

Governor's Behavioral Health Services Planning Council
Rural and Frontier Subcommittee

2019 Annual Report

Presented to:

Wes Cole, Chairperson
Governors' Behavioral Health Services Planning Council (GBHSPC)

Laura Howard, Secretary
Department for Aging and Disability Services (KDADS)

Laura Kelly, Governor

Prepared by:
GBHSPC Rural and Frontier Subcommittee
Nicole Tice, Psy.D. – FY2019 Chair

September 9, 2019

Introduction

Our VISION: Behavioral health equity for all Kansans. All residents of rural and frontier communities of Kansas will have access to essential, high quality behavioral health services.

Our MISSION: To collaborate through research to statistically understand and promote accessibility and availability of behavioral health services in rural and frontier Kansas counties.

Our HISTORY: Since more than 80% of Kansas is rural or frontier, this committee was originally developed under a state contract prior to becoming a part of the then Governor's Mental Health Services Planning Council (GMHSPC). Its original mission was to support the University of Kansas (KU) in forming a committee to represent the rural and frontier counties of Kansas that focused on the mental health needs of children in the child welfare system.

In July 2008, the task group was moved under the umbrella of the GMHSPC to become the Rural and Frontier (R/F) Subcommittee. This new collaboration increased partnerships with other sub-committees to serve as a planning and advisory council to the state, a requirement of federal Mental Health Block Grant funding. This affiliation, which is now inclusive of substance use disorders (SUD) and named the Governor's Behavioral Health Services Planning Council (GBHSPC), provides us with a formal process for making recommendations to the system and acknowledges the uniqueness of the behavioral health needs of rural and frontier areas. We are the only behavioral health subcommittee based upon geographic location.

We have learned... "Epidemiologic evidence suggests that the prevalence and incidence of adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) are similar between rural and urban populations (Kessler et al., 1994). However, access to mental healthcare, practitioners, and delivery systems to provide care, and attitudes and cultural issues influencing whether people seek and receive care differ profoundly between rural and urban areas." (*New Freedom Commission on Mental Health, Subcommittee on Rural Issues: Background Paper. DHHS Pub. No. SMA-04-3890. Rockville, MD: 2004. p. 2*)

We also know... "The vast majority of all Americans living in underserved, rural, and remote rural areas also experience disparities in mental health services. . . Rural issues are often misunderstood, minimized and not considered in forming national mental health policy." (*New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003, p. 50*)

One significant barrier to addressing this disparity is the lack of a consistent definition as to what constitutes frontier, rural, and urban areas in Kansas. This lack of consistency increases the risk of continued use of inaccurate information to make a wide range of policy and fiscal decisions that directly impacts the care and treatment available to Kansans who call rural and frontier areas home.

From the beginning the subcommittee has advocated for state-wide use of **KDHE's definition of the Frontier through Urban Continuum**. Defining the continuum ensures that limited resources intended to address critical rural issues in 84% of the State, are then transmitted

to meet those diverse needs in rural locations. Adoption of this definition will benefit the **entire state** in the development of further policy and decision making. Federal funding and State grant proposals will be strengthened by the adoption and use of this definition as well. To accomplish this, an executive order submitted in 2016 has been followed up by education and advocacy in 2019.

The Rural and Frontier Subcommittee continues to gather significant data based on this definition to highlight the unique behavioral health needs of those living in rural and frontier areas. Collectively, we believe these four behavioral health needs most need to be addressed:

- 1. Lack of Urban/Semi-Urban Resources in 89 out of 105 Kansas counties**
- 2. Higher percentage per capita of Hispanic residents**
- 3. Behavioral Health Provider Shortage**
- 4. Increased Suicide Rates**

This Subcommittee also recognizes that innovation and creativity is necessary – and must be embraced! Organizations are now often designed to help meet diverse needs, and collaboration with other agencies and businesses are commonplace. Technology is one of the tools that are highly beneficial. For example, telemental health service provision and use of iPads in the field let us meet people where they are – any place – at any time. Addressing rural barriers with new and innovative ways of doing business often requires advocacy. We work hard to provide that advocacy supported by research data and information to promote behavioral health service accessibility!

Membership

Subcommittee members represent a variety of agencies and community partners who either reside in or serve residents of rural and frontier areas. Examples include, but are not limited to representation from Community Mental Health Centers, Veterans Services, Child Welfare Agencies, Private and State Psychiatric Hospitals, Managed Care Organizations (MCOs), University Partners, Law Enforcement, and adults and/or parents of children who are consumers of behavioral health services. A membership list with the Kansas counties they serve is provided in (Appendix A).

The subcommittee meets six times per year, usually during odd numbered months, on the fourth Thursday of the month. Members are able to participate in person at Compass Behavioral Health Outpatient office in Dodge City, as well as by phone conference or televideo.

FY2019 Objectives & Progress

- **#1 - Rural and frontier counties have smaller economies of scale and must provide services in more creative ways... or not at all. Because we believe it is the fundamental cornerstone necessary to build “Behavioral Health Equity for all Kansans”, we continue to share the message about the importance of adopting KDHE’s definition of the Frontier through Urban Continuum.**
 - Draft of Executive Order re: Frontier through Urban Definition, and KDHE Population Density Classifications in KS by County (Appendix B)

