



Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities

Financing Behavioral Health Services in Rural and Remote Areas

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GRANT STATEMENT

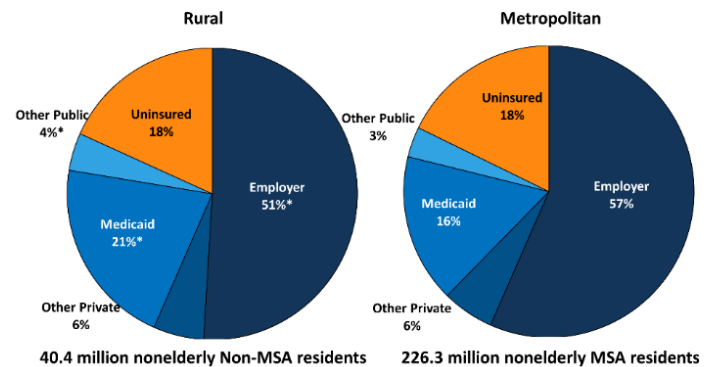
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Financing Behavioral Health Services in Rural and Remote Areas

Adults living in rural areas with mental health needs receive fewer mental health services than their counterparts living in urban and suburban areas. A 2019 analysis of a nationally representative sample of adults with mental health needs found that adults in rural areas had fewer visits to ambulatory providers, fewer visits to specialty providers, and fewer mental health prescriptions (Kirby, et al., 2019). The study was unable to determine if the reduced provision of mental health services in rural areas was due to the lack of insurance coverage and inability of rural residents to pay for mental health services, an overall lack of mental health providers, or other issues such as stigma that could potentially lead to a reduced willingness of individuals in rural areas to try and access mental health services. However, the documentation that persons with mental health needs in rural areas receive fewer mental health services than their counterparts in urban and suburban areas suggests that state and provider efforts aimed at assuring that a broad array of high-quality services are available is important to reducing rural behavioral health disparities.

The availability of high-quality behavioral health services in rural areas is challenged by the need to adequately pay for these services. Individuals living in rural and remote areas are less likely to have health insurance than those living in urban areas. About 12.3 percent of people in completely rural counties lacked health insurance compared with 11.3 percent for mostly rural counties and 10.1 percent for mostly urban counties (Census, 2021). The Kaiser Family Foundation found similar levels in rural and non-rural areas of individuals having no health insurance, but among individuals with insurance coverage, persons living in rural areas were more likely to rely on public insurance programs (Medicaid or Medicare) than have employer-sponsored private insurance (see figure to the right) (Newkirk & Damico, 2014). The higher levels of reliance on public insurance in rural and remote areas mean government agencies can play a large role in developing behavioral healthcare financing systems that fund the necessary comprehensive array of behavioral health services and supports described elsewhere in this document (Newkirk & Damico, 2014).

Rural residents were more likely to have public coverage and less likely to have ESI than metropolitan residents



Brief Lessons for Policymakers:

- » Individuals with mental illnesses in rural areas receive fewer behavioral health services than those in urban and suburban settings. Rural clients are also more likely to rely on Medicaid, Medicare, and state-funded services.
- » States can use the flexibility of Medicaid and State General Funds to assure appropriate rates are set to support evidence-based services and an adequate behavioral health workforce (including peers).
- » SMHAs and rural advocates can work together with their state insurance commissioners to ensure that the [federal Mental Health Parity and Addiction Equity Act](#) (MHPEA), Pub. L. 110-343, and regulations adopted under that Act are enforced and that private insurance plans provide equitable reimbursement rates for behavioral health services.

Although SAMHSA's Mental Health Block Grant (MHBG) data do not allow identification of clients by rural areas, MHBG data demonstrate that clients of state mental health systems rely heavily on Medicaid and other public funding to pay for behavioral health services. Because of the high levels of disability associated with SMIs, many adults with SMI may lack commercial health insurance and instead rely on a mixture of Medicaid, Medicare, and state and local government-supported services. SAMHSA data show that only about 21 percent of adults served by state mental health systems are competitively employed, and the employment rate for persons with schizophrenia disorders served by the SMHA system is even lower at nine percent. Thus, most adults with SMI will not have a job that can provide private health insurance (SAMHSA, 22 May 2020). Medicaid is the most common insurance program for adults with SMI. In 2019, 73 percent of clients served by SMHA systems had Medicaid paying for at least some of their mental health services (SAMHSA, 22 May 2020).

[SAMHSA's National Spending Estimates](#) report approximates that total expenditures for mental health services were \$156 billion in 2015, and that 58 percent of this funding came from public sources, while 42 percent was private spending. By contrast, for overall health care in America, public and private sources were both at 50 percent. Medicaid was the largest public payer for mental health services, followed by Medicare and state and local government sources (SAMHSA, 22 May 2020). Unfortunately, the SAMHSA report was unable to analyze mental health spending by geographic region (rural/urban areas).

The Importance of Public Funding to Assure Evidence-Based Mental Health Services in Rural Areas

States have used combinations of state and local government funding, SAMHSA funding (such as the MHBG, CCBHC funding, and other grants), and Medicaid to prioritize support for evidence-based services in rural areas. The reliance on public funding sources (e.g., Medicaid, state, and local government funding) needed to support mental health services for rural clients provides an opportunity for state and local governments to actively design the funding structures for those supports, making full use of the flexibilities of those various funding sources.

