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

2020 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
Shawna Wright, PhD. – FY2021 Chair

Amanda Pfannenstiel, LCP- FY2021 Co-Chair

September 18, 2020

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: Please see Appendix A

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 Organizations, 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 B.

The subcommittee meets six times per year, usually during odd numbered months, on the fourth Thursday of the month. Historically, members have been able to participate in person at Compass Behavioral Health Outpatient office in Dodge City, as well as by phone conference or televideo. In response to the COVID-19 pandemic, the subcommittee transitioned meetings to televideo.

FY2020 Goals & Progress

#1 - Continue focusing on finalizing the Executive Order for the Frontier through Urban Definition and strengthening the continuum of care in Rural and Frontier areas

- A draft of the Executive Order re: Frontier through Urban Definition and KDHE Population Density Classifications in KS by County (Appendix C) was presented at the GBHSPC Annual meeting in September 2019.
    - The R/F Subcommittee was advised that the Frontier through Urban Definition initiative might be better addressed through the Kansas Office of Primary Care & Rural Health
- The R/F Subcommittee continues to strongly endorse and encourage the adoption of the Frontier through Urban Definition adoption and is willing to partner with other committees/agencies/organizations in support of this effort. However, the R/F Subcommittee has decided not to focus on this goal in FY2021 and to dedicate subcommittee resources to more achievable goals.

#2 - Continue to increase Suicide Prevention in Rural and Frontier areas

- The Subcommittee addressed suicide prevention at each meeting and shared information and projects from across the state.

- Discussed suicide awareness in the aging population as well as farming communities. Members reviewed different resources and trainings.
- Collaborated with Matt McGuire (VA Subcommittee and previous CIT organizer, attended January 2020 meeting). Identified prevention resources and training for rural and frontier communities.
- Shared resources on prevention in the LGBTQ which have been particularly isolated during with COVID 19.
- Subcommittee members are highly involved in Suicide Prevention in their respective counties. Members share resources, ideas, and trainings that can be implemented in their communities.
- The Subcommittee adopted rural and frontier language for suicide prevention to decrease stigma.
- Multiple committee members provide Suicide Prevention training in their areas.

#3 - Finalize the Telehealth Use Survey and begin the study.

- Designed, developed, and presented a community-engaged approach to studying telemental health adoption in rural areas with the KU Center for Telemedicine and Telehealth and the KU School of Medicine's Population Health. Lack of funding resources and COVID-19 rendered the previously proposed study (2019) ineffective.
- Designed and developed a new telebehavioral health study with KU Center for Telemedicine & Telehealth in response to the surge of telemental health utilization in response to COVID-19 (See Appendix D). The R/F Subcommittee will present this study to the GBHSPC and the Secretary to request and identify funding sources. The study designed has been informed and endorsed by several mental health centers and substance abuse counseling providers.

Noteworthy Efforts FY2020

The Subcommittee partners with other service organizations across state to increase access to services. The Subcommittee will continue to share information regarding rural and frontier strengths, needs, and unique issues as well as advocate for solutions to address the behavioral health workforce shortage.

- The Subcommittee actively participates in local and state conversations and initiatives to address this goal.
- Hosted a Legislative Luncheon in November of 2019 in Dodge City, Kansas with presentation on the Rural and Frontier Subcommittees objectives and goals.
- Partnered with the State Epidemiological Outcome Workgroup to share data needs for Rural and Frontier areas.
- R/F Subcommittee members serve on a variety of GBHSPC subcommittees to increase communication and collaboration across subcommittees and workgroups (e,g., **Ric Dalke**- Exec Committee as Vice-Chair; **Shawna Wright**- Kansas State Epidemiological Outcomes Workgroup and Aging Subcommittee; **Vicki Broz**- Prevention Subcommittee; **Shereen Ellis**- Service Members, Veterans, and Families and Prevention Subcommittees, etc.)
- The Subcommittee supported the Opioid Response Network (ORN) initiated by The Mid-America Technology Transfer Center (ATTC) Collaborative to Advance Health

Services. Sherry Watkins presented the ORN to the Subcommittee, and members disseminated information through their networks.