- Presented our draft Executive Order to the previous Secretary of the Department for Aging and Disability Services (KDADS) in October of 2018.
 - Plan to present the draft Executive Order to Laura Howard, Secretary of the Department for Aging and Disability Services (KDADS)
- **#2 - Strengthening the Continuum of Care in Rural and Frontier areas is the foundation upon which the Behavioral Health System operates.**
- A.** "...technology itself is no longer the barrier to use. Perceptions of technology and related local and state legislation and organizational policy are now the more significant barrier." (R/F Subcommittee, FY2016 Annual Report pg. 5, 2c)
- Actively championing use of telemental health to address barriers to receiving behavioral health services – like workforce shortage and transportation.
 - Developing a Telehealth Use Survey with KU Center for Telemedicine & Telehealth to explore telehealth as a tool for delivering an alternative service – especially for the elderly.
 - Presented a proposed Telehealth Use Survey to the Governor's Behavioral Health Services Planning Council on July 17, 2019.
 - Plan to present a final proposed Telehealth Use Survey to the Governor's Behavioral Health Services Planning Council in later this year (Appendix C).
- B.** Increase funding for crisis beds for the non-insured &/or underinsured to fill the gap in rural and frontier areas of the state.
- When the opportunity arises, the subcommittee will advocate for the next crisis center to be in Western Kansas west of Barton County. The subcommittee thinks of crisis resources beyond crisis beds. More community outreach is always needed.
- C.** Advocate for adequate resources to meet consumer and provider behavioral health needs.
- Plan to host a Legislative Luncheon in November of 2019 in Dodge City, Kansas and presented on the Rural and Frontier subcommittees objectives and goals.
 - Presented a proposed Telehealth Use Survey to the Governor's Behavioral Health Services Planning Council on July 17, 2019.
 - Plan to present a final proposed Telehealth Use Survey to the Governor's Behavioral Health Services Planning Council later this year.
 - Collaborated with University Center in Dodge City on its development.
 - Advocating for Fort Hays University Social Workers program in Dodge City.
 - Partnered with the State Epidemiological Outcome Workgroup to share data needs for Rural and Frontier areas.
- D.** Increase Suicide Prevention in Rural and Frontier areas.
- Collaborate with the Crisis Intervention Team organizer to look at way first responders respond to suicide calls in Rural and Frontier areas.

➤ **#3 - Continue to diversify membership to ensure that needs and resources are considered within and alongside the behavioral health system.**

- Added two stakeholders to Subcommittee.

Noteworthy Efforts pre FY2019

- Provided testimony on the need for telehealth parity in Kansas for House Bill 2028 on October 12, 2017. The bill was essential to meeting the mental health care needs of Kansans living in rural and frontier communities. The bill was signed on May 12, 2018.
- Presented on the need for telesupervision at the BSRB meeting on October 8, 2017.
- Presentation to GBHSPC re: R/F data and how use of televideo technology and protocol can meet behavioral health needs in R/F areas. 2016
- Developed implementation program for sharing resources related to the expansion of telemental health services in R/F areas. 2016
- Presentation at Larned State Hospital Mental Health Conference 2016
- Developed and implemented the Tele-mental Health Consumer Survey 2014 (FY2015)
- Hosted Legislative Luncheon/January 26, 2012 with R/F presentation
- Hosted Legislative Reception/October 25, 2012 with R/F presentation
- Presented at state and national levels to advocate, educate and promote public awareness of behavioral health issues based on the KDHE continuum definition.

FY2020 Goals

- In FY2020, the R/F Subcommittee will continue focusing on finalizing the Executive Order for the Frontier through Urban Definition and strengthening the continuum of care in Rural and Frontier areas. The R/F subcommittee added a goal for 2020 to work with the Crisis Intervention Team organizer to see how the program can be effective in Rural and Frontier areas.

FY2019 Goals and Recommendations

Subcommittee members have collaborated in this formal process to provide data and make recommendations. Our literal “window of opportunity” is the window of advocacy. We appreciate and recognize the value of behavioral health equity for all Kansans, and will continue to work towards making access to essential, high quality behavioral health services for rural and frontier residents a reality!

The R/F Subcommittee recognizes the need for collaboration regarding identified goals and recommendations. As presented below, the weight of primary ability to affect change for each is more heavily weighted with the State at the top of the list and upon the R/F subcommittee toward the bottom. We acknowledge that in order to affect meaningful change across the state, both entities must partner creatively to implement tangible change.

- 1) Statewide adoption of KDHE’s Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order.
- 2) Strengthening continuum of care in R/F areas by:

- a) Championing use of telemental health to address barriers, advocating for BSRB approval of telehealth supervision, providing data regarding telemental health efficacy to promote its use and conducting a Telehealth Use Survey.
 - b) Partner with other service organizations across state to increase access to services; continue to share information regarding rural and frontier strengths, needs, and unique issues; and advocate for solutions to address the behavioral health workforce shortage.
 - c) Advocate for crisis beds for the non-insured and/or underinsured to fill the gap in the western half of the state.
- 3) Continue to diversify subcommittee membership to ensure that needs and resources are considered both within and alongside the behavioral health system.

Summary

The behavioral health needs of Kansans in Rural and Frontier areas are unique and need to be taken into consideration regarding fiscal issues and related policy development. The adoption of a consistent definition of the Frontier through Urban Continuum (already utilized by KDHE) would help meet the behavioral health needs of all Kansans. In examining the continuum of care, the R/F Subcommittee has identified that telemental health has the ability to address multiple barriers, but local and state legislation related to it needs addressed. Lack of Urban/Semi-Urban resources, the rural legacy of depopulation, a higher percentage per capita of Hispanic residents, and a significant Behavioral Health Provider shortage all continue to be significant barriers to getting the quality behavioral health care Kansas residents in rural and frontier areas need and deserve. Therefore, the Rural and Frontier Subcommittee of the Governor's Behavioral Health Planning Council will continue to partner with a wide variety of individuals and organizations to identify ways to strengthen the continuum of care by using research and technology to advocate for, and meet the needs of, those who live in rural and frontier areas.

