RURAL HEALTH NETWORK DEVELOPMENT PROGRAM: LANDSCAPE ANALYSIS

Behavioral Health in Rural Communities 2020

Table of Contents

Background

The Rural Health Network Development (RHND) program is designed to support integrated rural health care networks that combine the functions of the network participants in order to address the health care needs of a targeted rural community. Program participants address a range of aims within their network, including achieving efficiencies within the healthcare system, expanding access and coordinating and improving the quality of essential health care service, and strengthening the rural health care system as a whole. High priority is placed on innovative solutions to local health care needs and community-based identification of needed supports. Lastly, the program is an opportunity for rural health networks to set priority around mental health, substance use disorders, and value-based care.

The goals for the RHND program are:

- to improve access and quality of health care in rural areas through sustainable health care programs created as a result of network collaboration
- prepare rural health networks for the transition to value-based payment and population health management
- demonstrate improved health outcomes and community impact
- promote the sustainability of rural health networks through the creation of diverse products and services
- utilize and/or adapt an evidence-based or promising practice model(s) in the delivery of health care services.

Networks include traditional and non-traditional health care partners who have a proven track record of collaboration together. This will be especially crucial in upcoming years as health system reform and potential payment models leans towards an incentive structure that values collaboration across diverse clinical and community sectors at a population health level. By working as a network as opposed to individual entities, rural health care delivery will be strengthened by the collaboration, and each individual organization in the network will be able to expand capacity.

Activities undertaken by the RHND grantees often include telehealth, health information technology, care coordination and integration, workforce training, health care enrollment, health and wellness, and behavioral health. This landscape analysis will focus on behavioral health interventions and programming in rural health care settings, highlight emerging behavioral health themes, areas of behavioral health innovation, and provide examples of successful rural behavioral health programs. Additionally, this analysis will highlight successful community engagement and networking models as well as provide resources for further information and implementation.

Importance of Behavioral Health in Rural Settings

Studies have shown that addressing behavioral health in rural communities is an integral part of improving the overall health of rural populations. According to findings from the Rural Health Policy Institute, there are three core factors that influence behavioral health issues in rural areas—the prevalence of behavioral health disorders, access to care, and social factors that affect access and prevalence. Access to care is influenced by factors such as stigma, affordability, acceptability, availability, and accessibility (Gale, Janis, Coburn, & Rochford, 2019). Social factors include geography, culture, socioeconomics, and high-risk populations (Gale et al, 2019).

The prevalence of certain behavioral health diagnoses such as suicidality and depression tend to be higher in rural areas (Ivey-Stephenson, Crosby, Jack, Haileyesus, Kresnow-Sedacca, 2017). Studies have found that these higher rates are in part due to limited access to behavioral health services, high levels of substance use, and reduced access to timely health care and emergency medical services (Clay, 2014). Rural communities have been especially vulnerable to opioid and other substance use disorders due to a lack of recovery supports (e.g., recovery community centers or recovery housing) and supportive infrastructure (e.g., transportation or employment). Because of the lack of services, many rurally-based individuals must permanently migrate to large metro areas to start and sustain long-term recovery. This in turn drains recovery capital from rural communities. Additionally, rural areas are challenged by a limited housing stock, frequent substandard housing conditions, and limited housing development capacity and resources, leading to housing instability and homelessness. Researchers widely acknowledge that housing instability is a social determinant of health and well-being (Sandel et al., 2018), predicting poor health and behavioral outcomes (Fowler, 2015; Tsai, 2015). Addressing housing instability is challenging because it requires decent affordable housing as well as recovery-oriented supports and services, both of which are limited in rural areas.

Socioeconomic factors also play a role in behavioral health outcomes in rural areas. Higher proportions of the population below the poverty level, higher levels of unemployment, and higher rates of under-insured or uninsured residents all lead to poorer behavioral health outcomes (Allen, Balfour, Bell, & Marmot, 2014; Newkirk & Damico, 2014). This is particularly true for at-risk populations such as women, children and adolescents, veterans, and minority populations (Burton, Lichter, Baker, & Eason, 2013; Robinson, Holbrook, Bitsko, Hartwig, et al, 2017; Olenick, Flowers, Diaz, 2015; James, et al, 2017). According to the 2017 National Survey on Drug Use and Health, 19.1% (6.8 million people) of residents 18 years and older in non-metropolitan areas experience some type of behavioral health disorder.

