Governor's Behavioral Health Services Planning Council

Rural and Frontier Subcommittee Report

2014 Annual Report

Presented to:
Wes Cole and the Governors' Behavioral Health Services Planning Council (GBHSPC)
Kari Bruffett, Secretary, Department for Aging and Disability Services (KDADS)
Sam Brownback, Governor

Mission

The GMHSPC Rural and Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health SERVICES IN FRONTIER AND RURAL Kansas counties. As defined by KDHE's frontier (less than 6 people per square mile) through urban continuum, we assure accessibility/availability of mental health services in frontier/rural Kansas counties.

Prepared by:
GBHSPC Rural and Frontier Subcommittee

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Committee Members:

Cheryl Rathbun- St Francis Community Services - Chair

Travis Hamrick– Iroquois Center for Human Development - Co-Chair

Amanda William- St. Francis Community Service

Amy Tuttle- Youthville

Barbara Clark- St. Francis Community Service & Adoptive Parent

Cheryl Holmes- KU School of Social Welfare

Cory Turner - Larned State Hospital

Leslie Bissell- Southwest Guidance Center

Michael Hinton-Wheatland/KVC

Renee Geyer- Compass Behavioral Health

Rhonda Kinser- Seward Community College

Ric Dalke- Compass Behavioral Health

Sheldon Carpenter- Iroquois Center for Human Development

Wendy Lockwood- The Center for Counseling and Consultation

Pam McDiffett- KDADS Central Office Support Staff

Introduction:

The Rural & Frontier Subcommittee has worked diligently to increase public awareness of rural and frontier realities in order to assure broad inclusion and representation of rural and frontier perspectives in policy and decision making.

2014 Recommendations:

1) Continue to lobby for statewide adoption of the Frontier through Urban Continuum definition.
2) Replicate the Rainbow Model in Kansas to prioritize needs in Rural and Frontier areas.
3) Aide in the implementation of Tele-conferencing to increase access of behavioral health resources to those in rural and frontier communities.
4) Increase funding for crisis beds for the non-insured and/or underinsured. There is a need to fill the gap in the rural and frontier areas of the state.
5) Subcommittee offers support to the state for the Federal Qualified Behavioral Health Center (FQBHC)
6) Assess statistically state administrative level of funding decision making and the impact it is having on rural and frontier communities. Develop an avenue for communities regarding coordination of data points and include the effects of managed care.
7) Problem solve avenues to address the changes and how they are impacting the community and the residents in the community.

Significant Accomplishments in past years:

1) Developed and implemented the teleconferencing Consumer Survey
2) Hosted Legislative luncheon on January 26, 2012 and Legislative reception on October 25, 2012. Made presentations at each outlining the importance of statewide adoption of the KDHE Frontier through Urban Continuum Definition.
3) Advocated for the adoption of the KDHE Frontier through Urban Continuum Definition.
4) Made presentations at state and national levels to advocate, educate and promote public awareness of mental health issues based on the KDHE continuum definition.
5) Developed membership to include consumers, families and stakeholders representing all geographical regions of Kansas.
6) Developed a Rural and Frontier Evaluation Tool to be used in assessments.
7) Advocated for representation of the rural/frontier voice in regard to policy and decision making.
8) Advocated for evidenced based practices found to be effective in rural and frontier communities.
9) Advocated for the need for fiscal responsibility through all goals of the Rural & Frontier Subcommittee.

Accomplishments in 2014:

1) Continued to lobby for the adoption of the KDHE Frontier through Urban Continuum Definition.
2) Applied for and successfully received grant money to support reimbursement of transportation costs for consumers and families.
3) Identified process for new membership.
4) Reviewed other committee's process and develop written process for this committee (See Attachment D).

Goals 2015

1) State wide Adoption of the KDHE Frontier through Urban Continuum Definition (See Attachment B) .
   Action Steps:
   A. Follow up on State wide Adoption Process
      1. Receive regular reports from larger GBHSPC
   B. Educate and gain support from government entities and decision makers for the adoption of the definition
      1. Request support for the adoption of definition in our presentations.
      2. Legislative receptions - for the purpose of education of legislators on the issues of rural and frontier realities (availability and accessibility of resources) and the necessity of being defined.
      3. Track and provide position statement (and be ready to testify) on legislation that has rural and frontier concerns.
      4. Identify stakeholders and provide educational information and data on rural and frontier issues as opportunity presents.
   C. Identify Association and Community Partners to meet, present and collaborate with regarding like needs and concerns.

