The Future of Rural Behavioral Health

Background

Recent estimates by the Centers for Disease Control and Prevention show that approximately 25% of adults nationwide have a mental illness or diagnosable mental disorder and close to one-half of all U.S. adults will at some point experience at least one mental illness in their lifetime[1]. Another study indicates that "at least 15 million rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric comorbid conditions[2]." Currently, approximately 25% of all adult stays in U.S. hospitals are related to mental health and/or substance abuse disorders. Across the country, behavioral health ranks at or near the top of both hospital and public health community health needs assessments. While recent studies indicate that the prevalence of behavioral health problems is similar in rural and urban areas, a notable exception concerns the incidence of suicide. The Department of Health and Human Services (DHHS) estimates that approximately 20% of rural residents aged 55 and older have a mental disorder and rural communities report significantly higher suicide rates than urban areas for both adults and children[3,4]. In addition, general health status is poorer in rural areas, and rural residents experience higher rates of infant mortality and morbidity[5,6,7]. In this paper, the term "behavioral health" will be used to describe both mental health and substance abuse disorders.

The 4 A's - Availability, Accessibility, Affordability, and Acceptability of Behavioral Health Services

Rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct mental health disparities compared to urban residents. One study concludes that "the mental health needs of rural America are immense, and it is increasingly recognized that the implementation of adequate services in non-metropolitan areas is a critical national health imperative[8]." To build a comprehensive policy framework around rural behavioral health reform, expanding the **availability**, **accessibility**, **affordability**, and **acceptability** of behavioral health services must encompass all major components of a multi-pronged approach:

- **Availability** includes the staffing or service shortages limiting the receipt of services,
- **Accessibility** addresses the knowledge of when and where to obtain services, including coordination of services across sectors of the health and social service system, as well as the travel issues which may be involved,

[1] (Centers for Disease Control and Prevention, 2011)
[2] (Roberts, Battaglia, & Epstein, Frontier ethics: mental health needs and ethical dilemmas in rural communities, 1999)
[3] (Mohatt, Adams, Bradley, & Morris, 2006)
[4] (New Freedom Commission on Mental Health, 2004)
[5] (National Center for Health Statistics, 2001)
[6] (Warner, Monaghan-Geemaert, Battaglia, Brems, Johnson, & Roberts, 2005)
[7] (Thurston-Hicks, Paine, & Hollifield, 1998)
[8] (Roberts, Battaglia, & Epstein, Frontier ethics: mental health needs and ethical dilemmas in rural communities, 1999)

- **Affordability** involves the costs associated with receiving care and availability of benefits/insurance to offer services, and;
- **Acceptability** incorporates the persistent issues related to the negative perception and stigma attached to the need for services[9].

These four factors influence various facets of rural behavioral health care and need to be considered together, as any policy agenda is crafted. It is these variables which "lead rural residents with mental health needs to: enter care later in the course of their disease than do their urban peers; enter care with more serious, persistent and disabling symptoms and require more expensive and intensive treatment response[10]." Any proposed intervention in 1) workforce development, 2) reimbursement and financing mechanisms, 3) integration and communication between health care professionals, and the 4) implementation of technology in the delivery of care must be mindful of all four factors. The unique challenges involving these areas will be discussed along with corresponding policy recommendations.

Workforce Development

Although national data suggests that the prevalence of clinically defined behavioral health problems among the adult population is similar in rural and urban settings[11, 12], the **availability** and **accessibility** of behavioral health services is limited for people living in rural and frontier communities[13]. In particular, psychiatrists are far less likely to practice in a rural area. This can be seen in the marked disparities in the number of practicing psychiatrists between rural and urban areas[14,15]. "Among 1,253 smaller rural counties with populations of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist, and 95 percent lack a child psychiatrist[16,17]." More than 90 percent of all psychologists and psychiatrists and 80 percent of professionals with Masters in Social Work practice exclusively in metropolitan areas[18]. Due to this shortage of behavioral health professionals, primary care caregivers provide a large proportion of behavioral health care in rural America and may lack the training and experience necessary to handle serious behavioral health issues[19,20,21,22,23,24,25].

