

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

2017 Annual Report

Presented to:

Wes Cole, Chairperson & Gary Parker, Vice Chairperson
Governors' Behavioral Health Services Planning Council (GBHSPC)

Tim Keck, Secretary
Department for Aging and Disability Services (KDADS)

Sam Brownback, Governor

Prepared by:

GBHSPC Rural and Frontier Subcommittee
Renee Geyer, MMC - Fy2017 Lead Chair
Nicole Tice, Psy.D. – Fy2017 Co-Chair

August 30, 2017

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 2017.

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. Rural Legacy of Depopulation**
- 4. Behavioral Health Provider Shortage**

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, SUD Treatment Providers, 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.

FY2017 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, 2014 (Appendix B)

- **#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.
 - Established partnership with KU Center for Telemedicine & Telehealth, and the Heartland Resource Center. 12.1.16
 - Planning Telehealth Use Survey to explore telehealth as a tool for delivering an alternative service – especially for the elderly. 1.26.17
 - Letter to BSRB re: use of telesupervision for QMHP's seeking behavioral health independent licensing. 2.27.17 (Appendix C) At their October 8th meeting, we've been granted an hour on the BSRB agenda to present on use of telesupervision.
 - B. Further define specific transportation challenges for both routine and emergency mental health and SUD needs based on current trends and observations.
 - Attended United Healthcare community meeting re: service delivery. 1.26.17
 - C. 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. Must think about crisis resources beyond crisis beds. More community outreach is always needed. 1.26.17
 - Addressing need for Medicare Provider Panel expansion by providing info to Aging Subcommittee i.e. (telehealth services reimbursement issues, higher cost of delivery in rural areas due to lower patient volume, MCO licensing restrictions on providers, increased provider costs due to complex and fragmented funding systems). Member volunteered to join that committee to bridge efforts. 3.23.17
 - D. Advocate for adequate resources to meet consumer and provider behavioral health needs.
 - Efforts to conduct a R/F Telehealth Use Survey began and are ongoing 1.26.17
 - Letter to BSRB (GBHSPC approved) re: telesupervision use sharing an array of barriers that membership agencies and individuals have encountered. 2.27.17
 - Partnered in Children's Mental Health Awareness Day at Ashland 5.4.17
 - Article "Mental health: the next farm crisis in rural America" re: Ashland with quotes from R/F members 5.9.17 (Appendix D)
 - GBHSPC & R/F Subcommittee function/work highlighted in SAMHSA webinar followed by community of practice "Addressing Rural Homelessness and Behavioral Health Needs" by R/F member 4.24.17 (Appendix E)
- **#3 - Continue to diversify membership to ensure that needs and resources are considered within and alongside the behavioral health system.**
 - Added seven stakeholders to Subcommittee

- Letter to BSRB re: use of telesupervision for QMHP's seeking behavioral health independent licensing. Upon request, provided links and documents supporting electronic efficacy to BSRB for their review.
- Shared availability of Darkness to Light Training; and Clover House (residential home) for sex trafficking victims

Noteworthy Efforts pre Fy2017

- 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.

Fy2018 Goals

In Fy2018, the R/F Subcommittee will remain focused on the same objectives/goals as 2017.

FY2017 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, conducting a Telehealth Use Survey, advocating for Medicare Provider Panel expansion.
- 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 and KDHE Population Density Classifications in KS by County, 2014

Appendix C: BSRB Letter

Appendix D: "Mental health: the next farm crisis in rural America" article

Appendix E: SAMHSA "Addressing Rural Homelessness and Behavioral Health Needs" webinar and community of practice slide deck and notes

Rural & Frontier Subcommittee

2017 Annual Report

August 16, 2017

Governor's Behavioral Health Services Planning Council

Topeka, KS

Who we are:

- Renee Geyer, MMC – Lead Chair
 - Grant Coordinator, Compass Behavioral Health
 - Garden City, KS
- Nicole Tice, PsyD – Co-Chair
 - Program Director of Larned State Hospital Psychiatric Services Program, Larned State Hospital
 - Larned, KS

Annual Report Overview

- Vision, Mission & brief Subcommittee history
- What we know about behavioral health issues and needs in rural & frontier areas
- FY2017 Objectives, and Progress to date
- Recommendations and Advocacy Appreciation

Because we know that...

“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.”¹

¹ 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

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.”**

March 24, 2016 Rural/Frontier Charter

We have learned that...

“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 health care, 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.”

