Governor's Behavioral Health Services Planning Council

Rural and Frontier Subcommittee

2023 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

Monica Kurz, LMSW, Chair

Audra Goldsmith, MS, LMLP, Co-Chair

September 2023

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: The GBHSPC Rural and Frontier Subcommittee is dedicated to utilizing data-driven and needs assessment approaches to address the unique behavioral health challenges and requirements of rural and frontier counties to assure the accessibility, availability, and acceptability of behavioral health services for all Kansans.

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/Certified Behavioral Health Clinics, Veterans Services, Child Welfare Organizations, Private and State Psychiatric Hospitals, Managed Care Organizations (MCOs), University Partners, and Law Enforcement. A membership list is provided in **Appendix B**. The Subcommittee continues to strive to diversify membership. New members are noted in the membership table. The Subcommittee actively engaged in outreach to CMHCs/CCBHCs who serve rural/frontier counties. It is hoped that additional membership will be finalized in FY 2024.

The Subcommittee meets six times per year, usually during odd numbered months, on the fourth Thursday of the month. The sub-committee transitioned to virtual meetings in 2020 and meets in person once per year in the Fall for a legislative luncheon. Planning is in progress to add a summer in person meeting.

Legislative Luncheon FY2023

The Sub-Committee hosted its first in-person Legislative Luncheon November 15, 2022, and presented the R/F Subcommittee's goals and objectives. While this luncheon was not as well attended as those hosted prior COVID-19, it did offer an important opportunity to not only share the subcommittee goals/objectives, but to also hear from legislators. Legislators shared the concerns about access to care that they heard from their constituents. There was a lively discussion about Mobile Crisis Response Teams, the use of technology and interest in how volunteer response could be utilized. The sub-Committee is committed to continuing to rebuild legislative engagement for an in-person luncheon. The plan is to host in October of 2023 prior to the election to encourage robust attendance.

FY2023 Goals & Progress

The R/F Subcommittee heard the Secretary's call to action at the beginning of the fiscal year to examine how the behavioral health priorities and plans were impacting the communities and populations served by the system. As the only subcommittee exclusively dedicated to representing the interests of the rural and frontier communities which make up most of the state, the subcommittee dedicated much of its focus this year on examining the unique needs of these areas to implement initiatives for CCBHC, Stepping Up and 988. A heavy emphasis was placed on learning about crisis services and the needs of providers and communities when it comes to crisis mental health services.

In FY2023, the R/F Subcommittee focused on addressing the primary goals listed below with progress included for each.

Goal 1. Crisis Response in Rural and Frontier Communities

The subcommittee chose a primary focus on examining, understanding, and making recommendations regarding the organization and delivery of crisis response services in rural and frontier communities. The subcommittee was uniquely suited to crisis services as focus for FY 2023 as membership includes representation from the Stepping Up Technical Assistance (TA) Center, 988 service provider, CCBHC/CMHCs, inpatient psychiatric providers and foster care agencies. Our objective was to thoroughly examine mobile crisis response and the implications for this modality in the rural/frontier areas of our state.

Work Summary and Findings:

The Legislative Luncheon in November 2022 surfaced feedback from the lawmakers present about constituents reporting difficulties navigating crisis situations including the availability of local psychiatric hospital beds, space at state hospitals and potential gaps when those with a mental illness diagnosis are released from correctional facilities.

The committee planned a presentation from Steve Denny from Four County CCBHC and David Anderson from High Plains CCBHC regarding the development of their crisis services with an emphasis on the building out of the Mobile Crisis services. Feedback from these two individuals led to highlighting some common challenges arising in rural/frontier communities.

- Cost of staffing and delivering services-- questions regarding the billing model; estimates for cost for staffing are not adequately covered by the income from services; using law enforcement officers as a resource can create more overtime.
- Potential volume of crisis calls and how to best staff when there is limited volume in frontier areas that need coverage.
- Staff recruitment -- mobile crisis requires a different mindset; decisions about what level of education is needed; cross training for IDD and MH; observation that CCBHC are at risk of losing staff with higher levels of educational attainment to other settings providing MH services like schools.

- Staff training-- need for “cop culture” training to help MH staff understand LEO mindset; telehealth delivery is enhanced/more successful with specific training on delivery; need for CIT training which is accessible for rural/frontier agencies.
- Community trust-- need to connect to communities in a way that is meaningful.

Subcommittee member, Roger Barnhart, shared his expertise on the Community Health Worker (CHW) model and potential application in the need for unique approaches to crisis mental health work in rural communities.

- It is essential to understand the psychosocial needs of the community and to meet the community where they are;
- Peer support model in R&F communities should consider the importance of shared life experiences and not be exclusive to having and mental health diagnosis;
- Criteria to consider for CHW is similarities in ethnicity, culture, language, etc.;
- Micro-credentialing for “Crisis Mental Health Technician”;
- A drawback to this model is the lack of clarity and flexibility in reimbursement for the CHW model is a challenge.

