MINUTES OF THE BOARD OF TRUSTEES
JACKSON COUNTY COMMUNITY MENTAL HEALTH FUND
August 1, 2015

Chair J. Moore called the Board Retreat to order at 9:30 AM. Meeting held at the Kansas City Zoo, Education Bldg. 6800 Zoo Drive, KCMO 64133

Present: J. Moore, R.Harris, M.Campbell, D.Moore, C.Clark Campbell, A.Kitchen, E.Wesson, G.Thompson
Staff: B. Eddy, S. Jones, T. Cummings, A. Marshall, M. Fortin

B.Eddy welcomed the Board to the retreat and briefly discussed the agenda for the day.

Client Demographics: B.Eddy reported.

Adult Services: Adult case management is the largest cost item. This will be analyzed in the coming year. J.Moore asked how much of the smaller services such as transportation and medication could be covered by other sources if the funding process were more coordinated so that Levy dollars could be dedicated more to the top five psychiatric services. B.Eddy said that it will be interesting to see what happens in this regard when Medicaid is expanded and also mentioned that he has been discussing transportation issues in the area with R.Makinen, who also serves as Board President of the Kansas City Area Transportation Authority.

Children's Services: Residential treatment constitutes by far the largest cost of children's services. M.Campbell remarked that it appears many services such as individual therapy are grouped into residential treatment for billing and S.Jones confirmed. M.Campbell suggested that we consider unbundling the services for billing purposes. G.Thompson then asked about how Crittenton – the largest Levy provider of children's residential treatment – operates, to which B.Eddy responded that they are very innovative and flexible. G.Thompson would like to have further dialogue on the subject. Next, D.Moore suggested a presentation and discussion of residential treatment and where it is going at a future date.

Case Management: Given that such a large amount of funds are billed as case management, what can we do to incentivize quality of services and make rates more rational? An analysis was requested by the Accountability & Compliance Committee and frank discussions with providers have begun. A.Kitchen asked how we are interfacing with other payers in the area. B.Eddy responded that as a payer of last resort, Levy billing is an indicator of what other sources are not covering, particularly case management. G.Thompson added that you often need case management for high-risk populations. Discussion followed. T.Cummings said that we are going to be looking more into case management and into who is being served with these dollars and best practices as a guideline for rates. For example paying a credentialed professional to case coordinate high-risk participants should be paid higher than sending people to Harvesters. M.Campbell added that we are not necessarily saying that what providers are billing for case management is not useful but rather that some services should probably be funded elsewhere.

Demographics: Ethnicities Served by Catchment Area. There were about 1,000 fewer people served in 2014 that in 2013 which may be due to the available health exchange and that previously uninsured people are now covered. Overall, the percentages of Latinos served in the area are far fewer than the percentage making up the population, which is an area of major concern. R.Harris asked if it is possible to know the number of unduplicated clients served to which B.Eddy replied that staff are still working on the client demographic counts, as the data was just recently compiled.
In Service Area 3 the number of Latinos served fits more closely to the number making up the population. It also looks like there are many poor Caucasians in the area that need service. Service

Area 4 matches very closely to the County data and has not changed much. Service Area 5 is serving a far greater number of Latinos this year than last, most of which are coming from CAPA. We will be watching these in the future in order to monitor trends in access. G.Thompson added that the larger service areas served fewer clients and was wondering if this was due to a higher level of affluence in those areas. B.Eddy responded that yes, the areas were created by the Missouri Department of Mental Health based on income levels but things have changed and DMH has thus far not been willing to change the boundaries.

Insurance Status: We will post a 2014 report on the website. It is looking like there are some improvements as reflected in several areas the data. S.Jones noted that our definition of "being insured" is based on the individual having insurance coverage for mental health care at some point during the grant year.

Cultural Competency On-Site Review Project: T.Cummings presented an overview of the provider Cultural Competence assessment. On site-meetings are conducted using a structured interview. The process is at its midpoint, with a final report planned for October 1. The CLAS Standards (HHS Culturally and Linguistically Competent Services Standards) provide a conceptual foundation. A.Kitchen asked if there was a relationship to federal funding / EEOC reporting; that information is included in the review.

Agencies tend to fall into two groups: those with demonstrable action and substantive processes, and those for whom the cultural competence plan is merely a document submitted at grant time. Technical Assistance (TA) recipients are much farther along in implementation. Those not engaged generally report saying they still don't know where to start. For those agencies taking action, there is a noted growth in staff diversity and in board development.