Our Mission

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



History of the Rural & Frontier Subcommittee

- Originated as a committee subgroup focused on the mental health needs of children in the child welfare system.
- In July 2008, the subgroup moved under the umbrella of the GMHSPC to become the Frontier and Rural Subcommittee.
- The GMHSPC functions as the Kansas planning and advisory council that is required to receive federal Behavioral Health Block Grant funding.
- This affiliation (which is now inclusive of substance abuse disorders and renamed the GBHSPC) provides us with a formal process for making recommendations to the system and acknowledges the uniqueness of frontier and rural issues.

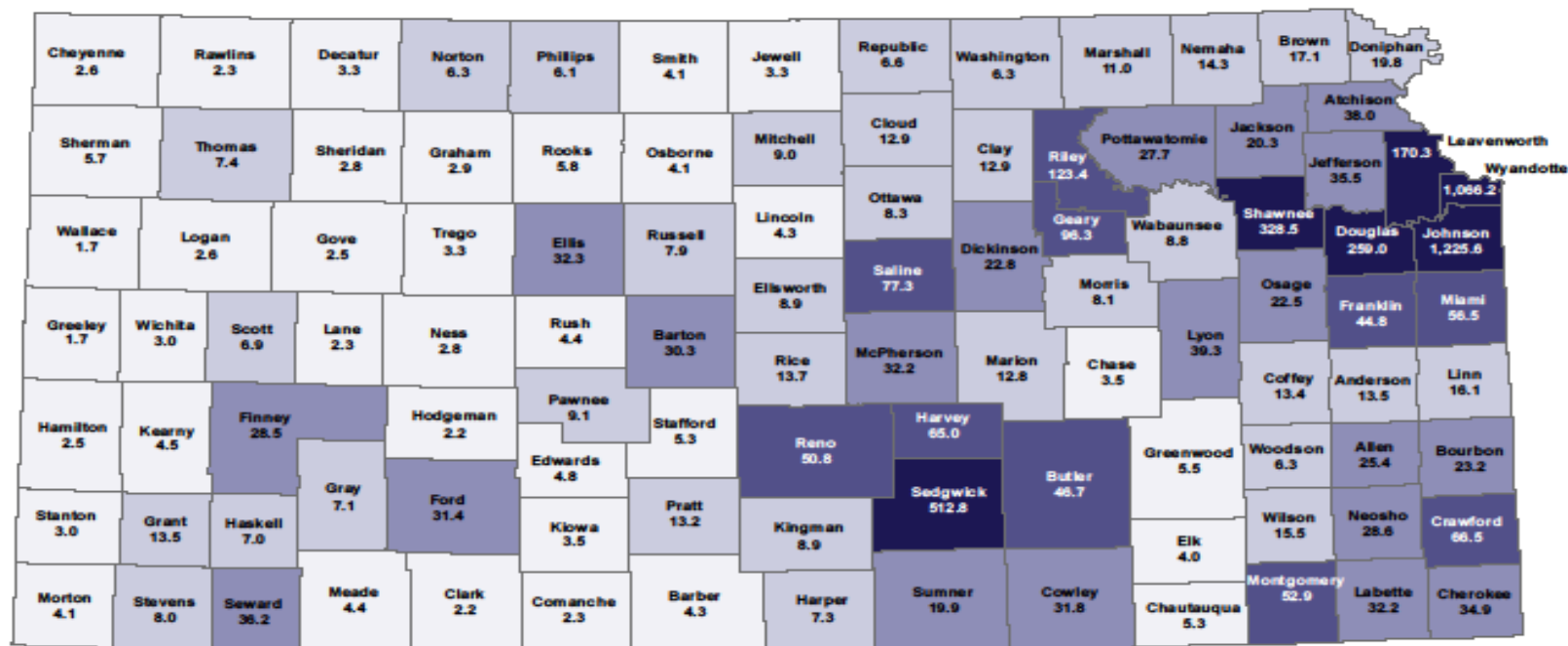
Why do we advocate for the use of KDHE's definition of the frontier through urban continuum?

“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.”

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 <http://ftp.hrsa.gov/ruralhealth/RuralMentalHealth.pdf>

Population Density Classifications in Kansas by County, 2015



Source: Institute for Policy & Social Research, The University of Kansas; data from the U.S. Census Bureau, Population Estimates, Vintage 2015.

Population Density by Classification* (persons per square mile)

State: 35.6

- Frontier (less than 6.0 ppsm)
- Rural (6.0 - 19.9 ppsm)
- Densely-settled Rural (20.0 - 39.9 ppsm)
- Semi-Urban (40.0 - 149.9 ppsm)
- Urban (150.0 ppsm or more)

* Kansas Department of Health and Environment classifications.