In many rural areas, patients may need to travel great distances to access behavioral health services[26]. When rural patients are admitted or transferred to an urban facility, distance to the healthcare setting, reluctance to receive care in a far-off and unfamiliar city, and the realization that one's family

[9] (Health Resources and Services Administration, 2011)
[10] (Mohatt, Adams, Bradley, & Morris, 2006)
[11] (Kessler, et al., 1994)
[12] (Kessler, et al., 2005)
[13] (Ricketts, 2000)
[14] (Johnson, Brems, Warner, & Roberts, 2005)
[15] (Baldwin, et al., 2006)
[16] (Gamm, Stone, & Pittman, 2003)
[17] (Holzer, Goldsmith, & Ciarlo, 1998)
[18] (Health Resources and Services Administration)
[19] (Gamm, Stone, & Pittman, 2003)
[20] (Holzer, Goldsmith, & Ciarlo, 1998)
[21] (Rost, Owen, Smith, & Smith, 1998)
[22] (Geller, 1999)
[23] (Lambert, Agger, & Bolda, How do older rural Medicaid beneficiaries with depression access care?, 1998)
[24] (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999)
[25] (Rost, Kirchner, Fortner, & Booth, 2000)
[26] (Roberts, Battaglia, & Epstein, Frontier ethics: mental health needs and ethical dilemmas in rural communities, 1999)

and friends might be less able to travel to provide support can be seen as insurmountable obstacles[27, 28,29]. Obtaining medication from pharmacies also poses challenges due to the limited **availability** of facilities and the travel costs required. For behavioral health providers, maintaining a sustainable patient panel can be prohibitive to rural practice, while isolation and a lack of support can pose challenges to those who do practice in rural areas.

Behavioral health professionals may encounter problems related to the **acceptability** of their services in the rural population. Rural residents may be more likely to make use of informal supports such as neighbors, family, churches, and other community groups and behavioral health professionals trained only in urban settings may be inadequately prepared to understand these rural cultural characteristics[30,31]. Living in a small, isolated rural community where everyone knows each other can heighten the stigma as this may cause those in need to avoid seeking care due to confidentiality concerns. Such stigma can undermine the quality of care as well as the provider-patient relationship[32]. In addition, some people in rural areas may not receive culturally appropriate behavioral health services due to language or cultural barriers[33].

Policy Recommendation

The development and expansion of recruitment and retention enhancements, such as loan repayments, bonuses, and other perks, could serve to attract behavioral health care professionals to rural areas. Existing programs aimed at bolstering the rural health workforce should focus more resources on attracting, training, recruiting, and retaining behavioral health providers. For example, financial incentive programs such as the National Health Service Corps, State Loan Repayment Programs, or state-run Loan Forgiveness programs could fund a greater percentage of behavioral health providers. Salary or payment bonuses for behavioral health professionals, based on a well-defined shortage designation program such as the Mental Health HPSAs, might also attract new providers. Programs must also focus on preventing burnout by minimizing the effects of professional isolation and providing both professional and personal supports to behavioral health providers.

An increased emphasis on rural practice in general during professional training could reduce barriers to providing quality mental health care in rural settings, including the number of behavioral health professionals choosing to practice in rural communities and the cultural competency of those professionals[34,35,36]. Training for all behavioral health care professionals should include at least an awareness of behavioral health issues prevalent in rural areas and a thorough understanding of the resources that are available to patients. Similarly, other rural community residents, such as school counselors and members of the clergy, should receive educational material and information from Medicare, Medicaid, and private insurance companies concerning available resources for behavioral health and substance abuse issues. Programs like Mental Health First Aid, which are becoming popular

[27] (Roberts, Battaglia, & Epstein, Frontier ethics: mental health needs and ethical dilemmas in rural communities, 1999)
[28] (Roberts, Battaglia, Smithpeter, & Epstein, 1999)
[29] (Bushy, 1994)
[30] (Bushy, 1994)
[31] (Murry, Heflinger, Suiter, & Brody, 2011)
[32] (Roberts, Battaglia, & Epstein, Frontier ethics: mental health needs and ethical dilemmas in rural communities, 1999)
[33] (Primm, Vasquez, Mays, Sammons-Posey, McKnight-Eily, & Presley-Cantrell, 2010)
[34] (Gamm, Stone, & Pittman, 2003)
[35] (Geller, 1999)
[36] (Lambert & Agger, Access of rural AFDC Medicaid beneficiaries to mental health services, 1995)

due to the minimal costs associated with and resources required for the program, may be useful in providing basic training to providers and other community stakeholders, and in reducing stigma in the community. Additionally, the promotion of programs that value the use of bilingual professionals such as bilingual therapists should be advanced.