For rural areas to effectively address behavioral health diagnoses, they need to develop a health care infrastructure that is often not available (Gale, et al, 2019). This comprehensive model is one that will need to address physical health, behavioral health, and community supports. This is why programs like the Rural Health Network Development program are necessary—they are tasked with mobilizing networks around important rural health issues.

Emerging Themes in Rural Behavioral Health Interventions

Behavioral health has increasingly become a focus of rural health systems and communities. As a result, those health systems and communities often develop community-focused interventions. There are a number of emerging trends in how rural health systems and networks are implementing behavioral health interventions. These trends vary across health systems and networks, with the setting of the intervention often determining the implementation strategy. This analysis will review the themes of integration of behavioral health practitioners onto primary care teams, telehealth, and creating robust prevention and recovery supports in addition to treatment programs.

Integration of behavioral health practitioners onto primary care teams

In rural areas, the primary care physician is often the first, and maybe only, provider of depression treatment for patients (Swinton, Robinson, & Bischoff, 2009). Rural areas tend to have fewer providers in general, which often leaves rural communities without a full array of behavioral health services. As a result, there are many programs that focus on integrating behavioral health practitioners into primary

care teams. This integration model puts psychologists, counselors, social workers, and other behavioral health experts into the primary care and acute settings where patients are most likely to seek help. Implementation models vary from coordinated to co-located and fully integrated, team-based models. Some of the models that have been used include using a shared space, setting up contractual agreements between behavioral health providers and primary care teams, developing employment arrangements where a behavioral health specialist is present on the job site, and setting up referral agreements between the primary care physician and behavioral health specialists (Cerimele, Katon, Sharma, & Sederer, 2012; Collins, Hewson, Munger, & Wade, 2010; Correll, Cantrell, & Dalton, 2011; Crowley, Kirschner, & Moyer, 2016; Guerrero, Takesue, Medeiros, Duran, et al, 2017).

To assist providers in assessing and respond to a person's integrated care needs, SAMHSA's Four Quadrant Clinical Integration Model (Mauer, 2006) provides a conceptual framework for assessing severity. Depending on a person's mental health, substance use, and/or primary care concerns and the severity of these issues, the model guides practitioners to develop a person-centered, responsive, integrated, team-based treatment and recovery plan. Different quadrants represent different configurations of team members, team leads, and service settings. Integration can be even more comprehensive—an initiative authorized by the Affordable Care Act called Health Homes supports the integration of primary, acute, behavioral health, and long-term services and supports for Medicaid patients with chronic conditions (Burgess & Coburn, 2016).

Integration of behavioral health and primary care often includes universal screening of all primary care patients (Burgess & Coburn, 2016). Under these integration models, primary care staff screen for behavioral health disorders and make the necessary referrals through either a cold referral or a warm hand-off. This type of integration typically works best for less complex behavioral health disorders like depression and will need more research into how it could work for more complex disorders (Gale et al, 2019). The evidence-based approach of Screening, Brief Intervention, and Referral to Treatment (SBIRT) framework delivers universal screening, intervention, and treatment services for individuals with or at risk of substance use disorder. Using SBIRT, a person is screened by a health care professional in any health care setting (urgent care, primary care, student health center) using standardized, validated screening tools. Screening is followed by positive reinforcement or a brief (5-15 minutes) motivational conversation about reducing or stopping use. If indicated, a provider will issue a referral for further assessment or treatment.

Emerging innovations in SBIRT include screening that incorporates mental health risk factors including childhood trauma (Topitzes et al., 2017), as well as SBIRT adaptations that are developmentally appropriate for youth and young adults, and SBIRT delivery by peers with lived experience or through computer-based platforms (Paquette et al., 2019). This adaptable, universal screening model has great value in rural communities where access to care may be limited. For example, the Vermont Department of Health received a grant from the Substance Abuse and Mental Health Services Administration to train health practitioners on SBIRT—between 2012 and 2015, they trained 325 practitioners and screened 34,000 individuals in medical settings (Burgess & Coburn, 2016).

Integrated approach to identify and respond to behavioral health concerns have the potential to provide a high level of care for patients with behavioral health diagnoses and help prevent unnecessary emergency room visits. A study looking at the utilization of emergency departments for behavioral disorders proposes that increasing the availability of behavioral health professionals, either onsite or

through a telehealth program in rural areas can help reduce emergency room visits (Wani, Watanabe-Galloway, Tak, et al, 2020). Increasingly, peer support professionals are being integrated into emergency departments to address people experiencing an overdose or mental health crisis. Often, peers have the time and skills to engage someone more effectively than a physician or other clinician, drawing on their personal lived experience. Other integration models use patient or peer navigators to help patients with behavioral health issues access services.