Unique Rural/Frontier Behavioral Health Needs

- Lack of Urban/Semi-Urban Resources in 8 out of 10 counties in Kansas (89 of 105 counties)
- Rural legacy of depopulation has continued over the past decade; a disproportionate share of the elderly population remains
- Higher percentage per capita of Hispanic residents in Rural/Frontier counties, especially in the southwest corner
- Behavioral Health provider shortage which creates barriers to service provision

Lack of Urban/Semi-urban Resources

Implications:

- Fewer services are available
 - People must travel farther and bear the related travel costs
- Kansas policies or services that are financed or supported on a per-capita basis, result in underfunded programs and service shortages in more than 80% of the state
 - Rural/frontier counties have smaller economies of scale and must provide services in more creative ways... or not at all

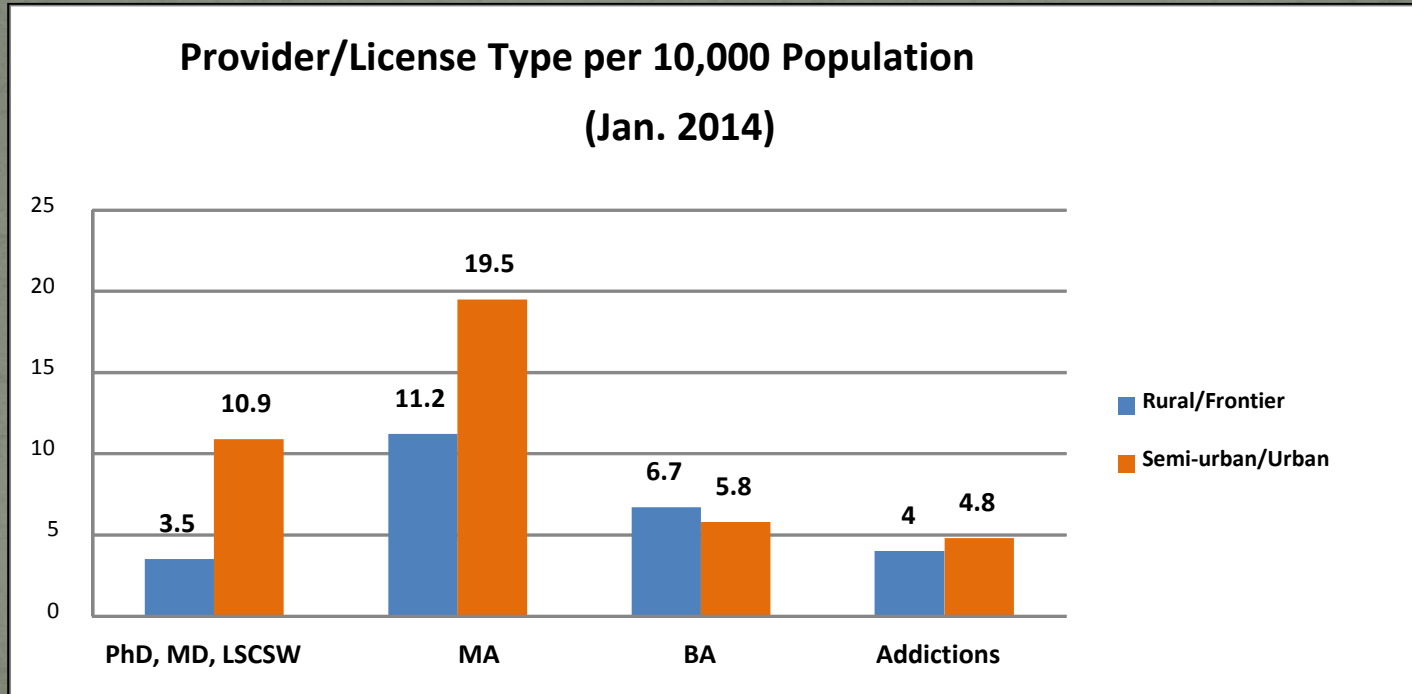
Behavioral Health Provider Shortage

An overall shortage in health care services in rural/frontier areas

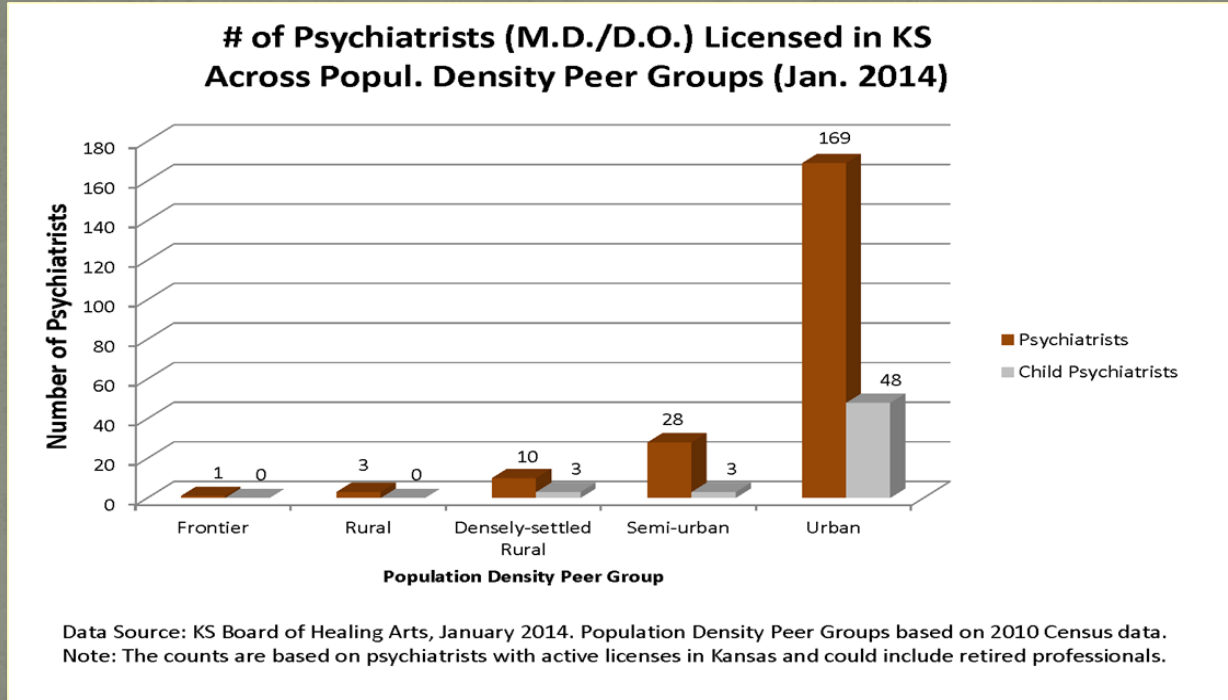
is compounded

by an even greater shortage of behavioral health providers and services.

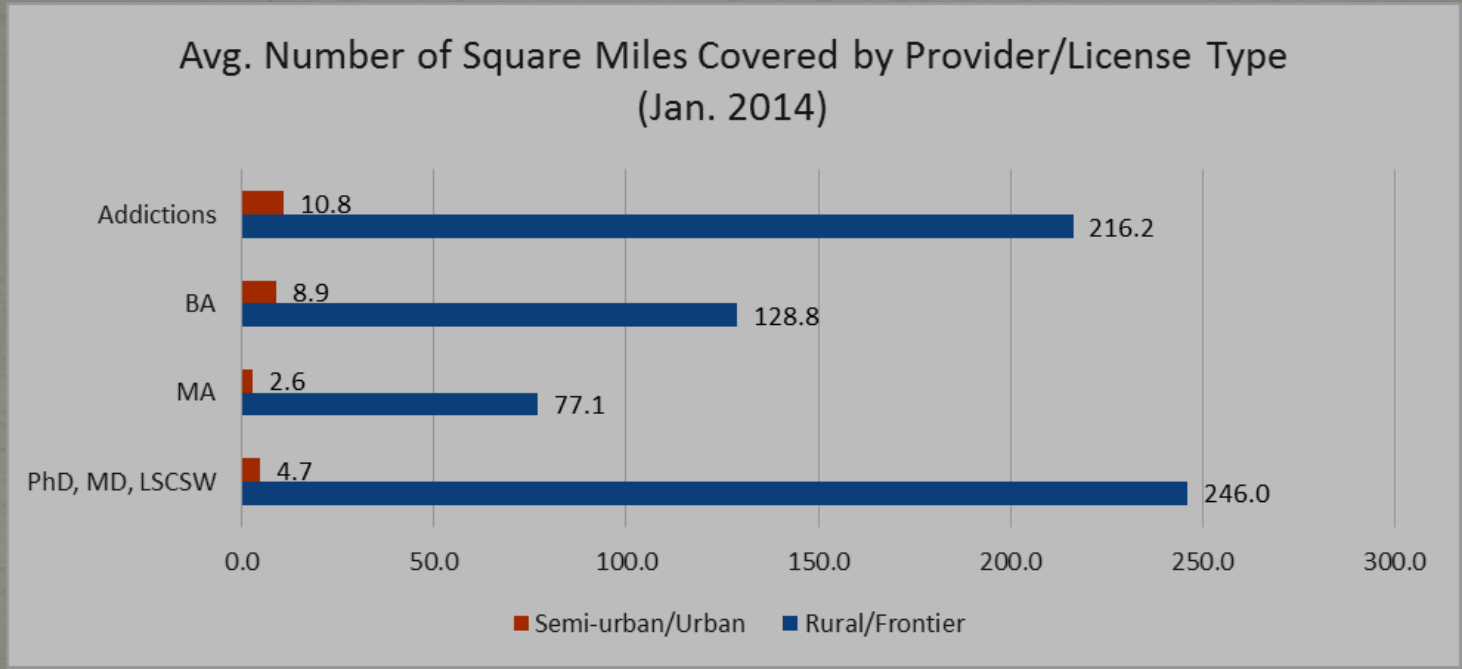
R/F counties have fewer behavioral health providers per 10,000 population than Semi-Urban/Urban counties.



