Master of Public Health

Integrative Learning Experience Report

A Comprehensive Review of Annual Reports from Community Mental Health Centers in Kansas

by

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MASTER OF PUBLIC HEALTH

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Abstract

Growth in the field of mental health care has provoked an evolution of the definitions of mental health and mental illness, as well as a new understanding of infectious disease and their involvement in the development of mental illnesses. Stigmatization and access to care are two primary issues faced by the institutions seeking to provide care for those with mental illness. A subset of these institutions is Community Mental Health Centers (CMHCs), which provide comprehensive public health care to underserved populations throughout the United States. Pawnee Mental Health Services (PMHS) is one of 26 CMHCs in Kansas, based out of Manhattan in Riley County, and serves ten contiguous counties.

The project I completed at PMHS was centered around the creation of an annual report. This report summarized the services provided by PMHS, the clientele they serve, and a financial summary for fiscal year 2018. This report was the culmination of work completed in three phases: (1) research of other CMHCs in Kansas, (2) data presentation, and (3) creation of the report in Adobe InDesign. Each phase of the report produced diverse challenges, and the overall project greatly expanded my view of mental health care. A challenge to public health care in Kansas, for example, is insufficient funding which is driven by poor or lacking public health policy. I gathered a more adequate understanding of Medicaid, and how the utilization of all governmental subsidized insurance is a significant barrier to care. Finally, I developed new skills in sectors including design software, such as Adobe InDesign, exemplifying the importance of multidisciplinary skills as the quintessential purpose of field experience.

Subject Keywords: Mental health, annual report, Pawnee (PMHS), infectious disease, community mental health center (CMHC), public health

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Chapter 1 - Literature Review

I. Mental Health

Mental health is defined by the World Health Organization (WHO) as, “a state of well-being in which every individual realizes [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community”.[1] A 2015 paper, published in *World Psychology*, considered how the current definition of mental health utilized by the WHO could lead to misunderstanding or misinterpretation of what it means to be mentally healthy. The authors argue that the identification of positive feelings and positive functioning as essential components to mental health disavows the fact that people in good mental health do not always have this positive affect in life. As a more inclusive definition of mental health, the authors offered the following:

> Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one’s own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.[2]

The continuation of work to discover a universal definition of mental health shows the level of complexity in this field.

The field of mental health encompasses a plethora of illness associated with a lack in one’s mental health. A mental illness is defined by the American Psychiatric Association (APA) as a, “health condition involving changes in emotion, thinking or behavior (or a combination of these)… [that is] associated with distress and/or problems functioning in social, work or family activities”.[3] Mental health and mental illness are often utilized interchangeably in everyday

language; however, the two terms are distinct from one another. This distinction is essential to the destigmatization of those with mental illnesses and those who seek mental health care.

Utilizing estimates from the *Institute for Health Metrics and Evaluation* and those reported in the *Global Burden of Disease Study*, the website Our World in Data reports that an estimated 1.1 billion people globally, or one in six people, had one or more mental health or substance use disorders in 2016 [4]. Anxiety disorders are the most reported and diagnosed disorders, at 3.8% of the world's population, followed closely by depressive disorders, as shown in Figure 1.1.[4] The National Alliance on Mental Illness, NAMI, reports that 18.1% of American adults live with an anxiety disorder.[5]

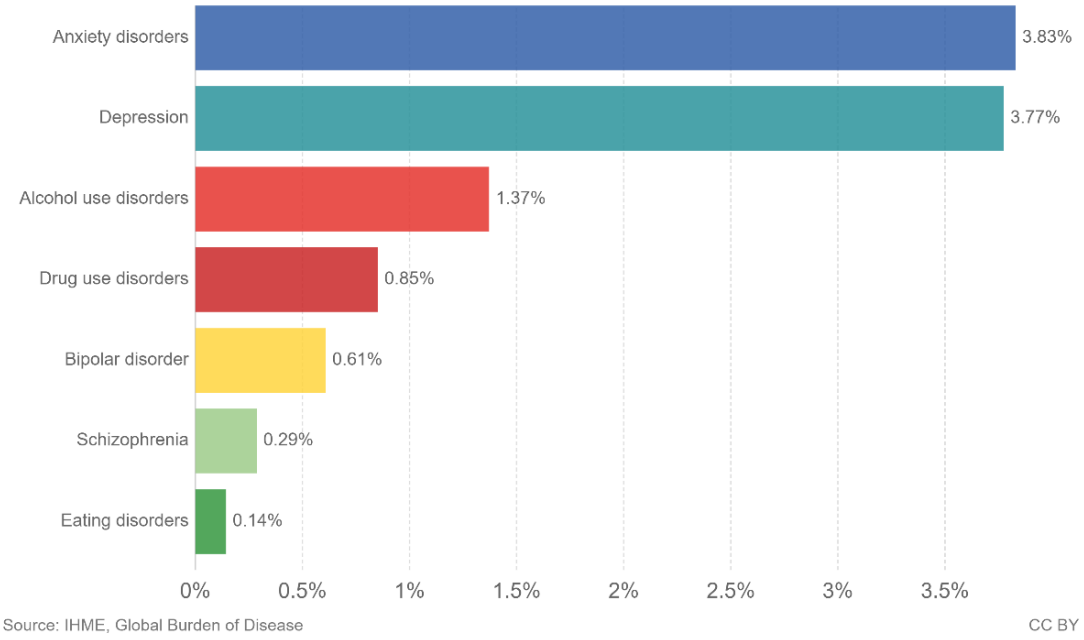

Figure 1.1 Prevalence of Mental and Substance Use Disorders in 2016[4]
From *Our World in Data*, this graph shows the highest prevalence of mental and substance use disorders falls into two categories: anxiety disorders, at 3.83% of the total population, and depression, at 3.77%. The remaining five categories, when combined, do not total the prevalence seen for either anxiety disorders or depression. This data gives a true estimate, which is based on diagnosis data as well as epidemiological and medical data, surveys, and meta-regression models. The graph only estimates the mental and substance use disorders as part of the total prevalence of all disorders, so the total of all seven does not add to 100%.

Anxiety has the broadest definition of mental illnesses, including social, phobic, post-traumatic, obsessive compulsive, and generalized anxiety disorders. Depression, on the contrary, is only

divided into two major categories, mild persistent depression and severe depressive disorder.[6] To put mental and substance use disorders into context with other health issues, Figure 1.2 depicts the share of total disease burden in the world by cause. The data indicates that mental and substance use disorders fall in the top ten.[7] Figure 1.3 shows the share of the total disease burden by country, in Disability-Adjusted Life Years (DALYs), that mental and substance use disorders hold.[4] The National Institute of Mental Health (NIMH) reports that nearly one in five adults in the United States lives with a mental illness, roughly 46.7 million individuals in 2016.[8] The United States and Australia have the highest contribution to their overall disease burden by these mental health and substance use disorders.

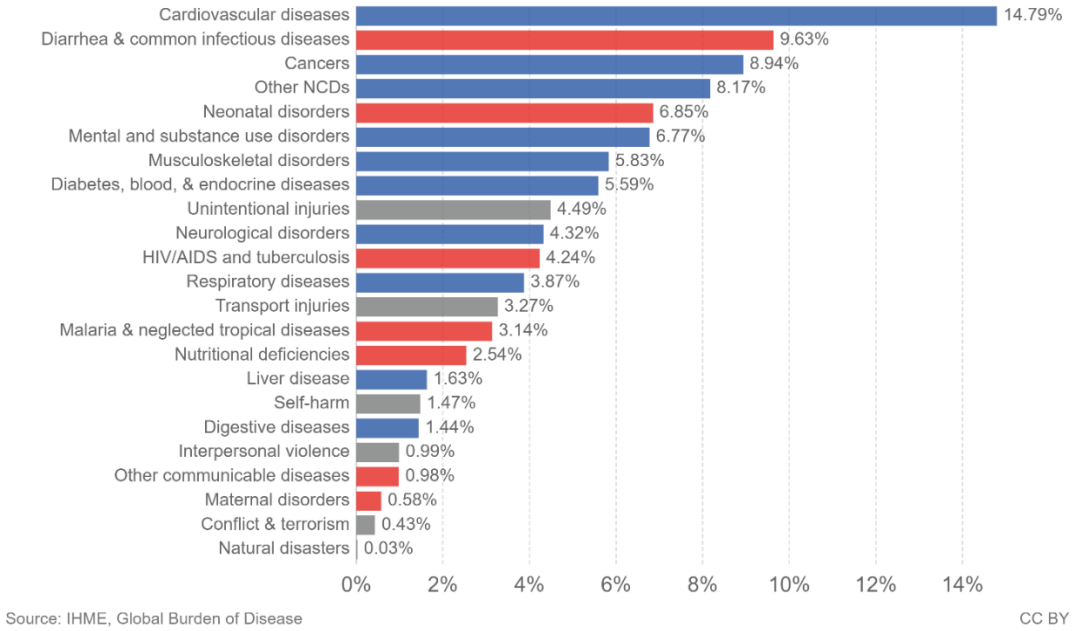

Figure 1.2 Share of the Global Disease Burden by Cause in 2016
Burden of disease by cause as a share of the total disease burden, measured in Disability-Adjusted Life Years (DALYs). DALYs include years of life lost and years lived with a disability, where one DALY represents one lost year of healthy life. Mental and substance use disorders are ranked number six, at 6.77%. Blue represents non-communicable diseases, red represents communicable or vertically transferrable diseases, and gray represents those that do not fall in either category.

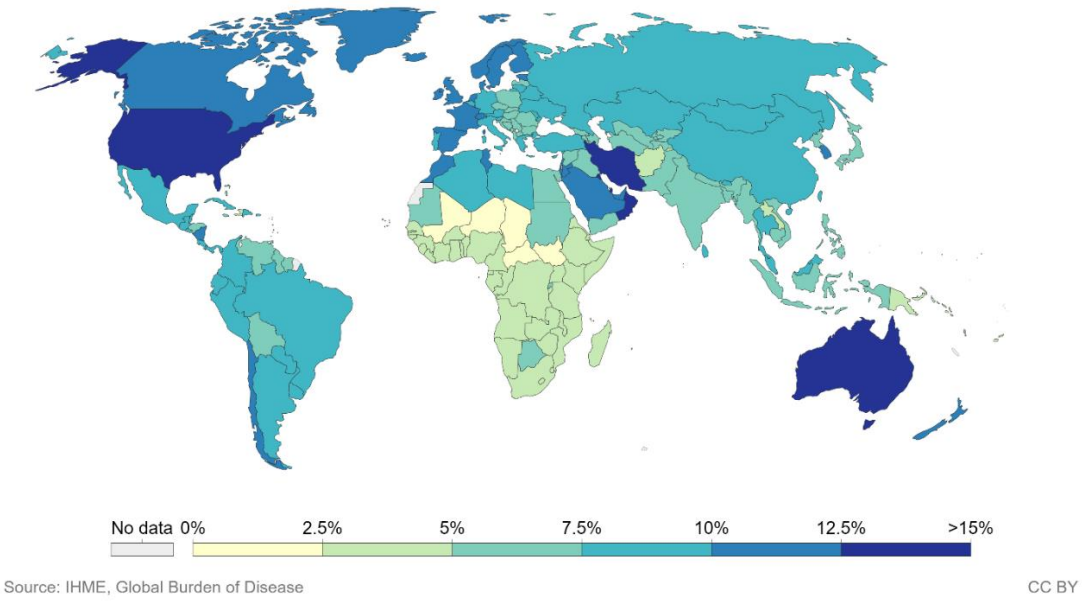

Figure 1.3 Mental & Substance Use Disorders as Share of Global Disease Burden in 2016

The percentage of the global disease burden taken up by mental and substance use disorders, measured in disability-adjusted life years (DALYs). DALYs include years of life lost and years lived with a disability, where one DALY represents one lost year of healthy life. Mental and substance use disorder account for the greatest percentage of the total disease burden in the United States and Australia.

Due to stigma, economic and social burden, and violation of human rights or freedoms, the prevalence of mental illnesses are known to be underreported and underestimated.[9,10] A review published in March 2014 in *JAMA Psychiatry*, considered the accuracy of reports from a Baltimore epidemiological study. On comparison of retrospective and cumulative evaluations of both mental and physical illnesses, the authors concluded that the lifetime prevalence of mental disorders are underestimated by certain types of evaluations, specifically single-time, cross-sectional surveys.[11] It is important to note that because of this underestimation, the previously discussed prevalence of mental and substance use disorders are not likely to accurately represent the true prevalence of these disorders.