2) The GBHSPC has requested that the subcommittee research what telemedicine technical assistance is offered nationally, what is presently being used and/or has been tried in the state and its usefulness, and what opportunities and services would be beneficial to Kansas.
   A. Our subcommittee developed and distributed a tele-video infrastructure survey in September of 2013. Please refer to the survey results for more information (See Attachment C) but general results included:
      1. Thirteen (13) respondents from varied disciplines ranging from schools – LECs to CMHCs and a Health Department.
      2. Only 28% of these rural respondents were using tele-video.
      3. Two thirds (2/3) of those using tele-video utilized hardware and software solutions
      4. One tele-video bridge exists at High Plains CMHC
         5. Hardware and software solutions include a range from Polycom to Skype.
         6. Most are interoperable with the other systems
         7. Policy development was still a need

8. Systems in place were being used regularly and mostly for provision of services

B. Develop an integrated, statewide blueprint and plan for use of technology for supports, enhancement and increased efficiency of services, care coordination, consumer supports and system planning.

C. Tele-mental Health Consumer Survey 2014: A brief review of the tele-video literature suggests that the use of technology to provide routine services to consumers is effective. This same review also revealed that consumers were often asked about their experience after a tele-video program had been developed and was in use (i.e. given a survey after a tele-video appointment). Little to no information was available as to consumer's understanding, interest, or concerns about tele-video services prior to the implementation.

1. Discussion within the Rural/Frontier Subcommittee revealed a desire to better understand the current thoughts of mental health consumers regarding this technology for two reasons:
    i. For those areas that have already begun using tele-video technology for mental health services to assess current consumer understanding and/or concerns about it
    ii. For those areas that have not been able to implement tele-video technology to date to assess consumer understanding of it and any possible concerns or fears about its use with the goal of avoiding barriers to use.
2. At the time of the literature review, no established survey could be found; therefore the 2014Telemental Health Consumer Survey was created.
    - Items include basic demographic information, items related to type, frequency, and location of services provided, and 56 additional items presented on a 5 item Likert scale.
    - The survey has been made available to consumers 18 or older and parents/guardians of consumers via the CMHC system, NAMI system and CRO's in rural/frontier areas.
    - Participants have the option of completing a paper copy of the survey or completing it via a Survey Monkey link.
    - Paper and electronic versions are available in English and Spanish.
    - As of 4/1/14, the first rounds of surveys are due by April 30, 2014; however, depending on the number of responses, this deadline may be extended.
    - Once all surveys are collected, the results will be reviewed and findings summarized in a report that will be provided to the Rural/Frontier Subcommittee as well as those entities that assisted with data collection. Participants may also have access to the results of the survey upon request.
3. Summary of Telemedicine Survey Results

D. Continue to broaden membership; Identify and recruit members to represent other community stakeholders

- Continue to identify and recruit additional consumer and family participants.

Summary:

The Rural and Frontier Subcommittee works to understand the effects of our economic and geographical conditions on all consumers of behavioral health services as seen through the lens of the continuum of population density. We understand that on either side of the continuum the lack of resources and adequate funding places a hefty burden for the population of people who experience serious emotional and brain disorders. The subcommittee has identified the political arena as the primary forum to provide opportunities for moving forward in achieving its goals.

Attachment A:

Background information for Kansas

Rural and Frontier Subcommittee of the Governor's Mental Health Services Planning Council

Why Define Frontier and Rural?

"Defining rural does make a difference in ensuring limited resources intended to address critical rural needs actually are transmitted to locations that have those needs."[1]

"Population decline has broad social and economic consequences for the residents of these counties. None perhaps is more serious than the potential impact of population loss on the provision of health and health care services. At the current rate of population decline, the provision of health and health care services in many frontier and rural counties in Kansas eventually will become economically unsustainable."[2]

Description of Kansas – Population and Population Density

The subcommittee recommends use of KHDE's population density peer group continuum, defined as follows:

- Frontier is less than six people per square mile (p/m^2)
- Rural is 6-19.9 p/m^2
- Densely-settled rural is 20-39.9 p/m^2
- Semi-urban is 40-149.9 p/m^2
- Urban is 150+ p/m

Based on this continuum and using 2010 Census data, Kansas has the following peer groups.