Medicaid Funding

Medicaid provides health coverage to more than 77 million individuals each year and is a joint state-federal program where every state has wide discretion under Medicaid rules to design benefits that can help provide access to needed mental health services and supports to adults with SMI. However, since every state's Medicaid program is unique, the benefits available in one state may not be available in other states.

Medicaid often covers a broader array of behavioral health services and supports than private insurance, which typically uses more limited "medical necessity" criteria in determining what benefits it will pay for. A recent report, [Medicaid Forward: Behavioral Health 2021](#), by the National Association of Medicaid Directors (NAMD), while not specifically addressing rural behavioral health disparities, emphasizes the ability of states to use Medicaid to support important services to (Browning, et al., 2021):

- » Advance prevention and promotion of mental health and well-being, including providing opportunities for linkages to other social services and supports, and paying to screen members for social risk factors;
- » Streamline eligibility for services by eliminating administrative barriers that prevent people from accessing needed behavioral health treatment;
- » Continue to promote integration of physical and behavioral health services;
- » Build a comprehensive approach to addiction treatment that begins with prevention and addresses all addiction; and
- » Strengthen and broaden crisis response systems (NAMD, 2021).

The Affordable Care Act of 2010, Section 2703 ([Section 1945 of the Social Security Act](#)) created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions (e.g., mental health, substance use, asthma, diabetes, heart disease, and overweight) (<https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html>). Health Homes are for people with Medicaid who 1) have two or more chronic conditions, or 2) one chronic condition and are at risk for a second, or 3) have one serious and persistent mental health condition. Many states have used Section 2703 to create Behavioral Health Homes to integrate primary care providers with behavioral health providers, and thus address both the behavioral health and other health conditions of adults with serious mental illnesses. This model can be used in rural areas to integrate care and help treat the whole person. [Michigan](#) and [Minnesota](#) have leveraged Medicaid to fund Behavioral Health Homes to provide integrated care to individuals with behavioral health needs throughout their states.

While Medicaid is the major funder of mental health services in rural areas and provides states with great flexibility in benefit design, our Expert Panelists identified several challenges to using Medicaid in rural and remote areas, including that Medicaid frequently will not pay for the substantial time clinician or peer specialists spend driving in rural areas to provide services to clients in their homes, school, or workplace. In addition, not all behavioral health providers participate in Medicaid—which can be particularly limiting in access for clients relying on Medicaid in rural areas that have shortages of behavioral health providers. For example, many psychiatrists do not participate in Medicaid (or private insurance). According to research published in *JAMA Psychiatry*, “the percentage of psychiatrists taking Medicaid fell from nearly 48 percent in 2010-2011, to 25 percent in 2014-2015,” meaning that individuals with mental health needs have a more limited pool of providers if they need services (Carroll, 2019).

The Expert Panel guiding the development of this document identified ways they have worked with their state Medicaid agencies to cover services important to rural areas with limited behavioral health workforces. Many state Medicaid programs reimburse for behavioral health peer specialists. In New Mexico, Medicaid will pay for services provided by traditional (Native American) healers.

In response to the COVID-19 pandemic, the declaration of a national Public Health Emergency included new flexibility for Medicaid reimbursement of telehealth services. Experts from rural states described these new flexibilities in reimbursement for telehealth as being very positive for increasing access. By allowing expanded use of telehealth—including audio only (telephone) telehealth in areas with limited Internet broadband—rural states have been able to expand access and maintain services during the pandemic.

State and Local Government Funding

In 2019, state and local government funds paid for over \$19 billion in mental health services and supports (SAMHSA, 22 May 2020). These government funding sources are often critical to providing robust behavioral health services in rural areas, as they can cover services and supports for clients without any insurance and can also be used to pay for services that Medicaid and private insurance will not reimburse, such as housing and employment supports and the transportation of providers or clients to receive home-based services.

While state and local government funds provide SMHAs with maximum flexibility in how they use these resources to support adults with SMI, there are limitations to their use. First, many states have experienced substantial state tax revenue decreases during the COVID pandemic and as a result must reduce spending to balance their state budgets. Additionally, the use of state and local tax funds by SMHAs must be approved by legislatures and governors, and in some instances those entities may direct the use of tax funds to their preferred regions or providers.

Our Expert Panel discussed the importance of state and local funding to support the continuum of crisis services for adults with SMI in rural areas. Supporting the necessary crisis system infrastructure (24/7 call centers, mobile crisis teams, crisis respite centers) is difficult to support through public and private insurance systems that only reimburse for services provided to eligible members. The Expert Panel noted that in order to have the crisis system ready to respond to an adult with SMI in crisis, the crisis system infrastructure needs to be staffed and open 24/7 ready for an individual in crisis, regardless of an

individual's insurance status. While Medicaid and some private insurance plans will reimburse for crisis services provided to their eligible members, supporting the infrastructure to be ready to provide these services relies almost entirely on state and local government funding.

State and local government funds can be very useful in helping behavioral health providers prepare to implement evidence-based practices. For example, South Dakota used state funds to pay for training and the upfront costs for providers to become certified in the Family Functional Therapy service model. Once trained, the providers were then able to bill Medicaid for services (Discussion with expert panelists, October 21, 2021).