Psychiatrists are VERY LIMITED in R/F counties



Square Miles Covered in Service Provision



According to the Rural Assistance Center

OUTCOMES can be far worse for people when services are a great distance away or not available at all.

- For example, suicide rates rose faster in rural areas according to data from the Centers for Disease Control & Prevention.
- From 2004 and 2013, small towns and rural counties experienced a **20%** increase in the suicide rate, while the metropolitan counties showed a **7%** increase.
- www.raconline.org/topics/mental-health

Rural Legacy—Depopulation

Implications:

- Over the last decade, decreasing populations in rural/frontier counties have resulted in erosion of the economic base and a decline in vitality for many communities.
 - As the economic base declines, health services become more difficult to support locally.
 - Therefore, the focus is on illness rather than on adequate early intervention and prevention.

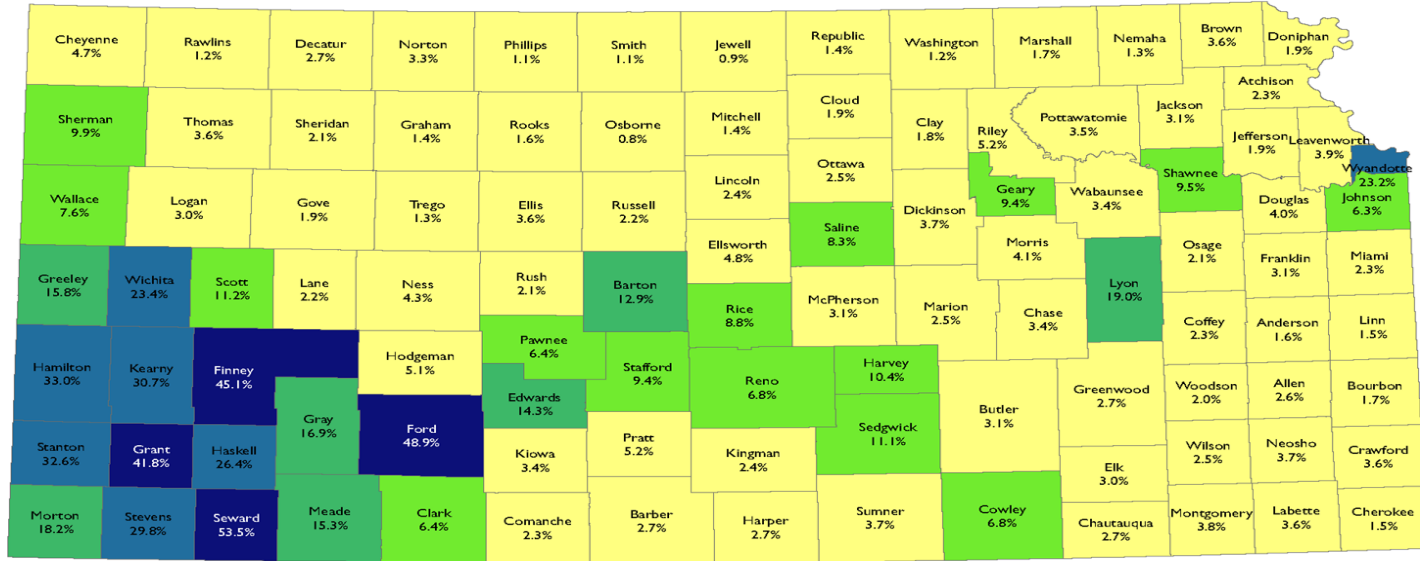
Rural and Frontier Ethnicity

The ethnic landscape is also considerably different in Kansas' rural and frontier counties.

- Although the Hispanic or Latino population comprises approximately 10% of Kansas' total population, there are 21 counties with Hispanic or Latino populations **greater than 10%** — 18 of which are rural or frontier.
 - **Ten counties concentrated in the southwest corner of the state all have more than twice the state average for this population segment**, with the top 4 considerably higher—Seward (54%), Ford (49%), Finney (45%), and Grant (42%).