Various opioid response efforts have yielded innovations that reduce barriers to behavioral health care and could be replicated for other behavioral health concerns. For example, the Office-based Opioid Treatment (OBOT) model delivers addiction treatment in a primary care environment. Established in conjunction with the Drug Addiction Treatment Act of 2000 (DATA 2000), the law enables physicians to receive training and a waiver to prescribe specific medications to treat opioid use disorder (OUD) from their individual practice locations. Previously, OUD patients would primarily access evidence-based agonist therapy for OUD through federally regulated methadone programs that were sparsely located and often required patients to visit daily to receive care. The OBOT model has significantly increased access to buprenorphine and naltrexone medications and experienced a boost with Comprehensive Addiction and Recovery Action of 2016 (CARA), which gave additional permission to other healthcare professionals, including nurse practitioners and physician assistants, to prescribe OUD medications (ASAM, 2018)

Integration in Action: Program Examples

One example of successful behavioral health integration is the **Cherokee Health Systems Integrated Model.** This program serves rural communities in Tennessee by embedding behavioral health consultants into primary care teams. The primary care team screens all patients for behavioral health disorders, mood disorders, and substance use—anyone who screens positive is referred to the behavioral health consultant (usually a psychologist or a clinical social worker). Patients also have access to a psychiatrist if needed. Treatment planning and delivery is co-managed by the behavioral consultant and the primary care contact in consultation with the individual receiving care, and services are coordinated through the use of shared electronic medical records.

The **Behavioral Health Services of the Shenandoah Valley Medical System** is another example of behavioral health integration. This program co-locates behavioral health care within a Federally Qualified Health Center (FQHC) that provides primary care services in West Virginia. All individuals are screened annually for behavioral health issues and can receive an immediate, onsite behavioral health consultation if needed. If a person requires longer term support, they can continue treatment at the same location. The primary care and behavioral health care providers communicate through team meetings and the electronic medical records.

More than 30 years ago, advocates for people experiencing homelessness launched **Health Care for the Homeless**, an integrated model of care where a person's needs, preferences, and wishes are central to care planning and delivery. The essential elements of the Health Care for the Homeless model include 1) outreach and engagement; 2) community collaborations to address social determinants of health; 3) intensive case management (small caseloads with medium to high intensity contact); 4) respite care; and 5) patient-driven care (Boyer et al, 2018). Recognizing social determinants of health such as transportation and housing as priority needs and helping to address those needs along with providing behavioral and primary care leads to better overall health care compliance. Unique to this model are

agreements established between an individual and their care provider. The agreement explores, *What do you need from us? What do we need from you to make this work?.* These agreements share decision making and reduce common power differentials between patient and provider. This model utilizes a trauma-informed and multidisciplinary approach to care delivery (Boyer et al, 2018).

Behavioral health integration is not without its challenges. Reimbursement can be difficult since behavioral health is often billed differently from primary care, and providers often cannot bill for every behavioral health service provided. Buy-in from both primary care and behavioral health providers is crucial for integration but not always possible. Even when there is buy-in, barriers related to stigma, a lack of treatment and recovery support resources, and electronic records and other logistical and administrative challenges can be substantial. Facilitating multidisciplinary collaboration and sharing knowledge across disciplines also takes times and resources. However, building a network in the community and establishing shared goals for population health can be helpful to achieve integration.

Telehealth

Telehealth is one of the most widely recommended solutions for bringing behavioral health services into rural health clinics (Griffiths & Christensen, 2007). Rapidly expanding telehealth options allow patients in rural and remote areas to connect with specialists that they may otherwise not have access to and to expand access to diagnostic, monitoring, and therapeutic care (Goodridge & Marciniuk, 2016). There are different models for telehealth delivery—it can include remote monitoring, remote consultations, remote rehabilitation, and telepharmacy (Goodridge & Marciniuk, 2016). Telehealth has been shown to be an acceptable solution for rural areas—studies have shown that patients are open to the technology and connecting with providers through telehealth programs (Swinton, Robinson, & Bischoff, 2009; Myers, 2019).