There are many barriers in access to treatment for mental illnesses. Two primary barriers are lack of financial means, such as generational poverty, and being underinsured or

uninsured. The U.S. Census Bureau reported that, in 2017, 8.8% of the U.S. population did not have insurance, and 19.3% of those insured were covered by Medicaid.[12] In Kansas, the numbers run similarly, with 8.5% uninsured in 2017, and 13.5% covered by Medicaid, including those covered under the Children's Health Insurance Program (CHIP).[12] These statistics show a need for services that are available to those who fall in these percentages. While these individuals can get care by paying out of pocket, these expenses are often too great for the individual to cover. Other barriers to mental health care, such as the influence of stigma, directly affect the productivity of mental health care agencies. Analogous to its effects on the underreporting of mental illnesses, stigmatization impacts the likelihood of an individual to seek services as well as the location where that individual might seek those services. If an individual is concerned about what another person will think when they discover that they received services from a publicly funded center, that individual may be less likely to get the care they need. This is especially true if that individual is underinsured or uninsured. Someone with private insurance might seek care at a non-publicly funded center, but the impact that stigma has on whether a potential client seeks services is clear.

II. Mental Health & Infectious Diseases

Researchers have long wondered about a connection between mental illness and infectious diseases. The comorbidities of infectious diseases, such as the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) complex or infectious meningitis, are relatively common with prevalent mental illnesses, like neuropsychiatric and depressive disorders. Considerable research regarding these comorbidities has been conducted, but little significant data can be shown as criteria for a causative relationship[13–16] In fact, some mental illnesses may have a protective effect against communicable diseases due to behavioral patterns exhibited by those with mental illness. Coughlin reports that, during an influenza pandemic, people with higher state anxiety, a

temporary condition categorized by worry and fear about a particular situation, are more likely to practice hand hygiene behaviors.[14] The connection between mental health and infectious disease is contradictory, lacking a direct causative pathway. Currently, discussion regarding the unclear connection is centered around the ability of pathogens to cause central or peripheral nervous system effects in individuals with neurodevelopment disruption or adverse childhood experiences.[16–18] An infection hypothesis, considered in connection with the development of schizophrenia, was detailed in a 2014 review examining immune activation in rodent systems. The authors reported that prenatal exposure to many viral agents, in humans, has been connected to risk of schizophrenia, including: influenza, rubella, measles, polio, and herpes simplex 1 and 2.[18] Human epidemiologic research has been unable to establish causality for these associations, which is the premise for the development and study of these rodent models.

Human Immunodeficiency Virus

Many studies have investigated a connection between HIV/AIDS and the development of neurocognitive changes – specifically depression, mania, and frank dementia. The NIMH describes depression as common but serious mood disorder that causes severe symptoms that persist for two or more weeks, and describes mania as an extreme increase in talking or level of activity.[8] Dementia is defined by the National Institute on Aging and the National Institute of Health as a loss of cognitive functioning and ability to an interfering extent.[19] A shared term used in this research is HIV-associated neurocognitive disorders (HAND), which are comprised of three conditions – asymptomatic neurocognitive impairment (ANI), mild neurocognitive disorder (MND), and HIV-associated dementia (HAD).[20] Each of these conditions are essentially dementia, with HAD being the worst. HAD is defined by cognitive impairment in two different areas at two standard deviations below the normative mean, difficultly in activities of daily living (ADLs), and lacking delirium or comorbidity. MND and ANI are both defined by cognitive impairment at one standard deviation below the normal and lacking qualifications for more advanced diagnosis. The distinguishing factor between these two is that MND requires

impairment in everyday functioning, with ADLs.[20] HANDs have been substantially affected by the introduction and widespread use of highly active antiretroviral treatment (HAART). A 2007 review of the nosology of HANDs reported that the disorders remain frequent, with an increase in prevalence, since the inception of HAART, even though there has been a reported decrease in the incidence of HAD, the most severe condition.[20] HIV-1, the more prevalent and virulent form of HIV, is known to have direct effects on the central nervous system (CNS) which may be responsible for the development of neuropsychiatric conditions.[21] A 2018 review concerning the neuropsychiatric aspects of infectious diseases considered the comorbidity of HIV/AIDS and substance abuse with depressive and anxiety disorders. The authors reported that in medical inpatients that were HIV-positive, depressive spectrum disorders were the most commonly diagnosed disorders.[16] Considering the potential effects of mental illness on the likelihood in contracting HIV/AIDS, a 2005 study reported that individuals with schizophrenia are at an increased risk becoming infected with HIV, hepatitis C virus, or both. This is due to a variety of factors, most markedly higher rates of substance abuse and increased high-risk sexual behavior seen in individuals with schizophrenia.[22]

Other Infectious Diseases

HIV/AIDS is only one of several diseases associated with mental illness. A review by Coughlin in 2012 explored the links in available scientific literature surrounding anxiety and mood disorders as they relate to viral diseases. The authors reviewed those viruses that were most heavily discussed in literature, notably discussing a connection between influenza A (H1N1) and anxiety-related behaviors.[14] They reviewed literature demonstrating that stress-induced dysregulation of the immune system can reduce the immune response to vaccines for influenza, thus manipulating the viral spread. They also indicated a potential protective effect against viral spread in individuals with state anxiety, or a feeling of negative emotions when faced with a threat. Another study linked gestational influenza with the development of bipolar disorder – type I, II, or not otherwise specified – in children, with a near 4-fold increase in the

risk of bipolar disorder in children whose mothers has influenza at any time during preganancy.[23] The relationship between gestational influenza and the increase in risk of bipolar disorder was only found to be significant during the third trimester, with a near 5-fold increase. This supports the infection hypothesis, as discussed previously. In 1998, a primary article giving a description of the first 50 cases of a similar symptoms course for childhood-onset obsessive-compulsive disorder (OCD) and tics related to streptococcal infections.[24] This novel pathway of developing OCD and tic disorders became known as Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).[25] PANDAS are distinguished by an association between neuropsychiatric symptoms and Group A Strep (GAS) infections. GAS infections are the cause of strep throat, but also of more serious diseases like scarlet fever, rheumatic fever, and necrotizing fasciitis.[26] Recent evidence indicates that anti-neuronal autoantibodies react with dopamine receptors in the brain thus causing the neuropsychiatric symptoms of PANDAS.[27]

Several studies discuss the neuropsychiatric symptoms of Lyme disease, a tick-borne zoonotic illness caused by the bacterium, *Borrelia burgdorferi*.[28,29] Lyme disease is considered to be endemic in the northeastern and north-central parts of the United States and its vectors are *Ixodes scapularis* (northeastern, mid-Atlantic, and north-central USA) and *Ixodes pacificus* (Pacific Coast USA).[30] Similar to HIV/AIDS, Lyme disease is known to be connected with neuropsychiatric symptoms, though the etiology remains controversial.[31] Johnco et al. reports that approximately 15-40% of patients with Lyme disease present with neurological symptoms. While there has not been a causal link established between Lyme disease and mental illness, Lyme disease patients have been shown to have greater rates of depression when compared with controls.[28]

Susceptible Populations

Specific subsets of the general population are at a high risk for both communicable and non-communicable diseases. One of the most susceptible populations for the development of

these disease are the homeless. As reported in Homelessness, Health, and Human Needs, there are three different relationships between health and homelessness: (1) some health issues come before and contribute and homelessness, (2) some health issues are a consequence of homelessness, and (3) homelessness makes treatment of many illnesses difficult or futile.[32] Mental illness fall into all three of these categories. Chronic schizophrenia and affective disorders are reported to be some of the most common mental health precedents to homelessness, while anxiety and phobic disorders are more likely to be a consequence of homelessness.[32] Many health problems that result from homelessness, such as sexually transmitted infections, tuberculosis, and infectious hepatitis, are seen comorbidly with mental illnesses which have many barriers to be treated in these populations.[33]

III. Community Mental Health Centers in Kansas

In Kansas, there are 26 Community Mental Health Centers (CMHCs) that serve the 105 counties and their constituents under the Kansas Department of Aging and Disability Services (KDADS). See Appendix 2 for a listing of each CMHC, their locations, and their sitting Executive Director as of June 2018. CMHCs receive federal funding from the Community Mental Health Services Block Grant that was established in 1981 and is currently allocated by the State of Kansas [34]. Some additional funding comes from local county governments and any remaining funds needed are received through the work of grant applications and client fees. The majority of CMHCs in Kansas are operating on extremely limited budgets.

A combined staff of over 4,000 individuals provide mental health services in over 120 locations in Kansas, with at least one service location in each county. Services provided by CMHCs vary from comprehensive rehabilitation services and outpatient clinical services to substance abuse treatment and mental health hospital referral.[35] All services at CMHCs are provided regardless of ability to pay and are available to those with private insurance, Medicare, Medicaid, and to the underinsured and uninsured. Not all therapists and programs are available

to every potential client due to insurance restrictions laid out by the federal and state governments.

CMHCs are governed by separate Board of Directors that are elected or appointed in each county that a CMHC serves. These boards are held accountable to the citizens they serve, their county officials, the Kansas State Legislature, and the Governor of Kansas. Due to the variability of their catchment areas, each CMHCs is unique in how their government structure is set up. Figure 1.4 lists all the CMHCs in Kansas and depicts just how varied these catchment areas are. High Plains Mental Health Center covers a large portion of northwestern Kansas, while Shawnee County is served by two different CMHCs: Family Service & Guidance Center, treating children only, and Valeo Behavioral Health.

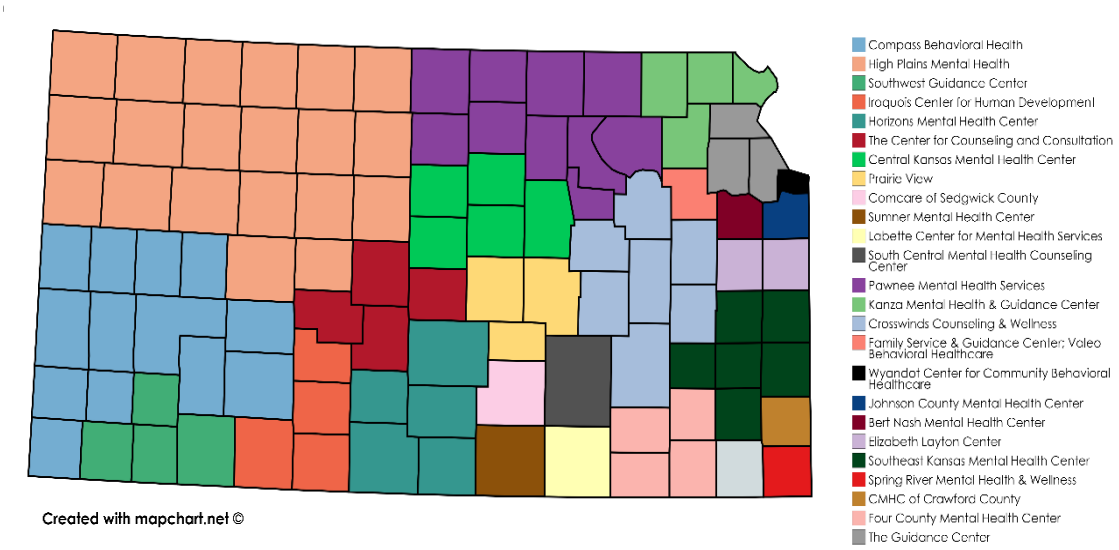

Figure 1.4 Community Mental Health Centers in Kansas

IV. Pawnee Mental Health Services[36]

Pawnee Mental Health Services opened on November 19, 1956 as Riley County Mental Health Center (RCMHC) and through support from Riley County Mental Health Association. After a tax law was passed by the Kansas Legislature in 1957, community mental health centers were able to receive support via this county commissioner levied tax and RCMHC was able to grow. Throughout the 1960s, Geary, Clay, and Marshall counties joined the service area of

RCMHC, and the center was renamed North Central Kansas Guidance Center (NCKCG). Another community mental health center, Sunflower Guidance Center, was formed via funding given by Cloud County Commissioners, which eventually grew to cover Cloud, Jewell, Republic, Mitchell, and Washington counties. In 1977, Pawnee Comprehensive Mental Health Center was formed from the affiliation of NCKGC, with the addition of Pottawatomie County, and Sunflower Mental Health. An official merger under one board of directors was completed in 1981 and the name was changed to Pawnee Mental Health Services (PMHS) in 1982. The affiliation and merger joined these ten counties together to be served by one CMHC. Since the affiliation, the catchment area of PMHS as remained relatively the same and in 2016, PMHS celebrated 60 years of service.