	Eastern KS		Western Kansas	
Population Density Peer Groups	# of counties	% of counties	# of counties	% of counties
Frontier	6	10%	30	65%
Rural	21	36%	11	24%
Densely-settled Rural	16	27%	5	11%
Semi-urban	10	17%	0	0%
Urban	6	10%	0	0%
Grand Total	59	100%	46	100%

*Western Kansas is the column of counties including Barton County, west to the Colorado border.

Using Census 2000 county population density status and comparing its county population from Census 2000 to Census 2010, population loss had occurred in 30 of the 31 frontier Kansas and

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U.S. Department of Health and Human Services, Health Resources and Services Administration, Rural Health Policy (2007). *Mental Health and Rural America: 1994-2005: An Overview and Annotated Bibliography*. Available at ftp://ftp.hrsa.gov/ruralhealth/RuralMentalHealth.pdf, page 13.

[2] Is The Health Care System Sustainable in Rural Kansas? Kansas Health Policy Forums, Forum Brief, No. 7, January 2004. Keith Mueller, Ph.D., Professor & Director of Center for Rural Health Policy Analysis University of Nebraska Medical Center Leonard E. Bloomquist, Ph.D., Associate Professor of Sociology and Department Head Kansas State University Richard Morrissey, Ph.D., Interim Director of Health, KDHE

32 of the 38 rural counties. In contrast, four of the five urban counties had population gain. Given the second quote shown above, this is a critical issue for Kansas.
A comparison of population to land mass illustrates the vast distance that frontier and rural providers, consumers, and family members must cover for service delivery of all types:

- Frontier and rural counties together have 12% of the population and 67% of the land mass.
- Densely-settled rural, semi-urban and urban counties together have 88% of the population and 33% of the land mass.

Finally, an examination of population age groups illustrates differences across the continuum that can affect service needs. While frontier and rural counties have roughly the same percentage of their population in the 17 and under age group, they have a higher percentage of individuals who are 65 and older.

	% of 2010 Census Population by Peer Group	
Population Density Peer Group(s)	**Age 17 and Under**	**Age 65+**
Frontier and Rural	23.7%	19.8%
Densely-settled Rural	25.9%	14.5%
Semi-urban and Urban	25.7%	11.7%

For more information, please contact:

For information about the subcommittee, please contact: Cheryl Rathbun, cherylr@stfrancis.org; Wendy Lockwood, wendyl@thecentergb.org; or Ric Dalke: rdalke@areamhc.org.

Please also visit http://www.socwel.ku.edu/occ/viewProject.asp?ID=76

Attachment B:

2014 Tele-Mental Health Consumer Survey Results
Rural & Frontier Subcommittee
June 2014

Introduction:

In July 2013, the Rural and Frontier Subcommittee of the Governor's Behavioral Health Service Planning Council was directed to explore the use of current technology to meet the ever growing mental health needs of Kansans who live in rural and frontier areas. While initial discussion by the Subcommittee identified a need to assess current available infrastructure, it was discovered that the view of potential consumers' perceptions of available technology might also be helpful. As a result, the 2014 Tele-Mental Health Consumer Survey was developed.

Prior to the development of this survey, a brief literature review was conducted as well as information from Heartland Tele-Health Resource Center was obtained. Of those studies located, the majority involved the survey of consumers after a tele-video system and/or program had been implemented rather than assessing consumer views prior to implementation. It was also noted that more available studies focused on practitioner views and comfort, rather than that of the consumer. To date, little to no attention has been paid to consumer views prior to implementation.

Therefore, the purpose of this survey was to assess consumer views of tele-video /tele-mental health services. Specific concerns include the following: to what degree are consumers in rural and frontier areas aware of tele-video services? How comfortable would consumers be with receiving various mental health services via tele-video? What factors might positively or negatively influence consumers' decision to receive mental health services either in person and/or by tele-video? And for those who have not experienced the use of tele-video, what might make it easier for them to utilize it in the future?