Appendix A: County Membership Representation

Appendix B: Draft of Executive Order: Frontier through Urban Definition, and KDHE Population Density Classifications in KS by County, 2016

Appendix C: Telehealth Use Survey Proposal

GBHSPC - Rural & Frontier Subcommittee Members

Organization representation(s), county(ies) served, office location(s), & email

* David Anderson –High Plains Mental Health Center (20 counties)/KS Assoc. of Master’s in Psychology (KS counties)–Ellis david.anderson@hpmhc.com
^ Charles Bartlett –KS Dept. for Aging & Disability Behavioral Health Commission Liaison/GBHSPC Member & Liaison (KS counties)–Jefferson Charles.Bartlett@kdads.ks.gov
+ Leslie Bissell –Southwest Guidance Center (4 counties)–Seward lbissell@swguidance.org
= Diann Brosch –Senior Companion Program/Fort Hays State University (15 counties)–Hodgeman dbvillagenurse@yahoo.com
& Vicki Broz –Compass Behavioral Health (13 counties)–Ford vbroz@compassbh.org
Kendal Carswell –Fort Hays State University (KS counties)
Dale Coleman –Ford County Law Enforcement (1 county)–Ford dcoleman@fordcounty.net
! Ric Dalke –Iroquois Center for Human Development, Inc. (4 counties)/GBHSPC Member–Reno RicDalke@irqcenter.com
! Shereen Ellis –Aetna(KS counties)– EllisS3@aetna.com
Gina Gall _Dodge City Peaceful Tribe, Inc. (1 county)–Ford Dodgecity_peaceful_tribe_06@yahoo.com
~ Diane Garvey –Finney County Committee on Aging (1 county)/GBHSPC Prevention Subcommittee/KS Community Health Worker Coalition/KS Prevention Collaborative/KS Leadership Center/Frontier Breastfeeding Coalition (1 county)–Finney DianeGarvey@Centura.org
& Renee Geyer –Compass Behavioral Health (13 counties)–Scott rgeyer@compassbh.org
Geovanni Gone ’–United Health Care/Dodge Cultural Relations Board (KS counties)–Ford geovannie.gone@uhc.com
Janine Gracy –KU Center for Telemedicine and Telehealth/Heartland Telehealth Resource Center (KS counties)–Sedgewick jgracy@kumc.edu
> Scott Kedrowski –Russell Child Development Center (10 counties)–Finney skedrowski@rcdc4kids.org
Monica Kurtz –KS Suicide Prevention Resource Center (KS counties)/GBHSPC Prevention Subcommittee/Prevention WorkS Steering Committee/KS Prevention Collaborative Conference Planning Committee monica@kansassuicideprevention.org
% Chris Lund –City on a Hill, Inc. (4 counties)/KS Citizen’s Committee/Behavioral Health Assoc. of KS /KS Assoc. of Addiction Professionals/Seward County Coalition of Addiction Treatment Services/Opioid Task Force of Garden City chilu@aol.com
= Jolene Niernberger –Foster Grandparent & Senior Companion Programs/Fort Hays State University (15 counties)–Ellis jniernbe@fhsu.edu
Melissa Patrick –KS Consumer Advisory Council for Adult Mental Health (KS counties)–Kiowa melissapatrick@kansascac.org
@ Amanda Pfannenstiel –Saint Francis Ministries (75 counties)/KS Assoc. of Masters in Psychology (KS counties)–Ellis Amanda.Pfannenstiel@st-francis.org
: Janene Radke –Family Crisis Services, Inc. (7 counties)–Finney Fcs.janene@sbcglobal.net
Ann Ruder –Mosaic (1 county)–Seward ann.ruder@mosaicinfo.org
Larry Salmans –Behavioral Sciences Regulatory Board Member (KS counties)/KS Association of Master’s in Psychology (KS counties)–Hodgeman senatorsalmans@yahoo.com
[Debbie Snapp –Catholic Charities of Southwest KS (28 counties)–Homeless & Housing Subcommittee/ Problem Gambling Task Force/Southwest KS Homeless Coalition (28 counties)–Ford dsnapp@catholiccharitiesswks.org
& Lisa Southern –Compass Behavioral Health (13 counties)–Garden City lsouthern@compassbh.org
\$ Nicole Tice –Larned State Hospital (61 counties)–Pawnee nicole.tice@lsh.ks.gov
Shawna Wright –KU Center for Telemedicine & Telehealth/Wright Psychological Services (KS

counties)/GBHSPC State Epidemiological Outcomes Workgroup-Neosho swright6@kumc.edu

& **Dorothy Ziesch**–Compass Behavioral Health Board Member (13 counties)/Silver Haired Legislator (Hodgeman)-Hodgeman [no email address](#)

***** **High Plains Mental Health Center/20 counties:** Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Ness, Norton, Osborne, Phillips, Sheridan, Sherman, Smith, Rawlins, Rooks, Rush, Russell, Thomas, Trego & Wallace; **6 offices/Hays, Phillipsburg, Osborne, Norton, Colby & Goodland**

^ **KDADS Behavioral Health Commission/KS counties:** with **office** in Shawnee County

+ **Southwest Guidance Center/4 counties:** Haskell, Meade, Seward & Stevens; with **office** in Liberal

= **Foster Grandparent & Senior Companion Programs/15 counties:** Barton, Ellis, Ford, Gove, Graham, Hodgeman, Logan, Ness, Osborne, Pawnee, Phillips, Rooks, Rush, Russell & Trego; with **office** in Hays

& **Compass Behavioral Health/13 counties:** Ford, Finney, Gray, Greeley, Grant, Hamilton, Hodgeman, Kearny, Lane, Morton, Scott, Stanton & Wichita; **4 offices/Dodge City, Garden City, Scott City & Ulysses**

! **The Iroquois Center for Human Development Inc. /4 counties:** Comanche, Clark, Edwards & Kiowa; **5 offices/Ashland, Coldwater, Greensburg, Kinsley & Minneola**

> **Russell Child Development Center/19 counties:** Clark, Ford, Finney, Gray, Greeley, Grant, Hamilton, Haskell, Hodgeman, Kearny, Lane, Mead, Morton, Ness, Scott, Seward, Stevens, Stanton & Wichita; **4 offices/ Dodge City, Garden City, Liberal & Scott City**

% **City on a Hill, Inc.** (Finney, Wichita, Seward & Chautauqua counties; **offices & facilities in each county**