A growing area of research in telehealth is focused on defining the factors that are necessary for a successful telehealth program. A study by Swinton, et al that looked at acceptability of behavioral health telehealth interventions found that patients were concerned that professional and therapeutic relationships would be hard to maintain virtually (2009). Patients reported that for telehealth to be effective at treating behavioral health disorders such as depression, it is important that the therapeutic relationship between the provider and the patient be preserved and maintained. This can be done by addressing the patient-provider relationship from the outset and developing a collaborative care environment that provides accessibility to and communication with a provider.

Another study by Hasselberg (2020) showed that there are numerous hurdles that providers will need to overcome in adopting digital health care. The main hurdles identified through the study were provider resistance, lack of reimbursement parity, restrictive credentialing, and overregulation at both the state and federal levels. Other studies have suggested that telehealth diffusion will require changes in professional training and care delivery models (Myers 2019). Lastly, Gale et al (2019) identified coverage and reimbursement policies, cross-state professional licensure issues, practice regulations, inadequate broadband access, workforce, issues related to the exchange and security of patient information as potential barriers to expanding telehealth in the behavioral health space. However, when these challenges are addressed, telehealth can be a powerful tool for addressing rural behavioral health needs.

Telehealth in Action: Program Examples

The **Wyoming Trauma Telehealth Treatment Clinic** provides domestic violence and sexual assault survivors with no-cost therapy services using a telehealth platform. Using secure, encrypted videoconferencing technology, survivors are connected to psychology doctoral students from the University of Wyoming Psychology Department. Participating students have been trained in trauma intervention theory and are supervised by a doctoral-level psychologist. The program is relatively low-cost, needing only the initial purchase of equipment and funding for therapists.

Another effective telehealth program is the **Madison Outreach and Services through Telehealth (MOST) Network.** Concerned about the level of depression in the Brazos Valley in Madison County, Texas, the Center for Community Health Development came together in 2011 to identify local organizations that could help implement mental health and substance use disorder prevention and treatment services. The MOST network is focused on finding a way to link the behavioral and mental health services in Texas' urban communities to rural residents. They were able to successfully implement a telehealth model that involves free telephone or tele-video counseling with doctoral-level psychology students from Texas A&M in College Station. Patients in rural areas are able to connect with counselors either by phone or video.

A final example of a successful telehealth program is the **South Carolina Department of Mental Health's Emergency Department Telepsychiatry Consultation Program**. The program arose out of a shortage of mental health professionals in rural South Carolina, which resulted in patients going to the emergency room when they were in need of psychiatric care. The South Carolina Department of Mental Health (SCDMH) partnered with The Duke Endowment to create a program that allows rural emergency departments to reach a psychiatrist to assess a patient via telehealth. The SCDMH psychiatrist is able to provide a diagnosis and recommend a course of treatment to the patient's physician, who can then follow-up on the treatment. The psychiatrist can also provide a referral to the nearest community mental health center for follow-up care.

Creating robust prevention and recovery service delivery programs in addition to treatment programs

Behavioral health disorders have the ability to negatively impact a person's life and ability to function. When communities are able to develop comprehensive behavioral health service systems that address the spectrum of prevention, treatment, and recovery from behavioral health disorders, individuals and families are able to thrive (Gale et al, 2019). Evidence-based prevention strategies are low-cost and minimize the eventual cost of behavioral health disorders (Gale et al, 2019; UNODC, 2017; Health Foundation of Greater Cincinnati, 2010; Kogan et al, 2016; Leitjen et al, 2017). Examples of effective prevention program strategies that are appropriate for rural communities are school-based social learning programs aimed at preventing behavioral health disorders, community-based parenting programs, and needle/syringe exchange programs that promote harm reduction and engagement in services (Gale et al, 2019).

At the same time, communities need to have access to recovery programs that serve their members. These programs are designed to help individuals with a behavioral health condition to live independently, purposefully, and healthfully (Gale et al, 2019). Recovery programs take many forms and represent multiple pathways—self-help and mutual aid groups, peer support programs, recovery

support services including housing, education, and employment, and the development of peer-run and recovery community organizations (Gale et al, 2019; Laudet & Humphreys, 2013; Markowitz 2015; SAMHSA, 2010). Additionally, many youth and adults are finding recovery support through online recovery support groups, radio shows, texting and app-based supports, and other outlets that are positive, pro-social, safe, supportive, and alcohol -and drug-free. Together with peers or clinical providers, individuals can also engage in Wellness Recovery Action Planning (WRAP), Illness Management and Recovery, and other modes of active recovery planning and self-monitoring. Educating and supporting family members is essential to both prevention and recovery, through psychoeducation, peer-run and family-run support groups and coaching roles, and advocacy opportunities. In addition to learning about how to help loved ones in recovery, family members are also the first line of support when clinicians are not available. Successful prevention and recovery programs are adapted to the unique characteristics and challenges of the rural community they are intended to serve (Gale et al, 2019).