Strategies are needed to establish relationships between health professional schools and Critical Access Hospitals (CAH) to create rural behavioral health practice training sites. Professional schools responsible for training behavioral health students should form relationships with CAH and Community Health Centers (CHC) to develop mentoring relationships and practice rotation programs that include a rurally-based training component. This method has been proven to help establish a comfort level with rural practice among health professionals. Mentoring programs also give students access to seasoned professionals who have practiced in a rural area for an extended period of time.

Paraprofessionals and emerging professions can also augment the behavioral health workforce in rural areas. For example, Behavioral Health Aides (BHAs) can be utilized as care coordinators, case managers, and support workers[37]. Various BHA models exist throughout the states. Training and supervision programs for BHAs should be made available via distance learning and off-site supervision. Community Health Workers (CHWs) can bridge cultural gaps between behavioral health providers and patients from minority communities. Also, the emerging field of Peer Support Specialists can improve outcomes and reduce the stigma associated with behavioral health care[38]. Peer Support Specialists themselves have personal experiences with mental illnesses and can offer invaluable perspective to patients in the most acute settings[39].

Reimbursement and Financing

The payers of behavioral health include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), states, counties, and private insurance[40]. Medicaid operates as the largest payer of behavioral health services. Patients in rural areas are more likely to have their services paid for by public insurance and rural patients with serious mental illness (SMI) are more likely to use self-pay than similar individuals in urban areas[41]. The Affordable Care Act (ACA) requires plans to cover certain preventive behavioral health services at no cost and prohibits denial of insurance for pre-existing conditions. Increased coverage of behavioral health services directly influences the **availability**, **accessibility**, and **affordability** of these services. However, approximately half of all states rejected the expansion of Medicaid under the ACA. Consequently, certain states will not receive an expansion of federal funds that could finance behavioral health programs that could serve rural areas. And as geography is one of the factors that insurance companies use to determine premiums, health insurance rates in certain rural areas may exceed those of urban areas due to underlying costs present in rural areas.

Uncertainty in the policy/reimbursement landscape, increasing restrictions, lack of

[37] (van Hecke, 2012)
[38] (Mental Health Consumer/Survivor Network of Minnesota)
[39] (Minnesota Department of Human Services)
[40] (U.S. Department of Health and Human Services, 2010)
[41] (Harman, Dong, Xu, Ewigman, & Fortney, 2010)

coordination, and complexity often plagues the funding mechanisms for the provision of sustainable rural behavioral health care[42]. Funding systems suffer from inflexibility and fragmentation leading to increased costs or lower reimbursement rates for providers and reduced **accessibility** for patients. Low volume in remote areas increases the difficulty in maintaining an adequate behavioral health safety net. While the 2008 passage of the Mental Health Parity and Addiction Equity Act requires doctors and insurers to treat and cover mental illness the same as physical illness, there appears to be a general lack of enforcement at this time.

Policy Recommendation

Public policy should incent, and where appropriate, require insurance companies to offer policies that include affordable behavioral health services, and states need to provide subsidies to assist policyholders with the personal **affordability** of behavioral health coverage. ACO models offer the opportunity for payers and providers to provide quality care, and reap savings from reduced readmissions and better population health outcomes. Financial assistance remains of critical importance in rural areas to counteract the adverse economic effects of high poverty rates. It is also crucial that public payer reimbursement rates for behavioral health professionals provide a sustainable incentive for professionals to remain in rural areas.

To address behavioral health care funding issues that affect **affordability** and **accessibility**, cost-based approaches to funding need to be implemented. In 2014, Congress passed the Protecting Access to Medicare Act, a provision which will select eight states to participate in a pilot program to create Certified Community Behavioral Health Clinics, which will offer a broad range of treatment services in coordination with primary care providers. As reimbursement for this new model will be cost-based, rural models will more likely achieve sustainability, particularly in partnership with Critical Access Hospitals and Rural Health Clinics. Close monitoring of the eight pilot states can help promote the rural expansion of this innovative approach.

Greater enhancements for Rural Health Clinics to provide behavioral health services would also increase access. Rural Health Clinics currently receive an enhanced Medicaid rate for behavioral health services, but it is not enough to for many clinics to start delivering services, especially for smaller clinics in isolated areas.

The ACA encourages financing structures that do not depend on fee-based reimbursement; instead, these structures provide payment to manage a population in an efficient way. The hope and expectation is that access to care and the patient experience will be maximized, costs will be kept down, and that the health needs of the population will be met[43]. Accountable Care Organization (ACO) models of shared risk/shared savings are being tested across the country and their effectiveness in managing costs will need to be monitored and analyzed. As ACO models expand and broaden their scope into rural networks, providing services to address behavioral health needs to be encouraged – and where appropriate, required – to participate in the development of these shared savings arrangements.