A total of 13 locations are served by PMHS, with at least one service location in each of the ten counties within the catchment area. Regional offices for PMHS are in Manhattan, Junction City, and Concordia, Kansas. The location where I completed my experience was one of three Manhattan locations, located at 2001 Claflin Rd. PMHS is currently in the process of reconstructing their Manhattan offices to accommodate for the opening of a new crisis center in Manhattan and to more effectively utilize space for their therapists. Part of being a growing institution with limited funding means that spaces need to be flexible and highly utilitarian. By the end of this fiscal year, the portion of administrative offices where I completed my hours will move to join the remainder of PMHS administration at the Houston Street location. The Claflin location will be reorganized to utilize more office space for clinical services, including children's programs. This reconstruction will provide a single location for both the clinical and administrative sides of PMHS, helping them more adequately service their community.

The governing structure of PMHS is led by both a foundational board of directors and a governing board of directors. The governing board of directors is made up of elected or appointed individuals from each of the ten counties served by PMHS. This board works with the day-to-day needs of PMHS, provides the annual budget, and oversees the executive director.

Contrarily, the foundational board is made of up individuals selected by appointment only. They work almost exclusively in fundraising and grant acquisition to further the development of PMHS. The executive director of PMHS reports directly to the governing board and is reported to by the remainder of the management team. The Chief Operations Officer (COO) is a newly developed position to oversee the clinical side of PMHS. This additional position has shifted the management style of PMHS to look more like other CMHCs in Kansas. An overview of the management team, as of January of 2018, can be viewed in Figure 1.5.

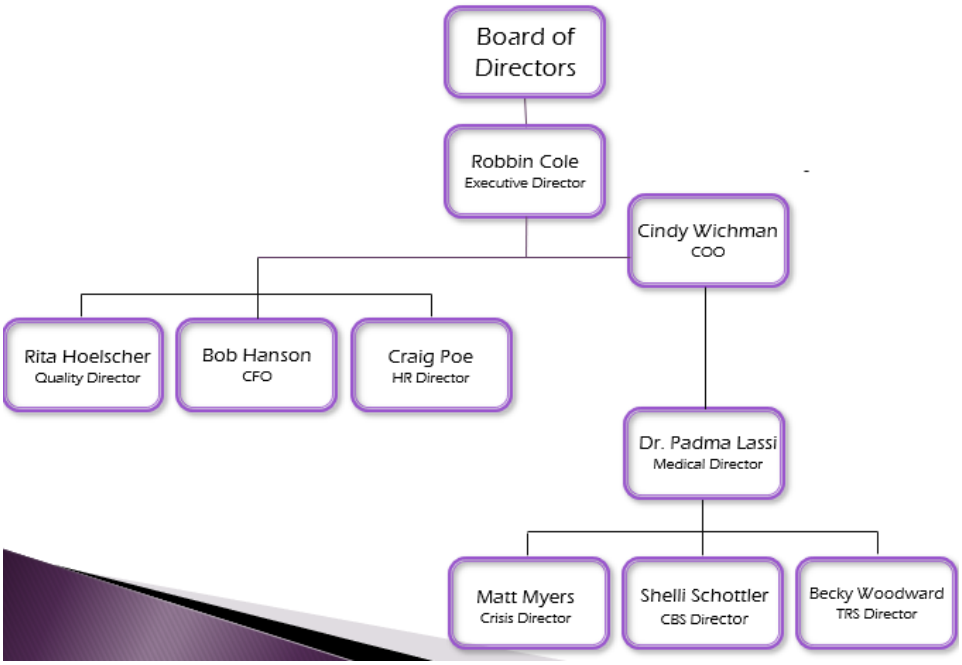

Figure 1.5 Pawnee Mental Health Services Governance[37]

V. Preceptors at Pawnee Mental Health Services

Robbin W. Cole, LSCSW

Robbin Cole is a Licensed Specialist Clinical Social Worker (LSCSW) and has worked in different capacities at PMHS for over 15 years. Currently, she serves as the Executive Director at PMHS, reporting to the governing board of directors and overseeing the other eight members of the management team. Robbin has worked in a variety of public health settings, including in a nursing home, a hospital, and in three different mental health clinical settings as a licensed

therapist and administrator. Her work extends into the greater Manhattan community, through support to programs like Helping International Students (HIS), AFS-USA, and the Manhattan Rotary. She served as my primary preceptor, providing support and guidance for meeting the goals for both the Kansas State Graduate School and for PMHS.

Deanna J. Hall

Deanna Hall serves as the Marketing Manager and Employee Assistance Program (EAP) Director at PMHS. Newly hired to her position, Deanna was an integral part of guiding my experience at PMHS. She worked with me on the day-to-day, focused more specifically on the production of my products and integrating me into the workforce. Before beginning at PMHS, Deanna was the president of Manhattan Advertising Agency, Inc., where she had served since 2001. She holds a Bachelor of Science from Kansas State University in Consumer Economics and is a member of the KSU Alpha Chi Chapter of Phi Upsilon Omicron honorary professional fraternity. Living in Manhattan for all her life, Deanna has been highly involved in community outreach. Notable, she has served as Vice Chair on the Homecare and Hospice Board of Directors, worked on the marketing committee for the Flint Hills Breadbasket and United Way, and has sat on the Board of Directors at Manhattan Arts Center.

Chapter 2 - Learning Objectives and Project Description

I. Learning Objectives

1. To develop a comprehensive report that summarizes the activities and populations served at PMHS.
2. To increase knowledge about the informal and formal structural processes at PMHS and other CMHCs that create an environment for a successful community mental health center.
3. To effectively communicate the agency mission and vision to clients, community stakeholders, and staff.

II. Project Description

At the beginning of my project at PMHS, my preceptors and I developed a goal-oriented plan for my project. During this time, we scheduled weekly meetings with Robbin and Deanna for Mondays at 8:00am. Later, this developed into meeting whenever needed with Deanna, and scheduling meetings with Robbin as time allowed. The primary goal was to complete the annual report for fiscal year 2018 through a variety of smaller exercises split into phases. The phases allowed for great flexibility and guided my daily activities at PMHS. When unexpected event would arise, I was able to set aside my work and involve myself in the community at PMHS while still adhering to a deadline. One example of this was the Mardi Gras for Mental Health or Pancakes for Pawnee event on March 5th. During this day, I put aside my work on the annual report to volunteer at this annual fundraiser at Early Edition.

Phase One

Phase one of the project was to review the annual reports of other CMHCs in Kansas, and utilize previous annual reports completed by PMHS to develop content for the annual report for fiscal year 2018. This included deconstructing the previous ten years of PMHS Annual Reports and reviewing annual reports from all other CMHCs in Kansas. We also determined

which Kansas CMHCs did not have their annual report available online, as well as details on how many annual reports were listed, if they were available. I called each of the CMHCs that did not have their annual report available online, and generated details from those conservations that could be used to adjust how PMHS handles all of their incoming calls.

To conclude phase one, I presented a summary to Robbin and Deanna of the information, style, and data I gathered from other annual reports, and reported what features I would like to integrate into the most recent annual report for PMHS. Robbin provided guidelines for producing a presentation, including graphics and visual display from annual reports of other agencies that I reviewed. Before moving to phase two, Robbin required that she and Deanna come to a consensus on what PMHS data should and would be accessible to me.

Phase Two

Phase two was centrally focused around the data reported for fiscal year 2018 at PMHS. This was to include: (1) making recommendations on what data should be presented in an annual report; (2) indicating what data was presented by other CMHCs in Kansas; and (3) considering methods to inspire and motivate the constituent audience of the annual report through this data.

Phase Three

Phase three was focused on the design and creation of the annual report document. Essentially, the annual report was to be created with the following two questions in mind. First, what makes the audience want to know more about a mental health care facility? Second, what makes the audience feel good about referring people or feel likely to refer people to the facility? This was intended to include research about how non-profits accurately report information to their constituents, while balancing the needs to communicate with diverse audiences. The culmination of these phases was to produce material that demonstrated the narrative and purpose of PMHS, including, but not limited to, the influence of financial support and the diversity of clientele served.

III. Advocacy Day on the Hill

On February 21, 2019, Deanna Hall, Diane Hinrichs (PMHS Development Manager), Morgan Mitchiner (intern at PMHS), and I traveled to Topeka, Kansas for Community Mental Health Center Advocacy Day on the Hill. This is an annual event held by the Kansas Association of CMHCs that is dedicated to lobbying for policies that further mental health care or mental health care funding in the state of Kansas. We spent approximately four hours in the morning staffing an informational booth in the Capitol Rotunda, providing materials and information to attendees. Additionally, Deanna and I delivered policy materials to the two of the five Senators and six of the eleven House Representatives that represent the catchment area of PMHS, see Figure 2.1. The remaining eight legislators were visited by Diane Hinrichs and Morgan Mitchiner. The materials we delivered could be easily retrieved online, but importance can be placed on delivering these materials in person. Having a person in the legislator's constituency take the time to come to their office and advocate for change shows a vested interest by the constituency, the same constituency that has influence over how long that legislator will be in office. The Capitol Rotunda was filled with many of the CMHCs in Kansas to advocate for these policies as well, which included Mental Health 2020, Medicaid expansion, and a push for funding in terms of 13.2 million dollars. These policies were laid out in a handout we used for talking points and delivered to each legislator, which can be found in Appendix 3.

Figure 2.1. CMHC Advocacy Day on the Hill with House Representatives.

Left picture: ***Amy Wedel, Diane Henricks, Rep. Tom Phillips, Deanna Hall, Morgan Mitchiner***
Right picture: ***Deanna Hall, Rep. Susan Carlson, Amy Wedel***

IV. Presentation to PMHS Management Team

On Monday, March 18, 2019, I presented a draft of the annual report to the management team of PMHS and Deanna Hall. As described above, the management team of PMHS currently consists of nine individuals, including Robbin. This presentation was an opportunity for me to meet the remainder of the management team, and to give me an opportunity for an explanation and a description of the work I had been doing for the previous several months. Included within the presentation was an introduction of myself, my internship requirements, and the degree I am pursuing. Deanna then introduced the project, explaining why the annual report is such an essential part of the marketing plan for PMHS. I presented the annual report product, and guided the management team through each page layout, including my influences in design and structural organization, and describing the clients-served data which are represented throughout the report. The management team provided input and suggestions, which I incorporated into the final adjustments to the document. This presentation is connected directly to my third learning

objective, which enabled me to enhance my communication skills and show the staff where PMHS is going into the future.

Chapter 3 - Results

Phase One

As the research-focused phase, this part of my experience includes the information I gathered from CMHCs in Kansas. Table 3.1 outlines information about the annual reports from other Kansas CMHCs and whether they were available for my research. It summarizes which reports were accessible online, and, if they were on their website, how many years of reports were available as well as which were provided through other means I gathered this information through a variety of methods, including thorough website searches, telephone conversations, e-mail requests, and faxing requests. As noted, not all of the CMHCs in Kansas were responsive to the requests, but many were interested in this project. Two CMHCs in Kansas indicated that they do not currently produce an annual report and nine others never provided their report for me.

The steps for accumulating this information began with an extensive search for and of each website, recording and downloading annual reports as I proceeded. If annual reports were unavailable online, I would call the telephone number provided on each website to request the report. The telephone communication and resulting voicemails and were further completed by providing my PMHS email address for their most recent annual report to be emailed to me. Deanna asked me to collect additional data on the 12 CMHCs that required a telephone call. Table 3.2 indicates which of these CMHCs had automated answering systems. Additional data was collected from these telephone conversations that is not included here. This data was compiled into a subjective rating scale for Pawnee's use only in the advancement of their telephone system. Since I had never called any of these centers before, my subjective rating gave Deanna & Robbin a unique opportunity to see how a third-party is impacted by certain factors during a simple telephone call.

Table 3.1 Annual Reports from CMHCs in Kansas

A green cell with “Y” indicates a yes, a red cell with “N” indicates a no, and a gray cell with “n/a” represents CMHCs that do not produce an annual report. The first two columns indicate the 26 CMHCs in Kansas and whether their annual report was available to me. This includes those reports that were pulled from the website, all of those indicated “Y” in the third column, as well as those provided via other means. The fourth column indicates the number of annual reports that were present on that CMHCs website. For example, Bert Nash had their most recent annual report online (FY17) and four previous years, giving a total of five years present.

CMHC Title	Annual Report Received	Annual Report on Website?	# of Years Present
Bert Nash Community Mental Health Center, Inc.	Y	Y	5
Central Kansas Mental Health Center	Y	Y	1
Comcare of Sedwick County	Y	Y	1
Community Mental Health Center of Crawford County	n/a	n/a	-
Compass Behavioral Health	N	N	-
Crosswinds Counseling & Wellness	Y	N	-
Elizabeth Layton Center	Y	Y	4
Family Service & Guidance Center	Y	Y	6
Four County Mental Health Center	N	N	-
High Plains Mental Health Center	Y	N	-
Horizons Mental Health Center	Y	Y	2
Iroquois Center for Human Development, Inc.	Y	N	-
Johnson County Mental Health Center	N	N	-
Kanza Mental Health & Guidance Center	Y	Y	1
Labette Center for Mental Health Services	N	N	-
Pawnee Mental Health Services	Y	Y	2
Prairie View, Inc.	Y	Y	1
South Central Mental Health Counseling Center, Inc.	Y	Y	3
Southeast Kansas Mental Health Center	N	N	-
Southwest Guidance Center	N	N	-
Spring River Mental Health & Wellness, Inc.	N	N	-
Sumner Mental Health Center	N	N	-
The Center for Counseling and Consultation	n/a	n/a	-
The Guidance Center, Inc.	Y	Y	15
Valeo Behavioral Healthcare	N	N	-
Wyandot Center for Community Behavioral Healthcare, Inc.	Y	Y	4

Table 3.2 Phone Conversations to CMHCs in Kansas.