@ **Saint Francis Ministries/75 counties:** Barber, Barton, Butler, Chase, Cheyenne, Clark, Clay, Cloud, Comanche, Cowley, Decatur, Dickinson, Edwards, Ellis, Elk, Ellsworth, Finney, Ford, Geary, Graham, Grant, Gray, Greeley, Greenwood, Gove, Hamilton, Harper, Harvey, Haskell, Hodgeman, Jewell, Kearny, Kingman, Kiowa, Lane, Lincoln, Logan, Lyon, Marion, McPherson, Meade, Mitchell, Morris, Morton, Ness, Norton, Osborne, Ottawa, Pawnee, Phillips, Pratt, Rawlins, Reno, Republic, Rice, Riley, Rooks, Rush, Russell, Saline, Scott, Sedgwick, Seward, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Sumner, Thomas, Trego, Wallace, Washington & Wichita; **20 offices/Colby, Concordia, Dodge City, El Dorado, Emporia, Garden City, Great Bend, Hays, Hutchinson, Junction City, Kensington, Liberal, Manhattan, McPherson, Newton, Pratt, Salina, Wellington, Wichita & Wyandotte County**

: **Family Crisis Services, Inc. /7 counties:** Finney, Greeley, Hamilton, Kearny, Lane, Scott, Wichita; **office/ Garden City**

Ⓢ **Catholic Charities of Southwest Kansas/28 counties:** Barber, Barton, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearny, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Rush, Scott, Seward, Stafford, Stanton, Stevens, Wichita; **3 offices/Dodge City, Garden City & Great Bend**

\$ **Larned State Hospital, Psychiatric Services Program/61 counties:** Barber, Barton, Butler, Cheyenne, Clark, Comanche, Cowley, Decatur, Dickinson, Edwards, Ellis, Ellsworth, Finney, Ford, Gove, Graham, Grant, Gray, Greeley, Hamilton, Harper, Harvey, Haskell, Hodgeman, Kearny, Kingman, Kiowa, Lane, Lincoln, Logan, Marion, McPherson, Meade, Morton, Ness, Norton, Osborne, Ottawa, Pawnee,

Appendix A

Phillips, Pratt, Rawlins, Reno, Rice, Rooks, Rush, Russell, Saline, Scott, Stafford, Stanton, Stevens, Seward, Sheridan, Sherman, Smith, Sumner, Thomas, Trego, Wallace & Wichita; **office**/Larned State Hospital

Executive order – For Behavioral Health Care in Rural and Frontier Counties of Kansas

By the Governor’s Behavioral Health Services Planning Council and their Rural and Frontier Subcommittee.

Assuring access and availability of behavioral health and medical care services for all Kansans from border to border;

WHEREAS, K.S.A. 48-925(b) provides that the Governor may issue orders and proclamations which shall have the force and effect of law under subsection (b) of K.S.A 48-924;

WHEREAS there are 105 Kansas counties, of which 36 counties are Frontier, 32 counties are Rural, 21 counties are Densely-settled Rural, 10 counties are Semi-urban and 6 counties are Urban;

WHEREAS the majority of the state is rural and frontier and all counties in Kansas should be adequately represented and considered in regard to policy and decision making;

WHEREAS the adoption of this Frontier through Urban Continuum Definition will allow for the clear and consistent definition of each population density and support the inclusion of all Kansans;

NOW, THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby acknowledge the need for a consistent definition of Frontier, Rural, Densely settled Rural, Semi-urban and Urban using the Kansas Department of Health and Environment (KDHE) Continuum definition designations of:

Frontier counties are designated as less than 6 people per square mile.

Rural counties are designated as 6-19.9 people per square mile.

Densely settled Rural counties are designated as 20-39.9 people per square mile.

Semi-urban counties are designated as 40-149.9 people per square mile.

Urban counties are designated as 150+ people per square mile.

AND, FURTHERMORE, state agencies shall use the designation to guide policy development; program and regulation implementation; to determine policy impact on Frontier, Rural, Densely settled Rural, Semi-urban, and Urban areas; and to address issues and develop strategies that take into account both population and geography.

This document shall be filed with the Secretary of State as Executive Order No. x-x and shall become effective immediately.

Submitted by the GBHPC Rural/Frontier Subcommittee

XX XX, 2016

For more information contact:

Leslie Bissell, Psy.D., LP, Southwest Guidance Center, lbissell@swguidance.org or Renee Geyer, MMC Compass Behavioral Health, rgeyer@compassbh.org

References

Holmes, C. (2011). *2010 Population Density Peer Group for Kansas Counties [map]*. (scale not given.) Lawrence, KS: University of Kansas.

Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2014.

Behavioral Tele-Health Study

Background

A May 2017 online report titled *Mental Health in Rural America* from the High Plains/Midwest Ag Journal¹ states that “one in five residents of nonmetropolitan counties in the United States had some sort of mental illness in 2015”, according to the Substance Abuse and Mental Health Administration (SAMHA). The article goes on to discuss a cycle that causes people to give up on ever finding mental health care. The cycle includes: access (challenges with insurance coverage), availability (behavioral healthcare services available in rural community), and acceptability (stigma) of mental/behavioral health issues. Behavioral healthcare providers in rural area of Kansas offered their vision of “how it could be”:

- 1.) a rural America where services are available in every local community, with even more partnerships among providers to ensure specialty mental health needs are met;
- 2.) mental health services covered by more insurance policies, with more logical coverage for rural providers able to meet with patients over internet access or in their primary physician’s office;
- 3.) more providers to provide bilingual services for the immigrant populations in our rural communities;
- 4.) Veterans Administration to work more with community mental health centers to cover closer service providers to veterans so they don’t have to travel so far for help;

Behavioral healthcare providers interviewed said that the best thing that could happen for improved mental health care in rural America “is for neighbors to speak up and reduce the stigma of seeking help when it’s needed”¹.

In October 2017 the Kansas Health Institute released a report titled, *Understanding the Mental Health System in Kansas*². This report reviews the historical changes in the mental health system that resulted from the passage of the Kansas Mental Health Reform Act in 1990, including a significant shift from inpatient services delivered through state psychiatric hospitals to outpatient services delivered through community providers. The report states that this shift resulted in the expansion of community mental health services, the elimination of two state psychiatric hospitals, and a reduction in mental health inpatient capacity. This report does an excellent job of reporting statistical data regarding both need and system capacity.

