, Four County Mental Health Center, Inc
- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Shane Hudson, Co-chair, Chief Executive Officer, CKF Addiction Treatment
- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Representative Megan Lynn
- Rachel Marsh, Executive Director, Children's Alliance of Kansas
- Christina Morris, Regional Director, Government Affairs, CVS Health
- Sherri Schuck, Attorney, Pottawatomie County
- Cassandra Sines, Parent, Advocate
- Brenda Soto, Deputy Director for Medicaid and Children's Mental Health, Kansas Department for Children and Services (DCF)
- Lisa Southern, Executive Director and Clinician, Compass Behavioral Health
- Deborah Stidham, Director of Addiction and Residential Services, Johnson County Mental Health Center
- Kelsee Torrez, Behavioral Health Consultant, Kansas Department of Health and Environment
- William Warnes, Co-chair, Medical Director for Behavioral Health, Sunflower Health Plan

System Capacity and Transformation Working Group

- Jane Adams, Keys for Networking
- Representative Barbara Ballard
- Sandra Berg, Executive Director, United Behavioral Health, KanCare
- Laura Brake, Co-chair, Director of Crisis Services, Kansas Department for Aging and Disabilities Services
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Representative Will Carpenter
- Jean Clifford, District 5, Kansas State Board of Education
- Denise Cyzman, Chief Executive Officer, Community Care Network of Kansas
- Amy Dean-Campmire, Mental Health and Housing Program Manager, Kansas Department of Corrections
- Sandra Dixon, Chief Clinical Officer, DCCCA
- Sheriff Jeff Easter, Sheriff of Sedgwick County, Kansas
- Sarah Fertig, State Medicaid Director, Kansas Department of Health and Environment
- Honorable Bruce Gatterman, Chief Justice, Pawnee County
- Senator Tom Hawk
- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Don Jordan, Former Superintendent, Osawatomie State Hospital, Former Secretary, Social and Rehabilitation Services (SRS)
- Kyle Kessler, Co-chair, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
- Sheriff Scott King, Sheriff, Pawnee County
- Spence Koehn, Court Services Specialist, Office of Judicial Administration
- Laura McCray, President and CEO, Konza
- Christina Morris, Regional Director, Government Affairs, CVS Health

- Josh Mosier, Manager of Client Services KHIN
- Representative Cindy Neighbor
- Honorable Sally Pokorny, Judge, Douglas County
- Don Scheibler, Chief of Police, Hays
- Sherri Schuck, Attorney, Pottawatomie County
- Representative Adam Smith
- Brenda Soto, Deputy Director for Medicaid and Children's Mental Health, Kansas Department for Children and Services (DCF)
- Honorable Robert Wonnell, Judge, Johnson County
- Representative Rui Xu

Telehealth Working Group

- Representative Tory Marie Arnberger
- Sandra Berg, Executive Director, United Behavioral Health, KanCare
- Andy Brown, Commissioner of Behavioral Health Services, Kansas Department for Aging and Disabilities Services
- Sarah Fertig, State Medicaid Director, Kansas Department of Health and Environment
- Jennifer Findley, Vice President for Education and Special Projects, Kansas Hospital Association
- Coni Fries, Blue Cross and Blue Shield of Kansas City, Vice President Governmental Relations
- Jason Grundstrom, Executive Director of Continuum of Care, The University of Kansas Health System
- Laura Howard, Secretary of Kansas Department for Aging and Disabilities Services and Kansas Department for Children and Families
- Dorothy Hughes, Assistant Professor for Population Health, KU Medical Center
- Chad Johanning, Family Medicine Physician, Lawrence
- Representative Brenda Landwehr, Chairperson, Special Committee
- Stuart Little, Association Representative, Behavioral Health Association of Kansas

- Senator Carolyn McGinn, Vice-Chairperson, Special Committee
- Sunee Mickle, Co-chair, Vice President Government and Community Relations, Blue Cross and Blue Shield of Kansas
- Christina Morris, Regional Director, Government Affairs, CVS Health
- Brittney Nichols, EMSC Coordinator, Kansas Department of Health and Environment
- Dennis Shelby, CEO, Wilson Medical Center
- Kandice Sanaie, Senior Director of State Government Affairs, Cigna
- Rennie Shuler-McKinney, Director of Behavioral Health, AdventHealth Shawnee Mission
- Claudia Tucker, Teladoc Health Inc
- Shawna Wright, Co-chair, Associate Director, KU Center for Telemedicine & Telehealth

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