Nationally, most states have adopted peer-delivered recovery support services models to incorporate people with lived experience of mental illness or substance use disorder into the behavioral health care continuum (Bassuk, Hanson, Greene, Richard & Laudet, 2016). There are peer support programs for individuals of all ages seeking services, including specialized youth/young adult and older adult programs, as well as programs for family members and caregivers. In many cases, states offer a certification option to combine practical knowledge and skills in areas such as WRAP, crisis intervention, trauma-informed care, stages of change ,and motivational interviewing along with the authentic personal experiences peers bring to their roles when assisting others seeking treatment and recovery.

Trained and certified peer recovery support services can be accessed in rural areas through telephonic help lines, health clinics, recovery residences, hospital emergency departments, first responders, community centers, faith-based organizations, independent recovery support groups, psychiatric day treatment centers and other key access points for health care. People engaged in peer support have shown decreased use of hospitalization and inpatient services and increased social functioning, feelings of hope and overall engagement in prescribed treatment (SAMHSA, 2017). In addition to supporting an individual's pathway to recovery, peers often function as "resource navigators" and connect individuals to other needed services such as legal assistance, public benefits, and housing support that can provide stability in other aspects of a person's life and increase their ability to continue with overall self-care.

Peers can also be included as stakeholders to give voice to the needs of people with mental illness or substance use disorder when local and state departments of mental health and substance use services or hospital administrators are enacting policies and procedures for service delivery. Their inclusion with other decision makers helps reduce stigma associated with mental illness and substance use disorder. When available behavioral healthcare services are more reflective of the target population's needs, individuals may be more likely to seek and sustain treatment and recovery.

Community Health Workers (CHWs) are similar to peer support specialists in that they play a bridging role between patients, health care systems, and the community and could be a valuable resource to address behavioral health concerns in rural areas (National Rural Health Association, 2017). Unlike peers, CHWs are not necessarily people experiencing similar behavioral health conditions or socioeconomic struggles as they people they serve. Rather, they are members of the communities they support, and these communities can be geographic locations as well as cultural groups or at-risk populations. CHWs improve the community's health knowledge and self-sufficiency through outreach,

community education, informal counseling, social support and advocacy delivered to individuals and as well other providers and organizations. Services are often delivered outside of traditional healthcare settings, including at health fairs, workplaces, schools and universities, and through home visits. Many states have seen improvements in health outcomes as well as socioeconomic factors, which have been attributed to contributions from CHWs. Training programs vary for the role and are based on the needs within the states and geographic areas being served

Prevention and Recovery in Action: Program Examples

The **4P's Plus Pregnancy Support Project** in northern California is an example of a successful prevention program. Organized by the Lake County Tribal Health Consortium and several local agencies who serve pregnant native American women, the program is designed to provide drug prevention services to women who are at-risk for substance use disorder. The program offers substance use screening throughout the pregnancy, depression and domestic violence/intimate partner violence services, prenatal care connections, and parenting classes and groups.

The **Addiction Recovery Mobile Outreach Team (ARMOT)** in Pennsylvania is an example of a successful recovery program being used in a rural community. ARMOT uses a comprehensive recovery model, providing case management and recovery support services to individuals with substance use disorders while providing education and support to rural hospital staff, patients, and family. Hospital staff screen patients for substance use disorder and make referrals when appropriate. ARMOT deploys a mobile case manager who starts working with a patient at bedside and helps to coordinate treatment. Patients also meet with a Certified Recovery Specialist who connects patients to community support and shares lived experiences.

Innovations in the Rural Behavioral Health Field

The challenges of behavioral health interventions in a rural setting are well documented. For those reasons, innovation is crucial when developing and implementing interventions. Rural communities are finding unique and innovative ways to address behavioral issues such as the opioid crisis, a shortage of behavioral health professionals in rural areas, and a need for early intervention in at-risk populations. Selected examples are summarized below.