In June 2017, the Kansas Legislature required the Kansas Department for Aging and Disability Services (KDADS) to establish an eleven-member Mental Health Task Force (MHTF) to assess the strengths and weaknesses of the state’s current mental health system and make recommendations for improvements. The task force issued two reports to the legislature in January 2018³ and January 2019⁴. The MHTF started their work in 2017 by reviewing eleven Kansas-specific behavioral health reports issued

between 2014 and 2017 by a number of different agencies. (List found on pg. 4 of the 2018 report) The MHTF reviewed approximately 150 recommendations from previous reports, characterized recommendations using specific criteria described in the report, and offered two to five recommendations in each of seven topical areas. These recommendations focus on changes in policy, regulations, systems, and funding. The purpose of the MHTF's work addressed in the January 2019 report was to:

- Create a strategic plan that addresses the recommendations of the report filed on January 8, 2018.
- Ascertain the total number of psychiatric beds needed to most effectively deliver mental health services and the location where such services would be best provided in Kansas

The 2019 report provides specific recommendations intended to address gaps in the existing behavioral healthcare system in Kansas. The MHTF developed a strategic plan for the implementation of their 2018 recommendations that they believe will improve the behavioral health system in Kansas and align with the state and national goals of more seamless care for mental illnesses, substance use disorders and addictions, and primary medical care. Again, the focus was on increasing system capacity, funding, and policy. There was no specific focus on the particular needs of rural and frontier counties.

The Kansas Telemedicine Act (Senate Sub. For HB 2018)⁵ became effective January 1, 2019 and provides for insurance payment for a number of healthcare services (including behavioral health services) when provided by a licensed/certified provider and already covered by the insurance when provided in-person. This policy change addresses one of the recommendations from the MHTF. However, there has been no assessment of how best to implement tele-behavioral health services and whether consumers/potential consumers will accept this method of service delivery.

While all of these reports provide a wealth of data and recommendations, none of them focuses on the needs of consumers/potential consumers of behavioral health services who experience unique challenges by virtue of the fact that they live in rural and frontier areas of Kansas. Additionally, none of these reports assesses and addresses the service provision barriers and specific educational needs of the healthcare and behavioral healthcare service providers related to behavioral healthcare or the acceptability of telebehavioral health by consumers/potential consumers and/or healthcare communities.

A June 2019 Policy Brief from the University of Minnesota Rural Health Research Center titled *Measuring Access to Care in National Surveys: Implications for Rural Health*⁶ reviewed access measures included in major national surveys and discussed the implications for rural research on access to care. Although the focus of the policy brief was not limited to access to behavioral healthcare, the assessment and implications provided are appropriate for discussion of access to behavioral health in

rural populations. More recently in August 2019, a *State of Kansas Public Opinion*⁷ poll indicated that the majority of Kansans believe that the state needs to increase investments in the mental health system. The results of the survey highlight growing public interest in mental health issues and notable support for continued investments in the state mental health system.

Castillo et al. published a review article⁸ in March 2019 that examined evidence of effectiveness of community interventions for improving mental health and some social outcomes across social-ecological levels. The review focused only on community intervention programs and did not examine the literature on policy interventions that promote mental health equity. The review also did not focus specifically on community interventions in rural and frontier communities. The authors examined literature in seven topic areas: collaborative care, early psychosis, school-based interventions, homelessness, criminal justice, global mental health, and mental health promotion/prevention. Community involvement in the reviewed studies took a variety of forms, including individuals (lay health workers), settings (churches, schools), community-based participatory research, and multi-sector coalitions. The authors adapted the social-ecological model for health promotion and provided a framework for understanding the actions of community interventions to address mental health.

Most interventions reviewed promoted mental health at the individual level. Lay Health Worker interventions were found to extend access and increase acceptability of mental health services by leveraging trusted relationships. Some studies adapted evidence-based models to deliver treatments in non-traditional locations, such as jails, churches, and senior centers. Many individual-level interventions also simultaneously acted at the organizational/institutional level. A second group of interventions intervened at the interpersonal level (e.g., parent and family interventions). A small number of studies intervened at the level of whole communities. Most interventions reviewed included one non-healthcare sector collaborator as opposed to collaborating with communities more broadly. The authors concluded that there is evidence for the effectiveness of community interventions in multiple topic areas and acting at all social-ecological levels.