A green cell with “Y” indicates a yes, a red cell with “N” indicates a no. This figure shows the 12 CMHCs that received telephone calls from me in search of their most recent annual report and whether they had automated answering as a part of their telephone system.

	Automated Answering?
Community Mental Health Center of Crawford County	N
Compass Behavioral Health	N
Crosswinds Counseling & Wellness	Y
Four County Mental Health Center	N
High Plains Mental Health Center	N
Iroquois Center for Human Development, Inc.	N
Johnson County Mental Health Center	Y
Labette Center for Mental Health Services	N
Southeast Kansas Mental Health Center	N
Southwest Guidance Center	N
Spring River Mental Health & Wellness, Inc.	N
Sumner Mental Health Center	Y
The Center for Counseling and Consultation	N
Valeo Behavioral Healthcare	Y

The culmination of this phase was the oral presentation I gave to Robbin and Deanna before moving on to phase two. The presentation slides from this presentation are included in Appendix 1 as a part of my products. These slides represent a substantial portion of the research compeleted during this phase, with details from the 15 annual reports received and from three non-profit reports I reviewed for comparison. This culmination of the first phase connects to my second learning objective, in regard to increasing knowledge about formal processes, such as creation of annual reports, at other CMHCs and at PMHS that create an environment of success as it relates to receviing funding from donors and providing services to clientele. This objective was valuable to me as it related directly to my interest in pursuing a career in the mental health sector, especially in the nonprofit area.

Phase Two

During phase two this project, I analyzed the data provided to me for fiscal year 2018 (FY18), defined as July 1, 2017 through June 30, 2018. The data was provided to me in simple table formats organized in Microsoft Excel. All graphical images and tables presented here were produced using Microsoft Excel. Many of the tables shown here were recreated in Adobe InDesign to facilitate capatabile graphs for the completed annual report.

The total number of clients served by PMHS during FY18 was 7,480. Table 3.3 shows the dispersal of clients by county based on the address given at time of service. These data represent the number of clients from each county that received services at any PMHS location, not the numbers from that specific county's location. PMHS also served 609 individuals from outside of the catchment area, in essense, people who did not live within any of the ten counties PMHS served but still received services at PMHS. Population-adjusted numbers show that the proportion of clients served is the greatest in Cloud County, at 6.24 clients per 100.

Table 3.3. PMHS clients served by county during FY18.

Number of clients served at PMHS by the county indicated on their intake form is represented in the first column. The second column is the percentage of total clients served from each county. The third column gives the population adjusted number of clients per 100 population.

County	# of Clients	% of Clients	Population adjusted # of clients / 100 population
Clay	342	4.57	4.30
Cloud	561	7.50	6.24
Geary	1839	24.59	5.43
Jewell	104	1.39	3.65
Marshall	448	5.99	4.60
Mitchell	213	2.85	3.48
Pottawatomie	492	6.58	2.06
Republic	157	2.10	3.35
Riley	2557	34.18	3.45
Washington	158	2.11	2.88
Out of Catchment	609	8.14	
Total	**7,480**		

Program utilization by clients, as shown in Table 3.4, represents a number greater than the total number of clients served by PMHS. This is because single clients often utilize more than one service. We cannot utilize percentages for the program data but can recognize that the most utilized service characterized here is therapy services. Therapy services include individual, martial, family, and group therapy for both adults and youth, as well as psychological evaluations and competency to stand trial evaluations. The clients utilizing these services could have any one or any combination of the diagnoses laid out in Table 3.5. An important discussion to have regarding the diagnosis data is that nearly 85% of clients served during FY18 fall into the unknown category. This category is made up of individuals for which data was not collected and is therefore not known. This drastically limits the sample size in the diagnosis categories, of which the distribution is not likely to accurately represent the true dispersal of client by diagnosis.

Table 3.4. Program utilization by PMHS clients from FY18.

Program	# of Clients
Recovery Services	1,385
Youth Rehabilitation	658
Adult Rehabilitation	383
Crisis Services	1,716
Medical Services	2,943
Therapy Services	4,365

Table 3.5. Diagnoses of PMHS clients from FY18.

Diagnosis	# of Clients	% of Clients
A/D Related	6	0.08
Anxiety	144	1.93
Childhood related	289	3.86
Dementia and related disorders	2	0.03
Depressive	291	3.89
Mood	250	3.34
Obsessive/compulsive	17	0.23
Other	5	0.07
Psychotic disorder(s)	154	2.06
Unknown	6,322	84.52
Total	**7,480**	

Demographically, the clients served by PMHS during FY18 were not racially diverse, but were split relatively evenly by gender identification, and were well-dispersed by age. Of the clients that indicated their race, 56% of the clients that were served in FY18 are white, while the other 44% are a racial minority. Table 3.6 shows the breakdown of race, with 26% of the total marked as other or unknown. The unknown category encompasses individuals for which racial data was not collected as well as individuals who selected other. This is a limitation of the data, as the categories of the data need to be well-defined or those individuals that fall into minority groups are easily misrepresented by these other and unknown categories. Compared to the racial data for all of Kansas, fewer PMHS clients identified their race as Asian or White and more identified their race as American Indian or Alaskan Native.

Gender, as shown in Figure 3.1, is identified by the client from three options: (1) female, (2) male, (3) other/unknown. Again, the unknown category includes individuals for which age data was not collected and those who do not identifiy within the binary. The limitation discussed in terms of race also applies to the gender identification data from PMHS.

Table 3.6. Race demographics of PMHS clients from FY18 compared to Kansas racial data.

The other/unknown category for the percentage of Kansas residents includes two census categories of race that were not available options for PMHS clients. They are: Native Hawaiian or other Pacific Islander and Some Other Race.[38]

Race	# of Clients	% of Clients	~% in Kansas
American Indian/Alaska Native	717	9.59	2.11
Asian	53	0.71	3.43
Black	466	6.23	7.28
White	4,002	53.50	88.03
Other/Unknown	2,242	29.97	2.79
Total	**7,480**		

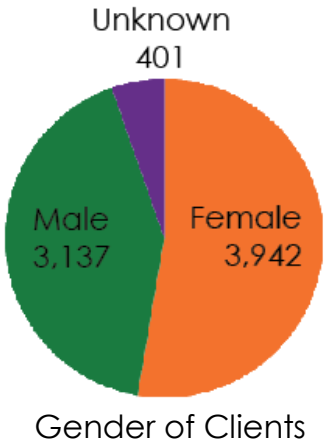

Figure 3.1 PMHS clients from FY18 by gender

The age distribution of clients served shows that over half of PMHS clients fall in one of two age categories: ages 0 to 12 and ages 19 to 34. The lowest served age group served by PMHS in FY18 is the 55-year-olds and older population, which makes up only 6% of the total served. Only 14% of the total is made up by 13 to 18-year-olds, less than each of the other age categories, excluding the 55 and older population (Figure 3.2). For comparison, Figure 3.3 shows the age dispersal individuals served at public mental health care agencies in the United States in 2016. There are considerable differences between the zero to twelve, 35-55, and 55

plus age groups when comparing PMHS client data to the national data, as will be considered in the discussion.

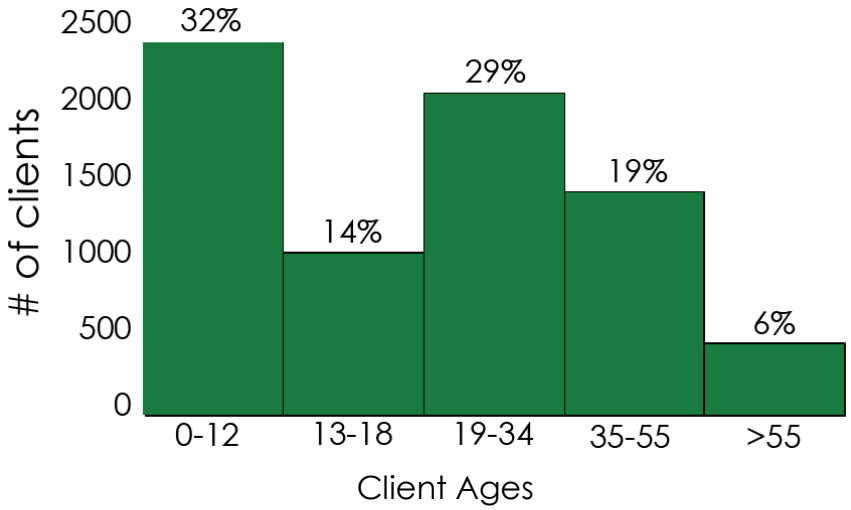

Figure 3.2 PMHS clients from FY18 by age

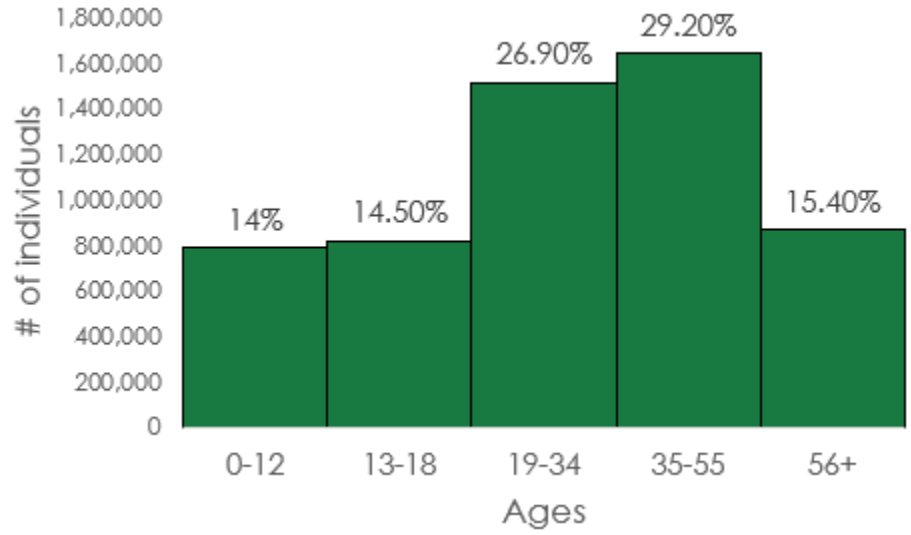

Figure 3.3 National percentage of individuals served by age, 2016[39]

In fiscal year 2018, the primary source of income for PMHS was from client fees at approximately 12.5 million dollars. Approximately 4.5 million dollars-worth of these fees were uncollectable, leaving a net gain from client fees of approximately 8 million dollars, which makes up about 65% of the total income brought in by PMHS. These 8 million dollars funded 81% of

the highest expense for PMHS in FY18, salaries and benefits of employees. In Figure 3.3, it is shown that the remainder of the revenue for FY18 came primarily from public support through federal, state, county, and local funding and the remainder of expenses came for operational or day-to-day costs. Miscellaneous income, representing 4% of the total income from FY18, comes primarily from donors and grants. Each year, PMHS applies for grant funding, in FY18, they received nearly $290,000 from these grants – detailed in Table 3.7.

REVENUE/INCOME

Client Fees	$12,417,363
Allowance for fee adjustments/uncollectables	($4,379,364)
Miscellaneous Income	$532,071
Public Support	
State/Federal Funding	$2,464,385
County Funding	$1,044,693
Local Funding	$261,752
TOTAL	**$12,340,900**

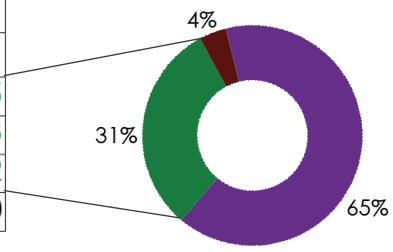

Figure 3.3. Revenue of PMHS during FY18.

EXPENSES

Salaries & Benefits	$9,930,981
Operational Costs	$2,843,300
TOTAL	**$12,774,281**

Figure 3.4. Expenses of PMHS during FY18.

Table 3.7. Grants awarded to PMHS during FY18. Grants are included in the miscellaneous income category of Figure 3.2.