The project is finding that agencies have challenges involving participants on their boards. Some people are reluctant to disclose their consumer status and then discussion ensued regarding anonymity of participants. This is a potential issue regarding translation and interpretation. Many participants in small communities prefer telephone interpretation; they do not want a live interpreter due to privacy/confidentiality issues. Retention of bi-lingual staff is another major challenge.

Based on the process providers identify needs and request TA on topics that include working with LGBTQ and presentations of findings to their boards/leadership. D.Moore suggested that staff present findings at Board meeting for providers and add as a regular piece to Board agenda. G.Thompson expressed his appreciation of Board support for Cultural Competency and the CCAC. J.Moore asked if other large funders are involved in CC. DMH is currently going for the Federal SAMSHA Excellence in MH Grant that includes cultural competency.

BUSINESS ITEM: NAMI continuation proposal. S.Jones reported that NAMI received six months of funding with the provision that additional consideration be based on an amended proposal. The revised proposal was received and transmitted to the Board. M.Campbell/G.Thompson moved to release the remaining funds in the amount of $57,500. Motion Carried.

M.Campbell opened discussion of the organization's ability to benefit from consultation. B. Eddy reported that there is precedent for this type of funding. M.Fortin reviewed statute and noted that the organizational maintenance provision would apply to support of this type of project. C.Campbell/C.Clark Campbell moved to amend above motion to approve $57,500 for continuation of Consumer Services grant and up to $25,000 from the Provider Initiatives budget line item for staff identify and retain a consultant to advise NAMI regarding organizational sustainability and future planning. B.Eddy noted that the organization will be offered a choice of options. All voted in favor. Motion carried.

Future-Oriented Planning Discussion: B.Eddy reported. National Council for Behavioral Health (NCBH) findings were briefly reviewed, follow-by a recap of the Board's initial reactions to the NCBH presentation. Other events in the environment were presented. Several Board members had asked about the SAMHSA Certified Community Behavioral Health Center (CCBHC) pilot program. DMH is applying on behalf of the CMHCs. Staff have reviewed the criteria, which are extensive. There is also piloting of new methods of payment. This is a pilot program. Based on results and rulemaking they may fine-tune the process with the potential result of changes to block grants.

There was discussion of risk sharing. M.Campbell asked about the efficacy of hospitals buying nursing homes in order to control who goes in and out and help manage continuity of care. TMC does this to some extent. Has there been any evaluation of mostly self-contained programs like this? B.Eddy responded that it is not currently possible to know who drops out of our programs and becomes homeless. G.Thompson added that the rate of readmission for Medicare patients is 20% and the goal is 10%. Where are the potential improved outcomes in mental health? M.Campbell: Is this something we could fund as a pilot program with providers? We know that the high-risk population takes up the majority of the resources, but is there a better way to manage them? As one example, what if somebody were hired to transport them to all their appointments? R.Harris added that many of these systems were in place at one point before the funding for them was dismantled. This was when Western Missouri MH Center was the CMHC; the current CMHCs were satellite offices.

G.Thompson asked if staff needed the Board to approve money to fund another project with the National Council for Behavioral Health. B.Eddy replied that yes, the resources are necessary but it is important to know if this is something that the Board wishes to continue pursuing. We are not really pursuing radical risk-sharing at this time but are beginning to devote some time to more moderate approaches. M.Campbell added that this is a good idea but we need to be very careful to come up with a pilot project that can position us as leaders. This would be the second phase of our project with the NCBH and now it needs to become an area where we are closely engaged.

Then, J.Moore expressed concern regarding the ability to replicate or apply national models to our situation locally. That is to say, can we duplicate an outcome from a pilot project that works for ReDiscover in eastern Jackson County in a catchment area with different demographics? Even though it is a pilot it should have something that could be replicated or applied elsewhere. R.Harris added that it goes back to the comparison between public and charter schools – if you focus on a population with less severe needs then you will be more successful or as with the HMO debate – if you deny a service and someone doesn't die then you save money.

B.Eddy said that staff will work with NCBH, plan specific actions, and then request board consideration.
J.Moore added that it is important that a consultant give us ideas for something that will work here in Jackson County, i.e. ideas that could be taken to a Levy-funded agency with specific goals and requirements.

Adjournment: J. Moore thanked everyone for their time and participation and adjourned the meeting at 12:30PM.

Respectfully submitted,

Andrew Marshall, Office Manager