Partnerships with Law Enforcement

Burgess and Coburn (2016) identified partnerships with law enforcement as a crucial innovation for rural areas in light of the growing opioid epidemic. Rather than place individuals with substance use disorders into the criminal justice system, a partnership between law enforcement and behavioral health service could save lives and provide a path to treatment and recovery. An example of this partnership is the Angel Program in Gloucester, Massachusetts. Under this program, which started in 2015, anyone seeking help with a substance use disorder can walk into a police department and be placed in treatment. If they have drugs on them when they enter, charges are not pressed and the drugs are destroyed. Other police departments around the country are using the Angel Program as well—police departments in Dixon, IL have partnered with treatment centers in the area and are able to get individuals into treatment immediately. Nationally, the Police Assisted Addiction and Recovery Initiative (PAARI) is growing a network of over 400 police departments in 32 states to further this model.

Community Pharmacy Patient Care Services

Pharmacists are trained health care providers who can impact primary and behavioral health outcomes in rural areas through patient education, preventive screening and services, and medication therapy management (Biddle & Friend, 2015). Pharmacists can play a critical role helping people to understand medications they may be prescribed for behavioral health conditions as well as other chronic diseases treated pharmaceutically, which can improve compliance and self-management of care and reduce misuse or overdose of medications. Additionally, pharmacists can be accessed on a walk-in basis, which may be preferable based on a person's scheduling, transportation, or payment challenges. The ONE Rx Project in North Dakota is an example of how pharmacists are reaching people and increasing their access to opioid and naloxone education, with the goal of providing information before opioid misuse may occur (College of Health Professions, 2018). Community pharmacists use a screening tool and decision-making triage to provide patient-specific education and interventions.

Group Behavioral Health Training Courses

Another behavioral health innovation being deployed in rural areas is the use of group behavioral health training courses. The Strong African-American Families-Teen Program was created by the National Institute on Drug Abuse (NIDA) and is a family-centered prevention program designed to address the lack of interventions for teen behavioral issues, especially those common to rural African-American adolescents. The intervention consists of five 2-hour meetings for teens and their primary caregivers. The trainings are conducted by rural, locally trained leaders, and focus on reducing sexual risk, setting up strategies to resist personal temptation and peer pressure, and developing strategies for accomplishing academic and occupational goals. Caregivers receive sessions focused on monitoring teens, communicating with them about peer pressure, drugs, alcohol, and sex, and adapting parenting styles as teens get older. The program is effective—studies show that there were 36% fewer conduct problems, 47% fewer substance use problems, and reduced depressive symptoms (Brody et al, 2014).

Another evidence-based innovation in rural health is mental health training for community members. The Mental Health First Aid course is an early intervention program that trains the public in how to assist someone experiencing a behavioral health crisis. The course is a total of 8-hours and teaches the skills needed to identify, understand, and respond to individuals that are experiencing signs of a mental illness or substance use disorder. Mental Health First Aid is designed to provide support until the crisis is resolved or additional supports can be located. Since 2008, more than 150,000 individuals in rural areas of the United States have been trained in Mental Health First Aid. Studies have shown that participants in the course have improved knowledge of behavioral health disorders and treatment and better knowledge of appropriate strategies for helping individuals in crisis (El-Amin, Anderson, Leider, Satorius, & Knudsen, 2018; Mendenhall, Jackson, & Hase, 2013).

Increasing the Behavioral Health Workforce in Rural Areas

Some communities are innovating to reduce the shortage of behavioral health professionals in rural areas, by increasing the available behavioral health workforce. These programs are not quick fixes to the shortage but rather a long-term investment in ensuring a steady flow of behavioral health professionals. The first of these is the Frontier Area Rural Mental Health Camp and Mentorship Program (FARM CAMP). This program was designed to reduce the shortage of behavioral health professionals in rural areas of Nebraska, where 88 out of 93 counties are Health Professional Shortage Areas (HPSAs) in

mental health. FARM CAMP is a free camp where rural high school students can spend a week taking a college-credit class that covers a variety of psychology, social work, substance use disorder, and behavioral health occupations. Learning is hands-on, and participants use part of the week to design a community project to address a need in their own rural community. FARM CAMP organizers become mentors after the camp ends and provide support and career counseling on an ongoing basis. In 2019, the camp hosted 13 high school students from five rural counties and 6 alumni returned to mentor new students.