Grant Name	Grant Award Amount
Philanthropic Grants	
Blue Cross Blue Shield of Kansas	$2,000
Caroline Peine Charitable Foundation	$52,969
Dane G. Hanson Foundation	$19,137
Greater Manhattan Community Foundation	$6,750
Howe Family Foundation	$26,000
Lincoln W. and Dorthy I. Deihl Endowed Fund	$9,750
Tower Mental Health Foundation	$11,554
We Are Wamego	$1,000
Sub total	*$129,160*
Governmental Grants	
City of Manhattan - 2018 Special Alcohol Funds	$60,000
City of Manhattan - Community Block Grant	$27,450
Kansas Department for Aging & Disability Services PATH Grant	$43,753
Kansas Department of Transportation	$29,225
Sub total	*$131,203*
GRAND TOTAL	**$289,588**

Phase Three

The final portion of the experience was to culminate all of the research and data presentation I had completed into the official FY18 annual report for PMHS. Almost all of this work was completed in Adobe InDesign, a software built for graphic design and marketing. The final annual report, as will be printed by PMHS this spring, can be found in Appendix 1.

Chapter 4 - Discussion

My understanding of mental health care in Kansas was greatly expanded while working at PMHS Mental Health Services (PMHS). Mental health is an enormously broad field encompassing clinical, medical, rehabilitation, and crisis services which are all influenced by public health policy, access to care, and availability of therapists.

Public health policy plays an integral role in the ability of a CMHC to provide their services. These centers provide care regardless of patients' ability to pay. The number of individuals they serve that lack insurance or utilize government subsidized insurance is much greater than number of individuals served by private mental health care. In this manner, PMHS provides a service that fills a void in the access to care struggle faced by patients. Noting this service CMHCs can provide throughout the state of Kansas, it is also important to note that not all therapists accept Medicaid. Stringent requirements laid out by the state and federal government limit which therapists meet the qualification to accept Medicaid as payment for care. The expansion of Medicaid, which PMHS has advocated for, is a vital step in providing care for individuals that fall in the insurance coverage gap caused by these limitations.

While creating the annual report, there was a careful discussion on what information could be included and highlighted. When planning how to include information about which insurances are used by a majority of PMHS clients in FY18, we discussed that including this data might discourage certain individuals from coming to PMHS. If PMHS publicizes information on the proportion of clientele that utilized Medicaid or were uninsured, it could show the necessity of expanding Medicaid and providing supplemental funding in Kansas. The concern however, is that this information could inadvertently discourage individuals with private insurance from utilizing the services at PMHS, because they believe it could be incorrectly viewed as lower quality care than from private providers. Some CMHCs in Kansas do publish clientele insurance statistics. PMHS and other CMHCs provide services to clientele in diverse

financial situations, however, individuals and families that are underinsured or uninsured are more likely to pursue care at these public clinics. Conversely, individuals and families that have high levels of insurance may feel as though a CMHC will not provide adequate care. This concept is an extrapolation of the epidemiological concept of participation bias or non-response bias. Only the individuals that receive care at PMHS are included in the summary data which skews results by factors that correspond to the types of individuals who seek care at a CMHC. This results in summary statistics that are only representative of a subset of the population rather than the entire population. Considering bias as a barrier to mental health care, Dr. Snowden stated that bias occurs when assumptions become normative beliefs that then are shared by members in a community.[40]

The data from a community mental health center (CMHC), such as PMHS Mental Health Services, represents only a small sector of the data for that geographical area. CMHCs are not the only available form of mental health care in many areas and may disproportionately serve populations that confound the overall data. Identifying data to include in the annual report and designing methods to represent the data had to be carefully considered. Every decision was complicated by considering how any given population may interpret the data. This process challenged my ability to explore the data from different points of view.

The age dispersal of PMHS clients during FY18 and national data from 2016 show clear differences in the results (Figures 3.2 & 3.3). The difference between the zero to 12 age group the 13-18 age group caught my eye when first viewing this data, but after comparison with the national data I realized that the difference I was seeing was skewed by the services offered at PMHS. The other large difference, seen in the 55 plus population, may have to do with the lack of specialized services PMHS provides for this age group. Since there is little to draw the older population to PMHS, they may simply be receiving services elsewhere. It is also possible that this difference is showing a disparity in care for this population.

The data visualizations for this project were completed using Microsoft Office Excel and tables were recreated in Adobe InDesign. These two pieces of software are prime examples of the financial costs associated with data analysis and presentation. PMHS is limited in their ability to utilize software like this due to the cost, but the subscription service for the Adobe Cloud was purchased for one month of use during this project and I utilized a student version of Microsoft Office. The annual report design was completed in Adobe InDesign, a part of the Adobe Cloud. This software came with a substantial learning curve, which I learned mostly de novo and through the help of Ashley Neufeld, a senior graphic design student at Kansas State. Ashley is a member of a student group on campus, of which I am the president, and gave me input regarding font style, white space use, and suggestions of design elements for the annual report. Learning to use this program gave me clear insight as to why many nonprofits do not have professional visual pieces. Most non-profits are utilizing Microsoft Office software, such as Word, Publisher, and PowerPoint, and some may be using open source software, such as LibreOffice. These programs are inflexible, provide subpar templates, and produce products that are visually unprofessional when compared to true graphic design software. There is an importance to these kind of partnerships for PMHS. Connecting with Kansas State University, through the Master of Public Health program, provided them with access to Microsoft Office software and further knowledge about this software. My direct connections with a student in the graphic design program provided me with information about discounts attached to the Adobe Cloud, thus allowing PMHS to provide a small portion of funds to cover the use of this software. Without these partnerships, insufficiently funded agencies, like PMHS, in underappreciated fields, like mental health care, would struggle further to keep up with the fast-paced marketing and development departments of better funded agencies.

My culminating experience at PMHS developed a variety of skills, and greatly influenced how I view the impact of policy on health care. I established skills in verbal, written and visual communication, with Adobe InDesign and Microsoft Excel, and in time management and

information dispersal. The learning objectives, specified in Chapter 2, were all met throughout this project, as designated in this paper.

Chapter 5 - Competencies

I. Attainment of MPH Foundational Competencies

Competency #4: Interpret results of data analysis for public health research, policy or practice.

One of the essential parts of creating the annual report was displaying the data collected by PMHS in multiple ways to prepare for all potential interpretations before selecting how it would be displayed in the final report. The methods in which data are displayed can have a direct impact on how data is interpreted or understood. For the annual report, is was critical to consider how visual displays of data could influence the potential audience. The audience of the annual report is highly diverse, including potential clients, donors, and city council members, all with differing levels of education and different needs from the report. This diversity makes it difficult to decide upon how the data should be represented. After each graph or table associated with the data was created, as presented in Chapter 3, I considered the possible interpretations by each potential audience member. As an example, we chose to display the clients served data in the report without the percentages seen in Table 3.3. This choice was made after considering the impact including these percentages could have. They might discourage clients from outside the majority counties, Riley & Geary, from seeking care at PMHS. Additionally, they could discourage potential donors from giving to PMHS. Especially if those donors fall in the service area of PMHS, but not in the two majority counties. Another way to remedy this issue would have been to provide population-adjusted numbers.

Competency #13: Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes.

Marketing materials, such as brochures, annual reports, and web pages, are essential methods to influence public health outcomes. During this experience, I proposed and executed the development of strategies for potential stakeholders of PMHS through the publication of the

annual report. Strategies included, the use of client quotes or stories to encourage vested interest, an emphasis on the tagline of PMHS to show where the company is going, and the inclusion of grants received to indicate the financial effort PMHS is putting forward.

Competency #14: Advocate for political, social, or economic policies and programs that will improve health in diverse populations.

This competency was achieved through attendance to the Kansas Association of CMHC's Advocacy Day on Hill in Topeka, KS. Throughout the day we pushed the agenda laid out by the Association of CMHCs of Kansas, Inc., which is centered around Mental Health 2020. Mental Health 2020 includes the promotion of the needs of underinsured and uninsured populations, in connection with Medicaid expansion and enhancing the Medicaid rates for behavior health. The primary request of these policies was an allocation of funds from the Legislature of $13.2 million. We lobbied these policies to all the house representatives and senators who fall in the catchment area of PMHS.

Competency #19: Communicate audience-appropriate public health content, both in writing and through oral presentation.

This competency was achieved through the written annual report document and an oral presentation to Robbin and Deanna. These two items also are my products from this experience. The annual report provides public health content in the services section and data section, which make up much of the report. The services pages include descriptions of what public health services are available at PMHS, broken down by category, and the educational programs PMHS provides. The way in which to represent the data was a component in achieving this competency. Presentation of written and graphical information needed to be clear, but through, to function for all audiences of the annual report. The oral presentation to Robbin and Deanna functioned as an example to show the effectiveness, or lack thereof, of

other CMHCs in presenting public health data to their constituency. This competency is essentially my first learning objective, as indicated in Chapter 2.

Competency #21: Perform effectively on interprofessional teams.

Working with Robbin, who is trained as an LSCSW and has worked in administration for over 15 years, was an incredibly different experience to working with Deanna, who has worked in marketing and advertisement for 20 or more years. These two functioned as my primary team at PMHS and performing effectively with them required. We met approximately once a month to discuss the progress on my project. Integrating the marketing skills from Deanna's background, the administrative and clinical skills from Robbin's, and my public health knowledge was vital to the completion and production of an annual report. When making decisions on how to move forward with a design style or data representation, Deanna would have thoughts on why that data could encourage or discourage a client from coming to PMHS and Robbin would have thoughts on how it might discourage or encourage donors from giving. This back-and-forth allowed for the development of a report that is foundationally both interdisciplinary and multidisciplinary.

I also interacted some with other PMHS employees, specifically the management team through email. Since my interactions with these individuals were limited, I would not say we worked as a team. However, it was interesting to see how individuals in different disciplines reacted and responded to my requests for information.

Table 5.1 Summary of MPH Foundational Competencies

Number and Competency		Description
4	Interpret results of data analysis for public health research, policy or practice	Taking the data collected by PMHS and considering different ways of interpretation to determine what should be included in the annual report.
13	Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes	Marketing materials are essential methods to influence public health outcomes. I used the specific marketing material of an annual report to execute these strategies.
14	Advocate for political, social, or economic policies and programs that will improve health in diverse populations	Advocacy day on the hill for the Association of CMHs of Kansas, Inc. was a day full of advocating for Mental Health 2020 to legislators in the PMHS catchment area.
19	Communicate audience-appropriate public health content, both in writing and through oral presentation	Public health content communication was achieved through the writing and publication of the annual report services and data, as well as through an oral presentation on the services and data presented by other CMHCs in Kansas.
21	Perform effectively on interprofessional teams	My primary team at PMHS came from three different backgrounds, all seeking to further mental health care. Being a member on this team provided the space to create an annual report that included influences from clinical, marketing, administrative, and public health sides of PMHS.

Attainment of MPH Emphasis Area Competencies

The competencies for an emphasis in infectious diseases and zoonoses were all covered in my coursework. However, for this project there are two competencies in particular that connect to mental health. Competency number one is to evaluate modes of disease causation through pathogenic mechanisms. Infectious diseases are a possible pathogenic mechanism for the development of mental illness, as is supported by research. The most researched disorders are HIV-associated neurocognitive disorders or HANDs. HANDs include HIV-associated dementia, mild neurocognitive disorder and asymptomatic neurocognitive impairment, as discussed in the literature review. These three disorders are essentially all dementia, but do not fall into the typical causative pathway for dementia. The more pathogenic and widespread type of HIV, HIV-1, is known to have direct effects on the central nervous system, which may be responsible for the development of these neuropsychiatric conditions.

The second competency that is relevant is number 3, which is examining the influence of environmental and ecological forces on infectious diseases. Similarly to infectious disease, the environment can be a major influencer when it comes to the development of mental illness. An at-risk population for both mental illness and infectious disease is the homeless population. There are three different relationships between health and homelessness: (1) some health issues come before and contribute and homelessness, (2) some health issues are a consequence of homelessness, and (3) homelessness makes treatment of many illnesses difficult or futile. Mental illnesses and many infectious diseases fall into each of these categories. One example, that combines infectious diseases and mental illnesses in this context, is chronic schizophrenia as a precedent to homelessness, then infectious hepatitis (commonly known as Hepatitis A) as a result of homelessness, and then an inability to get access to care for a sustained period to go through complete treatment to prevent the cycle from repeating itself.

Table 5.2 Summary of MPH Emphasis Area Competencies

MPH Emphasis Area: Infectious Diseases & Zoonoses		
Number and Competency		**Description**
1	Pathogens/pathogenic mechanisms	Evaluate modes of disease causation of infectious agents.
2	Host response to pathogens/immunology	Investigate the host immune response to infection.
3	Environmental/ecological influences	Examine the influence of environmental and ecological forces on infectious diseases.
4	Disease surveillance	Analyze disease risk factors and select appropriate surveillance.
5	Disease vectors	Investigate the role of vectors, toxic plants and other toxins in infectious diseases.