- Collaborated with other subcommittees through the year (e.g., Service Members, Veterans, and Families Subcommittee, Prevention Subcommittee).
- The Subcommittee continues to strive to diversify membership. New memberships include:
  - Juston White- KVC Hospitals
  - Kylee Harrison- K-State Research and Extension- Wild West District
  - Gina Gall- Dodge City Peaceful Tribe, Inc.

FY2021 Goals

The R/F Subcommittee is committed to addressing and achieving the four following goals in FY2021. The Subcommittee agrees that the upcoming year is an opportune time to study and research telemental health adoption, implementation, and utilization to inform best practices for providers and community members. The Subcommittee anticipates a significant need to address and support suicide prevention initiatives and to increase prevention efforts in rural and frontier communities, particularly in response to the financial, employment, and life challenges rural and frontier communities have faced in response to COVID-19. The Subcommittee will continue advocacy efforts to increase behavioral health service accessibility and support data integration with other subcommittees to adopt data-driven initiatives that address the specific needs of rural and frontier communities.

The R/F Subcommittee has partnered with KU's Center for Telemedicine & Telehealth in the development and design of the Kansas Rural and Frontier Telebehavioral health (KRAFT) Study. The **budget for this project is S195,529.** The Subcommittee is committed to identifying and seeking grant funding from local and national sources; however, the Subcommittee is seeking support with funding this project given the timeliness of the study and the potential for the study to inform best practices for behavioral health organizations, providers, consumers, stakeholders, and policy makers.

Goal 1: Telebehavioral health Study

- Actively pursue and secure funding
- Develop a plan and collaborate with partners

Goal 2: Suicide Prevention

- Invite members of the farming community to join the R/F Subcommittee
- Identify ways to increase awareness of available resources and engage with those resources
- Collaborate with community partners to address barriers

Goal 3: Service Accessibility

- Advocacy to BSRB on reciprocity of licenses across state lines
- Advocacy for all disciplines to maintain waiver changes for reimbursement from federal payors HR945/S.286, using data when possible
- Advocacy for Telehealth Supervision

Goal 4: Data Integration across Subcommittee

- Collaborate with other subcommittees on priority projects and data sharing.

Recommendations

The R/F Subcommittee recognizes the need for collaboration regarding identified goals and recommendations. The Subcommittee makes the following recommendations with the understanding that the State and the GBHSPC are instrumental in affecting change to support and enhance the goal of behavioral health equity in Kansas. The Subcommittee understands that in order to affect meaningful change across Kansas, we must partner creatively to achieve measurable change.

1) The R/F Subcommittee recommends statewide adoption of KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order.

2) The R/F Subcommittee recommends the dedication of resources to strengthen the continuum of care in R/F areas by increasing the number of available crisis beds for the non-insured and/or underinsured to fill the gap in the western half of the state.

3) The R/F Subcommittee recommends championing use of telemental health to address barriers through several mechanisms:

- Funding of the R/F Subcommittee's proposed Kansas Rural and Frontier Telebehavioral health (KRAFT) Study. **Budget: S195,529**
- Supporting/assisting with access to State behavioral health claims data to enhance the KRAFT Study
- Full adoption of the COVID-19 telehealth allowances into the future, including maintenance of telebehavioral health billing codes (with inclusion of telephone-only services), continued ability to deliver telehealth services to the home as an originating site, advocacy for all behavioral health disciplines to maintain waiver changes for reimbursement from federal payors HR945/S.286

Summary

The behavioral health needs of Kansans in Rural and Frontier areas are unique and need to be taken into consideration regarding policy development and fiscal issues. While the R/F Subcommittee continues to strongly support the adoption of the Rural through Urban Continuum (already utilized by KDHE), the Subcommittee has determined to redirect its resources toward more achievable goals in the future. The Subcommittee is agreeable to partnering with and supporting other organizations/committees that support this goal.