Another example of a program working to increase the behavioral health workforce in rural areas is the Fostering Futures in Menominee Nation program in Wisconsin. The program was started on the premise that historic events of displacement and loss of federal recognition have impacted the way of life for Menominee Indians living on the Menominee Reservation. As a result, behavioral and physical health issues have risen in the youth population. Through the Fostering Futures program, clinic, school, and Head Start/Early Head Start staff are trained to provide trauma-informed care for children. They also created a Pediatric Integrated Care Collaborative at the Menominee Tribal Clinic, which integrated the medical and behavioral health departments, and a trauma-informed care team comprised of clinical staff. The program has been effective—behavioral health visits at the Menominee Tribal Clinic have increased and graduation rates have gone up from 60% to 85% since 2008.

Among providers already reworking in rural areas, resources are available to provide waiver training and implementation support, to enable prescribers to issue medications for opioid use disorders. SAMHSA's Provider Clinical Support System for Medication-Assisted Treatment (PCSS-MAT) provides training and support for physicians, physician assistants, and advanced practice registered nurses.

Hub-and-Spoke Models

The Hub-and-Spoke Model of Care for Opioid Use Disorder in Vermont is an effective innovation in helping rural populations access medication-assisted treatment for opioid disorder. Hub-and-spoke models use telehealth or other technologies to connect rural patients to specialty providers, where the spokes are local service providers and the hubs are larger specialty providers (Gale et al, 2019). In the model used in Vermont, addiction specialists and specialty clinics worked together to initiate treatment, handle relapse management, and adapt a continuum of care model that embraced collaboration and integration. The uniqueness of this hub-and-spoke model was a bidirectional transfer process—the spoke can transfer to the hub and vice versa. As of 2019, there were no people in the state waiting for hub services (specialty addiction services) and the state saw a 50% reduction in overdose deaths in Vermont's largest county (Rawson, Cousins, McCann, Pearce, Van & Donsel, 2019). Drawing on the Hub-and-Spoke model for telehealth, initaitives like Project ECHO are using similar technology to facilitate telementoring of practitioners that are treating individuals with complex physical and behavioral health conditions in rural and underserved areas.

Technologies, Polices, Regulations, or other Factors That Can Affect or Improve the Services Provided by RHND Networks

Current policies and government programs have the potential to improve the services that RHND networks are providing. For example:

- The Affordable Care Act of 2010 created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate comprehensive care for Medicaid recipients with chronic conditions. The Centers for Medicare & Medicaid Services (CMS) established this new model to coordinate the full range of medical, behavioral health, and long-term services and supports. Services provided by Health Home are comprehensive care management, care coordination, health promotion, referrals to community and support services, and patient support. States have the flexibility to determine the eligible health home providers—they can use a designated provider, a team of health professionals, or a health team. Eligibility for a health home includes Medicaid recipients with two or more chronic conditions, one chronic condition and are at risk for a second, or one serious and persistent mental health condition.
- The CMS Rural Health Strategy has a program aimed at expanding access to telehealth across the Medicare program. This expansion allows patients to access specialists that they otherwise would not be able to access. The agency is also putting policies in place that raise payments for rural hospitals (Kahn & Morgan 2019).
- Kahn & Morgan (2019) note that the Medicare Dependent Hospital and the Low Volume Hospital programs are set to end in 2022—these two programs have contributed significantly to the success of rural healthcare and should be extended (Kahn & Morgan 2019).

In consideration of policy at the national, state and local level, Gale, et al (2019) identified four broad areas where focused policies are necessary in order to implement a comprehensive approach to improving behavioral health in rural communities. These four broad areas are:

- Promoting rural community engagement to support and design local and regional strategies for behavioral health challenges. This might include using state and local resources to support rural community education aimed at stigma reduction and promoting awareness of behavioral issues. It could also include working with local communities to explore additional support for behavioral health systems to augment local and state efforts, such as philanthropic foundation funding, in-kind contributions, or hospital community benefit resources.
- Supporting the development of local and regional behavioral health services through encouraging states to invest in regional evidence-based prevention, treatment, recovery, and harm-reduction programs.
- Reforming regulatory/payment policies to encourage the development of comprehensive systems of care and expand coverage for behavioral health. This includes encouraging behavioral health integration into primary care models, expanding telehealth technology, funding peer recovery staff, and improving how state health insurance functions and expanding Medicaid.
- Expanding the behavioral workforce, including incentivizing rural practice.

The authors argue that these priority areas are interrelated and will not achieve wide scale change without addressing all four of these areas.

Rural Health Network Models

Because this landscape analysis is aimed at contributing to the body of work undertaken by the Rural Health Network Development Program, it is important to include examples of successful community engagement and collaboration models around the country. While some of the programs previously

highlighted in this analysis do include collaboration, these models rely on a formal network structure for working together.