Private Health Insurance

No estimates were found to be readily available regarding the number or percent of adults with SMI in rural areas who are covered by private health insurance, but overall data for insurance status in rural areas suggest that many adults with SMI can be expected to have private health insurance—either through their workplace, through a spouse's employment, or through their parent's insurance for young adults up to age 26. MHPEA requires private health insurers that provide behavioral health benefits to provide those benefits without any additional barriers to access or co-payments above what are required for other covered medical conditions. However, panelists expressed a concern that while private insurance is important for supporting mental health services, private health insurance does not routinely pay for the intensive team-based services developed to meet the needs of adults with SMI that are routinely supported through Medicaid and state funds, such as ACT, First Episode Psychosis Coordinated Specialty Care, or innovative services using paraprofessionals such as certified peer specialists. Private insurance was found to focus on a more traditional "Medical Model" using medical necessity criteria; supportive housing administrative costs, supported employment, peers, and other supports provided through Medicaid and state funds were often not reimbursed by private insurance.

Grant Funding

Expert panelists identified grant funding as an important source for initiating innovative services for adults with mental illness in rural areas. Panelists described using grants from SAMHSA, including the CCBHC initiative, the MHBG, funds from HRSA, and funds from national and local foundations to support services. Grant funding was identified as a critical resource to test and expand service models and to fund training of providers to be ready to provide evidence-based services. However, a limitation of grant funding is that it is typically time-limited, requiring the grant-funded program to eventually transition to sustainable funding sources, such as Medicaid and other funding sources.

Special Financing Considerations for Financing Evidence-Based Practices and Peer Specialists

During the Expert Panel discussions, a representative from New Mexico noted that his state had an opportunity to incentivize implementation of ACT with a 20 percent bonus payment for providers to implement group therapy, but that providers proved under-resourced to accomplish this. Enrollment into ACT teams can take months, and providers could still not afford the start-up costs to create the ACT teams (Discussion with expert panelists, October 21, 2021).

Paying for mental health peer specialists was identified by many Expert Panelists as an important way to enhance appropriate mental health services in rural areas with a limited behavioral health workforce. However, panelists identified a number of existing barriers in Medicaid that can make it difficult to use peer specialists optimally, including that Medicaid reimbursement is often limited to approved settings, such as hospitals and EDs; in states with restrictive Medicaid policies, peers can only receive Medicaid reimbursement if they work in these settings.

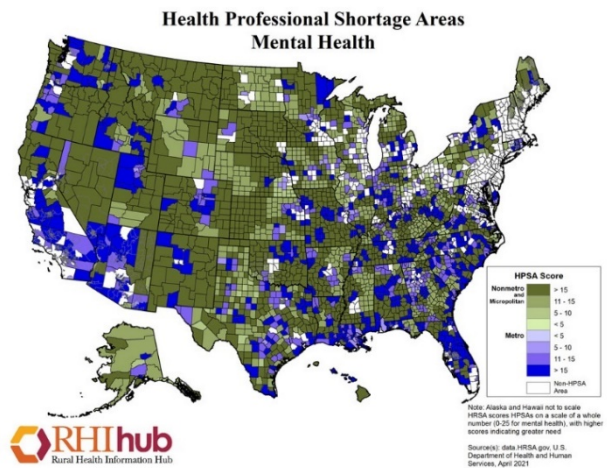
Financing Key Lessons:

- » Research on financing behavioral health services demonstrates that individuals with mental illnesses in rural areas receive fewer services when compared to individuals living in urban and suburban settings. Research also shows that clients in rural areas are more likely to rely on public insurance (e.g., Medicaid, Medicare, and state-funded services) to pay for care.

- » Because individuals with SMI in rural areas are more likely than individuals in urban/suburban areas to rely on public healthcare financing, state and local governments are afforded an opportunity to establish policies that will impact the availability of essential services and supports. States can use the flexibility of Medicaid and State General Funds to assure appropriate rates are set to support evidence-based services, and to support the behavioral health workforce. For example, states can use Medicaid and State General Funds to set reimbursement rates for peer specialists that provide them a living wage and career path.
- » SMHAs and rural advocates can work with their state insurance commissioners to ensure that the MHPAEA is invoked to ensure that private insurance plans provide adequate reimbursement rates and participate in provider networks that include behavioral health providers in rural areas.

Rural & Remote Behavioral Health Workforce

As of September 2018, HRSA had designated 2,672 Mental Health Professional Shortage Areas (MHPSA) in rural areas (RHIfhub, 2021). The primary factor HRSA uses to designate MHPSAs is “the number of health professionals relative to the population with consideration of high need,” with a minimum of one provider to 30,000 residents (or 20,000 if there are higher than usual needs in a given community (RHIfhub, 2021). Just 1.6 percent of the nation’s psychiatrists practice in rural areas, which is, on average, nearly 47,000 residents per each rural psychiatrist (New American Economy, 2017). Nearly 60 percent of all counties in the U.S. do not have a single psychiatrist (Beck, et al., 2018). While the MHPSA figures produced by HRSA are dire, it is likely that these figures are not entirely representative of the deficit of mental health providers. HRSA calculates the number of licensed professionals, rather than practicing professionals. It is possible that many of the mental health professionals included in these figures maintain their license, but do not offer services. Compounding this issue in rural and remote areas is that many of the counties without a single psychiatrist are clustered together, making it even more difficult for individuals to access psychiatric care quickly in case of an emergency, and, as mentioned in the *Financing* section of this document, not all providers accept Medicaid, further reducing the number of available providers (Carroll, 2019). A lack of behavioral health clinicians in rural areas leads to greater caseloads for those who are available, which can lead to burnout and a reduction in the types of services (e.g., EBPs) providers are able to offer. Multiple strategies and opportunities are available to help reduce the workforce shortage in rural and remote areas of the U.S., including reducing barriers to entry and retention (scholarships, loan forgiveness/repayment, assistance with supervision, modifying continuing education courses), and providing opportunities for residents to train in rural and remote areas. In addition, increasing the availability of telehealth, and reducing the barriers for providers to use telehealth, enables providers in all areas of a state to offer services to individuals residing in rural and remote areas, expanding the availability of high-quality services to underserved populations.