Potential Training Resources:

- **FarmResponse®** is an On-Demand 3.5-hour continuing education course developed by national experts from the AgriStress Response® Network. AgriSafe’s FarmResponse course provides the full range of competencies necessary to provide appropriate mental healthcare for agricultural producers and their families. https://www.agrisafe.org/courses/farm-response/
- **Down on the Farm: Supporting Farmers in Stressful Times** is a 3-hour workshop that teaches people who live and work in agricultural communities how to recognize and respond when they suspect a farmer or farm family member might need help. It can be offered in-person or online. Down on the Farm was developed by Minnesota Department of Agriculture and the AgCentric Northern Center of Agricultural Excellence at Central Lakes College.
- Tools consistent with the **Zero Suicide** model currently supported by SAMHSA’s award to KDHE e.g. **CSSRS, CALM and Stanley-Brown safety plan** training. Crisis team in Bossman, MT responders are not all mental health professionals but have been trained in the above tools.

Goal 2: Suicide Prevention and Postvention

Work Summary and Findings:

The sub-committee continued involvement with Kansas Suicide Prevention Coalition. Two members of the executive committee are also members of the sub-committee and the executive committee also has representation from the K-State extension office. The intentional inclusion of rural/frontier members is important because behavioral health policy and decision-making generally occurs in the state’s urban centers; however, more than 80% of the State is classified as rural or frontier. Rural and frontier representatives are imperative to strategic planning and implementation given their unique experiences, expertise, and familiarity with local behavioral health resources and barriers.

Through the connections made at the Kansas Suicide Prevention Coalition a training session focused on building cultural competence with Agriculture Sector workers, Land Logic, was delivered to 988 crisis counselors serving the rural/frontier counties in the state. Inclusion of rural/frontier communities and agricultural sector in discussions of culturally competent suicide prevention strategies as identified in the State Suicide Prevention Plan 2021-2025 is essential to reducing the impact of suicide on our R/F counties.

Goal 3: Service Accessibility and Workforce Shortages

The question of service accessibility and workforce development has been closely linked to all discussions about crisis systems throughout the work of the subcommittee this year. Work for the sub-committee centered on staying updated about new BSRB regulations, continued advocacy for telehealth and telephonic services, and examining strategies utilized in Kansas and other states. As with our work on crisis services, members undertook thoughtful discussion to identify trends and challenges currently being experienced by behavioral health providers.

Notable challenges identified by the sub-committee include:

- Western CCBHCs are noting the difficulty of replacing staff who are retiring;
- Competition with other settings like schools that offering employment with benefits like offering summers off;
- Integration of law enforcement into the delivery of crisis response has potential to increase their financial demands i.e. overtime budget increases when officers are “holding the iPad”;
- Lack of parity in reimbursement between in-person and telehealth services (HB 2337).

As telehealth continues to grow as a primary mechanism for addressing low staffing and large geographic areas, the subcommittee spent some time on understanding the kinds of training needed to enhance clinician competence for utilizing telehealth for crisis response. Components identified as having importance included: developing therapeutic relationships virtually, compensating for limited perception over screens, ethical and legal considerations, informed consent especially with regards to patient billing. There are additional factors regarding reimbursement which need to be considered to help to make telehealth sustainable. Telehealth appointments often take longer than in-person appointments, but physicians aren't paid for the extra time. Other staffing costs are medical assistance costs (e.g., virtual rooming, nurse assessments prior to the provider appointment, technical support, scheduling). There are associated technology fees (e.g., internet/broadband, computers, cameras, microphones, peripherals, EHR advancements and patient portals to support telehealth).

Recommendations

Funding Request:

The Rural-Frontier Sub-Committee is committed to ensuring and expanding access to mental health and substance use treatment throughout all rural and frontier regions. The subcommittee commends the agency on identifying an objective to increase access to services across the state, especially in rural and

frontier counties as a part of their strategic objectives. The following recommendations are respectfully submitted for further consideration.