Method:

For the sake of this study, rural and frontier counties were defined using the proposed Kansas Department of Health and Environment (KDHE) Frontier through Urban Continuum Definitions (Appendix A). Counties defined as urban or suburban in this definition were excluded; however, all other counties were eligible for participation. Community Mental Health Centers serving the remaining counties were asked by the principal researcher to make the survey available to consumers during regular service hours. The Kansas Chapter of the National Alliance for Mental Illness (NAMI) was also approached to make the survey available to its membership via email. Consumer Run Organizations were also considered for involvement; however, due to time constraints of the current study and logistical issues, they were not asked to participate.

Due to the dearth of research in this area to date, a majority of the survey items were created based on subcommittee consensus and with a consumer mental health consumer's input. The final survey obtained basic demographic information including the city or town of residence and county of residence. Participants were also asked to identify what type of mental health services they currently use, how long they have been receiving services, travel time from home to the mental health provider, and miles one way from home to the mental health provider. The remaining 55, 5-point Likert-type scale items asked participants to rate at what location you would feel comfortable receiving mental health services over a secure television or Internet connection (8 items plus write in), rate how important each of the following would be in your decision to receive tele-mental health services in addition to face-to-face services (8 items plus write in), rate how important each of the following would be in your decision to receive face-to-face services in addition to tele-mental health services (7 items plus write in), and which of the following might make it easier for you to agree to use tele-mental health services (4 items plus write in). Participants were also asked to identify which of the 8 types of communication tools his or her mental health provider presently uses to help with mental health treatment (yes, no, or not sure). At the end of the survey, participants were also given the opportunity to write in any other feedback or suggestions they may have for the Subcommittee.

The survey was made available in both English and Spanish as well as in paper/pencil and electronic format (Survey Monkey links). The timeframe of the survey was open for 30 days for the participants to respond and all hard copies were returned to the principal researcher. The results of the electronic survey and the hard copy results were combined and tabulated by the principal researcher.

Findings:

Demographics: At the end of April 2014, the electronic survey was closed and all data was tabulated. Of the 58 completed surveys, 15 were completed electronically, 14 in English. The remaining 43 were completed using the hard copy format. Of the 17 counties represented, three counties (12 participants) were either Urban or Suburban; however, due to the method of data collection, these responses could not be removed from the data set. Therefore, the following data should be considered with this in mind.

Of the 58 participants,

- Half (58%) were male, two reported they did not directly receive mental health services at the time of the survey, and three quarters (77.5%) self-identified as consumers of mental health services.
- A majority (79%) live in a county defined as densely populated rural, rural, or frontier and identified English as their primary language (96.5%).
- The average age of consumers receiving services: 44.67 years (7 years – 92 years). All participants who completed the survey; however, were over the age of 18.
- Regarding services, 64% received psychotherapy, 67% received medication management, and 52% received case management services. Sixty-five percent have received services for over one year.

Regarding the impact of geographic location in relationship to nearest mental health provider:

- Travel one way: 33% travel 0-15 minutes, 24% travel 15-30 minutes, 30% travel 30-60 minutes, and 10% travel more than an hour.
- Distance one way: 48% travel 0-15 miles, 35% travel between 15 and 50 miles, and 12% travel more than 50 miles, one way, to mental health appointments.
- Three quarters (75%) stated they have not used telemedicine services with another type of provider.
- Use of technology: 62% are most comfortable using the telephone, 51% email and 42% texting.
- Most comfortable location for receiving service: “very comfortable” 54% at home and 41% at a primary care provider’s office. Law enforcement office was split at 34% being “very comfortable” and 30% being “very uncomfortable” in this setting. The most uncomfortable settings were the library (35%) and school/college setting (39%).
- Participants also reported that they know that their mental health provider uses phone calls (83%) and voicemail (63%) to communicate with or help them; however, a majority of participants reported that they do not think their provider uses other forms of technology (email, text messaging, video conference calling, social media, etc.) to provide information or support.

Survey Items:

For each of the following survey item groups the response percentage was tabulated. The strongly agree/agree percentages as well as the strongly disagree/disagree percentages were further combined and the salient themes within each grouping are below. Exact percentages for each response item may be found in Appendix B: Survey Response Data.