Brief Lessons for Policymakers:

- » Develop policies and financial support for state and regional colleges and universities to offer behavioral health training programs specific to rural and remote areas.
- » Evaluate state policies related to the certification and supervision processes for peer specialists, keeping in mind that: peers are their own profession and prefer to be supervised by other peers; and that supervision hours should not be overly burdensome, especially when compared to supervision requirements for other clinical professions.
- » Expand the scope of practice of the current workforce to allow for greater prescribing authority for other licensed practitioners such as Nurse Practitioners and Physician Assistants, in order to reduce the burden on psychiatrists.

Brief Lessons for Providers:

- » Develop a career track for peer specialists that encourages job growth and reflects the value provided by peer specialists.
- » Involve peers in the process of supervision.
- » Hire peers directly to ensure they are paid a living wage and receive necessary benefits.

Reducing Barriers to Entry and Strategies for Retention

The high cost of a professional degree in behavioral health sciences is often a barrier for individuals in rural communities pursuing advanced training and education. However, a handful of federal educational loan repayment and forgiveness programs exist to help recruit health professionals—including behavioral health specialists who serve individuals with mental illness and co-occurring disorders in underserved areas—pay off their student loans. One such federal program is the [National Health Service Corps \(NHSC\) Rural Community Loan Repayment Program developed to help rural areas address the opioid misuse epidemic](#). This program covers up to \$100,000 in loan repayments for full- and part-time substance use disorder counselors, pharmacists, registered nurses, and certified registered nurse anesthetists who work to combat the opioid epidemic in rural communities across the U.S. Recipients of these awards are committed to three years of service. Similar programs to expand the behavioral health workforce trained to address the needs of individuals with SMI could help address workforce shortages in rural areas.



Most states also offer their own loan forgiveness and financial assistance programs to attract healthcare professionals to serve in rural and other underserved areas of the state. States use a combination of federal (e.g., [HRSA’s State Loan Repayment Program](#)) funds and state funds to support these programs and set their own qualification criteria. A comprehensive list of state programs for loan repayment and forgiveness is available [online](#); links for each state are provided, along with the criteria for participation and receiving a loan repayment (e.g., length of service commitment minimums and health specialty fields).

In addition to loan repayment and forgiveness programs, HRSA also offers scholarships for nursing students who agree to serve two years, full time, at an eligible Critical Shortage Facility in a mental health or primary care provider in a Health Professional Shortage Area (HPSA). The [Nurse Corps Scholarship Program](#) covers tuition, fees, and other educational costs for qualified applicants. To attract qualified behavioral health workforce candidates, state policymakers and providers can advertise the availability of these programs and help healthcare employees apply for funds from these programs.

In addition to providing and supporting scholarships and loan forgiveness and repayment programs, states and providers can also reduce barriers to entry by making it easier for behavioral health professionals to receive pay for supervision. A sentiment that was echoed by many members of the Expert Panel is that the costs associated with supervision can be prohibitive and

“A large number of individuals have finished graduate school, but do not have independent licenses because they have not been able to get on-site supervision to qualify for licensing. Allowing telehealth supervision can reduce this burden, especially for rural providers.”

Wayne Lindstrom, Ph.D.
Vice President, Western Region

finding someone to supervise behavioral health clinicians for state licensure is a challenge, especially in rural areas. An online review of supervision costs for behavioral health professionals shows a range of \$50 per hour to more than \$150 per hour for supervision, which can be prohibitive to new professionals just out of graduate school. An Expert Panelist suggested that paying supervisors an incentive for providing supervision would help retain people (Ivey, J., personal communication, November 19, 2021).

The State of New Mexico’s Social Worker’s Board allowed telehealth supervision and covered the cost of this supervision to facilitate the supervision process.

Additionally, while the number of supervision hours and fees required to complete supervision vary by state, on average, states require: between 1,000 and 2,000 hours of supervision for mental health clinicians; 2,000 hours after a Ph.D. for psychologists; around 3,000 hours for licensed clinical social workers, and up to 6,000 for peer support supervisors (Pritchard, J., personal communication, November 19, 2021). This disparity of required supervision hours between professional practices can lead to

resentment of colleagues. Jason Pritchard noted that, “there is an unfairness when folks who do not have lived experience get certified easier” (Pritchard, J., personal communication, November 19, 2021).

Another issue identified by the Expert Panel is that continuing education unit (CEU) requirements can be burdensome and even unhelpful, especially when providers have to travel long distances to attend the education and when the courses are geared toward more urban audiences. The Expert Panel noted that some of these requirements were relaxed during the COVID-19 pandemic and indicated that it would be helpful for these flexibilities to continue. Allowing providers, especially those in rural areas, to attend CEUs virtually can help alleviate the travel burden. Virtual courses can be designed to be interactive and skills-based, providing as much value as in-person learning.

When CEU courses are geared toward urban providers they can often feel out of touch for rural providers, especially when they are not tailored to their communities’ needs. One example is the annual ethics course most providers are required to attend. While it is important for providers to follow ethics guidelines, some guidelines, such as those

prohibiting treatment of individuals with whom the provider has a personal relationship may not be possible in rural settings. It is likely that many rural providers know just about everyone in their own communities on a personal and social level, making the distinction between the provider-client relationship and community resident a bit blurry. Continuing education requirements, and classes should be tailored with these contextual issues in mind.