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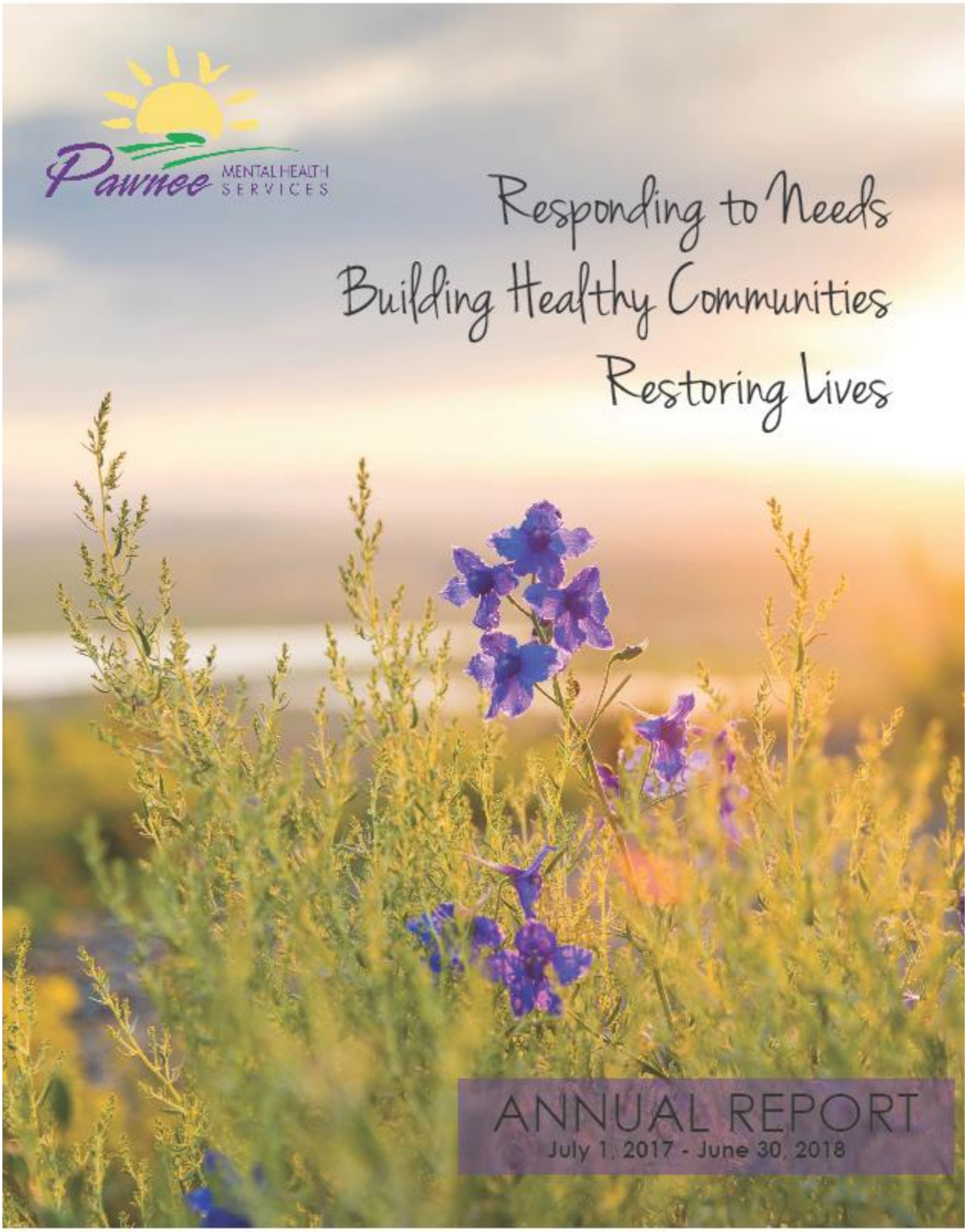
Appendix 1 - Products


Pawnee MENTAL HEALTH SERVICES
Responding to Needs
Building Healthy Communities
Restoring Lives
ANNUAL REPORT
July 1, 2017 - June 30, 2018

From Our Executive Director & Board Chair

Responding to Needs. Building Healthy Communities. Restoring Lives.

This is Pawnee Mental Health Services. In its first year, Pawnee had one therapist in one county who provided services to approximately 100 people. This year, Pawnee had approximately 240 employees in ten counties providing services to nearly 7500 people.

Pawnee Mental Health Services, along with the fire department, law enforcement, EMS and hospital emergency room, provides a public safety net for our communities. In recent years, law enforcement and the hospital emergency room have seen an increasing number of individuals with mental illness and substance use disorders enter the system through their doors.

In June, Pawnee received a grant for $725,000 from the State of Kansas to establish a Crisis Stabilization Center in Manhattan that will provide crisis observation (<24 hours) and crisis stabilization (>24 hours) to people from Pawnee's ten county service area. This partnership makes it possible for Pawnee to provide additional support to members of our community in crisis and to our community partners who have seen themselves become mental health first responders.

Pawnee Mental Health Services is proud to work alongside our community partners to serve individuals with mental illness and substance use disorders. We hope you'll enjoy reading this annual report to learn more about what we do and the impact we have in our communities.

Robbin Cole & Ed Koehler

Ed Koehler
Board Chair

Robbin Cole, LSCSW
Executive Director

We believe

Pawnee Mental Health Services is a leader in promoting healthy communities by providing mental health and substance use treatment services which are driven by community, family, and individual needs.

COUNTIES WE SERVE

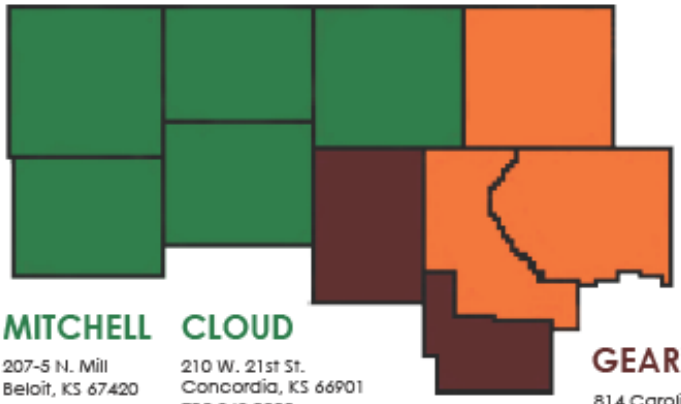
WASHINGTON
321 C. St. Suite 102
Washington, KS 66968
785.325.3252

MARSHALL
406 N. 3rd St. Suite 3
Marysville, KS 66508
785.562.3907

POTTAWATOMIE
510 E. US Hwy 24
Wamego, KS 66457
785.456.7408

REPUBLIC
1836 M Street
Belleville, KS 66935
785.527.2549

JEWELL
122 West Main
Mankato, KS 66956
785.378.3898



RILEY
2001 Claflin Rd.
Manhattan, KS 66502
785.587.4300

1558 Hayes Dr.
Manhattan, KS 66502
785.587.4315

423-425 Houston St.
Manhattan, KS 66502
785.587.4361

MITCHELL
207-5 N. Mill
Beloit, KS 67420
785.738.5363

CLOUD
210 W. 21st St.
Concordia, KS 66901
785.243.8900

GEARY
814 Caroline Ave
Junction City, KS 66441
785.762.5250

CLAY
503 Grant Ave
Clay Center, KS 67432
785.632.2108

1735 W. Ash St.
Junction City, KS 66441
785.238.1085

BOARD OF DIRECTORS

Pawnee is governed by a Board of Directors appointed by the County Commissioners of the ten counties served by the agency. Board members and alternates are appointed to three-year terms by their respective county commissions. Special board appointments include: an adult with a severe and persistent mental illness and the parent of a child with a serious emotional disturbance.

CLOUD COUNTY
Sister Beth Stover
David Remond

REPUBLIC COUNTY
Elizabeth (Leanne) DeJoia
Sharon Segerhammar, Vice-Chair
Melvin Jeardoe

CLAY COUNTY
Mindy Blake
Ed Koehler, Chair
Fadia Hamadah, Alternate

GEARY COUNTY
Andrea Mace, Secretary (2018)
Joy Davis, Secretary (2017)

JEWELL COUNTY
Mel Brown, Treasurer
Karen Boden

WASHINGTON COUNTY
Mary Tate
Anita Bott

BOARD APPOINTMENTS
Stan Wilson

MITCHELL COUNTY
Kathy Webster
Terry Bailey

MARSHALL COUNTY
Bill Oborny
April Todd

POTTAWATOMIE COUNTY
Lisa Kenworthy
Diane Hinrichs
Rick Hernandez
Todd Willert

RILEY COUNTY
Anne Browne
Jim Flynn, Treasurer

Our mission is to provide comprehensive quality mental health & substance use

Our Services

MEDICAL

2,943 clients served

- Medication Evaluation
- Medication Management
- Tele-medicine to Rural Communities

TRAINING & EDUCATION

COMMUNITY

1,041 clients served

Youth Rehabilitation Services

658 clients

- Community Psychiatric Support and Treatment
- Individual and Group Psychosocial Rehabilitation
- Independent Living Skills Building
- Family Support and Education
- Short-term Respite Care
- Targeted Case Management
- Wraparound Facilitation
- Attendant Care

Adult Rehabilitation Services

383 clients

- Community Psychiatric Support and Treatment
- Individual and Group Psychosocial Rehabilitation
- Targeted Case Management
- Benefit Specialist
- Attendant Care
- Peer Support

THERAPY & RECOVERY

Mental Health

4,365 clients

5,750 clients served

- Individual, Marital, Family, & Group Therapy
- Competency to Stand Trial Evaluations
- Psychological Evaluations

Substance Use

1,385 clients

- Individual, Family, and Group Substance Use Treatment
- Alcohol/Drug Screening & Referral
- Alcohol/Drug Evaluation
- Level 1 & 2 Alcohol/Drug Treatment
- Alcohol/Drug Information School (ADIS)
- Anger Evaluation
- Domestic Violence Assessment
- Batterer Intervention Program (BIP)
- Anger Management Group

CRISIS

1,716 clients served

- Screening and assessment of children/adults to state psychiatric hospitals or inpatient psychiatric units
- 2 licensed co-responders working with the Riley County Police Department
- Pre-admission Screening and Resident Review for continued stay at Nursing Facilities for Mental Health
- Court requested competency evaluations
- Crisis stabilization services for youth and adults
- Crisis house for youth in Junction City and Concordia
- Forensic interviews for Child Advocacy Centers
- Critical Incident Stress Management Team
- Provide Community Based Service Team meetings for Psychiatric Residential Treatment Facility Admissions and ongoing treatment plans
- Working towards completion of the Crisis Stablization Center in Manhattan, KS

treatment & recovery services to strengthen the wellness of our communities.

Mental Health First Aid is a public education program that teaches you how to identify, understand, and respond to signs of mental illnesses and substance use disorders. This 8-hour training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. For more information on a class near you, please contact us at 785.587.4300 or mhfa@pawnee.org.

DIVORCE & CHILDREN'S NEEDS

Divorce and Children's Needs teaches parents how to help their children navigate the difficulties associated with divorce.

12 Divorce & Children's Needs classes offered
92 parents served

BASIC Parenting

Basic Parenting is a course based on the National Extension Parents Education of Critical Parenting Practices.

4 Basic Parenting sessions offered

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Our Employee Assistance Program is an agreement between an organization or company & Pawnee Mental Health Services to provide assessment and referral in order to help employees and their families deal with problems that affect their personal lives and/or job performance. The EAP is free to employees and immediate family members. Businesses sign up for EAP services with us and payment is based on the number of employees. For further information please call us at 785.587.4300 or email us at deanna.hall@pawnee.org.

MARKETING

Staff represented the agency at health/wellness fairs, on community boards and committees, and gave presentations in person, print, and broadcast media.

Pawnee recognized:
World Suicide Prevention Day
Internatinoal Survivor of Suicide Loss Day

All our counties declared:
May as Mental Health Month
September as Recovery Month

Management Team

Pawnee is directed by an Executive Director and a management team which is responsible for program services across all ten counties served by Pawnee.