<u>How comfortable would you be receiving service over a secure connection?</u> Out of eight types of mental health services, participants reported the most comfort with intake appointments with APRN/Psychiatrist for medication evaluation (65%), emergency services provided after office hours in an emergency room (54%) and weekly therapy appointment with a therapist or psychologist (56%). Regarding the use of an interpreter,

responses were mostly neutral (49%); however, this is not surprising given the limited number of individuals (2) who reported their primary language as something other than English.

How important is the item to your decision to receive telemental health services in addition to face-to-face services? The top three most important themes were:

- 69% "Do not have to travel as far from home to get service."
- 66% "Able to meet with my provider more often."
- 60% "Access to an earlier or quicker appointment time than I can get for a face to face appointment."

How important is the item to your decision to receive face-to-face services in addition to telemental health services? The top three strongest reasons to receive face to face services:

- 93% replied that they have a good relationship with their provider or want to maintain the in-person relationship with the provider.
- 84% were unsure how secure their protected health information or the content of the session would be.
- 68% reported that face- to-face services feel more private.

Which of the following might make it easier for you to agree to use telemental health services? The top two things providers could do to make it easier for participants to agree to use telemental health services:

- 66% "Seeing how the session might work before I have my first "real" appointment."
- 49% "Someone explaining the technology to me in person."

Discussion:

The purpose of this survey was to obtain a consumer-based perspective of the use of tele-video in the provision of mental health services in rural and frontier areas of Kansas. Many facets of the medical community have been using this type of technology for years; however, the perspective of the consumer has often not been assessed prior to implementation of new technology. Overall, the preliminary findings were positive in that most people who live in rural or frontier areas of Kansas are open to using the technology, specifically if it supports them receiving care sooner or more timely; ability to see their provider more frequently and less travel time involved. One of the key reasons consumers choose in-person appointments over what they think technology can provide is the importance of the relationship with the provider as well as the security of the information shared.

Results of this survey suggest a significant issue to explore further would be how to better engage the growing Hispanic and Asian populations in the rural and frontier areas of the state. The survey was available in both English and Spanish formats with only one Spanish speaking participant filling out a survey. Based on 2010 US Census data, the top three counties with the highest number of Hispanic residents are in southwestern, densely populated rural counties (Seward 57%, Ford 51%, and Finney 47%) yet Hispanic residents were not adequately represented in this study. A Similar issue relates to the length of time a survey participant was engaged in the mental health system as a majority of the current survey participants stated being in the mental health system for over a year. Another aspect of research would be to survey people who are relatively new to the mental health treatment system and how to engage them sooner.

At the end of the survey, participants were also given the opportunity to give written feedback to the Subcommittee. A review of these responses revealed a dichotomy. Those who chose to respond were either strongly against the use of technology for the provision of mental health services (i.e. "*I just don't want any part of it*," and "*I just don't want it. It's the anti-Christ*"); or avid supporters of tele-mental health. One participant stated *"I do not currently use mental health facilities here, but my first husband needed this desperately 14 years ago. Maybe he wouldn't have committed suicide if this were available. I now have a*

couple of grandchildren who may be having issues and this would be great if they could be checked upon or have access to help if they feel they need it."

Research suggests that early intervention and engagement in mental health services can decrease the length of suffering by up to ten years. It also suggests that early intervention can decrease both the severity and duration of mental health symptoms. Although a small number of participants were in this survey; and keeping in mind that 12 of them were from the urban or suburban areas of the state; the outcomes suggest that people are open to using tele-mental health services and that the system should move forward with these supports.

Attachment C: Three Subcommittee Doucments

GBHSPC Rural and Frontier Subcommittee Information Sheet

Name: _____

Agency Name: _____

Program Name: _____

Address: _____

Phone Number: _____ E-Mail: _____

Population represented: (check all that apply)