1. Advocate for the expansion of Medicaid to increase reimbursement for all mental health substance use treatment services.
2. Work with the Office of the Governor to propose a comprehensive funding proposal targeted at mental health including line items for technology, training, and workforce expansion.
3. Rural and frontier behavioral healthcare providers would benefit from clear direction about funds being directed to meet the unique needs of these areas of the state and guidance on how to apply for funds from the relevant agency.
4. Engage in education to policy makers, that expanding Medicaid is essential for the delivery of high-quality crisis behavioral health services as Medicaid is one of the only payor sources for these services outside of direct allocation of other funds.
    a. The Sub-Committee encourages KDADS to tailor crisis funding to address the inherent challenges associated with delivering mobile crisis services in low-population density areas.
    b. Additional funds ($2M) to support rural & frontier providers mobile crisis response technology and staffing.
5. Utilize a portion of the $6M appropriated by the legislature for Substance Use Disorder treatment for the uninsured to expand access to assessment and treatment (residential and outpatient) in rural/frontier areas especially in the western parts of the state.
    a. Request additional funding for SUD treatment for uninsured to be targeted to rural/frontier areas in the amount of $3M.
6. Provide leadership in supporting novel strategies for expanding a qualified mental health workforce.
    a. The R/F Subcommittee recommends the speedy identification of processes and policies from the BSRB to expedite the implementation of new license types.
    b. Establish a grant or scholarship program which helps to support behavioral health employers (e.g. CCBHCs, FQHCs, inpatient and residential providers, etc.) in expanding clinical workforce by making educational opportunities available to their existing employees ($400,000).
7. Fund training initiatives that support the delivery of crisis mental health services.
    a. Telehealth training to providers of crisis mental health services. Consider the ECHO model to create a community of learning. ($100,000)
    b. Expansion of training available to address cultural differences between law enforcement and mental health. ($100,000)
    c. Pilot training for auxiliary personnel who may be available to respond to mental health crisis e.g. paramedics, clergy, other volunteers. ($70,000)
    d. Expansion of access to trainings which focus on cultural competence for those working in the agricultural industry. (see recommendations under Goal 1).

8. Advocate for fair reimbursement of telehealth services which helps to ensure that rural/frontier providers can continue to support good access to services while maintaining their need for quality facilities and staff.
9. Include telephone-only tele-behavioral health services in all Kansas geographies that have insufficient broadband access.
10. Include rural and frontier representatives on all state behavioral health initiatives (e.g., Mental Health Modernization, 988 Coalition, Mobile Crisis Initiatives, etc.).
11. Adopt KDHE's Frontier through Urban Continuum definition via partnerships with GBHSPC and other subcommittees by Executive Order.

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. Lack of Urban/Semi-Urban resources, the rural legacy of depopulation, 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. The COVID-19 pandemic has had a global impact on the health and well-being of the general population, and individuals living in rural and frontier areas have fewer resources to mitigate the impact of the pandemic. It is noted that even urban areas have struggled to meet workforce demands to address the increasing need for behavioral health services, which increases competition for available behavioral health professionals. 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.

Although the R/F Subcommittee is not dedicating resources to the adoption of the Rural through Urban Continuum, the Subcommittee continues to go on record in the statewide adoption of this definition that is utilized by the Kansas Department of Health and Environment (KDHE). The Subcommittee is agreeable to partnering with and supporting other organizations/committees that support this goal.

The R/F Subcommittee is glad to announce the incoming FY2024 Chair, Audra Goldsmith, the incoming FY2024 Co-Chair, Ian Cizerle-Brown, and incoming FY2024 Secretary, Amanda Benaway.

Submitted by the GBHPC Rural/Frontier Subcommittee

Monica Kurz, GBHPC Rural/Frontier Subcommittee Chair 2022-2023 term

For more information contact:

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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 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 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*)

"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.

Appendix B

GBHSPC - Rural & Frontier Subcommittee Members

Name	Organization	Email
Amanda Benaway	Saint Frances Ministries	amanda.benaway@st-francis.org
Audra Goldsmith	Stepping Up Kansas Technical Assistance Center	agoldsmith@csg.org
Charles Bartlett	KDADS Liaison	charles.bartlett@kdads.ks.gov
Dale Coleman	Ford County Law Enforcement	dcoleman@fordcounty.net
David Anderson	High Plains Mental Health Center; Behavioral Sciences Regulatory Board	david.anderson@hpmhc.com
Debbie Snapp	Catholic Charities of Southwest KS	dsnapp@catholiccharitiessmks.org
Eric Arganbright*	Statewide Homeless Coalition	earganbright@kshomeless.com
Ian Cizerle-Brown	Four County Mental Health Center	ibrown@fourcounty.com
Lisa Southern	Compass Behavioral Health	lsouthern@compassbh.org
Marshall Lewis	Southwest Guidance Center	mlewis@swgccmhc.org
Mary Jane Dowler	Iroquois Center for Human Development	maryjanedowler@irqcenter.com
Monica Kurz	HeadQuarters Kansas; Prevention Subcommittee	monicak@hqkansas.org
Nicole Tice	Larned State Hospital	nicole.tice@lsh.ks.gov
Roger Barnhart	Roger Barnhart Consulting	rbarnhartconsulting@gmail.com
Sarah Berens	Camber	sberens@cambermh.org
Sarah Feldhausen*	Aetna Better Health of Kansas; Service Members, Veterans and Families and Prevention Subcommittees	ellisS3@aetna.com
Sarah Gideon	Health Innovations Network of Kansas	sgideon@stormontvail.org
Shawna Wright	KU Center for Telemedicine & Telehealth; Kansas State Epidemiological Outcomes Workgroup	swright6@kumc.edu
Sherry White*	High Point Advocacy and Resource Center	sherry@highpointadvocacy.com
Vicki Broz	Compass Behavioral Health	vbroz@compassbh.org

***New Members for FY 2023**

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.

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.