“Finding continuing education courses that are relevant to their [rural providers’] practice is difficult. Rural providers who don’t have a personal relationship with their clients would never be able to serve anyone. Trainings should bring something different and make it more relevant to the rural context. Sometimes, trainings can be irrelevant if not tailored to the region, which takes more time and resources.”

Xiomara Owens, Ph.D.
Director of Behavioral Health Aide Training
Alaska Native Tribal Health Consortium

Reducing Barriers to Entry and Promoting Strategies for Retention Key Lessons:

- Promote the availability of scholarships and educational repayment and forgiveness programs. This can help reduce barriers to entry, allowing for more rural providers to enter the field.
- Encourage clinicians to work in rural and remote areas. States and providers can offer incentives to practice associates to provide clinical supervision for recent graduates. States may also try to find funds to cover the often prohibitive costs of supervision.
- Policy changes at the state level that allow for continuing education requirements to be achieved through virtual courses will help to reduce the burden and expense of transportation for rural providers and allow rural providers to take courses at times that are more convenient to their busy schedules.
- Tailor some continuing education courses to better reflect rural service delivery. Many courses are developed with urban providers in mind and may not be applicable or particularly useful to rural providers.

Internships, Residencies, and Rural Training Programs

A variety of academic partnerships and programs exist that help train residents and future behavioral health providers on service delivery in rural areas. By introducing students and residents to rural practices, the chances of them staying on to work in rural areas after graduation increase significantly. A study in Texas found that 75 percent of primary care residents trained in rural parts of the state stayed there to start their professional careers (Levin, 2016). Linkages between states, providers, and academic

institutions can facilitate these opportunities, thereby increasing the available rural behavioral health workforce. A handful of opportunities are spotlighted below.

Although this has shown to be an effective model, states with large rural areas often have a shortage of other health professionals (primary care physicians and other medical practitioners), and rural states may have competing priorities, allowing only one field to receive attention from the state. One representative from a rural state noted during the Expert Panel that “partnerships are hard to create because of competing priorities. Working with schools of medicine is something the SMHA Commissioner prioritizes but is not something she has had time to do. Our state struggles to get primary care physicians and basic healthcare and focuses on training providers so that they have some level of comfort prescribing medications for mental illness rather than always referring patients to psychiatrists.”

To overcome some of these challenges, in 2015, the 84th Texas Legislature directed \$8 million for the University of Texas Health to develop mental health workforce training programs for rural and underserved areas. These funds allowed the University to double the size of its clinical psychology internship program, and place more psychiatric residents in rural areas of the state.



Western Interstate Commission for Higher Education

Spotlight on WICHE’s Psychology Internship Consortia

The Western Interstate Commission for Higher Education’s (WICHE) Behavioral Health Program’s [Psychology Internship Consortia](#) supports the development of the behavioral health workforce in seven rural states – [Alaska](#), [Hawaii](#), [Idaho](#), [Nevada](#), [Oregon](#), [Utah](#), and [New Mexico](#). WICHE contracts with agencies in each of these states to develop and support an internship program for students at local universities to pursue training in psychology, thereby enhancing the behavioral health workforce in each of these states. WICHE helps to ensure that the internship programs meet accreditation standards set forth by the American Psychological Association and helps universities with the accreditation process. Annual award amounts for each of the states participating in the consortium range from \$25,000 to just over \$637,000 as of 2019 (WICHE, 2020).

Spotlight on Area Health Education Centers

The Area Health Education Centers (AHEC) program was established in 1971 by Congress with the goal to “recruit, train, and retain a health professions workforce committed to” serving underserved populations. AHEC accomplishes these goals through community-academic partnerships that “focus on exposure, education, and training” the current and upcoming health care workforce. AHEC works to develop partnerships between academic institutions, community health settings (including community health centers), behavioral health practices, and other community organizations. Across the U.S., there are more than 300 AHEC centers, serving 85 percent of U.S. counties (AHEC, 2021a).



AHEC places students training to become health professionals in real-world settings, including rural community health clinics and health departments. This exposure allows students to “develop an awareness of the economic and cultural barriers” that are unique to rural settings, providing them with a better understanding of the “complex needs of rural and underserved communities.” These placements help students build relationships within the rural communities they serve, leading the way for future engagement and networking, increasing the chances that students will return to their clinical practice regions, and thereby bolstering the rural workforce (AHEC, 2021b).

In addition to its scholarship program, AHEC provides accredited continuing education programs for health care professionals, including those in rural and underserved areas, and offers programs focused on recruitment, clinical placement, and retention to address workforce needs in underserved areas.



Spotlight on the National Center for Rural Health Professions' Rural Health Experience

The University of Illinois at Chicago is home to the National Center for Rural Health Professions, which affords students enrolled in any health-related degree program the opportunity to participate in the Rural Health Experience. As part of the Rural Health Experience, upper-level students (juniors and seniors) can observe and shadow rural healthcare providers, including social workers and other behavioral health professionals. This one-to-two-week program provides basic housing and meals to students and offers the opportunity for students to explore the local communities. During their time in the rural communities, Rural Health Experience students have the opportunity to: “learn about the social and health characteristics, needs, and resources of a specific rural Illinois community; understand the roles and responsibilities of different healthcare providers in a rural community; and reflect on a future career as a healthcare provider in a rural community and [establish] potential interest in [the] rural community” as a potential future career location (The National Center for Rural Health Professions, 2021). Students from rural communities in Illinois are given preferential consideration for this program.