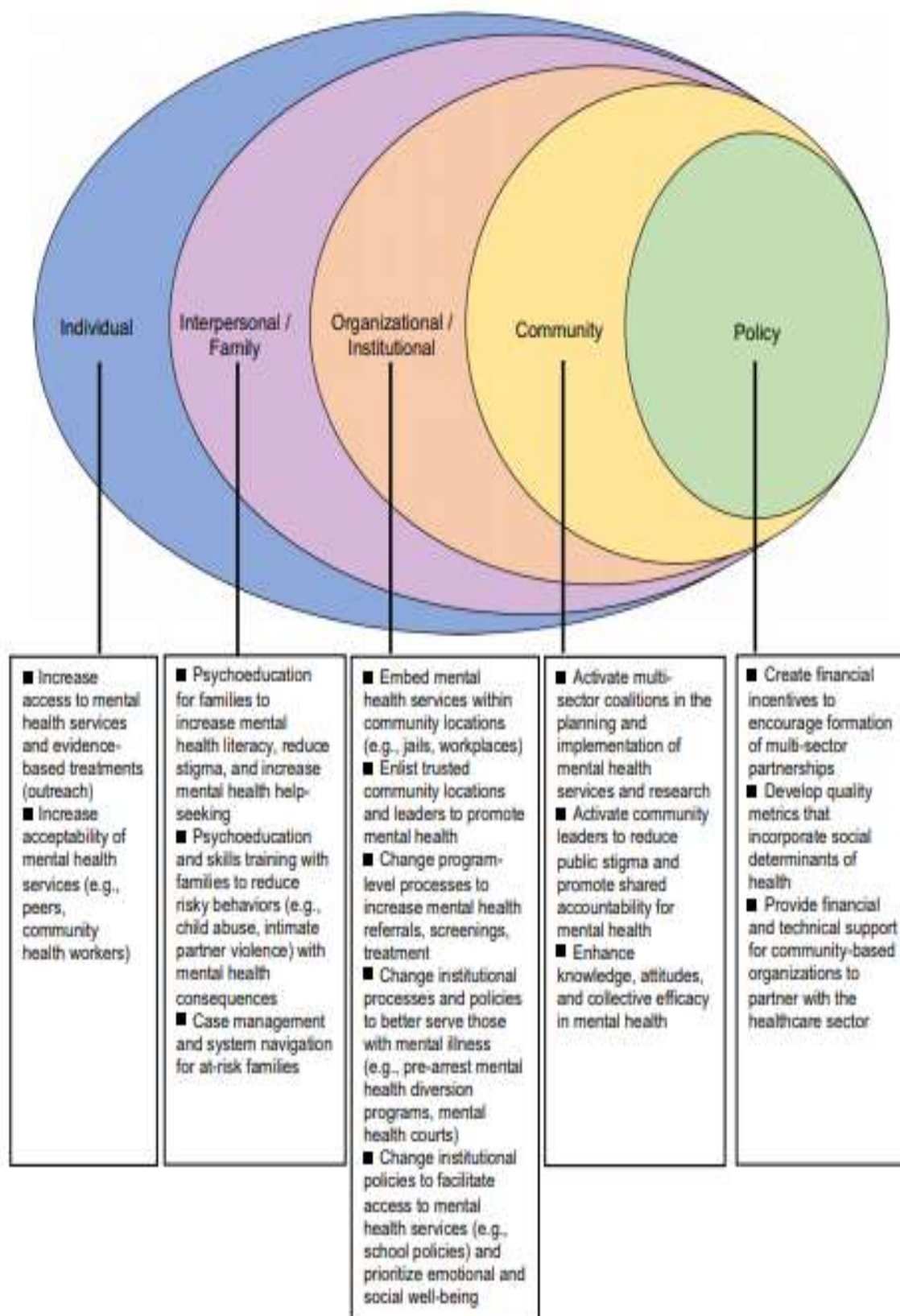


Fig. 1 Overview of community intervention processes by social-ecological level (adapted from McElroy, KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Educ Q.* 1988;15:351-377)

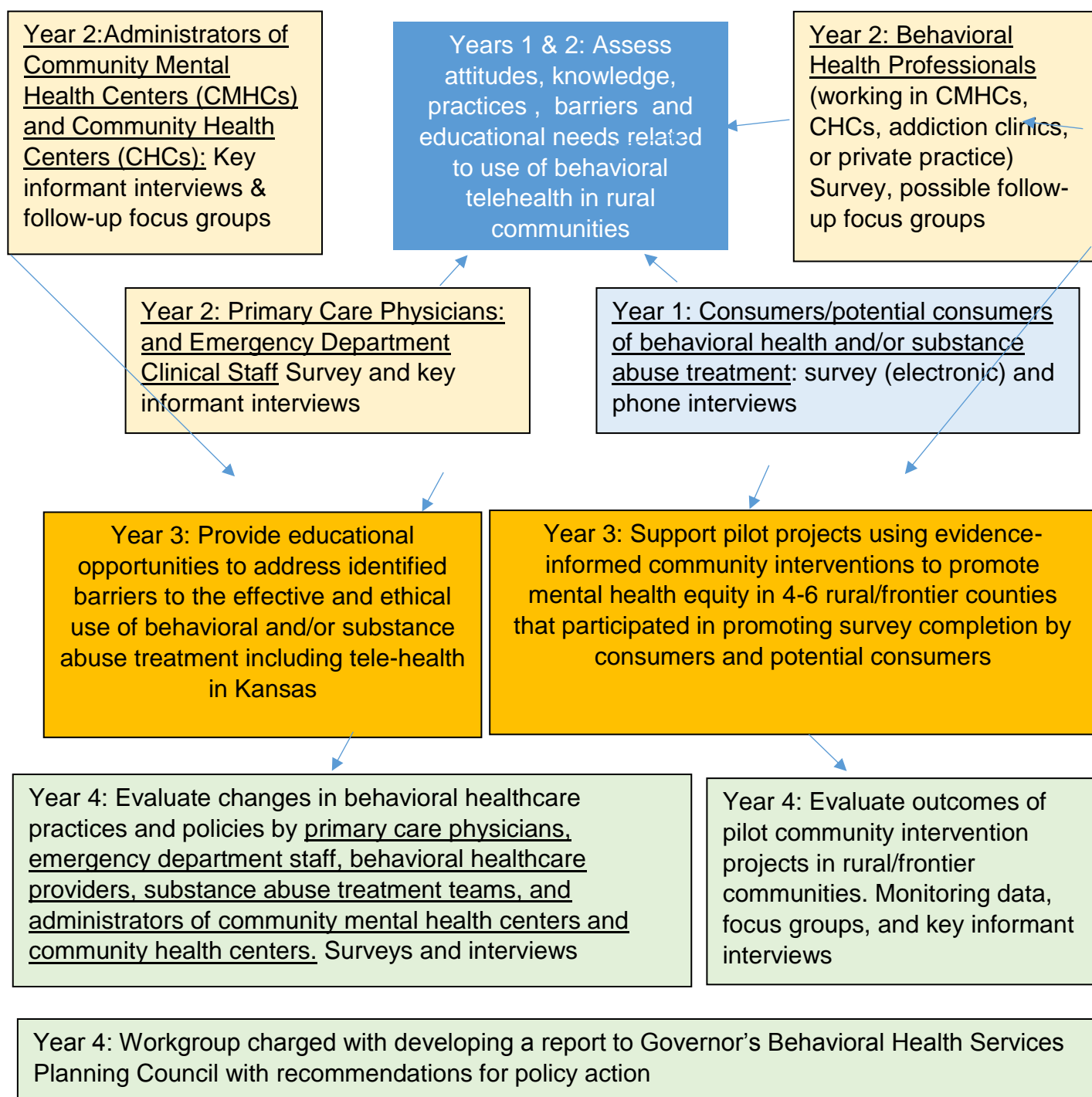
Proposal: Rural Adult Behavioral Healthcare Study