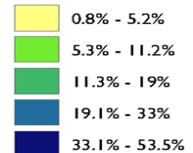
Source: U.S. Census Bureau, <http://www.census.gov/2000census/>

Rural and Frontier Ethnicity

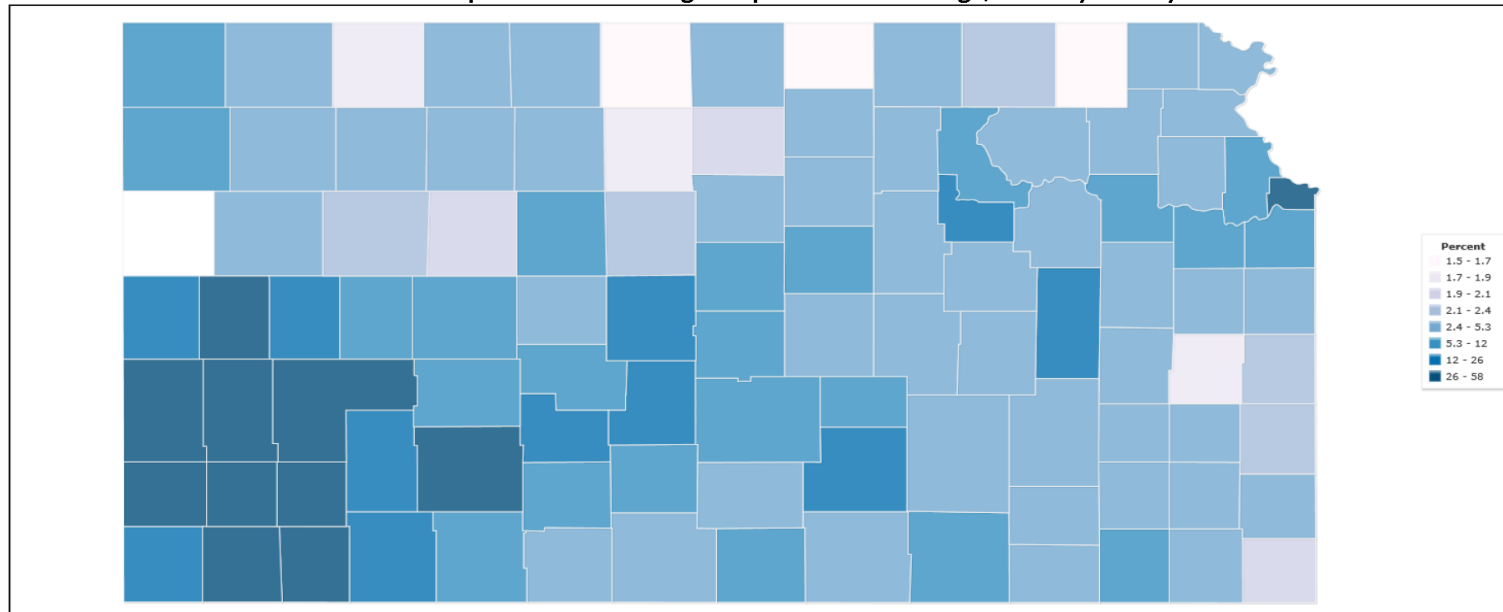


Source: Institute for Policy & Social Research, The University of Kansas using data from the U.S. Census Bureau, Population Estimates by Age, Race, Sex, and Hispanic Origin (ARSH), Vintage 2009.

Legend



Kansas Hispanic or Latino Origin Population Percentage, 2013 by County



Notes:

Data item: Hispanic or Latino, percent, 2013

Source: U.S. Bureau of the Census, Population Estimates Program (PEP). Updated annually. <http://www.census.gov/popest/estimates.html>.

Definition: Hispanics or Latinos are those people who classified themselves in one of the specific Spanish, Hispanic, or Latino categories listed on the Census 2010 questionnaire -"Mexican," "Puerto Rican", or "Cuban"-as well as those who indicate that they are "another Hispanic, Latino, or Spanish origin." People who do not identify with one of the specific origins listed on the questionnaire but indicate that they are "another Hispanic, Latino, or Spanish origin" are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or the Dominican Republic. The terms "Hispanic," "Latino," and "Spanish" are used interchangeably.

Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Spanish, Hispanic, or Latino may be of any race. Thus, the percent Hispanic should not be added to percentages for racial categories.

See source for additional information: <https://www.indexmundi.com/facts/united-states/quick-facts/kansas/hispanic-or-latino-population-percentage#map>

Ethnic & Cultural Diversity

Implications:

In rural and frontier areas, there is an increased need for providers who understand rural culture, have bilingual and bicultural skill sets, and are responsive to a diverse range of ethnic cultures **from an already limited workforce** .