Spotlight on the University of North Dakota's Residency Program

The North Dakota SMHA is involved with Project ECHO in training providers on mental health issues. The state is aware that, given its population and size, it likely will never be able to develop enough of its own psychiatrists. The state is using Project ECHO to train primary care providers who are willing to treat individuals with mental health needs in the more common, easier to treat mental health challenges that may present themselves more frequently in the primary care setting, thus avoiding having to wait to engage a psychiatrist, which would mean a long wait for services. This strategy enables the few psychiatrists in the state to more quickly address the needs of those with more complex challenges, including those with schizophrenia, bipolar, and major depression. North Dakota offers Project ECHO courses to its primary care physicians on mental health and prescribing, and on the use of behavioral health screening tools.

The North Dakota legislature recognized a need to increase access to mental health services. This led to an initiative to increase and bolster the psychiatric residency program at the University of North Dakota. The program doubled in size, from three residents to six residents per year. The current program director established outreach training for residency. Prior to COVID-19, the program consisted of one half-day per week of telepsychiatry training, and travel by the residents to 10 different rural sites across the state. All residents in their third and fourth years are trained in outreach for more rural communities, both in the private and public sectors, and there is some collaboration with tribes and reservations. North Dakota provides some scholarship funding for psychiatric residents, psychologists, and social workers who are willing to do integrated care in rural communities. The majority of psychiatrists in North Dakota working in the public sector are graduates of this residency program. Residents are being trained on clozapine, long acting injectables, collaborative care (to help primary care colleagues in rural areas), etc.

Setting residents up to work with primary care providers enhances access to behavioral health services and relieves the burden of having to know how to provide behavioral health services for primary care providers. Although the rurality of North Dakota presents some challenges, the small population of the state fosters a close-knit community and network in which behavioral health and physical health providers know someone they can call to discuss issues and identify service opportunities in all areas of the state.

Internships, Residencies, and Rural Training Programs Key Lessons:

- » Develop partnerships with state and regional institutions of higher education to encourage healthcare training in rural settings. As noted by the Texas example, individuals trained in rural settings tend to stay in rural settings when they enter the workforce.
- » Providers, colleges and universities, and other stakeholders can work with state legislatures to allocate funding for rural internships and workforce development initiatives at state and regional medical schools.
- » Work with national and regional organizations, such as AHEC and WICHE, to develop internship programs and place students in rural settings.

Peer Support Specialists

One evidence-based strategy to increase the availability and accessibility of mental health services in rural and remote areas is to increase the use of peer support specialists. Peer support specialists are individuals with lived experience of mental illness and/or substance use disorder who receive professional training to “assist others in their recovery journeys” (Mental Health America, 2021). Peer support specialists help to “model recovery, teach skills, and offer supports to help people experiencing mental health challenges lead meaningful lives in the community” (MHA, 2021). The core of the peer service philosophy and practice is that people with psychiatric difficulties can and do recover and live meaningful lives, and peers can help one another with the recovery process in ways that professionals cannot (SAMHSA, 2019). The use of peer support services also helps normalize the need for mental health care, and reduces the stigma associated with mental illnesses in rural communities. Members of the Expert Panel indicated that peer services are necessary and described them as essential for an effective system, rather than a service that is “nice to have.”

“I have seen better buy-in from peers when they’re being supervised by folks who also have lived experience.”

Jason Pritchard
Certified Peer Specialist, Virginia-Ballad Health

“When peers are not compensated appropriately for all they bring to the table, when they are paid less than the pay to flip hamburgers at Micky D’s, there is an inherent inequity.”


Wayne Lindstrom, Ph.D.
Vice President, Western Region

In addition to the value they provide to individuals working on recovery, peer support specialists provide rural providers an opportunity to bridge service gaps in rural and remote areas. By taking on tasks appropriate to them, including non-clinical tasks and connecting individuals in treatment to community supports, peer support specialists enable licensed professionals to work at the top of their scope of practice (Mead, 2019). Peer support specialists can also be tapped to serve as drivers to help transport individuals to services, and when necessary, court hearings or probation meetings. Gloriana Hunter, a peer support specialist in New Mexico, shared an anecdote of clients having to walk 40 miles from rural Camp Verde to meet their probation officers in urban Prescott because they [had] no other transportation options” (Mead, 2019). Another peer support specialist in Michigan who drives individuals to appointments indicates that the time spent traveling, which can range from 30 minutes to four hours, allows her to better connect with her clients, and “since they’re looking out a windshield instead of looking directly at her, they talk more freely” (Thinnes, A., personal communication, November 17, 2020).

While peer support specialists offer a lot of opportunity for rural and remote providers to increase the quality and availability of behavioral health services, reduce behavioral health workforce shortages, and help individuals access care through stigma reduction and transportation, the low wages peers often receive, the training requirements for certification, and the lack of established career tracks can create barriers to their potential.

Each state has different requirements for peer support specialist certification (a list of certification requirements can be found [online](#)). However, achieving certification requirements can be challenging, especially for peer support specialists living and working in rural and remote areas of the U.S. As discussed in the Transportation section of this document, travel to and from larger cities for services--and in the case of peer certification, certification classes--can be overly burdensome and discourage individuals from pursuing peer support certification. A recommendation from the Expert Panel was to allow peers to attend at least some certification classes virtually. [Delaware](#), [Idaho](#), and [Kansas](#) offer at least some of their certification classes online.