The significant surge in telemental health in response to COVID-19 highlights the ability of provider organizations to develop and deploy telehealth options. Additionally, anecdotal evidence indicates that rural and frontier populations are willing to engage with telebehavioral health. The Subcommittee remains dedicated to advancing the study, development, and accessibility of telemental health resources for rural and frontier communities to improve and increase mental health equity in the State. The Subcommittee has partnered with the KU Center for Telemedicine & Telehealth to design a study to inform best practices and telehealth adoption in rural and frontier communities. The Subcommittee will request financial support to conduct the telehealth study and will continue to focus on data-driven approaches to improve the quality of behavioral health service availability in rural and frontier areas.

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 accessing 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: Rural and Frontier Subcommittee History

Appendix B: County Membership Representation

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

Appendix D: Kansas Rural and Frontier Telebehavioral health (KRAFT) Study

Appendix A

Rural and Frontier Subcommittee 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!

Appendix B

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)/Prevention Subcommittee–Ford *vbroz@compassbh.org*
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) / Service Members, Veterans, and Families / Prevention Subcommittee ***EllisS3@Aetna.com***
Gina Gall- Dodge City Peaceful Tribe, Inc (1 county) Ford, Dodgecity_peaceful_tribe_06@yahoo
& ***Renee Geyer***-Compass Behavioral Health (13 counties)–Scott *rgeyer@compassbh.org*
Janine Gracy-KU Center for Telemedicine and Telehealth/Heartland Telehealth Resource Center (KS counties)-Sedgewick *jgracy@kumc.edu*
? ***Kylee Harrison-***K-State Research and Extension- Wild West District, (3 counties) kharrison@ksu.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*
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*
Justin White- KVC Hospitals (KS counties), Sedgwick jrwhite@kvc.org
Shawna Wright-KU Center for Telemedicine & Telehealth/Wright Psychological Services (KS counties)/ Aging Subcommittee / KansasState Epidemiological Outcomes Workgroup-Neosho *swright6@kumc.edu*
& ***Dorothy Ziesch***–Compass Behavioral Health Board Member (13 counties)/Silver Haired Legislator (Hodgeman)-Hodgeman *dot.ziesch@yahoo.com*

***** **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

Ford County Law Enforcement (1 county)–Ford

Aetna- (KS counties)

Dodge City Peaceful Tribe, Inc. (1 county)- Ford

KU Center for Telemedicine & Telehealth- (KS counties)

? **K-State Research and Extension- Wild West District/3 counties**: Haskell, Seward, and Stevens

! **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

KS Suicide Prevention Resource Center (KS counties)

% **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

(**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, 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

KVC Hospitals- (KS counties)

Appendix C

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

Nicole Tice, GBHPC Rural/Frontier Subcommittee Chair 11/05/2019

For more information contact:

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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.

Appendix D

Kansas Rural and Frontier Telebehavioral health (KRAFT) Study

Introduction

The purpose of this project is to leverage the COVID-induced, high-volume telebehavioral activity data in Kansas since March 2020 to better understand its effects on health equity in rural parts of Kansas, including Kansas frontier areas. This work will be the culmination of discussions and planning that have occurred for the last 2 years and will be conducted by telehealth experts at the University of Kansas Medical Center (KUMC).

The Rural & Frontier (R/F) Subcommittee of the Kansas Governor's Behavioral Health Services Planning Council has historically advocated for expansion of telehealth treatment options to increase behavioral health equity throughout the State. In 2019, the Subcommittee worked with researchers from the University of Kansas Medical Center to develop a research plan focused on a community-engaged approach to obtain feedback and guidance from rural and frontier populations to inform strategies for leveraging telehealth to increase *access, availability, and acceptability* of behavioral health treatment. However, the COVID-19 public health emergency has changed the landscape for conducting the previously designed study.