Robbin Cole, LSCSW
Exeoutive Direotor

Robert Hanson, BS
Chief Finanoial Offioer

Karen Smothers, LSCSW, LCAC
Assistant Direotor, Clinioal Direotor

Camber Boland, BS
Human Resouroes Direotor

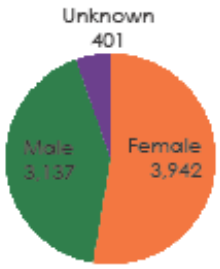
Padma Lassi, MD
Medioal Direotor

Adam McCaffrey, LSCSW, LCAC
Therapy & Reoovery Servioes Direotor

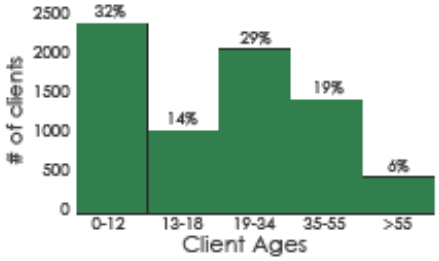
Shelli Schottler, LMSW
Community Servioes Direotor

Matt Myers, LSCSW, LMAC
Crisis Servioes Direotor

WHO WE SERVE



County	# of clients
Clay	342
Cloud	561
Geary	1,839
Jewell	104
Marshall	448
Mitchell	213
Pottawatomie	492
Republic	157
Riley	2,557
Washington	158
Out of Catchment	609



Race	# of clients
American Indian/ Alaskan Native	717
Asian	53
Black	466
White	4,002
Other/Unknown	2,242

WHO SUPPORTS US

Our foundation is grateful for the generous support of the following individuals, organizations, and foundations.

$10,000 & higher

Caroline Peine Charitable Foundation Trust
Howe Family Foundation
Manhattan Broadcasting
Tower Mental Health Foundation

$500-$999

Edward Polley
Elizabeth Skinner
Foot Locker, Inc.
Fraternal Order of Eagles Manhattan Aerie #2468
Gabrielle Thompson
Gregg & Marley Masterson
Hi-Tech Interiors Inc.
James & Debra Gordon
James and Vivivan Walsh
Jeff & Jill Pfannenstiel
John & Jelane Cook
John & Karen McCulloh
John & Loraine Farley
Jurdene & Eric Coleman
Kelli Schutter
K-State Credit Union
Larry & Donna Erpelding
Leland & Victoria Jurgensmeir
Leslie & Rhonda Briggs
Maurice & Jeanne MacDonald
Manhattan Optimist Breakfast Club
Network for Good
William & Linda Richter
Sink, Gordon & Associates, LLP
Mary Tate
S. Lee Taylor
The Kroger Co
Varney & Associates, CPAs LLC

$1,000-$9,999

Blue Cross & Blue Shield of Kansas Foundation
C. Clyde Jones
Dane G. Hansen Foundation
First Presbyterian Church
Geisler Roofing & Home Improvement
Greater Manhattan Community Foundation
Kyle & Lisa Bauer
Leo & Joy Schell
Lincoln W & Dorothy I Delhi Endowment Fund
McCown Gordon Contruction LLC
Parker Hannifin Corporation
Pilot Club of Junction City
Robert & Alison Boyd
Terry & Robbin Cole
The Trust Company
Tim & Tina Steffensmeier
Tresa Weaver Waldhauer & Kurt Waldhauer
Vic & Joy Davis
Wayne & Cindy Sloan

$100-$499

Adam E Butts
Andrea Mace
April Todd
Barry's Drug Center
Ben & Jo Ann Brunner
Ben & Rachel Wilson
Beth Kellstrom
Bill & Faye Kennedy
Bill & Anne Feyerharm
Brian & Shelli Schottler
Brian Niehoff & Usha Reddi
Britt & Camille Feltner
Cara & Jason Richardson
Century Business Systems Inc
Change the World
Chapter 88, B.P.O.
Christopher & Betty Banner
City of Belleville
City of Manhattan
City of Marysville
City of Onaga
Clay County National Bank
Clyde and Rita Wollenberg
College Avenue United Methodist Women
Dale & Susan Schinstock
Dan and Michelle Farha
Dan Expenoza
Darlene Smith
David and Roberta J Kromm
David Coe
David Defries
Dennis and Anita Bott
Diana Chapel
Diane Gaede
Diane Hinrichs and Jackie Toburen
Don and Lynne Rathbone
Dunne's Pharmacy
Ed Koehler
Linda L. Morse
Lorene & Robert Steimel
Margaret Conrow
Mark and Judy Schrock
McCownGordon Charitable Foundation Employee Matching Gift Fund
Michael & Sandra Kearns
Michael & Monica Roediger
Mitch & Jamie Binns
Monty & Kathy Webster
Myron & Nancy Calhoun
Pan American Group
Patricia Jackson-Istas
Patrick & Kelli Schutter
Penwell-Gabel Mortuary
Pilot Club of Manhattan
Randy & Cathy Hafner
Randy & Heather Peterson
Richard & Samantha Budden
Rick & Julie Hernandez
Ricky's Café
Robert & Terri Wahle
Roger & Linda Johnson
Second Baptist Church
Seth & Natalie Gordon
Stan Wilson
Steven & Cheri Graham
Sue F. Stout
Susan & James Jacobs
Sydney Carlin
The Dental Health Group
The Young Trustee
Therese Miller
Tim & Cindy Donohoue
Tyler & Sara Darnell
Victor Barbo & Sonia Toplitt
Welcome Club of Manhattan
Wendy Matlock
Zach McCaffrey

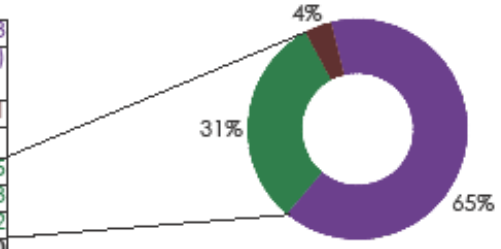
$1-$99

Architect One
B Duane & Norma Nordgren
Bill & Erma Riley Family Foundation
Bill Pallett
Boy Scout Troop 92
Charlene Trost
Charlie & Anne Browne
Chris Spooner & Kari Morgan
City of Concordia
City of Mankato
City of Washington
Dale & Deanna Hammond
Dan & Deanna Hall
David Cook
David Guthals
Deborah Berges
Deidra Lewis
Donna Alexander
Edwin Olson
Elizabeth Unger
Ellen Bucholtz
Family Center Budget Shop
Fresh Perspectives Counseling & Consultation Services, LLC
Freshman Success Academy
Gary & Joanne Ouellette
Gregg & Gwen Eyestone
Jan Carlson
Jay & Rita Rowh
John & Judy Ball
Joshua & Erin Burks
Karen Schroeder
Kari Morgan
Kevin & Jan Carnes
Kindel Auto, LLC DBA Budreau Muffler
Larry & Susan Seitz
Laura Hohenbary
Lucille Johnson
Mark & Pamela Miller
Martha Seaton
Mel Brown
Melissa Kirkwood
Melodie Pooler
Mike & Julie Clark
Myra Pfeifer
Nancy Hardy
Optimal Property, Inc.
Pamela Hatesohl
Patricia Strathman
Preston Chapel
Ray and Mary Jo Kurtz
Ray's Applemarket Clay Center
Rita Hoelscher
Roger & Virginia Reitz
Roger Kirkwood
Sara Lee Bakery
Smithfield Foods
Sue Guthrie
Susan Sayson
Terry Pfannenstiel
The Simmons Company
Tiffany Strohmeyer
Timeless Acapella
Travis & Ashley Mason
Tyler & Heidi Vela
Vern & Susie Swanson
Warren & Colleen Roblyer
William & Sharron Washington
William Oborny
Wilma Tunison
YourCause (yourause.com)

HOW WE SERVE

REVENUE/INCOME

Client Fees	$12,417,363
Allowance for fee adjustments/uncollectables	($4,379,364)
Miscellaneous Income	$532,071
Public Support	
State/Federal Funding	$2,464,385
County Funding	$1,044,693
Local Funding	$261,752
TOTAL	**$12,340,900**



EXPENSES

Salaries & Benefits	$9,930,981
Operational Costs	$2,843,300
TOTAL	**$12,774,281**

Philanthropic Grants

Blue Cross Blue Shield of Kansas.....$2,000
Caroline Peine Charitable Foundation.....$46,750
Dane G. Hanson Foundation.....$11,370
Greater Manhattan Community Foundation....$6,750
Howe Family Foundation.....$26,000
Lincoln W. and Dorthy I. Deihl Endowed Fund...$9,750
Tower Mental Health Foundation.....$11,554
We Are Wamego.....$1,000
Sub Total $115,174

Governmental Grants

City of Manhattan - 2018 Special Alcohol Funds.....$60,000
City of Manhattan - Community Block Grant.....$27,450
KS Dept. of Aging & Disability Services - PATH Grant.....$43,753
KS Dept. of Transportation.....$29,225
Sub Total.....$160,428

PLEASE SUPPORT US

Yes! I want to contribute to the work of **Pawnee Mental Health Services** by GIVING!

I will support by pledging a gift of $_____. ☐ My company will match my gift.

☐ Full Pledge Amount, Check Enclosed
(Payable to Pawnee Mental Health Foundation, PO Box 164, Manhattan, KS 66505-0164)

☐ Credit Card CC# _____ Exp Date _____/_____ CVC _____

☐ Donate online at www.pawnee.org/contribute-to-pawnee

Donor Name(s) _____
Please print name(s) exactly as you would like them to appear in recognition materials.

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Phone Number _____

Signature _____ Date _____

☐ Please check here if you DO NOT want your name used in recognition materials.
All contributions are tax-deductible.

OUR FOUNDATION

Our mission is to secure financial support and to manage assets and investments to help sustain and promote the mission of Pawnee Mental Health Services.

Pawnee MENTAL HEALTH SERVICES FOUNDATION

Seth Gordon
President

Tyler Darnell
Vice-President

Jeff Pfannenstiel
Secretary/Treasurer

Ed Koehler
Governing Board Liaison

Robbin Cole
Executive Director

Kyle Bauer
Mitch Binns
Maurice MacDonald
Heather Peterson
Wayne Sloan
Terri Wahle
Kathy Webster
Tresa Weaver

Pawnee's work of responding to needs, building healthy communities and restoring lives is powered by private donors. Philanthropic support helps equip Pawnee to provide comprehensive mental health care to the adults, children and youth who seek assistance. Private donors help bridge the gap between the cost of delivering the services that our neighbors need and what they can afford.

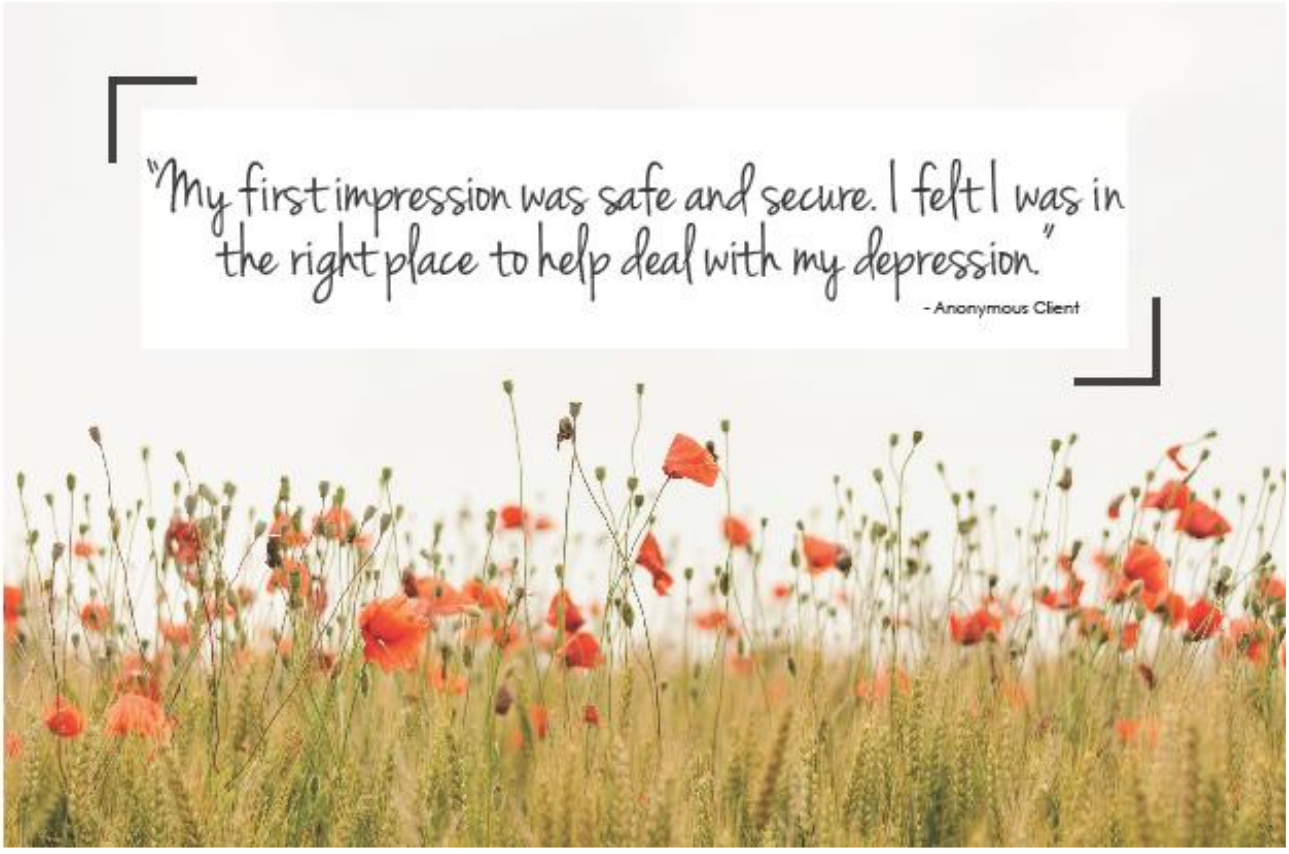
The Pawnee Mental Health Foundation is a 501(c)(3) non-profit organization. For information on how you can support the mission of Pawnee Mental Health Services through a tax-deductible charitable contribution, please contact the Development Manager at 785.587.4300 or development@pawnee.org.