As noted in the *Financing* section above, Medicaid reimbursement rates for peer support specialists are often very low. This can lead to high turnover. Jason Pritchard, a member of the Expert Panel and a certified peer support specialist, recognized that the Medicaid reimbursement for peer support specialists in his state is only \$26.75 per hour, a rate so low that by the time a peer support specialist is paid and the state processes the Medicaid bills, the state may lose money (Pritchard, J., personal communication, December 17, 2021). It was also noted that the Medicaid requirement that peer specialists need to be supervised by a licensed mental health professional or substance use disorder counselor creates a barrier preventing peer support specialists from entering the field, especially in rural areas, because it is difficult to find qualified supervisors for all peers. Also, a sentiment many members of the Expert Panel expressed was that peers prefer to be supervised by other peers, since peer support specialists bring a different set of skills to the recovery process than licensed mental health professionals.



Spotlight on Virginia-Ballad Health's PEERhelp Certified Recovery Helpline

Ballad Health's [PEERhelp Certified Recovery Helpline](#) is available to individuals experiencing substance use issues, loneliness, anxiety, and depression, and other emotional or mental health challenges. The PEERhelp service will soon be available 24/7, but now offers peer support services via a warmline Monday through Friday, noon to 10:00 p.m. Eastern; and provides structured virtual meetings through its Living Free program that: "equips people with the tools to overcome obstacles in their lives" and offers personalized, flexible support to meet the needs of each unique individual. The program hosts Pathways to Recovery virtual meetings with peers that bring a group of people with mental health and substance use challenges together to discuss recovery-focused topics and experiences each week. Through this program, volunteer peer specialists have the opportunity to gain the 500 contact hours required for certification of recovery specialists in Virginia.

Spotlight on Texas's Peer Support Stakeholder Workgroup

When defining a new Medicaid benefit for peer support, the Texas Health and Human Services Commission (HHSC) created a [Peer Support Stakeholder Workgroup](#) consisting of providers and individuals with lived experience from the peer support community. To certify peer workers, HHSC designated two entities to certify peers, peer supervisions, and peer/peer supervisor training entities" It created a qualified peer supervision track to allow peers to supervise other peers and provide ongoing certification. The state did this after realizing the risk of relying solely on licensed and certified non-peer professionals to supervise peers. Licensed and certified professionals have not been eager to supervise peers, and peers have not been eager to be supervised by licensed and certified professionals who might expect peer services to be more clinical. Peer support service offers the value of being a "warm" service that helps to make people feel more comfortable during the mental health service delivery process and provides someone to relate to during a vulnerable time.



National organizations, including Mental Health America and the National Association of Peer Specialists (NCPS) offer professional networking, educational, and training opportunities for peer specialists. Although not tailored for rural and remote peer specialists, these valuable programs provide opportunities for peer specialists to expand their knowledge and abilities, help them move up a career ladder, and find increased satisfaction in their roles. Mental Health America's [Center for Peer Support](#) features an advanced peer specialist certification program. It helps peers expand their networks of friends and colleagues and offers free webinars and other learning opportunities. Mental Health America also sponsors the [National Peer Specialist Certification](#) program that allows state-certified peer specialists to further their education and demonstrate their commitment to advanced training and expertise. The NCPS program also provides participants with access to a network of other NCPSs. This allows them to connect to and learn from others, gain leadership opportunities, stay up-to-date with policies related to mental health and peer support, and receive ongoing training from NCPS. The [National Association of Peer Specialists](#) offers three levels of membership: Professional, Ally, and Sustainer. Each level offers access to an array of educational and community-building resources to enhance understanding of peer support and connect members with peers around the U.S. and the world.

There are a variety of ways that peers can be integrated into a rural behavioral health provider system, including through the implementation of peer warmlines and face-to-face service delivery in clinical settings. Several strategies are included in the Spotlight section.

Peer Specialists Key Lessons:

- » Develop a career track for peer specialists that encourages job growth and demonstrates appreciation for the value provided by peer specialists.
- » Have peers involved in the supervision process for certification. Many states require licensed professionals to provide oversight for peer certification, but peer specialists are their own position and career track. Because of this, it makes sense for peers to be involved in the supervision process.
- » Develop national standards for certification and supervision hours for certified peer support specialists. The supervision requirement for peers can be burdensome and turn potential peer support specialists away from the field. The [Medicare PEERS Act](#) supports a peer certification process that is consistent with the National Practice Guidelines for Peer Supporters and inclusive of SAMHA's Core Competencies for Peer Workers in Behavioral Health Settings, as established by the state in which the peers work, or through a national certification process determined appropriate by the Secretary of Health and Human Services.
- » Provide training to behavioral health providers to improve their understanding about the benefits of peer support specialists.
- » A few states have developed Certified Peer Recovery Specialist Training in an online platform, and this should be considered by more states. This can help states to certify more peer specialists in a shorter amount of time, and reduces the travel burden for peers traveling from rural and remote areas to attend training. Texas and Tennessee have found success moving peer training online.
- » To demonstrate appreciation and recognition of the value that peer support specialists provide, peers should be compensated fairly, and have employee benefits (e.g., health insurance, retirement funds) made available to them.
- » Train providers on using recovery-oriented language to build a culture of inclusivity that values the experience peer support specialists bring to the practice.

Training Local Citizens and Expanding Responsibilities of Existing Workforce

States with large rural and remote areas may not have a medical school or university offering advanced degrees in behavioral health fields readily available to help boost the size of the behavioral health workforce. One option for these states is to train existing and interested citizens in how to: respond during times of need; triage individuals in crisis; and provide basic services while under the remote supervision of a licensed professional. In addition, states can implement policies that expand prescriptive authorities for nurse practitioners and physician assistants to reduce the burden on psychiatrists.