- ❑ Cash Assistance
- ❑ Mental Health Services
- ❑ Juvenile Justice Authority
- ❑ Community Planning
- ❑ Consumer
- ❑ Counseling
- ❑ Domestic Violence
- ❑ Med Management
- ❑ Faith Based Representative
- ❑ Council on Aging
- ❑ Employment Services
- ❑ Financial Support
- ❑ Health Care
- ❑ HIV/AIDS Services
- ❑ Independent Living
- ❑ Law Enforcement
- ❑ Psychiatric Hospital
- ❑ Family Member of SED
- ❑ Housing
- ❑ Adult Services
- ❑ Psychiatric Residential
- ❑ Children's Services
- ❑ Advocacy Organization
- ❑ Consumer Run Organization
- ❑ Educational Agency / Dept.
- ❑ Drug/Alcohol Services
- ❑ Foster Care
- ❑ Crisis Services
- ❑ Community Corrections
- ❑ NFMH
- ❑ Other (please list):

History and Mission of Agency (optional if you do not have agency affiliation)_____

_____

Why I want to be a member of this Subcommittee:_____

_____

_____

What I can contribute to this Subcommittee:_____

_____

_____

Signature:_____ **Date**:_____

GBHSPC Subcommittee Member Job Description

Report to: GBHSPC Rural & Frontier Subcommittee Co-Chairs

Purpose: To act as a voting member of the Rural and Frontier's Subcommittee with full authority and responsibility to develop recommendations to the Governors Mental Health Services Planning Council.

Subcommittee Members Responsibilities:

1) Review and research topics pertaining to the Kansas Behavioral Health System as identified by the Rural and Frontier's Subcommittee, GBHSPC and the KDADS Secretary
2) Prepare reports with recommendations for the full GBHSPC.
3) Assist with implementation of approved recommendations within the Rural and Frontier's Subcommittee scope as directed by the GBHSPC.

Individual Subcommittee Member's Duties:

1) Attend all fiscal year Rural and Frontier's Subcommittee meetings and activities, including special events and subcommittee retreats. Phone conferencing is available.
2) As a courtesy to Rural and Frontier's Subcommittee members, cell phones should be silenced and members should use discretion if performing other work during meetings.
3) If a member will not be able to attend a meeting they will be responsible to notify the Rural and Frontier's Subcommittee co-chairs or KDADS/MH Support Staff in advance.
4) Rural and Frontier's Subcommittee members will be responsible to contact Rural and Frontier's Subcommittee Co-Chairs or KDADS/MH Support Staff to be updated on topics/events that took place in their absence; if further clarification of meeting content is needed after reading meeting minutes.
5) A representative from the Rural and Frontier's Subcommittee member's agency may attend in Rural and Frontier's Subcommittee members place as long as Rural and Frontier's Subcommittee member takes the responsibility to ensure they are knowledgeable of the discussion at meeting. Rural and Frontier's Subcommittee member will contact the Rural and Frontier's Subcommittee Co-Chairs or KDADS/MH Support Staff in advance of representative attending.
6) Become knowledgeable about the topics assigned to the Rural and Frontier's Subcommittee.
7) Attend Rural and Frontier's Subcommittee meetings well prepared and well informed about issues on the agenda.

8) Contribute to meetings by expressing views and opinions about improving the Mental Health System in Kansas.
9) Express the interests of the constituency appointed to represent and provide input from the perspective of the population for whom you represent.
10) Consider others' point of view, make and/or give constructive suggestions/feedback and help the Rural and Frontier's Subcommittee make decisions that benefit all stakeholders in the mental health system.
11) Avoid conflicts of interest between the position as Rural and Frontier's Subcommittee member and personal or professional life. If such a conflict should arise, declare that conflict before the Rural and Frontier's Subcommittee and recuse oneself from voting on such matters.
12) Represent the Rural and Frontier's Subcommittee in a positive and supportive manner at all times and in all places.
13) Promote the work of the Rural and Frontier's Subcommittee to individuals, the public and other organizations with the understanding that as a representative of the Rural and Frontier's subcommittee and not represent or speak on behalf of the Rural and Frontier's subcommittee without approval of said Rural and Frontier's Subcommittee.
14) Consider Rural and Frontier's Subcommittee leadership roles or an officer's role when asked.