- All materials and services must be provided in at least two languages = increased costs

Addressing Barriers through Innovation

Rural and frontier agencies and residents recognize that...

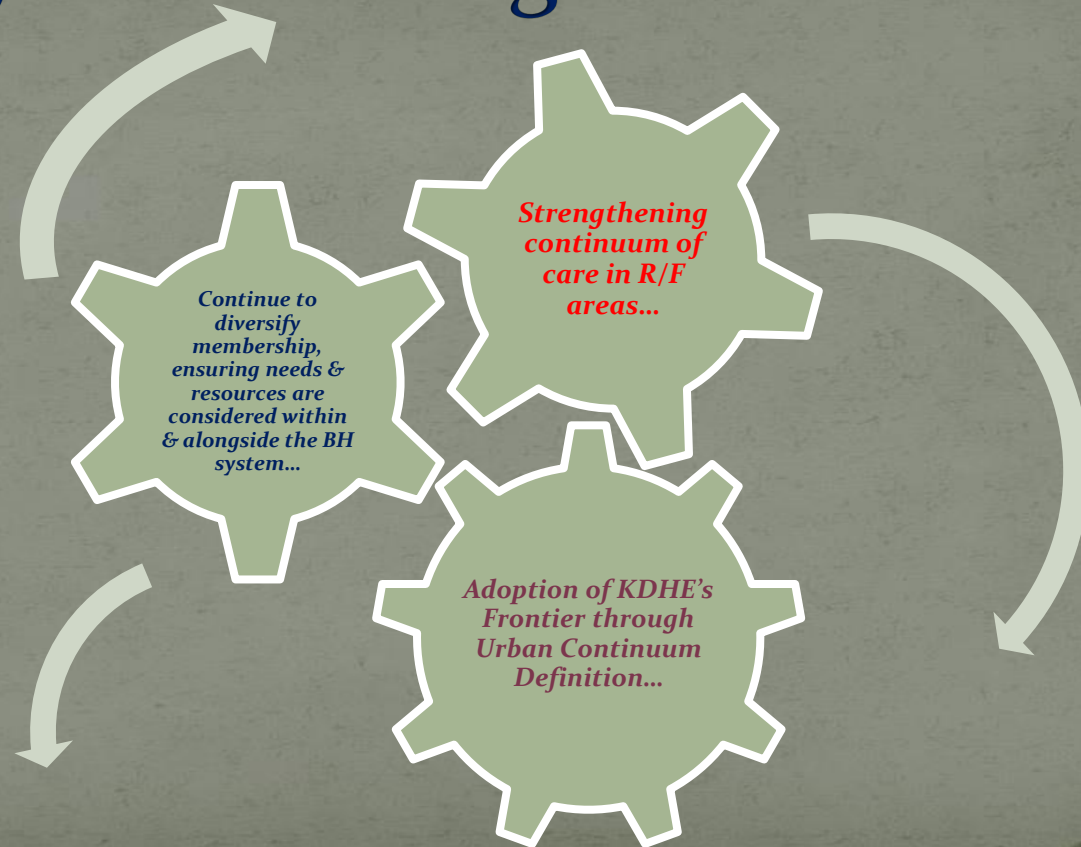
1. *collaboration is necessary to address behavioral health barriers*
2. *necessary partners must be brought to the table*

To affect meaningful change across the agency, county, or state...

1. *entities must work together creatively*
2. *a diverse group of stakeholders can implement tangible change*
3. *needs and resources must be considered from within and alongside the behavioral health system*

The Rural and Frontier Subcommittee is a partner in this effort.

Fy2017 Objectives & Progress



1st Fy2017 Objective

Adoption of KDHE's Frontier through Urban Continuum Definition

PROGRESS:

Rural and Frontier Subcommittee members continue to share the message and it's importance at every opportunity, with various agencies and in multiple venues. Defining rural is the fundamental cornerstone necessary to build Behavioral Health Equity for all Kansans.



2nd Fy2017 Objective

Strengthening the Continuum of Care in R/F areas



A. Championing use of telehealth technology, and sharing established protocol and resources to support those who need assistance implementing telehealth technology and practice.

PROGRESS:

**Established partnership with KU Center for Telemedicine and Telehealth & Heartland Telehealth Resource Center. 12.1.16*

**Plans for Telehealth Survey to explore telehealth as tool for delivering an alternative service. 1.26.17*

**Letter to BSRB re: use of telesupervision for qualified mental health professionals seeking behavioral health independent licensing. 2.27.17*

“... 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)

Strengthening the Continuum of Care in R/F areas

B. Further defining specific transportation challenges for routine and emergency mental health, and Substance Use Diagnosis needs based on current trends and observations.