Specific Aims

The specific aims of this multi-year study and evaluated educational intervention are:

- 1) Increase understanding of awareness, attitudes, experiences, and perceived barriers of rural/frontier dwelling consumers/potential consumers (both adults and teens) regarding access to behavioral healthcare and potential use of behavioral telehealth options for accessing these services through online surveys and phone interviews with individuals in selected rural/frontier counties in Kansas;
- 2) Increase understanding of the knowledge, attitudes, experiences, perceived barriers, and educational needs of healthcare and behavioral health practitioners statewide regarding current availability of and access to behavioral healthcare services in rural communities, use of behavioral telehealth to address behavioral health and/or substance abuse treatment needs in the communities they serve, and perceptions regarding potential solutions to address workforce shortage through key informant interviews, focus groups, and surveys.
- 3) Use data to develop educational opportunities for professionals to increase understanding of mental/behavioral health challenges and available resource options, explore potential integration of telebehavioral health options into their practices, and evaluate effectiveness of the educational sessions by measuring changes in behavioral healthcare practices following participation;
- 4) Provide consumer data to participating counties through town hall meetings to increase understanding of the scope of the issue in their communities.
- 5) Provide support for 4-6 participating counties to select (based on their county's consumer survey data) and implement evidence-informed community interventions to promote mental health in their communities and evaluate outcomes of those pilot projects.
- 6) Provide consumer and provider data to a workgroup charged with developing a report to Governor's Behavioral Health Services Planning Council with recommendations for policy action specifically related to access to behavioral care with a focus on implementation of tele-behavioral health in rural/frontier communities, reducing barriers to service access and service provision in rural communities, and behavioral health workforce expansion.

Rural Adult Behavioral Healthcare Study Framework



Proposal

Year 1:

- 1) Coordinate planning with appropriate professional organizations throughout Kansas
- 2) Complete literature review to identify potential validated survey/interview questions/tools and evidence-informed community mental health interventions
- 3) Identify or design and test consumer/potential consumer survey tools, interview questions, and protocols
- 4) Obtain IRB approval for consumer/potential consumer survey/interviews
- 5) Assess the awareness, attitudes, experiences, and perceived barriers of a convenience sample of adult and youth consumers and potential consumers living in five rural/frontier counties in Kansas regarding access to behavioral healthcare and/or substance abuse treatment resources in their communities and potential use of behavioral telehealth options for these services.

Products: Consumer survey/interview tools and methodology/protocols; data regarding a convenience sample of rural/frontier consumers'/potential consumers' awareness, attitudes, experiences, and perceived barriers; resources for evidence-informed community mental health interventions

Year 2:

- 1) Use consumer data to inform selection/development of survey/interview questions for development of statewide survey tools, key informant interview questions, and focus group questions to be administered to behavioral and other healthcare professionals.
- 2) Identify or design and test survey tools/interview and focus group questions for all categories of healthcare/behavioral healthcare providers; develop accompanying protocols
- 3) Obtain IRB approval for healthcare/behavioral healthcare providers survey/interviews and protocols
- 4) Assess the knowledge, attitudes, experiences, perceived barriers and educational needs of administrators of CMHCs and CHCs regarding current availability of behavioral healthcare services, use of behavioral telehealth to address behavioral health and/or substance abuse treatment needs in the communities they serve and perceptions regarding potential solutions to address workforce shortage.
- 5) Assess the knowledge, attitudes, experiences, perceived barriers and educational needs of behavioral healthcare providers regarding current behavioral healthcare services, use of behavioral telehealth to address behavioral health and/or substance abuse treatment needs in the communities

they serve and perceptions regarding potential solutions to address workforce shortage.

- 6) Assess the knowledge, attitudes, experiences, perceived barriers and educational needs of substance abuse treatment teams regarding current behavioral healthcare services, use of behavioral telehealth to address behavioral health and/or substance abuse treatment needs in the rural communities they serve and perceptions regarding potential solutions to address workforce shortage.
- 7) Assess the knowledge, attitudes, experiences, perceived barriers and educational needs of primary care physicians regarding current behavioral healthcare services, use of behavioral telehealth to address behavioral health and/or substance abuse treatment needs in the rural communities they serve and perceptions regarding potential solutions to address workforce shortage.
- 8) Assess the knowledge, attitudes, experiences, perceived barriers and educational needs of emergency department staff, EMS professionals, and law enforcement professionals regarding current behavioral healthcare services, use of behavioral telehealth to address behavioral health and/or substance abuse treatment needs in the rural communities they serve and perceptions regarding potential solutions to address workforce shortage, including tele-behavioral health.

Products:

- 1) Multiple survey tools/interview and focus group questions and methodology/protocols; data regarding knowledge, attitudes, experiences, perceived barriers and educational needs of behavioral healthcare, other healthcare professionals, and law enforcement;
- 2) Data regarding perceptions regarding potential solutions to address behavioral health workforce shortage, including tele-behavioral health.

Year 3:

- 1) Use knowledge, attitudes, experiences, perceived barriers and educational needs data to design and provide educational opportunities to providers statewide (primary care physicians, behavioral healthcare providers, substance abuse treatment teams, administrators of community mental health centers and community health centers, hospital personnel and law enforcement).
- 2) Use knowledge, attitudes, experiences, perceived barriers and needs data to design and provide educational opportunities statewide to community members to increase their understanding of the scope of behavioral health issues in their counties, the effective and ethical use of behavioral tele-health to meet behavioral

health treatment needs, and to increase understanding of available resources and strategies to address barriers to access.