The Co-Chairs and Secretary of the Rural and Frontier's Subcommittee agree to:

- *Call meetings as necessary until objectives are met.*
- *Ensure that the agenda and support materials are distributed to all members in advance of the meetings with the help of KDADS support staff, in accordance with the ADA.*
- *Conduct the meetings in an orderly, fair and efficient manner.*
- *Use Robert's Rules of Order as a guideline for voting procedures.*
- *Provide progress reports/minutes to the Rural and Frontier's Subcommittee at its scheduled meetings, using the adopted format.*
- *Provide reports to the GBHSPC upon request.*

I will follow the Organizational Procedures and exercise the duties and responsibilities of the appointment as a Rural and Frontier's Subcommittee member and /or elected Rural and Frontier's Subcommittee official with integrity, collegiality and care.

_____ _____

Signature ***Date***

(Revised 09-2013)

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

ORGANIZATIONAL PROCEDURES

ARTICLE I: Name, Purpose and Offices

1. Name

Governor Mental Health Services Planning Council's Rural and Frontier's Subcommittee.

2. Vision

Our vision is that Rural and Frontier communities of Kansas will have access to essential, high-quality behavioral health services.

3. Mission

The GBHSPC Rural/Frontier Subcommittee is a group of mental health stakeholders who collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties, as defined by KDHE's frontier (less than 6 people per square mile) through urban continuum. Through the statewide adoption of the KDHE definition of the frontier through urban continuum, we assure accessibility/availability of mental health services in frontier/rural Kansas counties.

4. Offices

Officers of the Rural and Frontier's Subcommittee consist of a 2 co-chair and Secretary each serving a one year term. The first year co-chair will act as second year Co-Chair in the second year Co -chair's absence and will become second year Co-Chair the following fiscal year.

5. Elections

The subcommittee shall appoint a nominating committee. The nominating committee shall submit the slate of candidate for a vote at the last scheduled meeting of the fiscal year. The Nominating Committee shall solicit from subcommittee any members who wish to be considered as a candidate for office. Officers may serve more than one consecutive term if elected through the process.

6. Voting

Members will be considered for quorum (1 member more than half) whether in-person or participating through conference call, or through a requested special vote by members through email. All members are eligible to vote on all matters requiring a vote. A majority vote, that is a majority of the votes cast, is sufficient for the adoption of any motion that is in order.

7. Year

Fiscal year for the Rural and Frontier's Subcommittee will be July 1st – June 30th.

ARTICLE II: Members

1. Members

The Rural and Frontier's Subcommittee shall consist of representatives form identified agencies, member(s) of the GBHSPC, adult and child consumers of behavioral health services,

1.1 Member Selection

In order to ensure broad representation, membership will be reviewed regularly. Persons identified for potential membership will complete a Subcommittee Information Sheet. This sheet will be provided to the subcommittee for review and vote at a regularly called meeting or by special email vote.

1.2.1 Attendance

In order to be an effective Subcommittee, attendance is considered critical to continued membership. Members of the Subcommittee are expected to participate in all regularly schedule Subcommittee meetings. Excessive unexcused absences will be reviewed by the Chair and KDADS Support Staff and appropriateness of continued membership will be determined. Absences shall be considered excused absences if notification is provided to the second year Chairperson or KDADS Support Staff prior to scheduled meeting date. The lead Chairperson has the option to extend a leave of absence to a member for extenuating circumstances.

2. Meetings

Rural and Frontier's Subcommittee meetings shall be bi-monthly. Meeting notification will be made to all members. Quorum consists of those who attend the meeting, provide the meeting has been properly called.

3. Work Groups

Additional work groups may be established either as time-limited or long-term duration with specific focus. These work groups will identify and address the barriers faced by residents of rural & frontier communities with a mental illness and will develop specific steps of action.

ARTICLE III: Robert's Rules of Order and Amendment of Organizational Procedures

1. Parliamentary Authority

1.1 Robert's Rules of Order

Robert's Rules of Order, newly revised, shall be used as a guideline for voting procedures.