Psychiatric mental health nurse practitioners (PMHNP) were given prescriptive authority in the 1980s. Currently all states have expanded their scope of practice laws to permit PMHNPs to prescribe medications and provide clinical care. Research supports that broadening prescriptive authority for nurse practitioners improves mental health and decreases mental health-related mortality, particularly in regions underserved by physicians (Alexander & Schnell, 2019).

Following the success of the implementation of PMHNP prescriptive authority, New Mexico, Louisiana, Illinois, Iowa, and Idaho passed laws permitting licensed psychologists to have the authority to prescribe psychotropic medications to treat mental health conditions. These specially trained psychologists are often referred to as prescribing or medical psychologists, abbreviated as “RxP”. It is important to note that most states require RxP psychologists and PMHNPs to obtain adequate levels of training and certifications in pharmacology to prescribe medications.

States that have implemented unique and innovative approaches to training citizens in behavioral health service delivery, and that have expanded the responsibilities of the existing behavioral health workforce—an initiative that other states with large rural and remote areas may want to consider implementing—are highlighted in the Spotlights below.



ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Spotlight on the Alaska Native Tribal Health Consortium’s (ANTHC) Behavioral Health Aide Program

In the late 1960s, the ANTHC initiated the Community Health Aide Program to respond to the tuberculosis (TB) epidemic and the increase in infant mortality rates in tribal villages across the state. This program trained citizens with little to no experience in health care to provide basic health services and respond to the needs of individuals in rural and tribal areas. The program was so successful that it was used as a model to implement the Behavioral Health Aide Program in 2008. It is a multi-level provider model that trains citizens on how to provide therapeutic services, respond to behavioral health crises, and support the general mental health and well-being of individuals in rural and tribal communities (Owens, X., personal communication, July 7, 2020). Support for the program was garnered through newspaper articles and publications that recognized the significant mental health and substance use challenges in rural communities. They noted that local villages, and the state overall, did not have adequate resources to respond to the need. Behavioral Health Aides (BHAs) are employed by their regional tribal health organizations. Citizens interested in becoming a BHA need to be 18 years of age or older and have a high school diploma or equivalent. There are four levels of BHA certification, including BHA-I, II, III, and Behavioral Health Practitioners. Potential BHAs receive training from the ANTHC, which operates the only BHA Training Center in Alaska and works closely with the Community Health Aide Program Certification Board. Most trainings offered through the BHA Training Center are typically facilitated using a blend of distance-delivered technology, making the transition between courses that are usually held in person relatively seamless in response to COVID-19. Once certified, BHAs are qualified to provide and bill for various Medicaid services based on their level of certification, including: SBIRT (Screening, Brief Intervention, and Referral to Treatment); tobacco cessation; and individual, group, and family psychotherapy. All BHAs are supervised by licensed clinicians who can assist BHAs in connecting individuals to higher levels of care as needed.

Spotlight on the Colorado Office of Behavioral Health’s Crisis Services Program



Colorado’s Office of Behavioral Health (OBH) is considering a model similar to, but less formal than, Alaska’s BHA program. OBH has heard from communities in rural areas that there are providers and peers who would like to do more to help individuals in crisis. The state is exploring training bachelor’s-level providers and peer support specialists to provide virtual mobile crisis response. The providers and peers would be equipped with a tablet (e.g., an iPad) that they would use immediately to connect individuals in crisis to a skilled or licensed professional via telehealth services. This would help reduce the time people in crisis spend waiting for a mobile crisis team to respond, would help reduce the burden on rural law enforcement who are often the first to respond to a crisis, and provide a more humane experience to individuals in crisis. Peer support specialists could also use their experience of being in recovery to relate to individuals in crisis and build rapport with clients to increase the likelihood that individuals will return for follow-up appointments post-crisis. While the plans for this program remain, the COVID-19 pandemic has unfortunately delayed the development of the program, and future budgetary decisions may determine whether these programs will be established.



Spotlight on Nevada

During the 2013 legislative session, Nevada lawmakers granted nurse practitioners full practice autonomy as healthcare professionals to address the physician and mental health provider shortage gap in rural regions. Since legislative passage, the Nevada State Board of Nursing has seen an expansion in psychiatric mental health nurse practitioners. This workforce increase improved access to care for many rural communities. In 2015, Nevada legislators passed a parity law requiring telehealth to be covered and reimbursed under private insurance, Medicaid, and worker’s compensation plans to further improve health care access. The expansion of reimbursement for telehealth services allows psychiatric mental health nurse practitioners to expand into rural regions that would otherwise have limited access to mental health specialists.

Training Local Citizens and Expanding Responsibilities of Existing Workforce Key Lessons:

- » Develop a local workforce to address the challenges of provider and peer shortages by training residents without prior experience in behavioral health to provide mental health and substance use services to fellow community members. This strategy both expands the behavioral health workforce and ensures culturally appropriate care. While the ANTHC developed the Behavioral Health Aide program for tribes in Alaska, lessons and educational materials from the BHA program are applicable to many other rural communities. Materials from the BHA program are available to be adapted by other tribes and communities in the U.S. Find more information on how to develop a program at www.anthc.org.
- » Expand the scope of practice of the workforce by implementing policies that expand prescriptive authorities for other licensed practitioners, such as nurse practitioners and physician assistants, to reduce the burden on psychiatrists and other licensed practitioners.

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