PROGRESS:

**United Healthcare review of service delivery with member of the community (R/F members Ric Dalke & Geovanni Gone' attended) 1.26.17*

C. Advocating for increased funding for crisis beds for the non-insured &/or underinsured to fill the gap in rural and frontier areas of the state.

PROGRESS:

**When opportunity arises, advocate for next crisis center in Western Kansas. Must think about crisis resources beyond crisis beds. More community outreach is always needed. 1.26.17*

**Medicare Provider Panel expansion info to Wes for Aging Subcommittee, i.e. (telehealth services reimbursement issues; higher cost of delivery in rural areas due to lower patient volume; MCO licensing restrictions on providers; increased provider costs due to complex & fragmented funding systems). 3.23.17*

**R/F Member Marilyn Roberts volunteered to join Aging Subcommittee. 3.23.17*

Mental Health Block Grant 2017 funded Residential Providers (for uninsured & underinsured)

WEST of Salina & Wichita

- New Chance Inc. - (32 beds in Dodge City)
- City on a Hill - (8-bed women's facility in Marienthal); (20 women's reintegration beds & 4 men's reintegration beds in Liberal)

For a total of 64 beds

EASTERN 3rd of Kansas

- Over 40 providers
- In over 100 locations

Offering countless beds

D. Advocating for adequate resources to meet behavioral health needs of consumers and providers.

PROGRESS:

**Efforts to conduct a R/F Telehealth Use Survey began & are ongoing. 1.26.17*

**Letter to BSRB (GBHSPC approved) re: use of telesupervision and the barriers membership agencies and individuals have encountered. 2.27.17*

**Partnered in Children's Mental Health Awareness Day in Ashland. (R/F members Ric Dalke, Vicki Broz, Tabitha Murski, and Renee Geyer attended). 5.4.17*

D. Advocating for adequate resources to meet behavioral health needs of consumers and providers continued...

PROGRESS:

**Article “Mental health: the next farm crisis in rural America” regarding Ashland with quotes from R/F members Ric Dalke & Tabitha Murski. 5.9.17*

**SAMHSA “Addressing Rural Homelessness & Behavioral Health Needs” webinar highlighting GBHSPC & R/F function/work 4.24.17 and*

**SAMHSA “Addressing Rural Homelessness & Behavioral Health Needs” community of practice with expanded focus on GBHSPC & R/F history & function 5.4.17 by R/F member Renee Geyer*

3rd FY2017 Objective

Continue to diversify membership ensuring needs and resources are considered within and alongside the behavioral health system.



PROGRESS: Added stakeholders to Subcommittee...

Family Services, Inc.; Kearny County Hospital; KU Center for Telemedicine & Telehealth; Wright Psychological Services; Heartland Resource Center; Behavioral Sciences Regulatory Board, and Russell Child Development Center

*Telehealth Use Survey; BSRB letter & upcoming presentation re: telesupervision

*Provided GBHSPC – links & documentation supporting efficacy of electronic supervision for BSRB review; Darkness to Light Training availability through KCSL; Clover House residential home for sex trafficking through SFCS

Fy2017 Goals & Recommendations

- 1) Statewide *adoption of KDHE's Frontier Through Urban Continuum Definition* by Executive Order.

To accomplish, recommendations include continued advocacy and collaboration with other Subcommittees.

Fy2017 Goals & Recommendations

2) *Strengthening continuum of care* in R/F areas

Recommendations include...

Continue championing use of telehealth technology

BSRB adoption of telesupervision option for licensing

Address various telehealth reimbursement barriers

Advocate for Medicare Provider Panel Expansion

(Above items address shortage of BH provider workforce.)

Advocate for next crisis center in Western Kansas

Fy2017 Goals & Recommendations

3) Continue to *diversify membership* in the subcommittee to ensure that needs and resources are considered within and alongside the behavioral health system.

Recommend continuing collaboration with GBHSPC and organizations across the state; in order to identify and address barriers to Behavioral Equity for all Kansans.

Rural & Frontier Advocacy

- Because the Governor's Behavioral Health Services Planning Council functions as the Kansas planning and advisory council for the State – it provides this **window of advocacy**.
- Members appreciate and recognize the value of advocacy through the Subcommittee; providing a formal process for making recommendations **regarding behavioral health equity for all Kansans** to the system and acknowledging the uniqueness of frontier and rural issues.

Thank You!



Sunrise on the Prairie by Marshall Lewis, 2014

Questions?

For more information about the Rural/Frontier
Subcommittee contact...

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