COVID-19 has forced a rapid surge of real-time, telehealth consultations for medical and behavioral health care at unprecedented levels in Kansas and across the U.S. in order to maintain social distancing and prevent broader exposure of health care professionals and patients to the virus. For the first time ever on a large scale, telehealth services have occurred in patients' homes, in urban and rural areas, and from clinical practices large and small. These telehealth events have been comprised of a mix of real-time video consultations and telephone visits. Continued telehealth growth is expected as both the uncertainty of COVID-19 continues as well as the heightened interest of clinicians and patients. Both federal and state governments are experiencing pressure to make emergency telehealth measures permanent, and Centers for Medicare & Medicaid Services (CMS) has signaled a willingness to review and consider revision of its guidelines for Medicare and Medicaid coverage of telehealth services.
A study such as proposed here is needed in Kansas to leverage the increased telehealth data available and to inform future best practices for telebehavioral health in rural and frontier areas.
A study such as proposed here is needed in Kansas to leverage the increased telehealth data available and to inform future best practices for telebehavioral health in rural and frontier areas.

Summary of Proposed Kansas Telebehavioral Health Study and Goals

The KUMC Kansas University Center for Telemedicine & Telehealth (KUCTT) proposes this study in partnership with the R/F Subcommittee for the purpose of examining how telebehavioral health has been adopted in rural and frontier counties. This adoption focus will help inform the feasibility of maintaining telebehavioral health options and to examine telebehavioral health's impact on improving behavioral health equity in these regions. To achieve these broad objectives, telebehavioral health attendance data and adherence with behavioral health treatment data during March, April, May, and June 2020 during the COVID-19 pandemic will be collected. This seasonal data will be compared with in-person behavioral health attendance and adherence with treatment data during the same seasonal periods in 2018 and 2019. This examination of

consumer attendance and follow-through with telebehavioral health options will inform telehealth feasibility, workforce impact, and potential cost savings for Kansas citizens living in rural and frontier areas. Study partners will also share consumer feedback surveys to inform telebehavioral best practices and to provide a community-engaged approach to telebehavioral health quality improvement efforts. Overall, this study will be comprised of four primary goals: 1) collect seasonal, organizational-level activity data from five mental health centers and one substance abuse treatment center in rural Kansas; 2) analyze data to determine utilization, productivity and financial implications; 3) aggregate and analyze 2020 telebehavioral consumer feedback survey data from the participating organizations to understand patient perceptions and inform future best practices; and 4) Access Kansas Medicaid claims data to analyze potential consumer-level cost savings and utilization of services. These goals are described in more detail in the **Study Design** section below.

In addition to KUCTT and the R/F Subcommittee, the Association of Community Mental Health Centers of Kansas, representative community mental health centers (i.e., northwest, southwest, central, northeast, and southeast Kansas) and CKF Addiction Treatment. These collaborators have all agreed to participate on this study due to the value of examining and evaluating telehealth issues in response to COVID-19. Overall, it will provide an opportunity to increase our understanding of the public's willingness to utilize telebehavioral health services and to understand behavioral health care services delivery priorities to inform strategies to improve behavioral health equity in rural and frontier geographies.

R/F Subcommittee and Study Background

The R/F Subcommittee's mission is to collaborate through research to statistically understand and promote accessibility and availability of mental health services in frontier and rural Kansas counties. The R/F Subcommittee envisions behavioral health equity for all Kansans where all residents of rural and frontier communities of Kansas have access to essential, high-quality behavioral health services. Moreover, the Subcommittee recognizes that "Epidemiological evidence suggests that the prevalence and incidence of adults with serious mental illnesses and children with serious emotional disturbances are similar between rural and urban populations."[1,2] 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."[3] We also 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."[4] Other contributors to disparities in these areas identified by the committee include:

- Lack of urban/semi-urban resources in 8 out of 10 counties in Kansas (89 of 105 counties)
- Disproportionate share of the elderly population
- Rural legacy of depopulation has continued over the past decade
- Higher percentage per capita of Hispanic residents in Rural/Frontier counties, especially in the southwest corner
- Overall shortage of health care services available in Rural/Frontier areas with an even greater shortage of behavioral health providers and services

As a result, the R/F Subcommittee works diligently to increase public awareness of rural and frontier realities in order to assure broad inclusion and representation of rural and frontier perspectives in behavioral health policy and decision making. Telebehavioral health is one type of service delivery that has long been examined and endorsed by the Subcommittee as a means to increase access to behavioral health services and to improve behavioral health treatment equity in the State. In addition, behavioral health providers in the rural and frontier areas of Kansas have long believed that the availability of telehealth would increase access to behavioral health care and improve behavioral health equity for rural Kansans.