bit.ly/PawneeMHS

www.pawnee.org

@PawneeMHS

Pawnee Mental Health Services is a 501(c)(3) non-profit organization
P.O. Box 747 Manhattan, KS 66505




ANNUAL REPORTS
REVIEW

1


CMHC IN KS
POSITIVES

2

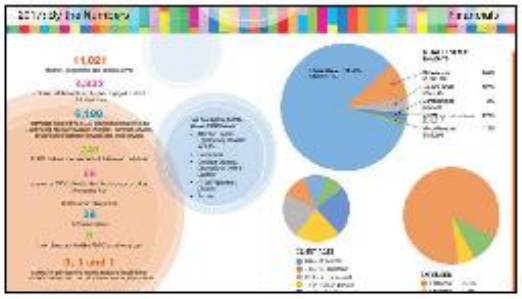

FACES
OF
BERT NASH

3


AN ABSOLUTE
JOY TO SEE THE
CENTER GROW.

4

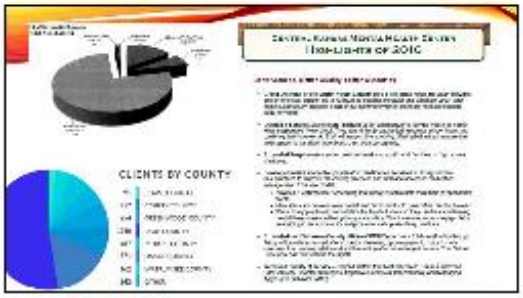
5



6


CMHC IN KS
NEGATIVES

7


CLIENTS BY COUNTY

8


2017 Annual Report
KANZA

9


Community Based Services for SED Youth
FRANKLIN COUNTY

10


OTHER CMHC
ANNUAL REPORTS

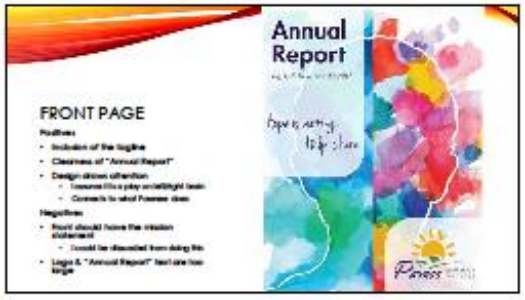
11


MAINE & NEW YORK

12

13

14



15

16

17

18

PAGE 5

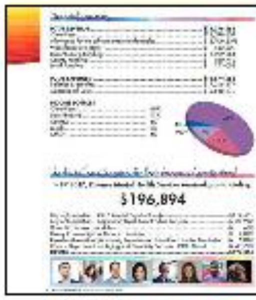
Positives

- Use of images
  - There are some negatives in regard to shaping & format
- Inclusion of training/education opportunities
  - Good opportunity here to link to a location with more information on these

Negatives

- Like to see the regions split up with "Counties We Serve"
- Would like this page connected to the list of services on page 4

19



PAGE 6

Positives

- Inclusion of this data is relevant
- Like the page numbers/running footer

Negatives

- How the data is portrayed
  - No 3D donut or pie charts with more than 3 items
  - What is "other"?
  - Do constituents/donors understand allowances for adjust/uncollect?
- Design is starting to feel 'busy'
- Many other CMHCs have more detailed data. I would like to include more data on who Pawnee serves.

20

PAGE 7

Positives

- These thank you's are relevant

Negatives

- Fourth use of the Pawnee logo
  - There is a bordeless logo to be used
  - Perhaps artwork from AEI/ISI

Adding the information from MCP grow green event, as well as any other match days.

21

BACK PAGE

Positives

- Inclusion of donation form
- Inclusion of website & social media

Negatives

- The removal of the donation form requires removal of donor list & the social media/website info
- I would like information on how much (previous FY) each fund received
  - Levels of each fund to help donor determine where help is most needed

22

Appendix 2 – CMHCs in Kansas

KANSAS COMMUNITY MENTAL HEALTH CENTER DIRECTORY

BERT NASH COMMUNITY MENTAL HEALTH CENTER, INC.
Patrick Schmitz, CEO
200 Maine, Suite A
Lawrence, KS 66044
Telephone: 785-843-9192
Fax: 785-843-0264
pschmitz@bertnash.org

ELIZABETH LAYTON CENTER
Leslie Bjork, Executive Director
2537 Eisenhower Rd/PO Box 677
Ottawa, KS 66067
Telephone: 785-242-3780
Fax: 785-242-6397
lbjork@laytoncenter.org

JOHNSON COUNTY MENTAL HEALTH CENTER
Tim DeWeese, Director
6000 Lamar, Suite 130
Mission, KS 66202
Telephone: 913-715-5000
Fax: 913-826-1594
tim.deweese@jocogov.org

CENTRAL KANSAS MENTAL HEALTH CENTER
Kathy Mosher, Executive Director
809 Elmhurst
Salina, KS 67401
Telephone: 785-823-6322
Fax: 785-823-3109
kmosher@ckmhc.org

FAMILY SERVICE & GUIDANCE CENTER
Brenda Mills, CEO
325 SW Frazier
Topeka, KS 66606
Telephone: 785-232-5005
Fax: 888-972-5031
bmills@fsgctopeka.com

KANZA MENTAL HEALTH & GUIDANCE CENTER
David Jasper, CEO
909 South 2nd Street
Hiawatha, KS 66434
Telephone: 785-742-7113
Fax: 785-742-3085
delsbury@kanzamhgc.org

COMCARE OF SEDGWICK COUNTY
Joan Tammany, Executive Director
271 W Third Street North
Wichita, KS 67202
Telephone: 316-660-7600
Fax: 316-660-7510
joan.tammany@sedgwick.gov

FOUR COUNTY MENTAL HEALTH CENTER
Greg Hennen, Executive Director
3751 West Main
Independence, KS 67301
Telephone: 620-331-1748
Fax: 620-332-1940
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Updated 3/31/18

Appendix 3 – Lobbying Policies

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2019 Behavioral Health Public Policy Agenda

FY 2019

The Association supports funding in the amount of $1.8 million from the State General Funding (SGF) to support the community crisis centers which were to be funded by 2017 HB 2194 relating to lottery vending machines. However, this revenue is no longer anticipated to be received this fiscal year.

FY 2019 and 2020

Mental Health 2020

The Association proposed a package of mental health improvement initiatives in August 2017 that we called Mental Health 2020. This aimed to restore funding balance to the Community Mental Health Center (CMHC) System as well as assist in workforce development programs to increase the number of psychiatrists who will be trained and incentivized to stay in Kansas. The Association also requested funding for the Kansas Department of Aging and Disability Services (KDADS) to invest in community-based crisis stabilization and treatment services similar to programs commenced in Kansas City with Rainbow Services, Inc. and in Wichita with the COMCARE Crisis Center.

Addressing the Needs of the Uninsured and Underinsured-Restoring the Promise of Mental Health Reform. The Kansas Mental Health Reform Act of 1990 paved the way for all Kansans to receive community based mental health treatment. The CMHCs are required to serve every person who walks through their doors, regardless of their ability to pay, much like community hospitals. This funding stream has been reduced significantly over the last decade, though the demand for services from the uninsured and underinsured continues to increase. If those in need of services do not receive timely treatment, they may have to be served in emergency rooms, state hospitals or jails, all of which are much more expensive than community-based services.

Leaders in the Legislature stepped forward to begin the process of restoring the promise of mental health reform during the 2017-2018 Legislative Biennium. $8.5 million was restored to the CMHC contracts program for FY 2018 and an additional $6 million was restored to this program for FY 2019. We ask that legislators help us keep these commitments and work toward the goal of returning to at least the same level of funding as FY 2007 and restoring the process of mental health reform and supporting Community Mental Health Centers. **To account for the growth in persons served, our request to the Legislature is for $13.2 million.**

Support Community Crisis Center Funding. Support and enhance current funding community crisis centers for FY 2019 as necessary. Funding to establish local public/private partnerships for regional Crisis Stabilization Units has helped provide treatment for those individuals who can be stabilized without utilizing a State psychiatric hospital. This model of care that provides a "port of calm" for patients should be replicated where possible across all communities in Kansas.

Medicaid Expansion. More than half of those who present for treatment at CMHCs have no insurance. Expansion of Medicaid will provide coverage for those who have a mental illness so they can access needed mental health treatment in their communities. What we know is that if a person with a mental health need does not have insurance, he or she is less likely to seek out care, which means that CMHCs oftentimes are dealing with crisis situations for those without insurance. Our Association strongly believes that mental health treatment parity needs to be a requirement of any expansion plan.

Enhance Medicaid Rates for Behavioral Health. Medicaid reimbursement rates for providers of specialized services are not adequate to maintain and enhance the behavioral health network in Kansas. With stagnant rates and increased expectations, we have seen increased turnover in many of the professions we employ. In order to support a robust public mental health system that can provide specialized services to individuals experiencing a mental illness, we need to ensure that our professionals are adequately reimbursed.

Support Increase of the Residency Program at the University of Kansas Department of Psychiatry. CMHCs and the State psychiatric hospitals are facing an alarming shortage of licensed psychiatrists who specialize in the treatment of persons with mental illness. Kansas has lost a significant number of psychiatrists over the last decade due to a reduction in training programs and retirements. This trend needs to be reversed and could be achieved by doubling the number of residents at KU to begin the process of replenishing this shortage and helping Kansas to be a national leader in mental health treatment.

Address Critical Needs in Psychiatric Inpatient Resources. Reductions in State psychiatric inpatient budgets, coupled with funding reductions in Mental Health Reform dollars, have resulted in our system reaching a crisis. The State hospitals are the inpatient safety net for individuals with severe mental illness in Kansas. Seventy (70) percent of those admitted to State hospitals do not have Medicaid as a payor source. We support returning the bed capacity at Osawatomie State Hospital to 206 beds either on that campus or through regional psychiatric hospital sites. Our state cannot afford to lose any more inpatient beds.

Support Use of Problem Gambling and Addictions Fund (PGAF) As Provided in Statute. Senate Bill 66, the Expanded Lottery Act, established the Problem Gambling and Addiction Fund to treat pathological gambling and other addictions. Two percent of state gaming revenues are supposed to go to establish prevention and treatment programs as well as long-standing funding gaps in the prevention and treatment of substance use disorders.

Support initiatives providing care coordination. Kansas should be a leader in establishing care coordination programs for individuals on Medicaid with chronic conditions. Health homes type programs that integrate physical and behavioral healthcare should be the cornerstone of Medicaid. Providing the right care at the right time for patients, and linking those patients to other community resources is a core value of CMHCs.

Increase access to critical housing resources. Lack of stable housing resources for individuals with a mental illness remains as an issue across Kansas. What we oftentimes see, is that without the availability of housing, recovery for those individuals remains beyond their reach. The Association supports the funding and implementation of the Medicaid housing programs that were approved and funded by the 2018 Legislature.

Support Recommendations of the Mental Health Task Force. The 2017 and 2018 Legislatures respectively authorized and reauthorized a Mental Health Task Force supported and facilitated by the Kansas Health Institute. Recommendations made by the Task Force as part of its work cover a wide array of issues not just in mental health, behavioral health and health care overall.

Oppose efforts that could destabilize the public mental health system. CMHCs are the foundation of the public health safety net. They have a statutory and contractual responsibility to serve every patient regardless of their ability to pay. Any changes to Medicaid, which is an integral partner in helping CMHCs provide behavioral health treatment, must be thoughtfully and thoroughly vetted.