[42] (Sawyer, Gale, & Lambert, 2006)
[43] (Lambert & Agger, Access of rural AFDC Medicaid beneficiaries to mental health services, 1995)

Integration

The SAMHSA-HRSA Center for Integrated Health Solutions defines integrated care as "the systematic coordination of general and behavioral healthcare," which encompasses services for behavioral health issues, substance abuse, and primary care[44]. Integrating primary and behavioral health care positively affects the **availability**, **accessibility**, **affordability**, and **acceptability** of behavioral health care for people in rural areas. When behavioral health services are provided in the same health care setting as primary care services, people are more likely to take advantage of the behavioral health services. Stigma is greatly reduced when the behavioral health professional meets with a patient in the same setting as the primary care provider[45]. The Affordable Care Act, along with Medicaid expansions, offers the opportunity to promote new integration programs such as co-location of physical health and behavioral services for collaborative care[46]. The integration of services would require physician training, proper screening tools, appropriate referrals and co-location of services.

Policy Recommendation

Resources should be provided to encourage integrated care and to increase the number of behavioral health providers, such as licensed clinical social workers, licensed clinical counselors, and licensed psychologists, practicing in primary care settings. There is a need for well-developed referral mechanisms to specialists, inpatient behavioral service providers, and inpatient substance abuse providers in other communities with referrals back to local community outpatient providers. The referral network should include "community leaders and other health care professionals such as nurse practitioners, physician assistants, pharmacists, social workers, and marriage and family therapists[47]." Protocols should be established for discharge planning and care coordination for the transition of the patient back into the community and back into the school system for children and youth. These efforts will support the **availability** and **accessibility** of behavioral health services.

Additionally, a national effort to compile rural hospital and public health needs assessments should be funded and undertaken. A small number states have compiled this information[48], which highlights the consistent need for behavioral health services in rural areas. A nation-wide effort will help crystallize the need for attention and policy change regarding behavioral health services in rural areas.

Technology

The **availability**, **affordability**, and **acceptability** of behavioral health coverage can be enhanced through telebehavioral health, which is defined as employing technology such as two-way video conferencing capacity to provide services[49]. This interactive technology has proven to be an effective method of delivering behavioral health consults and follow-up treatment, thereby increasing the **availability** and **accessibility** of behavioral health care. By taking advantage of recent advances in computer technology and high-speed telecommunications, communities have been able to help close the distance that exists between rural areas and the urban hospitals and large teaching facilities where

[44] (SAMHSA-HRSA)
[45] (Riding-Malon & Werth, 2014)
[46] (Mechanic, 2012)
[47] (Riding-Malon & Werth, 2014)
[48] (Becker, 2013)
[49] (Health Resources and Services Administration, 2013)

highly-specialized care is being rendered. Telebehavioral health furthers **acceptability** by potentially reducing perceived stigma and embarrassment created by physical contact with a behavior health professional. Telebehavioral health sessions allow the testing and observation of behavioral disorders almost as effectively as a face-to-face consultation[50]. The most common services provided by telemental health programs are medication management, initial diagnostic evaluation, psychotherapy, and crisis stabilization.

In situations where travel distances present insurmountable challenges, telebehavioral health offers **affordability** in its approach. People in rural and underserved communities frequently face limited access to behavioral health care providers due to the lengthy travel requirements for obtaining services. The ability to travel to services and to pay for those services if accessed is a significant barrier to rural persons. Public transportation is often not an option to rural consumers of mental health services[51]. Addressing these concerns includes promoting the **availability** of behavioral health coverage with the use of telebehavioral health delivery methods. Through the use of technology, individual, family and group consultation and care may be offered in a variety of settings.

Telebehavioral health serves as a way to increase the **availability** of behavioral health care providers because it can satisfy professional needs such as peer consultation and collaboration, increase access to academic input and ongoing education and training opportunities, and strengthen confidence and skills in treating patients[52]. The use of two-way video is also an acceptable method for addressing substance abuse concerns. Studies indicate that telebehavioral health appears to be viewed as culturally acceptable in rural settings, especially when local members of the community assist with the operation and function as liaisons with the remote professionals[53].

Policy Recommendation

Due to the ease of deployment and the time, effort, and expense that could potentially be saved by patients and providers, promoting the increased use of telebehavioral health can improve the **affordability** of care and help alleviate the access to care burden that many rural areas face. Such promotion must include the following policy recommendations:

1) Expanded reimbursement for the remote provision of care.