Kansas has had a long history of telemedicine and telebehavioral services provided in many rural areas of the State, and research has been done on feasibility, patient savings and many other variables. Yet, virtually no research has been done on telebehavioral health services that are provided in patients' homes, and not at the current volume levels. Now, the vast expansion of telebehavioral health services in response to the COVID-19 pandemic provides a fortuitous opportunity to examine telebehavioral health effects and impact on behavioral health equity in Kansas in a way that has never been done before. In addition, 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), and currently (CMS), many state Medicaid plans, and private insurers are all providing temporary home telehealth reimbursement during the pandemic.[6,7] All of these activities point to a promising future for telehealth as long as there is sufficient research to support its effectiveness and long-term benefit, particularly for the engagement of rural and frontier patients.

Study Design, Goals and Methods

The specific goals of this single year study are:

1) Collect seasonal (March, April, May, June) organizational-level activity data from five representative mental health centers and CKF Addiction Treatment across three years (2018, 2019, 2020) to examine telebehavioral health utilization during the COVID-19 pandemic with a focus on visit type, client/patient volume, and number of cancelations/no-shows for appointments.
    a. Methods: Each of the participating telebehavioral health partners have robust Electronic Health Records (EHRs). Each partner will assign a data specialist to collect de-identified, aggregate behavioral health visit data and practitioner productivity (e.g., no-shows/cancelations) for the designated time periods. This data will be securely transferred to the research assistants at KUCTT, where a data dictionary will be developed to categorize and examine trends across time (year) and visit type (in-person, telebehavioral health).
2) Analyze organizational-level data to understand treatment trends, telehealth implementation/utilization, workforce productivity, and estimate financial impact on behavioral health organizations.
    a. Methods: Study partners will collect and securely share provider productivity reports for the identified time periods to compare overall clinical productivity. Providers who were required to travel to outreach offices (e.g., lost productivity time) prior to COVID-19, will be identified to assess for the financial impact of increased availability for client/patient care.

3) Collect and analyze 2020 telebehavioral consumer feedback survey data from all participating organizations that conducted surveys. This data will help inform best practices, consumer needs and preferences, and to further understand benefits and barriers of telebehavioral health.
    a. Methods: Study partners will share their client/patient satisfaction surveys and raw data through secure data transfers. It is expected that patient satisfaction surveys and telebehavioral health questions will vary by partner. Each set of data will be analyzed qualitatively and quantitatively (theme analysis) as applicable. After client/patient satisfaction data is analyzed at the partner level, the KUCTT research team will collectively examine client/patient survey responses for statewide trends and themes.
    b. The KUCTT research team's analysis of client/patient satisfaction survey data will be processed in comparison with telebehavioral health best practices, guidelines, and competencies to generate feedback to partner organizations regarding possible training needs and telehealth quality improvement recommendations.
4) Access Kansas Medicaid and Blue Cross/Blue Shield of Kansas claims data to analyze potential consumer-level cost savings and utilization of services. This data will identify patient location and options for care to determine potential travel savings and other expenses, as well as the availability of telebehavioral health services effects the utilization of higher levels of care (e.g., crisis services, inpatient treatment). *Note: While this study will provide useful results from EHR data alone for the specific agencies selected for the project, state claims data would provide a more complete, statewide picture of telehealth activity particularly in rural and frontier areas that may not be covered by the participating organizations.*
5) Conduct structured interviews with administrative staff from each collaborating site to further understand local telehealth trends, unique needs, resources, and challenges. Each interview will be structured, conducted by Zoom, and recorded. Interview length is estimated to be under one hour. The interview will then be sent to a transcription company to allow the research team to review the transcribed records and identify key themes.