2. Amendment of Operational Policies

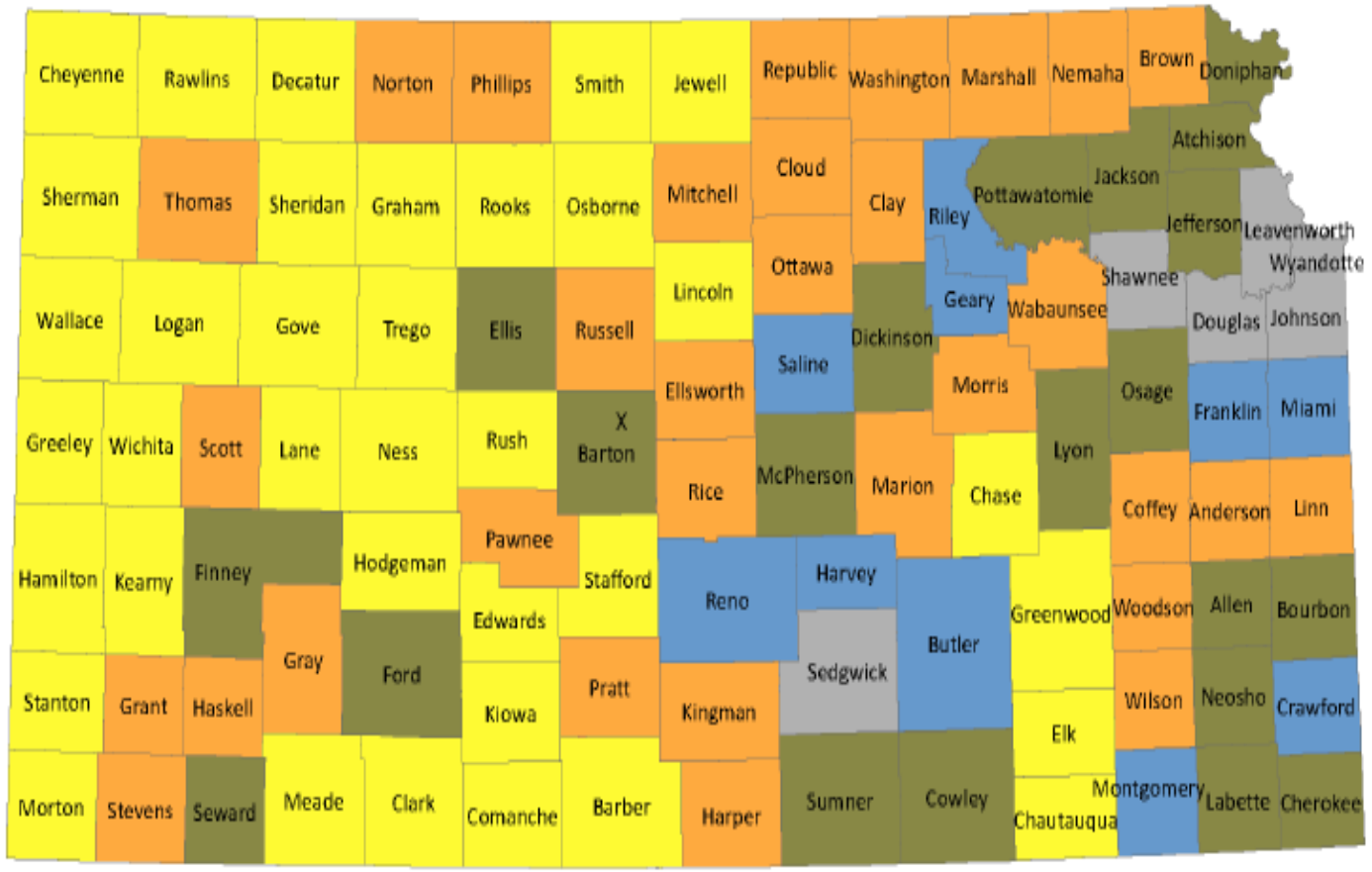
2.1 Organizational Procedures

Any part of these organizational procedures may be amended by two- thirds vote of the total membership of the Rural and Frontier's Subcommittee.

(Revised 9/13)

2010 Population Density Peer Groups for Kansas Counties

For more information, see http://www.socwel.ku.edu/occ/viewProject.asp?ID=76



The "X" in Barton County indicates the geographical center of Kansas.

Population Density Peer Group

- Frontier (less than 6 persons per sq. mile)
- Rural (6 to 19.9 persons per sq. mile)
- Densely-settled Rural (20.00 to 39.9 persons per sq. mile)
- Semi-urban (40 to 149.9 persons per sq. mile)
- Urban (150+ persons per sq. mile)