Project Name	Geographical Area	Partners Involved	Description of the Program
Project Vision	Rutland, Vermont	The Rutland Police Department, The Rutland Redevelopment Authority, and over 300 social and health service agencies and organizations, schools, business organizations, the City of Rutland, faith-based groups, and community members	The program was started in response to drug-related challenges and arrests in the community and seeks to make change by addressing the issues underlying substance abuse. This comprehensive, integrated collaboration believes that focusing on the positive allows the collaborative to work together in new and innovative ways. Work is done throughout the community through three subcommittees—Substance Abuse Prevention and Treatment, Community Policing & Engagement, and Building Great Neighborhoods. Each subcommittee has a set of goals and objectives that allow them to implement cross-sectoral programming aimed at prevention, treatment, and recovery.
Communities That Care (CTC)	US	University of Washington, local communities around the US	Communities that Care uses a prevention science based, five-phase change process to promote healthy youth development, improve youth outcome, and reduce problem behaviors. The five phases include activating communities and identifying key stakeholders, organizing or identifying a local coalition to spearhead the work, developing a community profile to assess community risks and strengths and identify existing resources, creating a community action plan for prevention work in their community, and implementing/evaluating the work. The CTC model has been shown to be effective—youth in CTC communities were 25%-33% less likely to have health and behavior problems that those from control communities. University of Washington distributes the CTC system, installs it, and offers personalized support in its implementation. The model has been adapted across both rural and urban settings.
SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC)	US—American Indian/Alaska Natives	Tribal TTAC, local AI/AN communities around the US	Tribal TTAC offers training and technical assistance for AI/AN communities on mental and substance use disorders, suicide prevention, and mental health promotion. They use a Strategic Cultural Framework to drive their work and focus on building local capacity and skills and leveraging resources through collaboration.

Conclusion

Rural behavioral health challenges have been widely documented and are being addressed in a number of innovative ways. Models and approaches for behavioral telehealth and behavioral health integration have proven effective and are becoming more commonplace, despite potentially significant barriers to implementation. Stakeholders in rural communities are working together to overcome those barriers by creating unique and innovative programs that seek to work in new ways and provide high levels of comprehensive care.

Resources and Toolkits

Barriers Rural Physicians Face Prescribing Buprenorphine for Opioid Use Disorder
http://www.annfammed.org/content/15/4/359.full.pdf+html

Critical Crossroads: Pediatric Mental Health Care in Emergency Department (Resource Toolkit, 2019)
https://www.hrsa.gov/sites/default/files/hrsa/critical-crossroads/critical-crossroads-tool.pdf

DIMENSIONS: Peer Support Program Toolkit (2015): https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf

Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan Volume 1
https://integrationacademy.ahrq.gov/sites/default/files/mat_for_oud_environmental_scan_volume_1_1.pdf

Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan Volume 2 Tools and Resources
https://integrationacademy.ahrq.gov/sites/default/files/mat-oud-environmentalscanvolume-2_revised.pdf

Mental Health America's Center for Peer Support. *Peer Support Across Settings: A "No Wrong Door" Approach to Recovery* (2018).
https://www.mhanational.org/sites/default/files/Peer%20Support%20Across%20Settings%202.12.19.pdf

Mental Health in Rural Communities Toolkit
https://www.ruralhealthinfo.org/toolkits/mental-health

National Rural Health Association Policy Brief – Community Health Workers: Recommendations for Bridging Healthcare Gaps in Rural America
https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf

Peer Support in the ED: A Report (attached) *(includes an initial checklist of activities to start peer services in an ED)*

Peer to Peer Support Services in Integrated Care Settings (May 2016)
https://www.integration.samhsa.gov/mai-coc-grantees-online-community/May_3_Webinar_-_Peer_to_Peer_Support_Services_In_Integrated_Care.pdf

Philadelphia Peer Support Toolkit (2017): https://dbhids.org/peer-support-toolkit/

Providers Clinical Support System – MAT (PCSS-MAT)
https://pcssnow.org/

RHI Hub: Rural Mental Health – Models and Innovations
https://www.ruralhealthinfo.org/topics/mental-health/project-examples

Rural Mental Health Resources
https://mhttcnetwork.org/centers/mountain-plains-mhttc/area-focus

State Community Health Worker Models
https://nashp.org/state-community-health-worker-models/

The Value of Peers
https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

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