This study will include the collection and analysis of administrative data from a sample of mental health centers that represent the following Kansas geographic areas: Northwest, Southwest, Central, Northeast, Southeast as well as data from CKF Addiction Treatment, which provides substance abuse counseling throughout the state. These organizations have all agreed to participate and will assign a staff person to help collect the EHR and survey data for the project, and funding will be allocated to each location to cover the employee effort needed for the data collection. All participating mental health centers and CKF Addiction Treatment have robust electronic health record (EHR) systems that will allow for collection of telehealth activity data (visit type, volume, no shows/cancellations, workforce impact/productivity, behavioral health populations served [severely emotionally disturbed; severely and persistently mentally ill], reimbursement, and length of appointment). Visit data will be analyzed using descriptive statistical methods as well as tests of significance to investigate potentially significant differences between years of data collection and telehealth compared to traditional, in-person care. Qualitative data will be coded and analyzed to identify themes and key points.

This study is designed to compare seasonal trends (March, April, May, June) across three years (2018, 2019, 2020) to examine and evaluate telebehavioral health utilization in response to the COVID-19 pandemic. The rapid transition from in-person services to telebehavioral health services to the home provides the research team with a unique opportunity to understand consumer response to telehealth and telehealth's potential to address behavioral health access, availability, and acceptance in underserved populations. A simple pre-post study design would not be sufficient since seasonal variations occur in patients' mental health needs and treatment activities.

Several of the mental health centers, the Association of Mental Health Centers of Kansas (AMHCK), and CKF Addiction Treatment have collected consumer perspective data focused on telehealth utilization. All participating organizations that have conducted consumer feedback surveys have agreed to share their de-identified patient survey data to allow for both quantitative and qualitative analysis of patient feedback data to inform consumer preferences.

KUCTT and the R/F Subcommittee believe that a similar review of Kansas Medicaid claims data would further inform a broader cost analysis in response to telebehavioral health availability during the COVID-19 public health emergency. Medicaid claims data would assist with comparing in-person and telehealth costs and would provide insight into whether the availability of telebehavioral health affects utilization of higher levels of behavioral health care (e.g., crisis screenings, crisis services, inpatient treatment). A KUMC Health Economist experienced with accessing and analyzing Kansas claims data will be responsible for seeking, managing and evaluating this data if available from the State. All project researchers are listed next.

Administrators from each participating behavioral health organization will be interviewed after data is collected and analyzed to assist with interpretation of telehealth trends, identification of resources and challenges, and to inform telehealth best practices for providers and clients/patients.

Study Team

Shawna Wright, PhD – Dr. Shawna Wright is the Associate Director of KUCTT and is a licensed and practicing mental health professional with over 12 years of telebehavioral health experience. She will oversee all aspects of the study including project personnel, communications with partner organizations, data collection and analysis and reporting.