To reflect the growing evidence base and consumer acceptance, the reimbursement arrangement for the provision of care via telebehavioral health needs to be restructured and broadened to overcome outdated disallowances and limitations including geographical constraints. Such funding and reimbursement reform will benefit patients receiving care and appropriately compensate providers for the delivery of services. Currently, 39 states have some form of specific Medicaid coverage and reimbursement for telemental health.

- Add Medicaid reimbursement for expanded case management. Reimburse screenings for depression, chemical dependency and anxiety at the same level as the primary care setting. All

[50] (Health Resources and Services Administration, 2013)
[51] (Mohatt, Adams, Bradley, & Morris, 2006)
[52] (Benavides-Vaello, Strode, & Sheeran, 2013)
[53] (Benavides-Vaello, Strode, & Sheeran, 2013)

states could expand their telemental health coverage through achieving full parity with in-person mental health services.
- Increase the Medicare originating site fee for behavioral health services. This would allow more sites to sustain telemedicine services.
- Fund partial hospitalization services. This intermediate level of care, where the patient resides at home and commutes to a care facility during the day, is very effective and provided at a lower cost.
- Allow for store and forward reimbursement where a social worker starts with an assessment and "stores" the information for a psychiatrist to review and then make recommendations for treatment, which allows care to remain at the local level.
- Allow for reimbursement of group behavioral health sessions, reducing the need for the patient to travel to larger cities for those meetings.

The Medicare Telehealth Parity Act of 2014 was introduced in July 2014 and aims to expand reimbursement regarding qualified technologies and provider types – this bill will need to be monitored as, at the date of this paper, it is being considered by the House Energy and Commerce Subcommittee on Health. However, the bill's introduction indicates prioritization of reimbursement mechanisms for telehealth services.

2.) Approve state credentialing and licensure compacts improving access to care beyond the state borders.

Arizona and New Mexico permit out-of-state physicians to deliver services with a patient's approval while Nevada and Utah allow out-of-state physicians to avoid state licensure regulations within a limited range of circumstances[54].

- Allow for specialized telemedicine licenses at the state level with the ability to practice across the state lines

3.) Establish online security and safety policies for virtual visits.

Regarding the **acceptability** of this technology, the development of its use as an effective means for addressing substance abuse should be continued. Similarly, additional research is needed to advance culturally appropriate evidence-based practices that achieve acceptance in rural communities.

4.) Enhance policies and funding for rural broadband.

In an effort to increase the **availability** and **accessibility** of telebehavioral health in rural areas, grant programs should advance increased connectivity and cost effective options. Mobile access to behavioral health services reduces the barrier to entry and effectively reduces the investments needed in today's brick and mortar facilities, potentially saving millions of dollars in building expansions and renovations.

[54] (National Conference of State Legislatures, 2011)

Summary

The 2002 New Freedom Commission on Mental Health was convened to investigate the problems and possible solutions in the current mental and behavioral health system. The Commission reported that the vast majority of Americans living in underserved, rural, and remote areas experience disparities in behavioral health services compared with their urban counterparts. The Commission concluded that "...rural issues are often misunderstood, minimized, and not considered in forming national mental health policy. Too often, policies and practices developed for metropolitan areas are erroneously assumed to apply to rural areas[55]."

State and national policy makers cannot continue to operate under a consistent and pervasive misunderstanding of rural realities regarding access to behavioral health care. The themes of rural behavioral health have remained constant over the past 20+ years. Mounting needs, a lack of available behavioral health providers, and restricted/limited resources strain existing services and limit access to rural residents in need[56]. Only policies aimed at resolving the panoply of issues that have resulted in these long-standing themes can make any headway toward resolving them.

Attracting, broadening, and training the workforce, addressing reimbursement and financing issues with appropriate compensation for professional behavioral health care providers and affordable options for patients, fostering the integration of health care services with care coordination and referral networks, being mindful of the changing cultural landscape in rural areas, and utilizing telebehavioral health will all play essential roles in reducing health disparities in rural communities. Leadership is critically needed to advance comprehensive policies at every level that ensure the **availability**, **accessibility**, **affordability**, and **acceptability** of quality behavioral health services for America's rural residents.

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[55] (President's New Freedom Commission on Mental Health, 2003)
[56] (Sawyer, Gale, & Lambert, 2006)

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Approved by the Rural Health Congress in February 2015.

Authors: Will Wilson
Angela Bangs
Tammy Hatting