- 3) Support pilot projects using evidence-informed community interventions to promote mental health equity in 3 rural/frontier counties that participated in promoting survey completion by consumers and potential consumers

Products:

- 1) Multiple educational presentations for professionals and white papers on behavioral healthcare resources and options in rural/frontier communities
- 2) Process measures of how to implement evidence-informed community mental health interventions in rural communities.

Year 4:

- 1) Evaluate changes in behavioral healthcare practices and policies by primary care physicians, emergency department staff, behavioral healthcare providers, substance abuse treatment teams, and administrators of community mental health centers and community health centers.
- 2) Evaluate outcomes of pilot community intervention projects in rural/frontier communities.
- 3) Use all data to form a state-level workgroup to make funding, policy, and training recommendations to the Governor's Behavioral Health Services Planning Council.

Products:

- 1) Effectiveness data of professional education efforts
- 2) Effectiveness data on rural/frontier community interventions
- 3) Workgroup to develop report to Governor's Behavioral Health Services Planning Council with recommendations for policy action.

Total Four-Year Project Budget: \$714,659.40 Direct costs**Budget – Year 1 - \$150,684.40****Salary & Fringe - \$146,478**

Shawna Wright 20% time @ \$104,006 + 35% fringe = \$28,082

Judy Johnston 35% time @ \$79,457 + 35% fringe = \$37,544

2 GRA 50% time @ \$24,000 (basic science rate) + 35% fringe = \$64,800

Kelsey Lu 20% time @ \$59,450 + 35% fringe = \$16,052

Travel - \$2,456.40**Travel (mileage) - \$1,571.40**

Two face-to-face team meetings – 900 miles @ \$0.54/mile.= \$486

Two meetings with Rural and Frontier sub-committee – 900 miles @ \$0.54/mile.= \$486

Meetings with community leaders in Thomas, Haskell, Kearny, Seward, Chase and Wilson Counties – 1,110 miles @ \$0.54/mile = \$599.40

Travel (hotels) – \$500

5 nights @ \$100/night = \$500

Travel (per diem) - \$385

7 days @ \$55/day = \$385

Consultation fees (Department of Psychiatry, KUSM-W) - \$1,500

10 hours of consultation with Department of Psychiatry physicians @ \$150/hour

Printing, Supplies, Misc. expenses - \$250**Budget – Year 2 – \$154,218****Salary (+ 3% raise) & Fringe - \$150,871**

Shawna Wright 20% time @ \$107,126.18 + 35% fringe = \$28,924

Judy Johnston 35% time @ \$81,841 + 35% fringe = \$38,670

2 GRA 50% time @ \$24,720 (basic science rate) + 35% fringe = \$66,744

Kelsey Lu 20% time @ \$61,234 + 35% fringe = \$16,533

Travel - \$1,597

Travel (mileage & tolls) - \$1,022

Travel to 6 state meetings to conduct focus groups and interviews ~ 1,800 miles @ \$.54/mile = \$972 + \$50 tolls

Travel (hotels) – \$300

3 nights @ \$100/night = \$300

Travel (per diem) - \$275

5 days @ \$55/day = \$275

Consultation fees (Department of Psychiatry, KUSM-W) - \$1,500

10 hours of consultation with Department of Psychiatry physicians @ \$150/hour

Printing, Supplies, Misc. expenses - \$250

Budget – Year 3 – \$280,824

Salary (+ 3% raise) & Fringe - \$125,282

Shawna Wright 20% time @ \$110,340 + 35% fringe = \$29,792

Judy Johnston 35% time @ \$84,296 + 35% fringe = \$39,830

1 GRA 50% time @ \$25,462 (basic science rate) + 35% fringe = \$34,374

Kelsey Lu 25% time @ \$63,071 + 35% fringe = \$21,286

Travel - \$3,792

Travel (mileage) - \$2,642

Two visits/rural/frontier county conducting pilot projects – 3,000 miles @ \$0.54/mile = \$1,620

Travel to 6 state meetings to provide professional education ~ 1,800 miles @ \$.54/mile = \$972 + \$50 tolls

Travel (hotels) – \$600

6 nights @ \$100/night = \$600

Travel (per diem) - \$550

10 days @ \$55/day = \$550

Sub-awards - \$150,000

3 subawards @ \$50,000 each to counties for implementation of pilot projects = \$150,000

Consultation fees (Department of Psychiatry, KUSM-W) - \$1,500

10 hours of consultation with Department of Psychiatry physicians @ \$150/hour

Printing, Supplies, Misc. expenses - \$250

Budget – Year 4 – \$128,933

Salary (+ 3% raise) & Fringe - \$125,282

Shawna Wright 10% time @ \$111,650 + 35% fringe = \$15,073

Judy Johnston 35% time @ \$86,824 + 35% fringe = \$41,024

1 GRA 50% time @ \$26,226 (basic science rate) + 35% fringe = \$35,405

Kelsey Lu 25% time @ \$64,963 + 35% fringe = \$21,925

Travel - \$1,901

Travel (mileage & tolls) – \$1,326

One visit/rural/frontier county conducting pilot projects – 1,500 miles @ \$0.54/mile = \$810

Two face-to-face team meetings – 900 miles @ \$0.54/mile = \$486 = \$30 tolls

Travel (hotels) – \$300

3 nights @ \$100/night = \$300

Travel (per diem) - \$275

5 days @ \$55/day = \$275

Consultation fees (Department of Psychiatry, KUSM-W) - \$1,500

10 hours of consultation with Department of Psychiatry physicians @ \$150/hour

Printing, Supplies, Misc. expenses - \$250

Studies that include a research component are subject to institutional indirect costs calculated at 33% (KUMC Research Institute).

Total Four-Year Project Budget: \$235,837.60 Indirect costs

Indirect Costs Year 1 - \$49,725.85

Indirect Costs Year 2 - \$50,891.94

Indirect Costs Year 3 - \$92,671.92

Indirect Costs Year 4 - \$42, 547.89

Total Four-Year Project Budget (Direct Costs + Indirect Costs): \$950,497

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