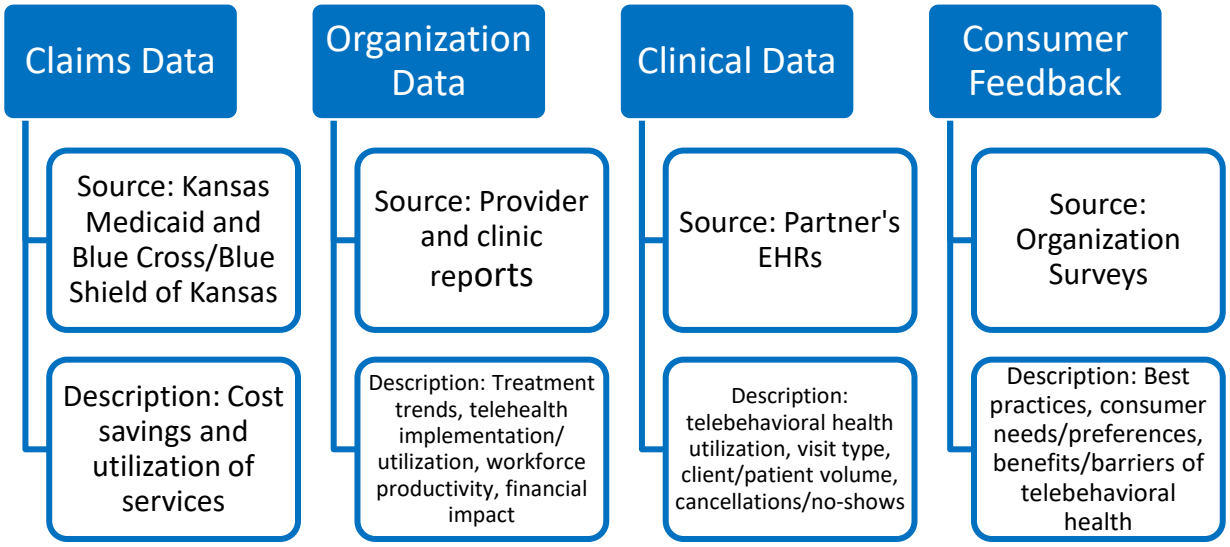
Ryan Spaulding, PhD – Dr. Ryan Spaulding is the Vice Chancellor of Community Engagement at KUMC and the long-time Director of KUCTT with 19 years of experience in telehealth implementation, research and policy advocacy. He will assist Dr. Wright with the study methods and with results dissemination to professional audiences.

Tami Gurley-Calvez, PhD – Dr. Gurley-Calvez is a health economist in the Department of Population Health at KUMC and is very experienced in analyzing claims data for a variety of diseases and research projects. She is currently tasked with predicting COVID-19 spread on a daily basis. She will manage all aspects of the consumer-level cost savings, insurer savings and consumer utilization aspects of this study.

Whitney Henley, MPH - Whitney Henley is a Research Associate in the Institute for Community Engagement and has assisted on a number of community engagement, telehealth and ECHO research studies. She is experienced in both quantitative and qualitative methods and will

manage and analyze the EHR and survey data for this study under the guidance of Drs. Wright and Spaulding.
To Be Named Research Associate – A second research associate from the Department of Population Health will be included in this study to assist Dr. Gurley-Calvez with the claims data management and analysis.
Jeremy Ko, MHI – Jeremy Ko is an informatics specialist and will help build the databases needed to organize the EHR, survey and qualitative data. He will work closely with Ms. Henley to manage these aspects of the study.
Local Employee Data Managers – Each participating organization will assign a local staff member to collect the necessary EHR and survey data and securely send to the KUMC study team. A total of six local employees (one representing each organization) will be funded.

This study is designed to inform policy makers and behavioral health service organizations about the feasibility of telebehavioral health services for rural and frontier regions of the state. Findings from the study will be applicable to informing: best practices for the delivery of telebehavioral health at both the organizational and provider level: strategies for telebehavioral health training; and overall quality improvement strategies including surveying behavioral health consumers to address the behavioral health care needs of Kansans across the State.



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Budget – 1 Year

Personnel	Salary	Effort	Requested
Shawna Wright, Ph.D	104,006	30.00%	31,202
Ryan Spaulding, Ph.D	169,800	5.00%	8,490
Tammy Gurley-Calvez	158,000	10.00%	15,800
Whitney Henley, PhD 37.5 FTE $23,400	62,400	20.00%	12,480
TBN, Research Assoc - GRA .50 FTE $24,000	48,000	15.00%	7,200
Jeremy Ko, MHI	58,427	20.00%	11,685
Total Personnel			86,857
Total Fringe Benefits (35%)			30,400
Travel			
Mileage - 2 meetings 260 @ .575/mile		150	
Lodging 2 nights @ $100/night		200	
Per Diem 2 days @ $55/day		110	
Total Travel			460
Supplies			
Supplies, printing, etc.			250
Other			
Data collection - 6 local data managers $1,500 per data manager			9,000
Total direct costs			126,967
Indirect Costs @ 54%			68,562
Total			**195,529**